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Top 5 issues for Doctors in Training *(October 2022)*

1 - Falling wages

Wages have been stagnant and have failed to keep pace with inflation for many years, leading to junior doctors facing ongoing cost of living pressures. This is compounded by a need to live relatively close to metropolitan hospitals to avoid dangerous commute times as shift workers. The costs of medical training continue to increase, including college training fees, pre-requisite courses, and examinations required for entry to specialist training.

WA used to have some of the highest wages in the country, which encouraged junior doctors to work and remain in WA. Wages in other states have now improved, and more attractive entitlements are also being offered.

Due to protracted EBA negotiations and wording of the revised State Wage Policy (SWP) doctors have been excluded from improved pay offers made available to other frontline workers. This is in contradiction to media statements made which stated that the revised SWP would apply to doctors.

Solutions

- Formally agree to apply the most recent Stage Wage Policy (greater of $3,120 or 3% annual wage increase for 2 years and $3000 bonus, as announced 20/9/2022) to junior doctors from 1 Jul 2022.
- Communicate the above clearly to all junior doctors and expedite payment of bonus and backpay amounts.

Comments from Doctors in Training

Public Hospital Surgical Registrar:
“I have spent almost $50,000 to try to get into surgical training and am not there yet, with no guarantee of getting in. We have to pay our usual fees to AHPRA etc. But then we sit the GSSE $4,895. Then the clinical exam $3,500. Then we have to do a master's or PHD ($25k+). Then we are required to do research and publications (minimum $15-20k). And this is all before we even have a guarantee of getting into training. I get paid less than my radiographer brother in the public system, and my sonographer partner in the private system, both who work less hours and on calls than I do. I work 72+ hour on calls and am expected to do life-saving operations or make life saving decisions for $11.50 an hour on call.”

Sir Charles Gairdner Hospital & Fiona Stanley Hospital Registrar (Trainee):
“Sometimes I want to take a break or reduce my FTE because of work burnout but I can't. Because every year costs go up and wages don't.”

WA Country Health Service RMO:
“I have had to spend around $10,000 this past financial year on professional development courses (such as ALS, APLS, etc) which are all requirements for training programs and necessary training to be an adequate doctor. On top of this, working rurally I need to travel very far to access these sorts of courses and therefore take more leave to travel to the courses and spend money travelling.”

Fiona Stanley Hospital Registrar (Service):
"Cost of training far exceeds PDL allowance. FRACP BPT costs $3,800 per annum, course for written exam prep is $2,000 not including accommodation or flights, other courses for exam prep are in excess of $2,000 in addition to the one above. And then written exam cost to sit from FRACP is approx. $2,000. Do the maths. Totally insulting to then not have a wage increase in line with inflation given cost of training and then rising cost of living."

Perth Children's Hospital Registrar (Trainee):
"This year I have spent a total of roughly $15,000 on written exam, clinical exam, college fees and highly recommended exam prep courses, and then another $2500 on compulsory APLS course."

North Metropolitan Health Service Registrar (Trainee):
"Last year I paid $21,000 in a combination of college fees, exam fees, costs to travel for exams, compulsory courses required by the college, and AHPRA registration."

2 - Unpaid overtime and a culture of fear

The acuity of medical jobs means start and finish times often do not reflect the prewritten roster. Increased activity within hospitals and staffing pressures has led to increasing unrostered overtime being worked by junior doctors. Unrostered overtime is not paid unless a claim form is submitted, which must be signed by the head of department. Often these are the same people who have control over career progression for junior doctors, both inside the hospital and within training programmes. Most junior doctors are on 12-month contracts, and many fear non-renewal because of applying for overtime.

Due to cultural and logistical barriers, fear of retribution, and the difficulty of doing so there are large amounts of unrostered overtime that go unclaimed or claimed but not approved. In some departments there is an "unspoken rule" against claiming overtime.

It takes considerable time when claiming for overtime for a junior doctor to complete Excel forms, email, and follow up requests, forensically examine their payslips for the amounts being paid, chase up missing amounts, and track the outcome of queries. In short, the systems in place actively discourage junior doctors from claiming the overtime they are owed.

Some departments have rosters that enforce continuous unrostered overtime, by not allowing sufficient time within the rostered hours to complete routine and expected duties. For example, a clear expectation for a surgical registrar or medical junior to commence handover or ward round 30 minutes prior to their rostered start time.

Solutions

- Institute a zero-tolerance policy for any forms of behaviour or policy that seek to deny junior doctors correct and timely pay, and related retribution or victimisation.
- Remove heads of departments from the approval process for overtime. Allow junior doctors to provide overtime forms directly to medical workforce or another independent party.
- Create a system for reporting of unrealistic rosters or systemic unrostered work directly to an independent party, which permits anonymous reporting, and which will require rosters to be amended where a discrepancy is found.
- Simplify process of claiming overtime via a single online portal. Ensure that this process is accessible from both desktop computers and mobile devices.
- Monitor overtime proactively to identify areas of fluctuating acuity, high levels of fatigue, and risk to staff and patients.

- Include the capability for claims to be tracked all the way from submission through to payment of overtime by HSS and require the hospital to take responsibility for following-up unpaid claims.

Comments from Doctors in Training

South Metropolitan Health Service Registrar (Service):
"Worked as an intern in the orthopaedic department at FSH. Worked 120+ hours of overtime throughout the term. The head of department refused to pay any overtime but told us to take time in lieu (which was impossible due to the requirement to do overtime). Required to come in before the starting time (7:30 but ward rounds often conducted at 6:45-7:00 and expected to be there). Roster already includes rostered overtime but doing 1-2 hours of overtime daily at minimum. Continually denied any of this overtime."

Perth Children's Hospital Registrar (Service):
"I've been told by multiple departments ever since internship, that they would not pay overtime. With one, they discouraged applying for overtime, and said they would "make it up in other ways", implying that I could leave earlier to make up for it. I was never able to do this due to workload. Two other departments outright said they would not pay. I often worked 1-2 hours of overtime a day during those terms. My current department pays me and my colleagues to work from 0800-1600, despite us actually being there from 0730-1830 (and sometimes later) - that is 3 hours of unpaid work a day."

Perth Children's Hospital Registrar (Trainee):
"Every day I am made turn up to work at 0730 (at the latest), we usually all arrive at around 0715. We don't start getting paid until 0800 so the hospital avoids paying penalty rates before 8am. I raised this with the head of department and she said 'take it up with the AMA'. This blatant wage theft needs to stop."

Fiona Stanley Hospital RMO:
"I have been directed by head of departments not to claim overtime in more than >50% of my rotations."

Sir Charles Gairdner Hospital Intern:
"Received emails from heads of surgical departments that overtime will not be paid for starting earlier than our rostered start time (7.30am), but that they expect juniors to be at work at 7am every day to pre-round and prep the ward round to start at 7.30am"

3 – Access to personal and professional leave
Workforce shortages and increasing patient numbers and associated workload make accessing leave incredibly difficult for junior doctors. This includes annual leave, which is crucial for preventing burnout and maintaining a healthy balance between work and life, as well as professional development and exam leave, which can deny junior doctors career progression opportunities.

Leave requests are often left without a response; or declined without any discussion or presentation of alternate opportunities to take leave.

Solutions
- Establish performance targets and reporting for the timely processing and proportion of leave requests which are accepted.
- Require that leave requests for junior doctors that are declined are discussed by phone, and that all reasonable attempts are made to offer a suitable alternative.

- Apply penalty payments for late processing of leave requests. If a junior doctor is unable to take annual leave or professional development leave in a six-month period despite requests being made, a penalty should apply.
- Ensure that each Medical Workforce department in major metropolitan hospitals has a Medical Administration Registrar (at least 1 FTE) whose duties include addressing leave capacity.
- Require hospitals to report on their leave liability annually and the number of leave relief doctors employed against this balance.
- adequate leave cover is substantially cheaper than allowing leave to accrue to the point of achieving consultancy and, paying out the liability at higher rates, and recruiting to cover the attrition of overwork burnout.

Comments from Doctors in Training

South Metropolitan Health Service Registrar (Trainee):
"When FSH opened in 2015 I had a zero leave balance. Today my leave balance is 15 weeks of annual leave. It's not for want of trying. I apply for multiple blocks every year, only to get routinely declined. I've managed to take 2 weeks this year - the most I've been approved for in some time. For my wedding in 2015, FSH gave me 3 shifts off before I was back on nights."

North Metropolitan Health Service Intern:
"One of my best friends passed away, I went to work that day as I felt to guilty letting down my team. I was rostered on the day of his funeral and asked medical admin to help me access leave for this. I got told that personal leave only extended to immediate family and that they wouldn't approve my leave."

Fiona Stanley Hospital Registrar (Trainee):
"Applied for leave in March, saying that I was happy to take the leave at any time when it was convenient for medical workforce over the next 5 months. Just wanted 1-2 weeks to manage burnout. Never received an email reply back, but received phone calls from medical admin to inform me that no leave was available in that period full stop. I had not had any leave since August the year prior, which was study leave for exams."

Sir Charles Gairdner Hospital RMO:
"I was denied annual leave in December 2022 which I applied for in November 2021. I was feeling extremely burnt out and exhausted having no annual leave all year. Having to plan leave 13 months in advance and that being denied would not happen in any other industry."

Perth Children's Hospital Registrar (Trainee):
"I have been denied leave later this year to attend a wedding where I am one of the groomsmen as there are no leave relievers available. I asked for 2 days leave and this was almost 12 months ago."

Sir Charles Gairdner Hospital Registrar (Trainee):
"Told I would be told 'closer to the date' if I could have leave... for my own wedding. Applied in January, wedding in November."

4 - Medical staffing shortages

Ongoing staffing shortages are a cause of many issues that impact on the welfare of junior doctors, and on the quality of care that is being provided to patients. Further, the issues caused by shortages lead to doctors choosing to leave WA Health to work elsewhere, or to work as locums. This leads to a vicious cycle if conditions are not improved.

Some doctors are forced out of public hospitals when their requests for more flexible working arrangements are unable to be accommodated by inflexible and archaic rostering arrangements. This includes parents with young children, other family responsibilities, and those pursuing dual careers in research or policy which should be valued by WA Health.

Solutions

- Increased contract flexibility by making part-time work universally accessible in all health services on application and ensure that part-time junior doctors can access a range of experience without undue restriction.
- Offer casual contracts to GP registrars and other community-based doctors in training who wish to increase variety and maintain their hospital skillsets by working occasional shifts.
- Require all large hospitals (over 150 beds) with junior doctors to have on-site or co-located child-care facilities with places reserved for the children of these doctors.
- Ensure all entitlements are met under the EBA and increase staffing in Medical Workforce departments and State-Wide Industrial Relations to address ongoing breaches, to prevent junior doctors from leaving WA Health.
- Increase interstate and international campaigns to recruit junior doctors to WA.
- Improve recruitment practices and career development pathways to train specialists within our system rather than requiring doctors in training to find their own way through complex term and exposure requirements that result in significant churn within the system.

Comments from Doctors in Training

South Metropolitan Health Service Intern:
"Very critical situation at times for staff shortages - for example there was one evening at RGH from 5-9pm where as an intern I was the only doctor covering surgical, medical, Geris and AMU wards with no other junior or a registrar. Have seen missed diagnoses due to very high patient load and shortage of doctors which causes significant guilt/worsening burnout for everyone involved. Many doctors are also coming to work sick as there is no sick cover and would result in dangerous staff to patients ratios, however this obviously puts patients/staff at risk of infection, potentially poorer decisions due to illness, etc."

South Metropolitan Health Service RMO:
"The shortage is absolutely pervasive and only gets worse as you progress in your career. This year it manifested as being asked to cover an advanced trainee as a resident who had never worked in that field, in being asked to cover a registrar in neurology for a week despite never working in neurology."

Perth Children's Hospital Registrar (Trainee):
"I am leaving WA at the end of my period of basic training because I am exhausted and burnt out by having to work in understaffed departments. Then PCH will be another registrar down and the problem will be worse for those left."

5 - Bureaucratic work and hospital processes

Junior doctors do a large proportion of the quasi-medical administrative work within our hospitals, and deal with other administrative burdens within hospitals including excessive and irrelevant mandatory training, audits, and surveys. As junior doctors move between hospitals, crucial for obtaining broad experience, they often complete many sets of duplicate employer onboarding paperwork across different HSPs.

Junior doctors are not allocated non-clinical time to complete these duties, and often have little or no time in their workday where they are not busy with clinical duties. Hence these duties are often neglected or pushed into junior doctors' own time.

Solutions

- Provide junior doctors with two hours per fortnight of quarantined non-clinical time for self-education and the supervision and training of students and junior colleagues.
- Require consultation with junior doctors on their work. Ensure all committees and working groups (or similar bodies by other names) that make decisions or provide input on work practices that impact on junior doctors, have representation by junior doctors including state ICT development and hospital MAC meetings.
- Commit to time in motion studies and review of current redundant and duplicitous processes that cost doctors time with their patients, clinical learning opportunities, and create risk of reproduction errors.
- Establish a MOU between HSPs to allow transfer and cross-acceptance of employer onboarding paperwork, with a simple one-step opt-in for junior doctors, to reduce burden on junior doctors transferring between hospitals.
- Established majority-junior doctor committees in each health service which are tasked with identifying and eliminating unnecessary and bureaucratic processes.

Comments from Doctors in Training

Bentley Health Service Registrar (Service):
"I don't even know where to start. The general public either put doctors on a pedestal or vilify us when things go wrong. We are normal, fallible human beings with valid concerns and emotions. We work long hours under difficult conditions often without protected break time, like nurses. You are expected to be in several places at ones, have tasks done yesterday, often without senior supervision or support. I have spent hours tossing and turning at night concerned about my patients, worrying that I have made the wrong decision or that I could have done more. No one understands the cognitive and emotional burden of the job."

Perth Children's Hospital Registrar (Trainee):
"As a DiT who has rotated through a different hospital every 3 or 6 months for the last 5 years I have had to fill out so many 'pre employment health questionnaires' that I could almost do them with my eyes closed. The level of duplication of bureaucracy between health service departments such as HR/med admin and occupation health is mind boggling."

Sir Charles Gairdner Hospital Intern:
"Paper based overtime forms that require a consultant signature which are difficult to attain and a conflict of interest for consultants who are trying to keep department budgets from going above budget."

Fiona Stanley Hospital Registrar (Service):
"Hard to know where to begin. Every single referral that comes from ED is associated with 5 separate phone calls from 5 different people, all wanting to know the same thing about the patient before you have even had a chance to see them. All the bureaucrats care about is the bed and they forget there is a sick person that needs help."

East Metropolitan Health Service RMO:
"I find that there is always a new form or process that has been put in place with good intention, but no thought for the extra burden it adds to the JMOs actually doing the work."