Dare to struggle, dare to win (incrementally)

Ian Powell

The Association of Salaried Medical Specialists (ASMS) has, after a lengthy and bitter process commencing in May 2006, settled a new national collective agreement, known as the MECA (multi-employer collective agreement), covering senior doctors and dentists who are ASMS members and who are employed by district health boards (DHBs).³

The dispute prior to the ballot on industrial action held in late 2007 has been previously discussed.² In this environment it did not take long before the ASMS was compelled to consider whether to take strike action. However, this was difficult for two reasons. The first was lack of precedent. The only senior doctors’ strike had been in 2003 in the South Canterbury DHB over a local collective agreement prior to the first national MECA (2003–06) which was confined to electives and other non-acute services.³

The second was the failure of the 1-week RMO strike in June 2006 and the negative, often public, reaction of many senior doctors to it despite the strike being provoked by an aggressive DHBs’ agenda. This strike has been aptly described as a ‘failed strike’ by a supporter of the right of health professionals to strike.⁴ The strike intruded too far into acute and emergency services, was too long, too many RMOs broke the strike (especially towards the end), and the strike weapon was unable to be used again during this dispute.

Many senior doctors were also angered by what was seen as a hard-line by the Resident Doctors’ Association (RDA) over life-preserving services plans. Consequently the ASMS faced an extraordinary challenge in order to achieve a mandate for industrial action should it be necessary.

The Association of Salaried Medical Specialists’ strategic direction

Consequently the ASMS opted for an approach of gradual escalation treating each enhanced action and decision as an event in its own right rather than simply a means to an end. The objective was not to paint either ourselves or the DHBs into a corner and to keep the talking going in between the actions and decisions. First, external mediation was initiated. Then, in November 2006, the ASMS Annual Conference authorised its negotiating team to proceed with national stopwork meetings should the impasse continue. Each of these actions attracted media interest but the decision to proceed with stopwork meetings was left for several months.

The national stopwork meetings in July–August 2007 were a considerable event. All the National Executive’s recommendations were adopted either unanimously or overwhelmingly including one authorising the ASMS to proceed to a membership ballot on limited industrial action.
The ASMS used the outcome of the stopwork meetings to explore further negotiating opportunities before proceeding to the industrial action ballot. However, although the DHBs’ bargaining position improved, it was insufficient to achieve resolution. Consequently the ballot was held in November-December after the decision to hold it was endorsed by the ASMS Annual Conference in early November.

The result represented a considerable shift in senior doctor attitudes towards strike action and would have been inconceivable in 2006. With a response rate of 75%, 88% voted for limited industrial action and only 12% against. Again, however, the ASMS did not proceed to the next step of industrial action. Instead it gave the DHBs (and Government) an opportunity to reflect on the significance of the ballot outcome.

On 21 February 2008, the ASMS National Executive was on the verge of giving formal notification of industrial action. However, in an unprecedented step, new Minister of Health David Cunliffe joined the meeting to ask the Executive to defer its decision on strike notification for a month so that he could try to facilitate a resolution. There is no doubt that had it not been for the ballot outcome, which itself built on earlier actions such as the national stopwork meetings, Mr Cunliffe would not have taken such a political risk.

The rest is, as they say, history. The National Executive accepted the Minister’s request, his facilitation proceeded; a provisional settlement between the ASMS and DHBs which was endorsed by a ballot of ASMS members in a result remarkably similar to the earlier strike ballot (88% voted to accept it; the only variation was 1% in the response rate); and both parties then ratified it.

It begs the question of why did the Minister make this offer of facilitation to the ASMS but not in the latest resident medical officers MECA dispute? First, the Minister was taking a considerable political risk in offering to facilitate. However, due to earlier working directly with the ASMS on developing a new policy document on enhancing clinical leadership known as ‘Time for Quality’\(^5\) he found a comfort zone with us. Second, the facilitation offer was conditional on the ASMS delaying formal notification of strike action. This was accepted by the ASMS. The RDA was offered verbally facilitation assistance by the Minister during a meeting with the Pan Professional Medical Forum\(^6\) but the RDA proceeded straight to formally notifying DHBs of strike action.

**The challenge of the arbitration option**

The ASMS was forced to address the question of arbitration during the dispute on two separate occasions. Arbitration is no longer part of the industrial landscape (except for the police in separate legislation). Historically the ASMS had been an ‘arbitrationist’ orientated union. But there has been a discernible attitudinal shift.

The first occasion was, when immediately after the first of the 26 stopwork meetings held at North Shore Hospital, the DHBs called for the ASMS to agree to ‘final offer arbitration’, a system which is provided in the Police Act. The ASMS rejected this for several reasons including believing it was an attempt to derail the remaining stopwork meetings and because it is a ‘winner takes all’ system which favours the position closest to the status quo.
The second occurred immediately prior to the conducting of the industrial action ballot. The DHBs applied for formal facilitation by the Employment Relations Authority (a form of non-binding arbitration provided under a 2004 amendment to the Employment Relations Act). The ASMS managed to delay the ERA’s deliberation on the application until such time as it was overtaken by events. Our reasons included concern that it might create confusion among members in the midst of the strike ballot; it risked getting in the way of subsequent Ministerial facilitation; and (in the absence of suitable criteria focussed on the ‘rate for the job’ to advise the ERA) the DHBs (contested) claims over affordability might have undue influence.

The ASMS was mindful at all times during the dispute of the ethical considerations while accepting that any form of effective industrial action would impact on patients. Consequently we strove to marginalise as much as possible its potential impact and confine it to patient inconvenience at most through two main means. First, in contrast with the RDA, the ASMS would have excluded acutes and emergencies. Second, the ASMS resolved to give at least 8 weeks notice of industrial action to avoid cancellation of lists and clinics. Instead they would have simply not been scheduled on the strike days in the first place. This contrasts with the RDA’s approach of adhering to the minimum statutory obligation of 2 weeks which requires cancellations.

**Where we have ended up**

Although this has been a corrosive and exhausting journey, on balance the ASMS have ended up in a stronger position. This conclusion is based on the following factors:

- The new MECA provides useful fiscal and related enhancements of existing terms and conditions of employment. These include a 13.3% salary increase covering a 34-month period; a $10,000 lump sum ‘retention’ payment in lieu of a ‘lost’ 12 month period; two additional higher salary steps; and a doubling of CME expense reimbursement to $16,000 per annum.
- It provides for a further expansion of senior doctor influence in DHB decision-making, particularly around how services are organised and delivered.
- The ASMS’s membership in DHBs has increased noticeably since the commencement of negotiations by over 300 to over 3000 in a potentially divisive situation with national stopwork meetings and possible strike action where membership losses might have been anticipated. This increased membership further strengthens the ASMS’s representational and advocacy role.
- The ASMS has proven to DHBs and Government that it can organise successful well-attended national stopwork meetings in all 21 DHBs and also achieve an overwhelming ballot for industrial action in a secret ballot. This will be an invaluable asset in the future.

But of greatest significance, and critical to the settlement, was persuading the Minister of Health (and, through him, the DHBs) to accept an independent commission of enquiry. The commission is to report to the Minister, DHBs, and ASMS by 31 August 2009 with recommendations for a recruitment and retention strategy for senior doctors...
in DHBs and, in particular, recommended competitive terms and conditions of employment.

One of the factors the commission will be required to take account of is employment opportunities in Australia. The Minister of Health has commented that the commission ‘will ensure that senior doctors working in New Zealand will have pay and conditions commensurate with those working elsewhere.’ To the best of our knowledge this is the first time that international relativity has been a factor to be considered by an industrial commission of enquiry.

This dispute has demonstrated that the ASMS has shifted from its historical arbitrationist’ preference and is prepared to adopt an industrial action strategy that includes adapting the old union slogan of ‘dare to struggle, dare to win’ to ‘dare to struggle, dare to win, incrementally.’

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References and footnotes:
5. The principles of ‘Time for Quality’ are incorporated into the new national MECA (Clause 57).
6. The meeting was held on 20 March 2008. The Pan Professional Medical Forum comprises the Council of Medical Colleges, ASMS, NZMA and RDA. The author was present while this offer was made. While the RDA had called for ‘intervention’, consistent with his involvement in the senior doctors’ negotiations, the Minister of Health deliberately used the word ‘facilitation’.