



Empowerment and the employment relationship

Ian Powell

The replacement of the *Employment Contracts Act 1991* by the *Employment Relations Act 2000* has offered new (previously unavailable) opportunities for salaried senior doctors employed by district health boards (DHBs). Based on economic rationalist philosophy, the former legislation saw the employer-employee relationship as narrowly contractual, not fundamentally different from any other economic transaction. The relationship between the employer and employee was considered to be inherently a level playing field and based on equality.

The *Employment Contracts Act 1991* was strongly weighted in favour of individual contracts, with single employer collective contracts the next best option. National- or multi-employer collective contracts were at the bottom of the list and extremely difficult to achieve. In the public health sector, the Association of Salaried Medical Specialists (ASMS), along with the Resident Doctors Association and Nurses Organisation, lost their rights to negotiate national terms and conditions of employment and, after repelling managerial and political drives for divisive individual contracts, were forced to accept single employer collective contracts.

In contrast, the *Employment Relations Act 2000* focused on the employment relationship and the assumption that the employer-employee relationship was inherently unequal (favouring the former in most circumstances). In seeking to provide a level playing field, it incorporated internationally recognised labour standards, in particular the rights to collective bargaining (including multi-employer) and recognition of unions, along with the western European and North American concept of 'good faith'. An important premise of the *Act* is that there is a beneficial connection between the quality of the employment relationship, on the one hand, and productivity and performance on the other, regardless of whether it is the provision of a non-commercial public good (such as education and health) or the production of commercial goods and services.

In DHBs, this relationship-based *Act* has changed the industrial environment and has led to the growth of multi-employer collective agreements (MECAs) for senior doctors, resident doctors, and nurses. In October 2004, agreement was reached between the ASMS and DHBs for a MECA covering senior doctors and dentists*. While the DHBs and ASMS hope that this will provide a stronger foundation for effective recruitment and retention, its role is much wider. Key elements of the new national agreement include new enhanced salary scales, 6 weeks' annual leave, DHB-subsidised superannuation, continuing medical education (CME) including reimbursement of expenses—and several other remuneration, leave and reimbursement entitlements.

*This MECA has been ratified by both the DHBs and the ASMS but, at the time of writing, has yet to be signed. It runs until 1 July 2006. The MECA covers 20 of the 21 DHBs; the 21st (Northland DHB) will have the opportunity to join the MECA when the current single DHB collective agreement expires on 30 June 2005.

But, of greater significance is the express linkage of the MECA to the importance of empowering DHB-employed senior doctors over their own working conditions, in their workplace, and in DHB decision-making. The scene is set by the MECA's preamble (Box 1) which emphasises the distinct vocationally trained occupational features of senior doctors and the importance of establishing and strengthening engagement with and empowerment of them. Another clause covering the MECA's underlying principles highlights the importance of collegiality within the workplace and actively encouraging collective negotiations and responses to workplace challenges and issues.

Box 1. Multi-employer collective agreements (MECA): preamble and underlying principles

Preamble:

Senior medical and dental officers are a distinct vocationally trained occupational employee group. District health boards (DHBs) as employers benefit from these employees having significant influence in their internal decision-making. The parties recognise both senior medical and dental officers and DHBs have different roles, responsibilities and distinctive features.

Both the Association and DHBs are committed to working together in order to establish and strengthen this engagement with and empowerment of senior medical and dental officers.

Both the Association and DHBs recognise that a relationship between DHBs and senior medical and dental officers based on engagement between them and empowerment of the latter has positive benefits for both recruitment and retention of employees.

This collective agreement is the foundation document for this underlying engagement and empowerment relationship between DHBs and senior medical and dental officers which is integral to the internal culture of each DHB.

Underlying principles:

The parties acknowledge the importance of collegiality within the workplace and will actively encourage collective negotiations and responses to workplace challenges and issues.

The parties recognise that employees are constrained by their ethical and professional obligations and public expectations not to refuse treatment to patients in need of their professional skills.

The parties acknowledge the increasingly demanding medico-legal environment in which employees are required to practise. Accordingly the employer undertakes to do what it reasonably can to ensure the workplace is well resourced, professionally supportive and conducive to a very high standard of individual clinical practice.

Elsewhere, the MECA builds upon these statements and principles and provides the platform for addressing the important employment and work-related issues facing senior doctors within the context of the ASMS's objective of empowering them or enhancing their influence. This is most pronounced in hours of work and job sizing, resources and facilities or 'tools of the trade' to do the job, the role of professionalism, workforce planning and development, and involvement in decision-making.

In establishing further negotiation, development, and enforcement facilities to give them practical effect, the MECA broadens the understanding of what might be considered 'industrial'.

The MECA clauses covering hours of work and job sizing (the average hours required for senior doctors to undertake their agreed duties and responsibilities), which relate directly to remuneration, are exigency-based; what one regularly has to do rather than some arbitrary notion of managerially determined operational requirements. Most senior doctors regularly work in excess of the hours that they are paid for. In addition, the MECA explicitly recognises that job sizing includes recognition of 'non-clinical time' (time for duties not directly related to the care of an individual patient such as peer review, clinical audit, departmental meetings, and journal reading).

Further, it acknowledges the endorsement of the Council of Medical Colleges that 'non-clinical time' should normally comprise 30% of the total time required for routine duties and responsibilities (excluding rostered after-hours call duties and clinical leadership responsibilities).

Resources and facilities are a second critical issue facing senior doctors. The MECA requires each DHB to provide 'good quality, suitable and safe workplace conditions, resources and accommodation'. This covers the full ambit of resource provision from information technology and journals to office accommodation and car-parking accessibility and security. Application and enforcement includes a requirement for each DHB and the ASMS to jointly evaluate the extent to which these are provided and to develop agreed plans for remedying any deficiencies that might be identified.

The values of professionalism are underpinned by the MECA and are reflected in a range of provisions which help shape employment relationships. These include recognition of one's primacy of responsibility to one's patients (even when this involves a clash with responsibility to one's DHB); dispute resolution process for addressing patient-safety concerns; protecting the right to speak out; encouragement of senior doctors undertaking research and publications; guaranteeing senior doctor involvement in appointment processes; and the right to work in a quality improvement environment in which errors that do not result from negligence are not to be handled in a punitive manner.

For the first time, a collective agreement covering senior doctors addresses workforce development and education, partly in response to the lack of pragmatic focused leadership from central agencies. Each DHB and the ASMS are required to establish joint workforce development taskforces charged with developing agreed staffing plans for the appropriate number of senior doctors in each DHB, recruitment and retention strategies to support these plans, and proactive plans for the provision of and access to high-quality professional development and education (sabbatical and secondment as well as CME). The performance and progress of these DHB-based taskforces will then be evaluated at a national conference most likely to be held in late 2005.

Finally, senior doctor involvement in DHB decision-making is as important employment matter as any other. Consistent with the Minister of Health's requirements for shared clinical leadership within DHBs in her letter of expectations to DHBs, the DHBs and ASMS are required to develop national guidelines for the empowerment of senior doctors in DHB decision-making, inclusive of democratic and

mandated processes. Following the completion of these guidelines, the DHBs and ASMS will then hold a national conference to consider progress in each DHB.

The main employment issues facing senior doctors are much wider than traditional 'pay and rations'. They all relate directly to a malaise which has confronted the health system for many years and continues unabated; the increasing disengagement, powerlessness and disenfranchisement of health professionals (in this instance, senior doctors). At times, this has led to demoralisation and, much worse on occasions, a culture of victimhood. The emphasis of senior doctor empowerment rooted in these employment issues is a concerted endeavour to turn this corrosive environment around.

Author information: Ian Powell, Executive Director, Association of Salaried Medical Specialists, Wellington

Correspondence: Ian Powell, Executive Director, Association of Salaried Medical Specialists, PO Box 10763, Wellington. Fax: (04) 499 4500; email: ip@asms.org.nz