

**The Medical Locum Challenge:  
Understanding the Impact of Locum Working  
Arrangements on the NSW Public Hospital System**

**GMCT Metropolitan Hospitals Locum Issues Group**

January 2005

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# **The Medical Locum Challenge: Understanding the Impact of Locum Working Arrangements on the NSW Public Hospital System**

## **GMCT Metropolitan Hospitals Locum Issues Group**

### ***Executive Summary***

The use of locum medical officers to fill junior and middle level shifts in the NSW public hospital system has increased alarmingly in recent years. Doctors providing these services include recent medical graduates and specialist trainees who have interrupted their training, and experienced clinicians who have worked previously in the hospital system as Career Medical Officers. Temporary doctors are used to provide cover for permanent staff on leave, but are also increasingly used to manage chronic vacancies, with appointments ranging from days to years.

The use of doctors without postgraduate vocational training as a temporary hospital workforce poses significant challenges to the NSW public health system, including cost, quality and safety of clinical care, legal and administrative issues, and sustainability of the trained medical workforce.

### **Cost**

Locum doctors are not employed under a public hospital medical officer award and can expect to earn up to three times the award rate. Most locums are employed through a locum agency, and the agency will usually charge the hospital a commission of 10-15% per shift filled. Agencies provide little more than introductions and price negotiations. They do not take responsibility for ensuring that the doctor is adequately skilled for the position or for training locum medical officers.

NSW Health conducted a survey of the hospital workforce in February 2004 which indicates that there are over 900 junior and middle level vacancies in NSW greater metropolitan hospitals, most notably in emergency medicine. These vacancies are largely filled by overseas-trained doctors and locums. A conservative estimate is that over one year employment of locums to fill these positions costs NSW Health 30 million dollars more than the cost that would be incurred by employing permanent staff, with an additional 5.2 million dollars per annum going to locum agencies.

### **Quality and Safety**

There is enormous variability in the skills of medical practitioners working as locums in the hospital system. Doctors can undertake locum work as early as postgraduate year 2 (PGY2). There are no systems for ensuring that locums have necessary clinical skills for positions that they fill. No system is in place for

ongoing training or performance review of doctors working in locum positions. Locums work across a number of health facilities and their working hours are not monitored to protect personal and patient safety.

Further safety issues surrounding employment of locum medical staff include lack of continuity of care, lack of familiarity with the employment setting including local hospital process and protocols, lack of adequate supervision and clinical support if required, and the possibility of impaired relationships with local staff due to resentment of the pay differential.

### **Legal and Administrative Issues**

Employment arrangements for locum doctors in the public hospital system have significant legal and administrative implications which are generally poorly understood by hospital administrators and locums themselves. Doctors may be engaged as a temporary hospital employee or as a private contractor. A locum engaged as an employee is provided with superannuation, workers' compensation insurance and medical indemnity by the employing public hospital. A locum engaged as a contractor is responsible for their own indemnity. Locums insured as a 'recent graduate' (PGY1-5) by an indemnity provider are unlikely to be insured for work with public patients in the public hospital system while working as a private contractor. Locums insured as 'senior medical officers' (PGY5+) are more likely to have adequate cover.

Locum doctors are not employed pursuant to a hospital medical officer award. The industrial and legal implications of this arrangement are not clear. Liability for decisions made by doctors working in the public hospital system outside the award structure is untested in NSW to date.

Locum doctors generally do not participate in hospital or college-based training programs and are therefore unlikely to satisfy Continuing Medical Education (CME) requirements for registration with the NSW Medical Board.

### **Sustainability of the Medical Workforce**

The increasing trend for doctors to undertake locum work poses a threat to the sustainability of the hospital medical workforce in NSW. Increasing demand for hospital services, changes to provider number legislation and General Practice training, changing demographics of the medical workforce, reduction of working hours and shifts in societal attitudes favouring lifestyle over career have effectively reduced the number of doctors available for salaried hospital positions. In a time of workforce shortage, locum work, which offers better remuneration and flexibility than permanent hospital employment, appeals to an increasingly large number of junior doctors, diverting them away from vocational training programs and reducing the number of trained specialists available to the NSW hospital system in the future.

### **Future Directions**

There is currently insufficient information about the hospital medical workforce in NSW to accurately predict the impact of increasing reliance on locum medical officers on cost, quality of patient care and sustainability of the hospital medical workforce in NSW.

There is an urgent need to clarify legal and industrial implications of employment of locum medical officers outside relevant industrial awards, including provision of medical indemnity insurance, liability for decisions made by locum doctors, potentially restrictive trade practices of locum agencies, occupational health and safety of locum doctors including safe working hours, and responsibility for ensuring quality of locum medical officers including credentialing, performance review and continuing medical education. Relevant industrial awards should be reviewed to explore the relationship between industrial conditions and hospital workforce trends.

The GMCT Metropolitan Hospitals Locum Issues Group is currently examining potential options for short and medium term solutions to address the issues raised in this paper. Comments and suggestions should be provided to:

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# **The Medical Locum Challenge: Understanding the Impact of Locum Working Arrangements on the NSW Public Hospital System**

## **Part 1: An Issues Paper**

**Clare Skinner, John Buchanan, Kerry Goulston  
for the GMCT Metropolitan Hospitals Locum Issues Group (see Appendix 1)**

**Purpose:** To clarify the key issues surrounding the emergence of locum employment arrangements in NSW public hospitals.

### **1. Definitions**

#### *1.1 What is a Locum?*

The term 'locum', from the Latin *locum tenens* (to take the place of) is used to describe a variety of employment arrangements within the medical profession. Traditionally, a 'locum' was a medical practitioner engaged to act as a substitute while the regular medical practitioner was absent. Substitute doctors were fully qualified, independent medical practitioners employed to replace a specialist or GP for a finite period, usually in a private practice setting.

In recent years, 'locums' have been increasingly used to fill junior and middle level shifts in the hospital system. Temporary doctors are used to provide cover for permanent staff on leave, but are also increasingly used to fill longer-term job vacancies in the capacity of an Intern, RMO, Registrar or CMO. The majority of doctors who provide this service are themselves recent graduates or specialist trainees who have chosen to interrupt their training. They often require supervision to provide safe and effective clinical care. Many of these doctors do not have relevant postgraduate vocational qualifications and are not participating in a relevant college training program. The locum workforce also includes a population of doctors with many years of clinical experience but no vocational specialist qualification who have chosen locum work as a long-term career option. These doctors have usually worked in the public hospital system as CMOs and possess necessary clinical skills to work unsupervised.

The use of doctors without vocational specialist training as a temporary medical workforce poses significant challenges to the NSW public hospital system. For the purposes of this paper a 'locum' will be defined as a doctor who:

- does not have postgraduate vocational specialist qualifications
- does not work under a public hospital medical officer award
- is employed on a temporary basis (usually under 3 months but may extend to years).

The definition includes those doctors who are employed full time in the hospital system and take on extra shifts ('moonlighting') and those doctors, for whom locum work is the primary source of clinical employment, including overseas-trained doctors (OTDs). Issues raised by temporary employment of medical practitioners with specialist qualifications will not be addressed in this paper.

### 1.2 How do Locum Arrangements Work?

In most cases, doctors and hospitals interact via a locum agency. Doctors interested in doing temporary shifts register with an agency, providing their curriculum vitae, names of referees and copies of relevant documentation (eg primary medical degree, medical registration, evidence of citizenship, medical indemnity). The doctor may also be asked to complete a checklist of clinical skills and experience, although relevant certification is not usually sought or checked. Hospital administrators contact the agency and advise available shifts and the agency finds a suitable doctor, either through telephone contact, the internet or SMS. Price negotiations are undertaken by the locum agency. The doctor can expect to receive up to 3 to 4 times the award rate for a locum shift (see Table 1). In addition, the agency receives a 10-15% commission from the hospital for each shift filled. Shifts to be filled at short notice are deemed 'crisis shifts' and rates increase accordingly. Should a locum be asked to join the permanent staff of an employing hospital, most agencies demand a 'finder's fee' (up to \$20 000) and ongoing commission for the first six months. The majority of locums do not sign a contract with the agency and may be unaware of this condition which potentially restricts their future employment opportunities as hospitals will choose to employ an applicant who is not attached to an agency to reduce costs.

**Table 1:** Comparison of Award and Locum Rates (per hour)

Shift	Award Rate (1)	Locum Rate	'Crisis' Rate
		(Estimates from locum doctors and hospital administrators)	
Junior – Day	\$24.04 – 26.44	\$70 – 80	\$90 – 120
Junior – Night	\$27.04 – 29.74	\$80 – 90	\$100 – 130
Junior – Holiday	\$42.06 – 46.27	\$90 – 120	\$130 – 150
Senior – Day	\$29.94 – 42.21	\$80 – 100	\$110 – 130
Senior – Night	\$33.68 – 47.49	\$90 – 100	\$120 – 150
Senior - Holiday	\$52.39 – 73.87	\$120 – 130	\$150 – 160

Note – Junior: RMO1 (PGY2) - RMO2 (PGY3), Senior: Registrar 1 (PGY3+) - Senior Registrar (PGY5+)

Alternatively, a hospital may engage the services of a temporary doctor directly. In this case, the factor that differentiates a locum from a casual employee is payment of above-award 'locum rates'. Award classifications and rates of pay for hospital medical officers are strictly enforced by NSW Health (2). Hospitals in areas of workforce shortage may opt to provide financial incentives not available

under the award system by paying so-called 'locum rates' in order to attract medical staff.

A locum may be employed to fill either regular or ad hoc shifts. A locum may be engaged as a hospital employee, in which case they sign an employment contract and are taxed through the PAYE (Pay As You Earn) system, or they may be engaged as a private contractor and be paid through an ABN (Australian Business Number). The employment status of the locum has significant financial and legal implications. A locum engaged as a temporary public hospital employee is provided with superannuation, workers' compensation insurance, and medical indemnity by the employing hospital. When a locum is engaged as a private contractor, the employing hospital has no responsibility for provision of superannuation, worker's compensation insurance or medical indemnity. Legal liability for decisions made by locums employed by public hospitals outside a hospital medical officer award appears not to have been tested in NSW to date.

Three major medical insurance organisations were contacted to clarify indemnity arrangements for locum medical practitioners. A locum indemnified as a 'recent graduate' (PGY 1 – 5) is covered for limited work with private patients only, as it is assumed that their public practice will be indemnified by the employing public hospital. Without arranging additional cover, a locum registered with their insurer as a 'recent graduate' has no indemnity to cover work with public patients when employed as a private contractor by a public hospital. It is unlikely that most junior locums are aware of these limitations and have arranged appropriate cover for their locum practice. Indemnity for senior medical practitioners (PGY 5 and above) includes cover for work performed in a locum capacity.

To obtain medical registration in NSW, doctors are required to demonstrate that they are participating in Continuing Medical Education (CME). CME of locum medical practitioners is contentious. The NSW Medical Board was contacted to clarify requirements. Most recent medical graduates and specialist trainees satisfy CME requirements through participation in a hospital or college-delivered training program. It is unlikely that most doctors covering junior and middle level hospital shifts in a locum capacity meet these conditions, although some hospitals do encourage locum staff to participate in hospital teaching sessions. The NSW Medical Board has limited power to enforce CME participation and currently it is only after three years of not providing evidence of CME that an individual practitioner will be asked to justify ongoing registration to the Medical Board.

Access to provider numbers, which enable patients to claim rebates for medical services through the Medicare system, is also problematic for locum doctors. Provider numbers are linked to discrete practice settings, thus are difficult to obtain for doctors working temporarily in a number of health facilities. The Health Insurance Commission (HIC) was contacted to clarify arrangements. The patient of a doctor working without a valid provider number in a public hospital is

potentially unable to claim rebates for specialist referrals, outpatient diagnostic services and assistance provided during surgery as a private patient. The HIC performs regular audit of doctors' provider numbers but acknowledges that there is little disincentive for an individual doctor to work without a valid setting-specific provider number. Prescriber numbers, which allow patients to access discounted medications through the Pharmaceutical Benefits Scheme, are allocated to doctors on completion of the intern year and are not facility-specific.

Whether a locum is engaged as an employee or a private contractor, it is unlikely that either the hospital or the agency is taking responsibility for their occupational health and safety, including appropriate vaccinations, blood borne virus status, tuberculosis monitoring and safe working hours. Hours worked by doctors who 'moonlight' are especially difficult to monitor. Salaried doctors are required to obtain permission from hospital administration for work conducted outside their primary employing hospital, although few doctors do this in practice.

It is unlikely that the majority of locum medical officers are fully aware of the potential legal and financial implications of their employment arrangements. Locum agencies in NSW do not take responsibility for these matters on behalf of the locum doctor or employing hospital.

## **2. How Widespread are Locum Arrangements?**

### *2.1 Statistics*

Statistical data regarding use of locum medical practitioners to fill junior and middle level vacancies in the NSW hospital system are sparse. Most hospital workforce surveys either exclude locums or define medical practitioners according to the position they fill, thus do not clearly differentiate locums from regular employees. The NSW Medical Board collects information about the employment arrangements of medical practitioners as part of annual registration documentation but does not specifically ask about locum work undertaken by salaried hospital doctors.

Limited information about use of locum doctors can be found in *Med Survey 2004*, a survey conducted by NSW Health in February 2004 using hospital payroll records (3). *Med Survey 2004* attempts to quantify medical practitioners according to hospital, specialty and employment status. The survey also quantifies hospital vacancies and how they were managed, providing information about current shortages of junior and middle level hospital medical officers by area and specialty, and information about employment of locums and overseas-trained doctors (OTD) to address these vacancies. Preliminary results from *Med Survey 2004* are presented in Appendix 2. Survey results indicate that vacancies are present throughout the hospital system with the greatest shortfalls occurring on the urban fringe. The specialties most affected include Emergency Medicine and Adult Medicine, and to a lesser extent, Anaesthesia, Psychiatry, and

Obstetrics and Gynaecology (O&G). Survey results do not allow identification of the specialty in which a locum or OTD was employed. It should be noted that information is not available for all hospitals in the greater metropolitan area, including some known anecdotally to use locums. It is difficult to estimate the true extent of the doctor shortage as there are no guidelines for medical staffing of public hospitals outside emergency departments, and accurate data about the total number of doctors employed in the NSW public hospital system and number of doctors in vocational training positions were not available. The need to provide maximal staffing 24 hours per day to meet episodic patient demand in the emergency setting means that vacancies in Emergency Medicine are likely to be over-represented compared to vacancies in specialties which provide longitudinal care and therefore have less requirement for out-of-hours staff cover.

In February 2004, there were a total of 906 vacancies in NSW greater metropolitan hospitals, including 243 vacancies at Intern (PGY1) and RMO (PGY2) level, and 663 vacancies at Registrar (PGY3+), CMO (PGY4+) and Other levels (not defined but assumed PGY3+). There were 348 vacancies in Emergency Medicine. These hospital vacancies were filled by 640 OTDs and 179 locums, leaving 87 vacancies to be covered by regular staff. Assuming ten hour shifts and minimum locum rates from Table 1, these locum doctors cost NSW Health at least \$142 500 per day. In addition, assuming 10% commission, locum agencies earn at least \$14 250 per day, bringing the total daily cost of locum doctors to at least \$156 750. In contrast, assuming maximum rates of pay under the award, permanent employees would cost only \$74 452 per day. A conservative estimate is that, over one year, employment of locum doctors costs NSW Health at least 30 million dollars above the costs that would be incurred by employing permanent staff, with an additional 5.2 million dollars per annum going to locum agencies.

Several hospitals report no use of locums in *Med Survey 2004*, including Canterbury Hospital, Concord Hospital, and Royal Prince Alfred Hospital in Central Sydney, John Hunter Hospital and the Mater in Newcastle, Prince of Wales Hospital and St George Hospital in South Eastern Sydney, Bankstown Hospital in South Western Sydney, and Westmead Hospital in Western Sydney. Many of these hospitals are tertiary referral centres and may find it easier to attract and retain both local and overseas staff due to size, clinical and academic reputation, and specialist patient throughput, all of which contribute to the ability of a hospital to provide teaching, supervision and a collegiate atmosphere. It should also be noted that *Med Survey 2004* was conducted in February, a time when hospitals are likely to have maximal staffing levels. In July and August, many UK and Australian doctors resign from NSW hospitals in order to seek UK hospital positions on commencement of the new UK academic year. Following the hospital medical officer recruitment period in August to September each year, a number of Australian doctors leave the system. It is therefore likely that vacancy rates described in *Med Survey 2004* are more optimistic than would be the case if hospitals were surveyed later in the year.

## 2.2 Previous Reports

No existing reports fully describe use of locums in the NSW hospital system. Several related reports refer to growing reliance on temporary workforce at junior and middle level. A considerable body of research has reviewed use of specialist and GP locums, particularly in the rural setting, but the issues described do not translate to the employment of medical practitioners without postgraduate vocational qualifications as locums in the hospital system.

The Audit Office of NSW conducted a review of delivery of services to patients in NSW public hospital emergency departments in 2000 (4). The review found that staffing levels in emergency departments significantly affected waiting times and critical incidents in the emergency setting. The mix of staff varied considerably across the site hospitals reviewed, with only one hospital adhering to the Australian College of Emergency Medicine (ACEM) staffing guidelines. The report directly refers to the practice of employing doctors from locum agencies to fill vacant shifts:

'Most hospitals employ doctors from locum agencies to fill casual vacancies on the roster (although the principal referral hospitals were keen to avoid having to do this). Hospitals indicated that where they had trouble rostering doctors to fill unpopular shifts in the emergency department (such as nights and weekends), locum doctors were employed. For example one site employed locum doctors from Friday to Sunday to cover the weekend and night shifts.

Those hospitals employing locum doctors did not report any concerns regarding the quality of treatment. However, additional costs are incurred and possible risks to patient care may need to be better managed.

Although senior medical staff reviewed the resumes of locum doctors before they commenced duty, mechanisms for reviewing the performance of these doctors were weak or non-existent. Also, for locum doctors working in unfamiliar surroundings there was often insufficient induction and little, or no, supervision available.' (4)

The Audit Office of NSW review of public hospital emergency departments recommends that locum staff be replaced with full-time staff where possible and that minimum skill requirements for locums be introduced along with appropriate performance review procedures (4).

The Australian Medical Workforce Advisory Committee (AMWAC) Medical Careers Survey 2002 provides information about the employment status of vocational trainees (5). AMWAC conducted a postal survey of all doctors in vocational training in Australia (including general practice) in September 2002 to explore the determinants of choice of medical discipline, satisfaction with career decisions, working conditions and short and long term career plans. Of 7899 doctors eligible for participation, 54% provided completed surveys. Of these 4259 doctors, 89.4% were practising in a vocational training program, 4.4% (187) were on leave and intending to return to training, and seven had decided to leave medicine as a career. Of the doctors who indicated that they were on leave, 69.4% were female and 28.7% were training in general practice. 28.8% of

female doctors and 10.3% of male doctors indicated that they intended to take time out in the next three years and 1.4% of doctors intended to leave medicine altogether. Reasons for taking time out included:

'A 3-6 month break to travel, to gain balance in my life, to prevent or to cope with burn-out, to recharge my batteries, to spend quality time with my family, to allow my partner to pursue his or her career, or to have a baby.' (5)

An additional 12.8% of doctors in training planned to undertake a higher degree. It is likely that vocational trainees either taking a break or undertaking higher study will contribute to the locum workforce.

Hawthorne and Birrell reviewed the impact of doctor shortages on the quality of medical care in Australia in 2002 (6). Their report describes an under-supply of doctors resulting from deliberate policies to curb growth of the medical workforce during the 1990s and increasing reliance on overseas-trained doctors (OTDs), often on temporary visas, to fill critical vacancies in the hospital system. While locums are not directly mentioned, use of OTDs involves similar problems such as lack of accreditation of clinical skills and familiarity with individual hospital settings. The areas in which OTDs are mainly used include Emergency Medicine and Psychiatry; areas which also had large numbers of vacancies in preliminary results from *Med Survey 2004* (see Appendix 2). Hawthorne and Birrell state:

'In our view the current shortage of doctors will not be resolved by increasing doctor remuneration. These shortages are chronic and are inherent within the structure of the medical workforce. More doctors are needed.' (6)

Shortages of junior doctors and non-specialist hospital medical officers, inadequate numbers of GPs, and insufficient medical graduates to fill places in public sector specialist programs (especially those which are least attractive) are listed as evidence of a doctor shortage in Australia (6). The Postgraduate Medical Council of NSW (PMC), which allocates local medical graduates to Intern and RMO positions according to a needs-based quota system, currently lists 19 vacancies for local graduate RMOs on their web-site (7). It is more difficult to quantify vacancies in specialist training programs, as detailed information is not available from the colleges however preliminary results from *Med Survey 2004* indicate widespread vacancies at Registrar level particularly in Emergency Medicine (see Appendix 2).

A recent Medical Training and Education Council (MTEC) review of postgraduate medical training in NSW (8) acknowledges the contribution of unstreamed trainees (PGY 3 and above), CMOs and locums to the hospital workforce and the lack of appropriate training systems for these doctors, stating that:

'Significant service gaps across the NSW health system are filled with locum staff, no system exists to identify or meet the training needs of this group.' (8)

Among the recommendations of the MTEC review is a request for more accurate workforce data to allow better prediction of both supply and demand and development of appropriate training systems.

Concerns about increasing use of locum medical officers were raised by Dr Elizabeth Swinburn, then Director of the Emergency Department at Mona Vale Hospital in a letter to the *Medical Journal of Australia* in August 2002 (9). She writes:

'There are significant disadvantages for the locum doctor (eg lack of ongoing education from patient follow-up, feedback about mistakes, mentor and peer support; inadequate supervision of "safe working hours") and for the healthcare system (eg lack of continuity of care; locums' unfamiliarity with the hospital and its procedures; variable skill levels of locums; resentment by regular staff of pay rate discrepancies; cost). While there is no doubt a role for locum doctors within the healthcare system, there is no overall control of the situation.' (9)

She raises concern that neither hospitals nor locum agencies take responsibility for training locum staff. It should be noted that concerns about rising numbers of locums and rostering pressure placed on permanent staff when doctors in PGY 2 drop out of the mainstream workforce to do locum work were also raised by Interns and RMOs at the PMC Junior Medical Officer Forum in September 2003 (10).

It is difficult to identify all locum agencies in Australia. A search of the Australian Business Register and the Australian Securities and Investments Commission (ASIC) Company Register was conducted, but business entities do not have to declare their primary activity on either register. An internet search revealed several agencies advertising junior and middle level shifts in NSW hospitals including agencies based interstate, in the United Kingdom, the United States of America and New Zealand.

### **3. Why Have Locum Arrangements Grown?**

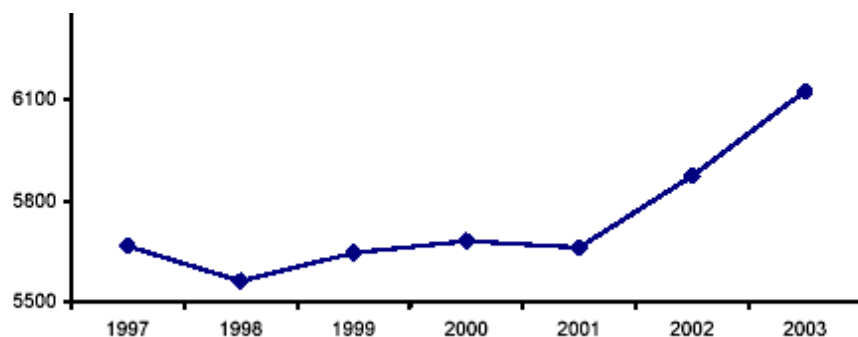
The most superficial explanation for the emergence and growth of locum arrangements is medical workforce shortage. As described by Hawthorne and Birrell, there are not enough local medical graduates to fill junior hospital positions, GP and specialist training positions (6), a position which is supported by preliminary results from *Med Survey 2004* which lists 906 hospital vacancies in the NSW greater metropolitan area (see Appendix 2). The National Health Workforce Strategic Framework, developed at the Australian Health Ministers Conference in April 2004, describes a background of health workforce shortages and maldistribution, and acknowledges the challenges posed by demographic change, particularly the ageing population, the introduction of new technologies, increasingly empowered consumers, and an increasingly 'global and mobile' health workforce (11). The emergence of the locum workforce can be seen as the product of market forces in a time of doctor shortage.

Deeper analysis reveals further dimensions to the problem. It is unclear whether the shortage of doctors is absolute (as argued by Hawthorne and Birrell) or relative (as argued by the Commonwealth Government) (6). Perhaps the problem is largely one of distribution, with organisational and training structures not keeping abreast of demographic and societal shifts. Shortages may also

reflect changing expectations about the working hours of hospital medical officers, increasing demand for health technologies by empowered and informed health consumers, and changing demographics of the medical workforce. It is necessary to explore reasons other than obvious financial incentives which may encourage a doctor to forego postgraduate vocational medical training to work as a locum.

Concern about the effect of long working hours on quality of patient care has been growing since the late 1980s. Research has demonstrated that working hours have a direct impact on rates of medical errors. A recent report in the *New England Journal of Medicine* found that interns working 24 hour shifts made 5.6 times as many diagnostic errors and 20.8% more serious medication errors than interns working on a rotating roster with limited hours (12). The Australian Medical Association published results of their Safe Hours Project in August 1998 finding that 70% of junior doctors worked in excess of 50 hours per week, 40% of junior doctors worked in excess of 60 hours, 15% worked in excess of 70 hours, and 5% worked in excess of 80 hours. Junior doctors working in outer metropolitan and regional hospitals were rostered for longer periods than their colleagues in inner-city teaching hospitals (13). The AMWAC Careers Survey found that the average time worked by full-time vocational trainees in 2002 was 50.6 hours per week (5). The AMA released their National Code of Practice for Rostering Hospital Doctors in March 1999, which although voluntary, has resulted in widespread changes to rostering practices (14). While these changes have improved working conditions for junior doctors and are likely to have reduced adverse events in the hospital system, limitation of hours has created demand for more doctors to fill hospital rosters, a demand which is not adequately met by local medical graduates (6). Although the number of doctors in vocational training has increased in recent years (Figure 1), the number of hours worked by doctors decreased in absolute terms between 1995 and 2000 (Figure 2 - overleaf).

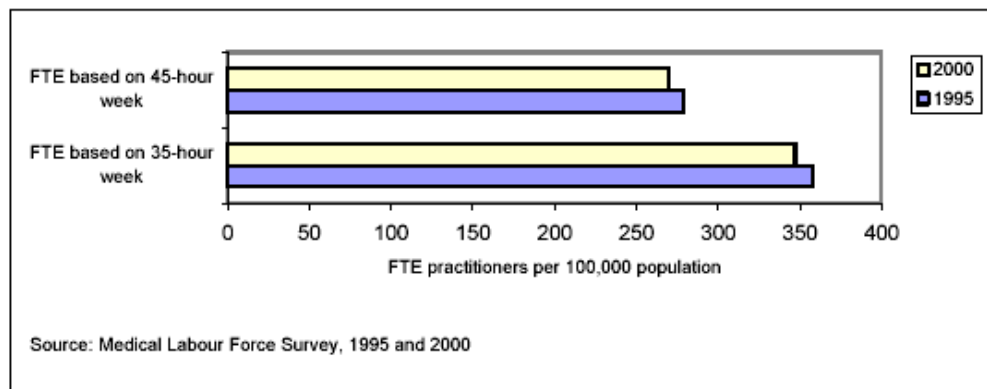
**Figure 1:** Vocational training positions Australia 1997–2001 (15)



Source: AMWAC, medical colleges, GPET and GPEA

Changes to rostering practices have also introduced new challenges such as problems with handover of patients and continuity of care, changes to the professional culture of medicine, and concerns about the adequacy of training with reduced patient access and lack of supervision of trainees on after-hours shifts (16).

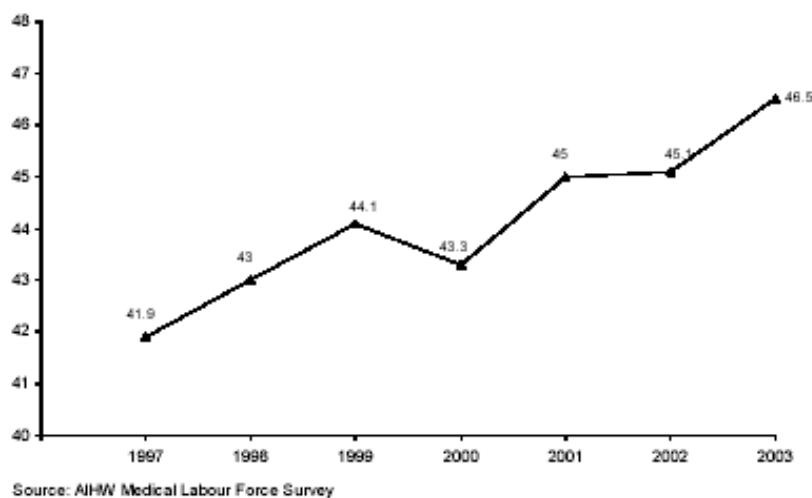
**Figure 2:** Medical Practitioners (full time equivalent) Australia 1995 and 2000 (15)



Commonwealth Government restriction of access to Medicare provider numbers under the *Health Insurance Amendment Act (No. 2) 1996* since December 1996 (17) is also likely to have affected the hospital workforce. The Act, which limited the ability to claim Medicare benefits to doctors holding recognised GP or specialist qualifications, coincided with Commonwealth Government initiatives to reduce the total number of recognised GP training positions to 400 nationwide. The Royal Australian College of General Practitioners (RACGP) set a maximum limit of five years to complete GP training at the same time. As a result, junior doctors felt pressure to enrol in GP training earlier and were less likely to spend time in the hospital system doing unstreamed RMO jobs which would not contribute to their training time. Representatives from the RACGP agree that these changes are likely to have decreased the number of junior doctors available to the hospital workforce.

The junior medical workforce has also changed. Medical graduates are more likely to be older, to have undertaken a graduate medical program, to be female, to be partnered, to have children or dependents, to have experience of other working environments, and carry higher levels of debt (18). The average age of doctors in vocational training in 2002 was 32.5 years, 46.5% were female, 69.4% were partnered, and 30% had dependent children (5). The proportion of female trainees between 1997 and 2003 is shown in Figure 3. 37.7% of doctors surveyed had debts associated with medical training, with 8.1% having debts greater than \$15 000. More recent graduates were likely to have a higher burden of debt following introduction of the Higher Education Contribution Scheme (HECS) (5).

**Figure 3:** Proportion of female vocational trainees Australia 1997–2003 (15)



AMWAC research into medical workforce participation predicts that this older, more female workforce will seek more flexible working conditions and will contribute less time overall to the workforce (19). Flexible work opportunities within training programs are limited. Only 8.6% of doctors in vocational training in 2002 were working part-time and less than 1% were in a job share arrangement. Trainees indicated that although flexible training was available in theory, it was difficult in practice, with responses such as:

“Apparently available theoretically”, “Availability dependent on staffing in the department”, “Available, but incredibly hard to get”, “Yes, but the option is a joke”.’ (5)

Only 60.9% of training doctors indicated that they were satisfied with their working conditions, and 42.8% indicated that they were dissatisfied with time available for ‘family, social and recreational activities’ (5). An AMA sponsored review of training and workplace flexibility published in November 2001 confirms that lifestyle and work practices of medical disciplines had the greatest impact on medical career decisions (20).

The AMWAC Medical Careers Survey also indicated that 10% of trainees are dissatisfied with their training program. The most dissatisfying components of training were:

‘Poor quality education, teaching, training and supervision, inadequate structures and procedures, non-supportive relationships with consultants, lack of guidance, lack of opportunities to develop skills, rural training requirements, discrimination and training costs’ (5)

55.8% of doctors in training indicated that they were moderately to highly stressed, with stress levels associated with hours worked, satisfaction with career choice, working conditions and time for family, social and recreational

activities (5). Hospital statistics from the Australian Institute of Health and Welfare (AIHW) describe increasing workloads for hospital staff, with increasing emergency department presentations, increasing hospital separations, and decreased length of stay. Increasing presentations of elderly people with multiple co-morbidities are also likely to have increased pressures on hospital staff (21). Wilhelm described stressors affecting junior doctors in the *Medical Journal of Australia* in 2002, listing tension between training and patient care, responsibility exceeding capabilities, rotation of staff through different hospitals, a growing culture of blame, less meaningful patient contact, rising rates of litigation, shrinking health budgets, the ageing population, verbal and physical abuse, and increasing politicisation of medicine as factors contributing to distress and impairment (22). International research suggests that burn-out is more likely in doctors who perceive they have little control over their working environment (23). Junior doctors working as locums have more control over their working conditions than doctors in hospital or college-based training programs, hence locum work may be attractive as a means to reduce work-related stress, to express dissatisfaction with training programs or work conditions, or to manage burn-out.

It is likely that a number of factors over and above rates of pay contribute to the appeal of the locum workforce for junior and middle level doctors, including changing work patterns resulting from the introduction of safe working hours, changes to training programs, changing demographics of the medical workforce, increasing workload and stress in the hospital system and dissatisfaction with work and training conditions.

A number of recent medical graduates were interviewed in-depth to explore their motivations for undertaking locum work and their experiences in the locum workforce. Reasons for leaving the regular workforce included need for part-time work to support travel, study or child-rearing, to explore career options, dissatisfaction with work and training conditions and to take time out. The most attractive features of locum work were flexibility and remuneration. Detailed results are provided in Part 2 of this report.

#### **4. What Has Been the Impact of the Emergence of Locum Arrangements?**

The Australian Centre for Industrial Relations Research and Training (ACIRRT) at the University of Sydney was commissioned to examine the use of locums at a NSW metropolitan hospital. A summary of findings is presented in Part 3 of this report.

##### *4.1 Service Quality and Service Levels*

There is no evidence available to link use of locums with adverse clinical events in NSW hospitals. The NSW Medical Board and the NSW Health Care Complaints Commission do not collect information about employment status

when investigating adverse events and complaints. Hospital and Area based critical incident monitoring systems do not differentiate locum and permanent staff. There is limited international research suggesting that locums are more likely to make mistakes. A study of prescribing errors in a UK teaching hospital published in *The Lancet* in April 2002 found that 'new or locum staff' had contributed to a prescribing error in 10 out of 88 cases, although it should be noted that 'inadequate staffing' contributed to 15 errors (24). A study of accuracy of documentation of surgical admissions in a Scottish hospital found that 13% of all errors were made by locum middle-grade staff due to lack of familiarity with the computer software (25).

#### *4.2 Doctors' Working Lives*

No research exploring the impact of locum arrangements on doctors' working experiences in the Australian context was identified.

#### *4.3 Co-workers and Other Workers*

Again, no published information was identified regarding the impact of locum arrangements on the permanent hospital workforce.

#### *4.4 The Supply of Doctors and Skilled Specialists*

There is currently insufficient information about participation in medical training programs, workforce participation, distribution of hospital positions and career intentions to accurately predict the impact of locum arrangements on the supply of vocationally qualified medical practitioners in NSW. There are also no clear guidelines about what constitutes appropriate hospital service, the mix of medical staff required to deliver safe and effective patient care, and the training required to produce these practitioners (8).

AMWAC has recently examined the specialist emergency medicine workforce (26). Between 1997 and 2002, the average intake of emergency medicine trainees was 90 per year. Given increasing demand for emergency services, increasingly complex patients including more elderly patients and more mental health patients, and changes to availability of acute beds, the recommendation is 130 trainees per year to meet predicted specialist staffing requirements. In NSW from 1997 to 2002, there was an increase in the number of doctors with Fellowship of the Australian College of Emergency Medicine (FACEM) of 9.6% per annum, a total of 52 emergency physicians. The specialist to population ratio in NSW is below the national average and is markedly below predicted need (26). Given the large amount of locum work available in the emergency setting (see Appendix 2) it is likely that a large number of doctors who may otherwise train in emergency medicine are diverted into the locum workforce.

## **5. How Does the Experience of NSW Health Compare with Other Sectors?**

### *5.1 Interstate*

The Victorian HMO Managers Group together with the Postgraduate Medical Council of Victoria compiled a paper exploring use of agency junior medical staff in public hospitals in April 2002 (27). Locum arrangements described are similar to those in NSW, with use of locums more prevalent in outer-urban and regional hospitals. The HMO Managers Group registered concern about quality of staff, continuity of care, cost, relationships with permanent staff and safe working hours. The group developed a standardised contract for use with locum agencies with agreed minimum standards for agency compliance. Locum agencies are required to show proof of visa, medical board registration, updated CV and reference checks consistent with the level of the job, and hours worked by the doctor in the last fortnight. The group has also worked towards an agreed fee structure for locum doctors, currently set at double time (approximately \$60 per hour). Although fee caps are not legislated, junior medical officers working in Victoria report that locum rates are fixed at double the award, hence locum work is not as lucrative as working in NSW. No information was available about other Australian states.

### *5.2 Overseas*

The UK General Medical Council and the Medical Council of New Zealand were contacted and report similar emergence of locums to fill junior and middle level hospital positions. No research has been conducted in this area in either country.

Research from the USA, where medical training structures are significantly different from Australia, suggests that use of locums in the hospital setting is rising, however doctors using locum work as their primary source of employment tend to have completed postgraduate vocational training (28, 29). Moonlighting is common among specialist trainees especially in emergency medicine. Reasons given for undertaking extra shifts include additional income to pay off student debts and supplementation of educational experiences (30).

## 6. Future Directions

There are currently insufficient data to accurately describe the NSW hospital medical workforce, including doctors with vocational specialist qualifications, doctors in vocational training positions, overseas-trained doctors and doctors working in a locum capacity. Without this information it is not possible to accurately predict the financial implications of employment of locums, the impact of increasing reliance on locums on quality and safety of patient care, training and supervision requirements of locum medical officers and the sustainability of the hospital medical workforce in NSW.

More urgent than collection of accurate workforce data is the need to clarify the legal and industrial implications of reliance on a locum medical workforce without postgraduate vocational qualifications. Matters to be examined as a matter of priority include:

- Implications of employment of locum doctors not pursuant to the relevant industrial award.
- Legal liability for decisions made by doctors working in a locum capacity and provision of appropriate medical indemnity insurance.
- Examination of relevant awards including classification of medical officers, pay and conditions, and the relationship between industrial conditions and medical workforce trends.
- Potentially restrictive trade practices of locum agencies.
- Responsibility for occupational health and safety of locum medical officers including safe working hours.
- Responsibility for ensuring appropriate quality of locum medical officers including credentialing, performance review and continuing medical education.
- Ability of patients of locum doctors to claim benefits through Medicare.

The GMCT Metropolitan Hospitals Locum Issues Group is currently examining options for potential short and medium term solutions to address key challenges surrounding employment of locum medical officers in the NSW public hospital system: cost, quality and safety, legal and administrative issues, and medical workforce sustainability. Comments and suggestions should be provided to:

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## **Part 2**

# **Experiences of Locum Work: Interviews with Recent Medical Graduates**

**Compiled by Clare Skinner**

Seven recent medical graduates were interviewed to explore their motivations for doing locum work and their experiences of the locum workforce. These doctors were identified through informal networks and ranged from postgraduate years 3 to 6 (PGY3 – 6). They ranged in age from 28 to 35 years. Three doctors were female, four were male. Six of the seven completed their primary medical degree in NSW and the other doctor had studied in Western Europe. Three had completed an undergraduate medical program while the other four had undertaken a graduate medical program. Five of the seven doctors had completed a degree prior to enrolling in medical school: four in biological science, one in economics. Two doctors were currently enrolled in a higher degree. Only two of the doctors interviewed had at least 12 months of full-time work experience outside clinical medicine. Three of the doctors were married and one had two dependent children. Five of the seven doctors were born overseas although all but two had undertaken secondary schooling in Australia.

The doctors were selected because they had used locum work as their primary source of clinical employment during the previous twelve months. Duration of locum work ranged from eleven months to two years. At time of interview (December 2004), four doctors were still working exclusively as locums and three had joined specialist vocational training programs within the mainstream hospital workforce. Three others had clear intentions to commence specialist vocational training within the next two years. Two of the doctors had worked locum shifts in addition to their full-time position ('moonlighting') and one continues this practice despite participation in a vocational training program in order to maintain skills in general medicine.

### *Reasons for Doing Locum Work*

Reasons given for opting out of the mainstream workforce to work in a locum capacity included a need to earn money, either to support travel or full-time study, or to pay off debts accrued as a student, to develop or maintain clinical experience outside their chosen specialty area, to explore career options, to look after dependent children and to take 'time out':

'I needed a break. I was going to start a registrar job in 2003 and realised that I would burn out in no time at all.'  
(Female 29 Married PGY4)

One doctor left because he was unable to get sick leave to manage a newly diagnosed chronic illness:

'I felt that I'd been treated like dirt. Other workplaces look after you – sick pay the whole way through. I nearly walked away completely. Ironically it's locums that have kept me in medicine.'  
(Male 35 Single PGY4)

Three out of seven doctors mentioned that they left full-time positions because they were dissatisfied with working and training conditions:

'I was working long hours and not getting paid for it. I was getting home too tired to do anything else. I lost touch with my friends and didn't have time for all my usual coping mechanisms.'  
(Male 32 Single PGY4)

'I think training programs are too hard, with overtime and nights and all that. I don't mind them being academically difficult, but they are too physically difficult. I cannot see myself doing that for another 5 years.'  
(Female 31 Married PGY4)

'If we treated patients in the public hospitals like the public hospitals treat us, we would be constantly up before the medical board.'  
(Male 35 Single PGY4)

### *Best Features of Locum Work*

Six out of seven doctors interviewed identified flexibility as the best feature of locum work. Notions of flexibility included the ability to choose hours of work, place of work and medical discipline:

'You organise when you want to work. You're your own boss.'  
(Female 31 Married PGY4)

'I could choose where I want to go, what I want to do, when I do it.'  
(Female 29 Married PGY5)

'I can dictate my work hours.'  
(Female 29 Married PGY4)

'When you have the ability to choose areas of work – geographically, technically, intellectually, shifts that suit you – you inherently do a better job.'  
(Male 32 Single PGY4)

Remuneration in the locum workforce was also attractive, however only one doctor claimed that 'the money' was the best feature of locum work. Other doctors interviewed believed above-award remuneration was secondary to flexibility:

'It's not the income. The good thing about the income is that it creates the flexibility.'  
(Male 32 Single PGY4)

'For the hours that I work it enables me to earn the same money as I would full-time under award rates.'

(Male 28 Single PGY3)

Other attractive features of locum work included exposure to a variety of clinical settings and maintenance of clinical skills, particularly in emergency medicine.

### *Worst Features of Locum Work*

The worst features of locum work were described as lack of supervision and training, uncertainty about level of responsibility, lack of continuity with patients and colleagues, and lack of recognition of clinical experience gained as a locum.

'You're pretty much on your own, there's no mentorship. You can get yourself into a black hole. You don't have much to show for it at the end'  
(Female 29 Married PGY4)

'You can find yourself in a more senior role than you thought you'd be in.'  
(Male 28 Single PGY3)

'You don't have any rapport with your colleagues, you're just there to fill in.'  
(Female 29 Married PGY5)

'You don't get any formal recognition of the skills which you've developed.'  
(Male 35 Single PGY4)

'I feel like I'm losing touch with mainstream stuff.'  
(Male 32 Single PGY6)

Lack of respect from colleagues was also a source of dissatisfaction:

'They think you are just doing it for the money. They don't think you care about the job or the patients, but you're still a doctor and you give what you can.'  
(Female 29 Married PGY5)

'Despite corrupting myself and locum-ing, I like to do an exemplary job. I was a better doctor as a locum than as an RMO. I was conscious that I would not be back the next day and put in extra effort to tie up loose ends.'  
(Male 32 Single PGY4)

### *Legal and Administrative Implications of Locum Work*

The doctors interviewed had variable understanding of the legal and administrative implications of locum work. All seven had checked their medical indemnity status with their insurance provider and one had taken out additional cover 'just in case'. Six out of seven chose to work always as a hospital employee rather than as a contractor in order to be indemnified by the hospital. Only one of the doctors interviewed was aware that employee status also conferred workers' compensation insurance. None of the doctors interviewed had valid provider numbers for all locations in which they perform locum work.

Doctors reported that the majority of locum agencies did not raise these matters, although most doctors reported a positive relationship with locum agencies:

'I use a good agency – a friendly person, personal approach. He calls me when shifts come up, looks after me, advises me not to do too many shifts.'  
(Male 32 Single PGY6)

### *Things to Change About Locum Work*

Suggestions included development of a centralised system to aid allocation of positions and payment, development of minimal standards for locums and locum agencies, specialty college accreditation of work performed in a locum capacity, and improved pay and conditions for full-time vocational trainees to reflect their loyalty and commitment and to encourage them to remain in training programs:

'I would have trainees on better conditions and locums on inferior conditions so that the two meet in the middle. I would have trainees treated like decent human beings.'  
(Male 35 Single PGY4)

### *Conclusions*

Interviews with seven recent medical graduates who have worked in a locum capacity in the NSW public hospital system indicate that reasons for choosing to work as a locum include a combination of positive and negative motivators. Dissatisfaction with training systems, administrative support, and pay and conditions in the public hospital system are likely to push people towards locum work. On the other hand, locum work is attractive to junior doctors because it offers freedom of choice and levels of remuneration not available in the regular workforce.

### Part 3

## **Locum Arrangements at a NSW Metropolitan Hospital: An Illustrative Case Study**

**Compiled by John Buchanan, Gillian Considine, Evan Rawstron and Clare Skinner**

This case study was undertaken to assist the GMCT prepare an issues paper on locum arrangements in NSW public hospitals. It is not definitive, but illustrative - designed to provide insights into how issues associated with locum employment come together at workplace level. The site studied was not necessarily 'representative' of all metropolitan hospitals - those knowledgeable of locum arrangements have confirmed unequivocally that neither is it 'atypical'. A comprehensive case study report is available for those interested in a more detailed account of the situation at this hospital.

### **1. Institutional Context**

It is impossible to understand locum employment without some appreciation of the occupational, organisational and workplace settings which have created the space for this form of employment to flourish.

#### *The Medical Profession: Occupational Fragmentation.*

Medicine is a profession experiencing considerable upheaval. Recent changes in the nature of medical work and the medical workforce means that there is a looming 'doctor shortage' with problems appearing to be particularly acute in certain parts of the health system (eg public metropolitan hospitals) and within particular specialties (eg emergency medicine and psychiatry). As GMCT has recently noted: these '[s]hortages threaten the provision of safe and effective hospital care for patients.' At this hospital services are currently just being maintained by locums and doctors trained overseas. As one interviewee noted: 'NSW metropolitan hospitals are totally dependent on locums and UK doctors.'

#### *The Department of Health: Rhetoric and Reality of Management Control*

There are at least three sources of external influence for the hospital involved with the management of labour at the workplace: in positions of authority are the central office of the Health Department and the Area Health Service Management Structure and also of influence is the associated teaching (tertiary) hospital. Generally speaking the hospital is able to fulfil its labour needs for much of the time within these organisational settings. The challenge for the system emerges in those sections of the hospital where chronic shortages of skilled medical personnel persist. In these situations labour management

arrangements break down. This leaves hospitals, as workplaces charged with delivering a service, to do whatever they can to obtain the labour they need.

### *The Hospital: Characteristics and Labour Management History*

This hospital is of average size and offers the range of services typically provided by a metropolitan hospital. All interviewees reported its recruitment difficulties could not be attributed to its geographic setting as it was conveniently located. Rather, its key problem was its scale of operation. As one nurse interviewed put it: the hospital is a good place for nurses to retire to, but not good for doctors interested in training and being part of a critical mass of expertise. While nearly all interviewees spoke well of the current team of local managers, several reported that there had been problems with previous managers. One had arbitrarily shifted a group of six experienced CMOs in the Emergency Department (ED) from permanent to casual employment status to save money. Five of these doctors subsequently left and have been difficult to replace. The memory of this experience as well as the tangible impact of leaving the ED with insufficient CMOs has left a lasting legacy in this Department. While the hospital can obtain most of the skilled medical staff from the official sources of labour, ED and Psychiatry have chronic vacancies which have existed for years.

### *The Locum Agencies: The New Intermediary*

Locum agencies have emerged to meet the pressing needs of these parts of the hospital's operations. Those involved with using their services reported that they were of highly variable quality. At best they assisted in allocating skilled medical labour. None shared the responsibility of developing it.

## **2. Operation and Impact**

### **2.1 General Features**

#### *Definition*

Most people interviewed defined locums as medical staff who were not part of the hospital's established workforce, they only came in as needed and were usually engaged with the assistance of a locum agency. They can be long term or short-term appointments. Their competence to undertake the particular jobs they are appointed to is not subject to the usual scrutiny and they are not paid pursuant to the relevant award. Their legal status varies: some are employed as casuals by the hospital and some are contractors. It would be an understatement to report that there is considerable confusion amongst staff at all levels about the legal status, rights and obligations of locum workers. As one senior staff member put it: locum arrangements involve 'a contracted arrangement, but they don't have a proper contract. There is no protection for the individual, the hospital or the agency.'

### *Different Types of Locum Vacancy*

These can be ad hoc vacancies associated with unplanned staff absences (eg sick leave). Most, however, are 'planned' vacancies and managed on the basis of rostering locums, with the assistance of locum agencies, weeks in advance of their use.

### *Different Types of Locum Workers.*

The motivations to undertake locum work ranged from those now making it the basis of their medical career because of its attractive rates of pay and ability to choose hours of work, through to those undertaking it as a break from mainstream work or to provide the occasional 'top up' to their regular income. Duration of placements were as short as one shift through to placements that went on for months. (At a nearby hospital one locum had, reportedly, been in the same position for three years.) While most locums in the ED had had some experience of this kind of work, in Psychiatry few had much more than their basic medical training to draw on in undertaking their work.

### *Rates of Pay and Cost*

Locums are usually paid in the range of \$80 - \$100 per hour. Locum agencies charge between 10 and 15 per cent on top of this. If a shift was difficult to fill considerably more could be paid. As one interview put: 'Hospitals will pay anything because other hospitals appear to be prepared to pay more.' If the hospital recruits someone within six months of a placement the agencies is paid in the order of \$20,000 and 10 percent of the salary for the first six months work.

## **2.2 Locums in the Emergency Department**

This ED requires six senior doctors to fill the roster. Currently it only has three permanently employed. The dependence on locums has increased in the last five years, although demand depends on the success of the hospital in recruiting overseas-trained doctors. Around half the locums are 'regulars'. Half are reported to be 'good performers'. One interviewee reported that as many as one in four have difficulty with English. At the time of field work, 43 per cent of shifts in ED were filled by locums. One or two were used on day shift. Half the weekend and evening shifts were staffed with locums. The night shift was usually entirely staffed by locums. On weekends and nights it was not unusual for the most senior doctor at the hospital to be a locum. The key impacts on ED operations associated with locums included: having junior doctors working in senior positions, lack of commitment/ability to following through on patient care, not preparing patient management plans and no proper handover of patients. The potentially negative impact of these weaknesses is mitigated by the activities of the permanent employees who reported that they constantly support or 'pick up' after the locums because they often do not know basic things such as computer passwords or procedures for ordering an X-ray. The major impact of locums on the working life of permanent staff is that the use of locums allows permanent

staff to work fewer hours and at better times of the day. There was some resentment, however, of the differential in pay rates.

### **2.3 Locums in Psychiatry**

Locum use in this area has increased in recent times, particularly over the last three years. Currently almost half the medical staff are locums. This has a major impact on the quality of care because continuity of care is central to the provision of psychiatric services. Most locums lack any serious training or experience in mental health and consequently require 'constant supervision.' The dependence on locums limits the ability of this part of the hospital to establish cohesive work groups. While the 'additional hands' were welcomed as better than nothing, there was some resentment of the pay differential between permanent and locum workers.

## **3. Causes**

All staff interviewed had views about what had been driving recent developments. Their views can be summarised as follows:

### **3.1 Growing Demand on the Health System**

This arises especially from an ageing population that has increasing expectations about the quality of health care

### **3.2 'Push factors': The Changing Nature of Public Hospitals**

There were four aspects to this:

#### *The 'Understaffing - Hours of Work - Locum' Nexus*

The increase in demand for service has not been matched by a commensurate increase in staffing levels. Levels of work intensification have consequently increased. For example, several staff report they rarely get a meal break and when they do they are constantly interrupted. The obsession with cost control in the public system is having a particularly negative impact on medical staff. As one long serving doctor noted:

'Working here is just a soul-killer. The public hospital system will suck everything out of you and spit you out - it's run on altruism and that's exploited by medical admin.'

In the past a key dimension to work overload has been systematic reliance by hospitals on doctors working unsafe hours. The recent push to introduce safer working hours has had an effect, which all doctors interviewed appreciated. Ironically, because extra permanent staff had not been gained in the system, reliance was placed on locums to cover the hours that had previously been performed on an overtime basis. In addition, locum arrangements meant that

individuals could avoid monitoring of safe working hours and work in one health service as a permanent employee whilst moonlighting in an another health service as a locum.

#### *Pressure on the System of On-the-Job Training*

Traditionally NSW public hospitals have relied on junior doctors undertaking vocational training to provide a key component of their workforce. This system is just not working like it used to.

#### *Metropolitan Hospitals Lack the Critical Mass of Expertise for Teaching*

This decreases their attractiveness to medical staff as places to work

#### *The Growing Significance of the Disutilities of Medical Work*

Given the above developments much of the pleasure of medical work in public metropolitan hospitals has been severely compromised. Under these conditions longstanding problems like shift work and being on-call assume even greater significance in people's assessment of where they want to work.

### **3.3 Pull Factors**

The good rates of pay and flexible hours make locum work very attractive to growing numbers of doctors.

### **3.4 The Dynamic of Growing Dependence on Locum Labour**

Push and pull factors have now developed an independent dynamic drawing more doctors away from permanent employment and into locum arrangements. For example, it appears that locums in ED today are what CMOs were a decade ago.

## **4. The Future**

One senior medical clinician spoke for all interviewees when he said:

'We have this monster now; I don't know how it's going to be turned around. I think it's unhealthy for the medical workforce to go on in this vein. It seems to be growing and growing.'

## References:

1. NSW Health Circular 2002/120, *Salary Increase for Staff in Public Hospitals. Health Services and the NSW Ambulance Service Covered by the Health and Research Employees Association*, North Sydney, 24 December 2002.
2. NSW Health Circular 2003/85, *Health Service Boards, Chief Executive Officers and Other Employees are Not Permitted to Offer Over-Award Salaries, and/or Conditions of Employment*, North Sydney, 28 November 2003.
3. NSW Health, *Medical Officers Workforce Data Collection - Med Survey 2004* (unpublished preliminary results).
4. Audit Office of NSW, *Hospital Emergency Departments: Delivering Services to Patients*, Sydney, March 2000.
5. Australian Medical Workforce Advisory Committee, *Career Decision Making by Doctors in Vocational Training*, Sydney, May 2003.
6. Hawthorne L, Birrell B, 'Doctor Shortages and Their Impact on the Quality of Medical Care in Australia', *People and Place*, Volume 10(3), 2002, Pages 55-67.
7. Postgraduate Medical Council of NSW, *PGY2/RMO1 Quota Positions for 2005*, Available at [www.medeserv.com.au/pmc](http://www.medeserv.com.au/pmc), Accessed 10 November 2004.
8. Medical Training and Education Council of NSW, *The Future of Postgraduate Medical Training and Education in NSW*, Sydney, May 2004.
9. Swinburn E, 'Hospital Locums: Expensive and Problematic', *Medical Journal of Australia*, Volume 177(8), 2002, Pages 460-461.
10. Postgraduate Medical Council of NSW, *Junior Medical Forum – Minutes 26 September 2003*, Available at [www.medeserv.com.au/pmc](http://www.medeserv.com.au/pmc), Accessed 10 November 2004.
11. Australian Health Ministers' Conference, *National Health Workforce Strategic Framework*, Sydney, 2004.
12. Landrigan CP, Rothschild JM, Cronin JW, Kaushal R, Burdick E, Katz JT, Lilly CM, Stone PH, Lockley SW, Bates DW, Czeisler CA, 'Effect of Reducing Interns' Work Hours on Serious Medical Errors in Intensive Care Units', *The New England Journal of Medicine*, Volume 351(18), October 2004, Pages 1838-1848.
13. Australian Medical Association, *AMA Safe Hours Project: Systems of Work for Junior Doctors in Public Hospitals, an Overview of Seven Case Studies*, Canberra, August 1998.
14. Australian Medical Association, *AMA National Code of Practice – Hours of Work, Shiftwork and Rostering for Hospital Doctors*, Canberra, March 1999.
15. Australian Medical Workforce Advisory Committee, *Annual Report 2002-03*, Sydney, September 2003.
16. Ofri D, 'Residency Regulations – Resisting Our Reflexes', *The New England Journal of Medicine*, Volume 351(18), October 2004, Pages 1824-1826.

17. Commonwealth Government of Australia, *Health Insurance Amendment Act No. 2 1996*, Canberra, 17 December 1996.
18. NSW Health, *Profile of the Medical Workforce in NSW, 2002*, North Sydney, 2004.
19. Australian Medical Workforce Advisory Committee, *Influences on Participation in The Australian Medical Workforce*, Sydney, June 1998.
20. Australian Medical Association, *Training and Workforce Flexibility – Final Report*, Melbourne, November 2001.
21. Australian Institute of Health and Welfare, *Australian Hospital Statistics 2002-03*, Canberra, 2004.
22. Wilhelm KA, 'The Student and Junior Doctor in Distress', *Medical Journal of Australia*, Volume 177, July 2002, Pages S5-S8.
23. Firth-Cozens J, 'Stress in Medical Undergraduates and House Officers', *British Journal of Hospital Medicine*, Volume 41(2), February 1989, Pages 161-164.
24. Dean B, Schachter M, Vincent C, Barber N, 'Causes of Prescribing Errors in Hospital Inpatients: A Prospective Study', *The Lancet*, Volume 359, April 2002, Pages 1373-1378.
25. Jutley RS, McKinley A, Hobeldin M, Mohamed A, Youngson GG, 'Use of Clinical Audit for Revalidation: Is it Sufficiently Accurate?', *Journal of Quality in Clinical Practice*, Volume 20, 2000, Pages 71-73.
26. Australian Medical Workforce Advisory Committee, *The Specialist Emergency Medicine Workforce in Australia*, Sydney, September 2003.
27. Sutton B, *Use of Agency Junior Medical Staff in Public Hospitals*, HMO Managers' Group Victoria, Melbourne, April 2002.
28. Thompson E, 'Use of Locum Tenens Grows', *Modern Healthcare*, Volume 30(13), March 2000, Page 84.
29. Thrall TH, 'Up, Up and Away: Provider's Spending on Temporary Docs Goes Through the Roof', *Hospitals and Health Networks*, Volume 76(9), September 2002, Pages 16-17.
30. Li J, Tabor R, Martinez M, 'Survey of Moonlighting Practices and Work Requirements of Emergency Medicine Residents', *American Journal of Emergency Medicine*, Volume 18(2), March 2000, Pages 147-151.

## **Glossary:**

*Intern* – Doctor in postgraduate year 1 (PGY 1). Employed by a teaching hospital and must complete supervised rotations in medicine, surgery and emergency to meet conditions for full registration with the Medical Board of NSW.

*Resident Medical Officer (RMO)* – Doctor in postgraduate year 2 (PGY 2) or above with full medical registration. Employed by a teaching hospital undertaking supervised rotations across a number of medical specialties.

*Senior Resident Medical Officer (SRMO)* – Doctor in postgraduate year 3 (PGY 3) or above with full medical registration undertaking supervised rotations in teaching hospitals, usually within one clinical ‘stream’ eg adult medicine, critical care, psychiatry.

*House Medical Officer (HMO)* – Doctor in postgraduate year 1, 2 or 3 not yet streamed into training in the Victorian hospital system.

*Registrar* – Doctor in postgraduate year 3 (PGY 3) or above enrolled in basic or advanced training with a specialist medical college.

*Career Medical Officer (CMO)* – Doctor in postgraduate year 4 (PGY 4) or above without a postgraduate vocational qualification employed by a public hospital on a salaried basis. They have full medical registration, are not enrolled in training, have no right of private practice and cannot claim benefits through Medicare.

*General Practitioner (GP)* – Doctor with a postgraduate vocational qualification from the Royal Australian College of General Practitioners.

*Overseas-Trained Doctor (OTD)* – Doctor who completed their primary medical qualification in a country other than Australia. OTDs achieve registration in Australia after successful completion of a series of examinations conducted by the Australian Medical Council or by recognition of specialist vocational qualifications by the relevant Australian medical college. OTDs may be employed on a short-term basis without undertaking re-certification under a temporary resident visa which restricts them to a specified hospital position for three or six months. OTDs are also known as international medical graduates (IMGs).

## **Appendix 1**

### **Membership of GMCT Metropolitan Hospitals Locum Issues Group**

#### **Working Committee:**

Professor Kerry Goulston – Chair, GMCT

Dr Clare Skinner – Project Manager, Locum Issues, GMCT

Dr John Buchanan – Project Advisor, Deputy Director, ACIRRT\*, University of Sydney

Evan Rawstron – Project Advisor, Executive Director, Medical Training and Education Council

#### **Reference Group:**

Dr Xavier Badoux – Medical Registrar, RNSH

Dr Asha Bowen – Paediatric SRMO, St George Hospital

Professor Jeffrey Braithwaite – Director, Centre for Clinical Governance Research

Auriol Carruthers – Program Manager, PMC NSW

Bernard Carrasco – Consumer Representative

Dr Louis Christie – Emergency Physician, Orange Base Hospital

Gillian Considine – Researcher, ACIRRT\*, University of Sydney

Dr Vasco de Carvalho – Director of Medical Services, Central Coast Health

Dr Steve Delprado – Emergency CMO, Baulkham Hills Private

Dr Kathy Esson – Sydney Health Projects Group, University of Sydney

Dr Eddy Fischer – Renal Physician and Director of Clinical Training, Nepean Hospital

Dr Karen Fisher – Locum Medical Officer

Professor Michael Frommer – Sydney Health Projects Group, University of Sydney

Dr Seumas Hyslop – Critical Care SRMO, Auburn Hospital

Dr Gary Nieuwkamp – ED Director, Wyong Hospital

Dr Grahame Robards – Medical Advisor, Metropolitan Hospitals, GMCT

Dr Amanda Stephens – RMO, Westmead Hospital

Dr Elizabeth Swinburn – ED Physician, RNSH

Dr Warwick Yonge – Retrieval Registrar, Alice Springs Hospital

Kylie Fraser – Project Manager, GMCT

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\* Australian Centre for Industrial Relations Research and Training

## **Appendix 2**

### **Hospital Vacancies from *Med Survey 2004* (Preliminary Results Only)**

**Table 2:** Hospital Vacancies and Use of Locums and Overseas-Trained Doctors from *Med Survey 2004* (Head Count Only) (3)

<b><u>Hospital</u></b>	<b><u>Vacancies</u></b>	<b><u>OTDs</u></b>	<b><u>Locums</u></b>
<i>Central Coast Area Health Service</i>			
<b>Gosford</b>	<u>ED:</u> RMO x 14 Registrar x 16 CMO x 3 <u>Adult Medicine:</u> RMO x 1 Registrar x 21 <u>Anaesthetics:</u> Registrar x 4 <u>O&amp;G:</u> RMO x 1 Registrar x 1 <u>Total:</u> 61	RMO x 22 Registrar x 25 CMO x 2  <u>Total:</u> 49	RMO x 2 Registrar x 1  <u>Total:</u> 3
<b>Wyong</b>	<u>ED:</u> CMO x 2 <u>Adult Medicine:</u> RMO x 1 Registrar x 3 <u>Total:</u> 6	RMO x 1 Registrar x 3 CMO x 1 <u>Total:</u> 5	CMO x 1  <u>Total:</u> 1
<i>Central Sydney Area Health Service</i>			
<b>Balmain</b>	No Information	No Information	No Information
<b>Canterbury</b>	<u>ED:</u> RMO x 1 Registrar x 4 <u>O&amp;G:</u> Registrar x 1 <u>Paediatrics:</u> RMO x 1 Registrar x 1 <u>Palliative Care:</u> Registrar x 1 <u>Total:</u> 9	RMO x 2 Registrar x 6  <u>Total:</u> 8	No Locums  <u>Total:</u> 0
<b>Concord</b>	<u>ED:</u> RMO x 12 Registrar x 6 <u>Adult Medicine:</u> RMO x 3 Registrar x 5 <u>Anaesthesia:</u> RMO x 2 <u>Dermatology:</u> RMO x 2 <u>Palliative Care:</u> Registrar x 1 <u>Psychiatry:</u> Registrar x 1 <u>Surgery:</u> RMO x 2 Registrar x 5 <u>Total:</u> 39	RMO x 18 Registrar x 18  <u>Total:</u> 36	No Locums  <u>Total:</u> 0



<u>Hospital</u>	<u>Vacancies</u>	<u>OTDs</u>	<u>Locums</u>
<b>Mater</b>	<u>ED</u> : Intern x 1 Registrar x 2 <u>Adult Medicine</u> : Intern x 2 Registrar x 3 <u>Anaesthesia</u> : RMO x 1 <u>Surgery</u> : Intern x 1 <u>Total</u> : 10	RMO x 1 Registrar x 5  <u>Total</u> : 6	No Locums  <u>Total</u> : 0

*Illawarra Area Health Service*

<b>Bulli</b>	<u>ED</u> : Other x 3 <u>Adult Medicine</u> : Registrar x 1 <u>Total</u> : 4	No OTD  <u>Total</u> : 0	Other x 3 Registrar x 1 <u>Total</u> : 4
<b>Shellharbour</b>	<u>ED</u> : Registrar x 1 Other x 7 <u>Adult Medicine</u> : Registrar x 2 <u>Total</u> : 10	Registrar x 3  <u>Total</u> : 3	Other x 7  <u>Total</u> : 7
<b>Wollongong</b>	<u>ED</u> : Intern x 1 RMO x 4 Registrar x 1 Other x 43 <u>Adult Medicine</u> : RMO x 1 Registrar x 8 Other x 4 <u>Anaesthesia</u> : Registrar x 5 Other x 1 <u>O&amp;G</u> : Registrar x 1 CMO x 1 <u>Paediatrics</u> : Registrar x 1 Other x 2 <u>Psychiatry</u> : RMO x 1 <u>Surgery</u> : RMO x 1 Registrar x 3 <u>Other</u> : Other x 1 <u>Total</u> : 79	RMO x 6 Registrar x 19  <u>Total</u> : 25	RMO x 1 Other x 51  <u>Total</u> : 52

*Northern Sydney Area Health Service*

<b>Hornsby</b>	<u>ED</u> : RMO x 10 Registrar x 5 <u>Adult Medicine</u> : RMO x 4 Registrar x 5 <u>O&amp;G</u> : Registrar x 1 <u>Paediatrics</u> : Registrar x 1 <u>Total</u> : 26	RMO x 13 Registrar x 12  <u>Total</u> : 25	RMO x 1  <u>Total</u> : 1
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<b>Hospital</b>	<b>Vacancies</b>	<b>OTDs</b>	<b>Locums</b>
<b>Nepean</b>	<u>ED</u> : Registrar x 1 CMO x 3 <u>Adult Medicine</u> : RMO x 1 Registrar x 3 CMO x 1 <u>O&amp;G</u> : CMO x 1 <u>Paediatrics</u> : RMO x 4 Registrar x 6 <u>Pathology</u> : Registrar x 1 <u>Surgery</u> : RMO x 1 Registrar x 2 <u>Total</u> : 24	RMO x 5 Registrar x 8     <u>Total</u> : 13	CMO x 4     <u>Total</u> : 4
<b>Springwood</b>	No Information	No Information	No Information

*Western Sydney Area Health Service*

<b>Auburn</b>	<u>ED</u> : RMO x 4 Registrar x 3 Other x 1 <u>Adult Medicine</u> : RMO x 2 Registrar x 1 <u>Paediatrics</u> : RMO x 1 <u>Surgery</u> : RMO x 1 <u>Total</u> : 13	RMO x 8 Other x 1     <u>Total</u> : 9	Registrar x 4     <u>Total</u> : 4
<b>Blacktown</b>	<u>ED</u> : RMO x 2 Registrar x 6 <u>Adult Medicine</u> : Registrar x 5 <u>Anaesthesia</u> : Registrar x 1 <u>O&amp;G</u> : RMO x 1 <u>Paediatrics</u> : Registrar x 4 <u>Surgery</u> : RMO x 1 <u>Total</u> : 20	RMO x 3 Registrar x 13     <u>Total</u> : 16	Registrar x 2     <u>Total</u> : 2
<b>Mt Drutt</b>	<u>ED</u> : Registrar x 11 <u>Adult Medicine</u> : RMO x 1 Registrar x 2 <u>Palliative Care</u> : RMO x 1 <u>Total</u> : 15	RMO x 2 Registrar x 5     <u>Total</u> : 7	Registrar x 8     <u>Total</u> : 8

