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By email: futureofwork.sen@aph.gov.au

The Senate Select Committee on the Future of Work and Workers

We refer to 22 November 2017 correspondence inviting lodgment of submission to the Committee's inquiry and subsequent submission deadline of 20 February.

As the peak bodies representing the professional and industrial interests of medical practitioners respectively, the Australian Medical Association (AMA) and the Australian Salaried Medical Officers' Federation (ASMOF) welcome the opportunity to jointly contribute to the inquiry.

Referring to the full terms of reference, we offer our submission (enclosed) as response to the impact of technology on future work patterns for public hospital employed doctors (both Specialist Consultants and Doctors-in-Training) in the context of the adequacy of industrial regulation.

If there is a desire for further information, please contact Mr Andrew Lewis, Senior Industrial Adviser, telephone 02 6270 5473 or email alewis@ama.com.au

Yours sincerely

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President, AMA

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The Senate Select Committee on the Future of Work and Workers

AMA and ASMOF's submission discusses the impact of technology on future work patterns for public hospital medical practitioners in the context of the adequacy of industrial regulation.

Recent advances in technology are changing the way that public sector doctors, both senior doctors (i.e. Specialist Consultants) and Doctors-in-Training (DIT), communicate and work and we expect these trends will continue. These changes have the potential to benefit public patient care and provide for greater flexibility in the working arrangements of public sector doctors. However, the lived experience of many public sector doctors is that innovations such as email, digital transmission of clinical images, smartphones and the like simply result in additional workload, responsibility and interruption when out of the workplace. This contributes to poor morale, fatigue and is often part of a deliberate cost containment strategy of public sector employers.

For the future and in respect of technology advancement, the key challenges for the public hospital sector appear primarily about ensuring employment rules keep pace with rapid change and useful new technology / artificial intelligence (including electronic records, new styles of communication along with varying or replacing some functions currently performed by the medical profession) are effectively implemented. Both of these fundamentally relate to maintaining the high standards of public patient care as presently enjoyed in Australia.

Managing the integration of new technology / artificial intelligence is a new challenge for which senior doctors and DITs (and public hospitals) are not necessarily equipped (in a managerial / administrative competency and skill sense). Technology necessarily changes behaviour which brings with it a new set of requirements to coordinate new systems of work and to guarantee effective communication between the doctor, the new technology and its implications for teams and administration. Public sector employers will need to support development of skills and ensure early respectful dialogue amongst its people to ensure there is carefully introduction of the new ways of doing things; this so that public patient care is not undermined.

Working as a public hospital medical practitioner

In public hospitals, senior doctors have extraordinary responsibility (ethical, regulatory and legal), extraordinary required commitments (hours, workload, quality review, training peers and DITs, continuing medical education) and have a vocational obligation to serve a public patient's wellbeing. DITs are balancing much of the above, particularly often substantial workloads, in conjunction with their (unavoidable) vocational training commitments (effectively 'two jobs' at once). In this context, opportunity to work rigidly in accordance with public sector employer defined hours of work (ordinary & On-call) can be impossible because of the often unpredictable need to intervene when a public patient so requires.

Both senior doctors and DITs will typically work to a roster but often job size can be difficult for public hospitals to accurately define in advance (meaning a heavy reliance on unrostered overtime, On-call / Re-call and some ad hoc work direction). Traditionally, On-call rostering can have the exclusive or combined purpose of providing clinical advice over the telephone and/or requiring availability to return to work for coverage of an absence or to meet the needs of a public patient in their care. The introduction of technology is expanding this meaning, at least amongst certain medical craft groups, to now include performance of work previously only able to be completed within the public hospital setting.

Change to patterns of work

We anticipate that public hospital medical technology and communication investment will see some work place change outmoding elements of current industrial instrument remuneration and organisation of work frameworks.

Entitlements requiring consultation where there is to be major change or introduction of new technology tend to be based on an unsophisticated, non-profession specific model clause. That is, after unilateral decision is made to implement by the public hospital, doctors would only then be made aware of materials that explain the case for change and be provided opportunity to influence.

We think, in an environment of rapid advancement and transformation, that the frequency, pace & unpredictability of change consequence will increase, and be of a different character, to usual managed adjustment processes. To effectively respond, we need to better emphasise public patient safety and quality, through a mandated more inclusive and targeted approach to consultation. That is, ensuring complex and nuanced engagement with senior doctors and DITs well in advance of decision in order to limit perverse or unworkable outcomes. There should also be mandated feedback and measurements to inform continuous improvement.

Technologically based doctor / public hospital patient consultations have existed for a number of years now. This is defined as being an alternative to face-to-face patient interaction using videoconferencing, the internet or similar. An obvious benefit is assisting patients with mobility restraint or who live in rural and remote locations to have some alternative access to public medical care. However, it is important to guard against public hospitals expanding the use of such technologies in pursuit of perceived efficiencies or savings (suggested to arise through reduced infrastructure and administration) because this will impact on quality. 'Video consults' are only adjunct to a physical examination, for clinically appropriate circumstances and could fragment the ongoing care and management of the public patient.

> Current public hospital remuneration systems do not necessarily account for the value and style of this different form of work, including time spent on preparation and post consultation.
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> In regional, rural and remote settings there are workforce supply & demand inequalities when compared to the urban experience. While there will be more ability for metropolitan doctors to engage with these communities using technology there is necessarily a corresponding increase in their professional commitments which will require compensation.

On-call and unrostered overtime are common features of senior doctor and DIT work and these will interact with new clinical information technologies that enable (i.e. expectedly or unexpectedly induce) different ways to perform duties and/or when away from the usual place of work. Referring to *Polan v Goulburn Valley Health* [2016] FCA 440 (about the nature of an employee's work when managing,

coincidentally, medical practitioner rosters from home when rostered On-call), we highlight its implication that a registered agreement needed Court definition because it was unable to be expressly applied to a long standing role when a new and necessary way of performing that work emerged (in this case through evolved use of the telephone).

> The same implication will likely apply to current public sector doctor industrial instruments when new technologies enable clinical practice away from the usual place of work (eg. when the senior doctor or DIT is On-call). Relevantly, in ***Polan***, the Court had to determine: whether "Re-call to duty" meant a return to the workplace must occur to attract the penalty payment, or whether there is a Re-call when remaining at home to do the work; AND whether Re-call eligibility requires a specific direction to perform work; AND whether overtime should instead apply if work was required but was performed at the employee's initiative.

With the implication of ***Polan*** in mind, we think some new industrial regulation is needed to ensure public hospital employed senior doctor and DIT entitlements keep pace with technological change when they are On-call (away from their usual place of work). This includes:

> Ensuring recognition and remuneration for otherwise invisible time before, during or after work is performed external to the workplace using technology. Current provisions will tend to be unsophisticated (Taylorist) in their accounting for time likely because, for example, historically a simple On-call telephone conversation occurred with a distinct start / finish time. For the future, complex clinical information and/or ability to perform some clinical tasks will become available via the home (computer or other terminal). During an On-call period, this will place more demands on the time spent as the clinical reasoning component, general case involvement will be greater. Remuneration and rostering methods will need modernisation to account for these expanded work value contributions and requirements.
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> Restricting potential exploitation (arising through public hospital management omission or strategy to achieve perceived efficiencies). Senior doctors and DITs may be exposed to unreasonable expansion of their responsibilities (evolved or directed) because technology newly enables some clinical responsibilities to be performed outside of a public hospital setting.
>
> It is quickly becoming straight forward for home computers (and potentially other public hospital installed equipment) to enable access to electronic clinical records, clinical imaging et al, case conferencing, video patient consultation etc. This makes it easy for a medical practitioner to fall into the trap of never being away from their work. The more information or opportunity to perform tasks that are available to a medical practitioner will necessarily increase their time commitment to a particular patient (when not actually "on duty" but rather On-call). There is incentive for public hospitals to increase their expectations while the senior doctor or DIT is then left with their vocational conundrum of being unable to stop serving the patient and being disempowered to force change.
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> At present, for a public hospital, work when On-call is potentially a cheaper service than when performed during ordinary hours and is far less regulated. Already there is example of DITs performing medical imaging / radiology tasking when at home On-call. Not only is there the practical implication described in ***Polan*** above, but this contributes to unmanaged generation of fatigue and creates informal prohibitions on the ability to have a reasonable break from workplace obligations.

Minimising negative effects on the quality of public patient care and doctor wellbeing (including their mental health) through preventing potential for a near constant connection to work. Arising through available technology, the expansion of further work obligations or more efficient public hospital contact methods (compared to the traditional model described above), can increase hours and therefore increase fatigue.

Best practice management of sleep interruption and work life balance needs mandating as a foil against new systems of work's inevitable negative impacts. Fatigue creates risk to public patient quality and interfaces with Occupational Health because it creates degrees of impairment for the medical practitioner. Without the full extent of potential technology impacts having yet emerged, already the *AMA Safe Hours Audit (2016)* - AMA's fourth audit since 2001, shows "one in two" doctors surveyed work hours subjecting them to "significant" or "high" risk of fatigue; are not accessing two days consecutive free from duty; and are rostered for three of more consecutive days On-call[i].

The practice of public sector medicine has seen the creation of significant additional workload and response pressures through technology advancement but can be inoculated to preserve quality patient care and ensure sustainability. Senior doctors and DITs have the same wants and desires as, likely, everyone else. We suggest that is, job satisfaction and security; reasonable work time commitment; observing good effects arising from their work; having clear purpose when at work; having opportunity for professional growth; having a family and recreation time and receiving a a fair day's pay for a fair day's work. Technological advancement is inevitably going to disrupt the established norms surrounding these concepts in the practice of public health medicine. Therefore, senior doctors and DITs must be given significant ownership to any mooted technological change to guarantee public patients benefit, effective and efficient implantation/integration and to ensure medicine remains a rewarding and much sought after career.

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[i] The AMA report can be found at: https://ama.com.au/article/2016-ama-safe-hours-audit