The challenge of locum working arrangements in New South Wales public hospitals

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ABSTRACT

- Use of locum medical officers is increasing in the NSW hospital system.
- Locums are expensive, and have highly variable expertise and experience.
- Locum employment arrangements are ambiguous.
- Locum work may divert junior doctors from participation in specialist training.
- Attempts to regulate the locum workforce must be accompanied by measures that increase the appeal of public hospital work and vocational training positions.

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The use of locum medical officers to fill resident and registrar shifts in the New South Wales public hospital system has increased markedly in recent years.[1] Doctors providing locum services to hospitals include recent medical graduates, specialist trainees, and experienced clinicians who have worked previously in the hospital system as career medical officers. A proportion of doctors undertake locum shifts in addition to full-time hospital positions. Locum medical officers can be used to temporarily replace permanent staff on leave, but are increasingly used to manage chronic vacancies, with appointments ranging from days to years. Hospitals in other Australian states, New Zealand and the United Kingdom are also increasingly dependent on casual medical labour.[1]

The changing medical workforce

Changes in the nature of medical work and the medical workforce have created a doctor shortage in Australia.[2] The shortfall is most keenly felt in certain specialties (emergency medicine, psychiatry) and parts of the health system (public metropolitan, regional and rural hospitals). In February 2004, there were an estimated 906 vacancies for trainees and non-specialist doctors in NSW hospitals, 348 of which were in emergency medicine (unpublished preliminary results of the NSW Health Medical Officers Workforce Data Collection 2004 medical survey, January 2005).

Public hospitals in NSW have traditionally relied heavily on recent medical graduates and specialist trainees to perform day-to-day clinical work. The junior medical workforce has changed significantly in the past two decades. The introduction of graduate medical programs across Australia in the mid 1990s means that medical graduates are now older, are more likely to have partners and dependants when they begin their medical career, have higher levels of debt than previous generations, and have experience of other workplaces.[3] Career decisions are greatly influenced by personal, family and financial needs, with graduates more attracted to procedural specialties with high private income expectations than to generalist, hospital-based disciplines.[4] Female medical graduates now outnumber males, but doctors of both sexes are increasingly electing to work fewer hours, reflecting broader community preferences for balancing work and private life.[5]

Patterns of medical work have also changed. Regulation of working hours and introduction of safe-staffing formulae have increased the number of doctors necessary to provide adequate medical care. More high-intensity work is occurring after hours. Many specialties have exchanged call-back arrangements for formal 24-hour rotating rosters, with an expectation that junior doctors will undertake regular after-hours shifts.

Concurrently, regulation of vocational training schemes has increased, with restriction of provider numbers by the federal government in 1996, introduction of the national general practitioner training quota, development of registrar training networks and introduction of capped training times by many specialty colleges.

As larger numbers of practitioners are opting to work fewer hours, demand for public hospital services is increasing.[6] NSW emergency departments reported that presentations increased by over 10% in 2005 compared with 2004 (unpublished data, Clinical Services Redesign Program, NSW Health, November 2005). The Australian population is ageing, increasing the burden of chronic disease. Lack of timely access to GPs and community services drives additional patients into the acute hospital system. The public and the media expect 24-hour, immediate, high-level care.

As the demand for clinical services has outstripped medical workforce supply, work intensity has increased. Tension between service and training demands on interns, residents and registrars may affect their ability to develop key cognitive and procedural skills. Morale in the public hospital system is low, with clinicians feeling they lack control over "system issues" such as waiting lists, access block and staff shortages. Often, budget concerns and patient flow improvements are perceived by clinicians as having higher priority than maintaining a high standard of patient care. In

1 Problems associated with locum arrangements

- Cost:
  - Locums earn up to three times the award rate, with agencies charging 10%–15% commission per shift.
- Quality and safety:
  - Skills and experience of locums are variable; working hours are not monitored.
  - There are no credentialling, training or performance review systems for locums.
- Legal and administrative ambiguities:
  - Roles and responsibilities of hospitals, locum agencies and individual doctors in locum employment arrangements are undefined.
- Medical workforce sustainability:
  - Locum work may be more attractive than vocational training, potentially reducing the number of specialists available to the hospital system in the future. ◆

2 Experiences of locum work — interviews with recent medical graduates

- Reasons for doing locum work included taking "time out", dissatisfaction with hospital working conditions, exploring career options and a need to earn money:

  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. (32-year-old man in postgraduate Year 4)

- Flexibility was identified as the best feature of locum work:

  I can choose where I want to go, what I want to do, when I do it. (29-year-old woman in postgraduate Year 5)

- Remuneration was also an attractive feature:

  For the hours that I work it enables me to earn the same money as I would full-time under award rates. (28-year-old man in postgraduate Year 3)

- The worst features of locum work were lack of supervision and training, uncertainty about expected skill levels, lack of accreditation of experience, and interrupted relationships with patients and colleagues:

  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. (29-year-old woman in postgraduate Year 4) ◆

many settings, infrastructure, technical and clerical support is inadequate to meet increased patient turnover. Under these conditions, many positive aspects of hospital work are seriously compromised, and locum work, which offers good rates of pay and flexible hours, becomes an attractive alternative.

Challenges posed by use of locum doctors

Use of doctors without vocational training as a temporary hospital workforce poses significant challenges to the NSW hospital system (Box 1). Locum medical officers are not employed pursuant to the Public Hospital (Medical Officers) Award, and can earn up to three times the relevant award rate, with locum agencies charging 10%–15% commission per shift. Skills and experience of locum doctors are variable, and locums are not subject to usual junior medical officer credentialling, training and performance review systems. Locums often lack familiarity with the workplace, local process and protocols, and with other clinical team members. Working hours of locums are not monitored for safety purposes, and the use of locums may affect continuity of care in some inpatient settings.

Employment arrangements for locum medical officers are often ambiguous, and legal relationships between hospitals, locum agencies and individual doctors may be unclear. Responsibility for indemnity, occupational health and safety, supervision and professional development is rarely explicit when a locum doctor is employed.

Perhaps the greatest challenge posed to the hospital system by locum arrangements is the potential impact that diversion of medical graduates into the locum market will have on long-term medical workforce sustainability. While there is a role for locums to fill ad-hoc, short-term vacancies in the hospital system, chronic vacancies in some specialties enable primary locum employment to be an alternative to an accredited training position, potentially reducing the number of specialists available to the public hospital system in the future.

3 Recommendations of the Greater Metropolitan Clinical Taskforce Metropolitan Hospitals Locum Issues Group

An effective response requires action on four fronts:

Prevocational and vocational trainees

- Improve hospital-based prevocational and vocational training experiences for "junior doctors", including interns (postgraduate year [PGY] 1), residents (PGY2), senior residents (PGY3) and registrars (PGY3–8). Emphasis should be placed on maximising involvement of junior doctors in higher-order clinical work by increasing clinical, clerical and technological support, improving administrative arrangements associated with allocation, rostering and payment of junior doctors, and by fostering development of clinical skills through active supervision, hospital-based training schemes and timely delivery of critical care courses (eg, Early Management of Severe Trauma, Advanced Cardiac Life Support, Advanced Paediatric Life Support).

Career medical officers and unstreamed doctors

- Provide greater professional and educational support for non-specialist hospital doctors, including career medical officers and doctors in PGY3–8 who are not engaged in vocational training programs, including regular accreditation of positions, performance review, credentialling and maintenance of training and service records. Alternative, competency-based training pathways for non-specialist hospital doctors need to be developed.

Locums

- Develop and maintain standards for locum employment arrangements. Centralised information about shift vacancies, employment of locums, individual locum credentials and performance history will reduce competition between hospitals for staff, and allow hospitals to find a suitable locum more effectively. A standard employment contract should explicitly define the roles and responsibilities of the locum doctor, locum agency and hospital. In the longer term, the number of agencies should be reduced through a tender process, allowing introduction of efficient credentialling, performance review, monitoring of locum working hours, and more equitable distribution of the locum workforce.

Public hospital clinicians

- Revitalise the commitment and engagement of the public hospital workforce. Improving satisfaction and morale of clinicians by implementing key performance indicators that value social capital and wellbeing should become a priority for health administrators. Non-financial aspects of hospital work need attention — accommodation, meals, parking, work environment and child care, if inadequate, communicate to clinicians that they are not valued in their workplace. Clinical leadership needs encouragement and reward, and clinical leaders of the future need to be developed by providing policy and management training for junior clinicians. ◆

Working towards change

The medical workforce is highly mobile. It is clear that in times of medical workforce shortage, no solution to the problems posed by locum employment will emerge unless broader issues concerning the training structures and working conditions of all junior and middle-level hospital doctors are addressed.

The Greater Metropolitan Clinical Taskforce (GMCT) was asked to examine locum employment arrangements on behalf of the NSW Minister for Health in September 2004. The working group comprised 52 junior and senior clinicians, health administrators, academic advisors, and representatives from key organisations, including the Australian Medical Association, the Postgraduate Medical Council of NSW, the Medical Training and Education Council, the NSW Resident Medical Officers Association and NSW Health. Local and international literature was reviewed. Locum arrangements were further explored through semi-structured interviews with administrators, senior and junior medical officers, nursing staff and recent graduates working as locums (see Box 2). Problems and solutions were workshopped at a weekend meeting. Hospital clinicians and administrators were invited to comment on proposed reforms through a series of open hospital forums. Recommendations developed during this process are shown in Box 3.

NSW Health has given in-principle support to the recommendations of the locum project, and is currently working towards implementing them in association with clinicians, administrators, industrial advisors and medical educators.

A key development is the formation of the NSW Institute of Medical Education and Training, which will provide continuity across prevocational and vocational training, with development of a hospital skills program, aimed at both locum and non-locum doctors, a priority.

Any attempt to regulate the locum medical market must be undertaken with caution. The NSW public hospital system relies heavily on locum medical staff, and overly strict regulation may increase pressure on an already stretched workforce. The challenge is to find an appropriate balance between casual and permanent employment, encourage professional development of all doctors, and support hospitals facing chronic vacancies by applying flexible industrial arrangements and non-financial incentives.

Competing interests

All authors were employed by the Greater Metropolian Clinical Taskforce while this article was being researched and written. Kylie Fraser and Rebecca Riordan were employed in an administrative capacity, Clare Skinner and John Buchanan were employed as academic consultants and Kerry Goulston is chair of the GMCT. The GMCT is funded by the NSW Minister for Health and represents clinicians in NSW hospitals.

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