



AMA

Opportunities and Impediments to Flexibility

Report on consultations with key stakeholders on
flexibility in medical training and work practices

Prepared by the Australian Medical Association Limited

March 2003

WORK LIFE
flexibility





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Introduction

The AMA's Work Life Flexibility Project aims to facilitate reforms to medical work and training practices necessary to respond to the changing demographics of the medical workforce and societal attitudes to the balance between work, family and other responsibilities.

Focus group research undertaken as part of the project in late 2001 revealed that lifestyle and flexible working practices are important issues for many junior doctors when determining which medical vocation to pursue, and are the single most important consideration for many junior doctors when making that choice.

An extensive report on the findings of the focus group research was circulated to medical Colleges, teaching hospitals, state and federal governments and other industry bodies for comment. The findings from the focus group research were then used as the basis for a program of consultations with those stakeholders during March - August 2002.

The findings of the stakeholder consultations, the initial focus group research and a range of industry perspectives were presented to a national forum *"The New Medical Workforce - Options for Change"* in November 2002. The forum was attended by over 100 representatives of hospitals, medical Colleges, health departments and other organisations, who participated in four policy discussion groups on the key themes identified in the consultations.

This paper seeks to document the broad common themes identified in the totality of the consultation process and policy discussion groups at the forum and aims to provide a basis for developing further strategies to advance greater flexibility in medical work and training practices. The views expressed in this paper do not necessarily reflect those of the AMA or any individual organisation involved in the consultations.

Changing Demographics

During the past decade a number of detailed research and discussion papers have been released dealing with the Australian medical workforce. Reports on workforce participation and training have been prepared by bodies such as the Australian Medical Workforce Advisory Committee (AMWAC), the Australian Institute of Health and Welfare (AIHW) and the Medical Training Review Panel (MTRP).

These reports identify emerging trends in the composition of the medical workforce and highlight the apparent growing divergence

between the aspirations and expectations of young doctors entering the workforce and present training and workplace practices.

The current junior doctor medical workforce comprises a very different demographic to the generations that have gone before it, and these differences are likely to be exacerbated with time. Two principal factors contribute significantly to this change in the junior doctor workforce: the growing number of women entering medical practice and the development of graduate medical schools.

Young doctors who complete the graduate medical degree are generally older than graduates from the undergraduate programs. Many have worked in other professions and have different expectations of their workplace. In addition, an increasing number already have young families and the consequent responsibilities of being parents.

Family responsibilities traditionally weigh more heavily on women, and often mean that women require their work to be more flexible. In 1999, 29.4% of the employed medical workforce were female. Today the proportion of female students commencing medical degrees is almost 55% and is continuing to grow. This fact is likely to have a significant impact on the Australian medical system, as women are apparently choosing to specialise in disciplines that offer more flexibility.

In 2002, 45.1% of Australian vocational trainees were female, ranging from a high of 65% of paediatrics trainees to a low of 12.1% of surgery trainees. Other training programs with high levels of female participation were obstetrics and gynaecology (62.5%), general practice (60.6%), radiation oncology (60.1%) and dermatology (54.7%). General practice, psychiatry, emergency medicine, and paediatrics accounted for over 85.7% of part time training in 2002.

Training programs with comparatively low levels of female participation, in addition to surgery, were intensive care (22.3%), ophthalmology (31.4%), occupational medicine (34.1%) and radio-diagnosis (34.1%).

Junior Doctor Attitudes

The initial research in the Work Life Flexibility project involved a series of focus groups conducted by TQA Research with medical students and junior doctors in Melbourne, Sydney, Brisbane and Adelaide. The focus groups aimed to establish a clear understanding of the issues surrounding vocational choice, medical

training and workplace flexibility from the junior doctor's perspective.

The focus group research reveals that lifestyle and flexible working practices are important issues for many junior doctors when determining which medical vocation to pursue, and are the single most important consideration for many junior doctors when making that choice. Another key finding of the research is that these issues are just as important for male as they are for female doctors.

Focus group participants claim to be less prepared than their predecessors to sacrifice all else for a career in medicine. One focus group participant commented:

"People are now not seeing medicine as a life, just part of it. Twenty years ago it was your life and your family either lived with it or left you."

The focus group research found that lifestyle and work practices of medical disciplines are evaluated by junior doctors in terms of their ability to allow for part-time or job sharing positions, working hours, on-call and after-hours requirements and the flexibility to spend time with family and friends.

Other key drivers of vocational choice include interest and appeal, training requirements and their impact on lifestyle, experience and exposure to the discipline, atmosphere and environment and competition for both training and consultant positions.

For some participants lifestyle as a registrar could be overlooked if the consultant lifestyle at the end of training was seen as desirable. For many participants, however, the lifestyle during training is just as important because they want to enjoy their late 20s and early 30s or have children soon after completing medical school.

Among other key results the focus group facilitators identify are:

- The mind-sets of consultants, medical Colleges and hospital administrators are perceived by junior doctors to be the greatest barriers to implementing change in the medical profession.
- To achieve change it is vital that flexibility in training and work practices is supported from 'the top down' - greater understanding of the issues and active support for reform from medical Colleges, hospitals and consultants is a key requirement for change.
- Flexible training and work opportunities need to be made available as a legitimate option. Senior doctors, Colleges and hospitals are seen to regard junior doctors seeking flexible training as not committed to medicine.
- Junior doctors believe that the medical College selection process is fair. Although there is a perception that some trainees are identified and helped by consultants to get into particular training programs, this process is perceived as generally ensuring that the right people are recruited into a discipline.

Consultations

TQA produced an extensive report on the findings of the focus group research (TQA Report) which was circulated to medical Colleges, teaching hospitals, state and federal health departments and other industry bodies for comment. In addition, the Executive Summary from the TQA Report was sent to all other hospitals, doctors' unions and other relevant bodies. The findings from the focus group research were then used as the basis for a program of consultations with those stakeholders.

Consultations were held in all Australian states and territories. The purpose of the consultations were to understand stakeholder perspectives on the changes considered necessary to expand the availability of flexible work and training practices and the impediments to the introduction of such changes. Face to face meetings were held with approximately 47 stakeholders, written submissions were received from a further 20 and over 100 stakeholders participated in the forum and policy discussion groups on the issues identified in the consultations. Stakeholders that participated in the consultations and forum are listed in Attachment A.

Broad Themes

The overwhelming majority of stakeholders agree with the findings of the TQA Report that a significant change in junior doctors' expectations of their workplace has taken place. This change in expectations is reflected in an increasing number of junior doctors requesting flexible work arrangements, taking sick and other leave and taking time out to pursue other interests or family obligations.

In contrast to the perception of junior doctors that:

The mind-sets of consultants, medical Colleges and hospital administrators are perceived to be the greatest barriers to implementing change in the medical profession,

a significant majority of stakeholders report that neither they, nor the majority of their colleagues were opposed to implementing change in medical work and training practices. Most stakeholders report a commitment to change and a genuine desire to make the medical workplace more flexible.

All stakeholders recognise the existence of "dinosaurs" opposed to change within the medical profession, however it was not felt that there was a pervasive "anti-flexibility" attitude among consultants, Colleges, administrators or government. Most stakeholders were able to illustrate their commitment to flexibility through programs for change initiated within their hospital, College or health system.

Policy and Practice

All medical Colleges have policies allowing vocational trainees to undertake at least part of their training on a part time basis, most also permit a break from training to be taken and usually refer to maternity leave when discussing the circumstances in which that break will be permitted. Most medical Colleges, however, state that they have no control over actual provision of flexible working arrangements and perceive it to be "primarily a hospital rostering and industrial issue".

Health departments and individual hospitals consulted were also able to point to written policies providing for maternity leave (in accordance with legislative requirements) and, in many instances, part-time or flexible working

arrangements. Most hospitals, when questioned about the provision of flexible working arrangements, state that in addition to resource restrictions, College training requirements were often an impediment to the provision of flexible working arrangements for junior doctors.

Most Colleges and hospitals admit that they do not have precise details regarding the number of junior doctors participating in flexible working arrangements or details regarding individuals who had made requests that could not be met. Nearly all Colleges and hospitals made it clear that "any proposal for flexible working arrangements brought to us by a junior doctor will be considered and we will do everything we can to make it work".

Despite the policy position of most Colleges and hospitals, and the genuine effort made to accommodate individuals who make requests, there does not appear to be any easily identifiable and accessible infrastructure for doctors wanting to apply for more flexible working arrangements. There is no consistent promotion of flexible work policies and no “standard pathway” for application. The blame shifting between Colleges and hospitals further complicates the issue for junior doctors seeking access to flexible working arrangements.

Many stakeholders could point to commendable initiatives undertaken in their hospital or College. Addressing the particular issues set out above, the New South Wales Government, for example, has established a workgroup to facilitate communication between Colleges and hospitals and the Royal Australasian College of Surgeons has established a register for trainees seeking job-share positions. The AMA publication *“Initiatives in Flexibility”* sets out a sample of other positive initiatives identified during the consultation process.

Individual Focus

Despite these initiatives one fact emerges clearly from the consultation process; the provision of flexible work and training arrangements for junior doctors in Australia is currently driven by individual requests and demands from junior doctors and tailored specifically for those individuals who request it. There is no nationwide norm that makes flexible work and training acceptable and accessible for junior doctors.

Very few stakeholders could point to the provision of flexible workplace arrangements as a right or entitlement for their medical staff. In nearly all cases stakeholders could show how they had worked hard to “make it work” in one way or another for individual staff members, but could not demonstrate a more concrete entitlement to flexible arrangements for all medical staff.

A result of the individual nature of arrangements currently in existence is that many stakeholders think only of part-time and job sharing arrangements when considering flexible work practices. During the consultation process stakeholders were encouraged to think about flexibility as any change to workplace practice or work structures resulting in a happier and more flexible workplace. A comprehensive canvassing of the various types of work re-structure that are possible is set out in Attachment B and in the Commonwealth Department of Employment and Workplace Relations publication: *“Work and Family: Work/Life Resource Kit”*

It was also clear from the consultations that some disciplines, such as general practice and emergency medicine, lend themselves most easily to the provision of flexible working arrangements, and it is in these areas that the majority of flexible working arrangements can be found.

Stakeholders identify a large number of barriers and solutions to the provision of flexible working arrangements for junior doctors.

Resources

The most significant barrier to the provision of flexible work and training practices in the medical profession identified by stakeholders was a lack of resources; a shortage of funds and a shortage of junior doctors.

Shortage of Junior Doctors

All stakeholders report that despite their desire to offer more flexible working arrangements to junior doctors, this was often impossible because hospital wards are required to be staffed twenty four hours a day, seven days a week. Many hospital administrators state that even providing doctors with "Safe Hours" compliant rosters was difficult because they did not have the required number of junior doctors on staff. This problem was reported in all states but was particularly severe in Tasmania and South Australia.

This stakeholder observation is borne out by reports showing that medical school graduate numbers have been static for almost two decades - 1,356 in 1985 and 1,195 in 2000. The identified problem is likely to get worse in future years as the proportion of female students commencing medical degrees increased from 43.6% in 1989 to 55% in 2001. Women doctors work fewer hours on average per week than do their male clinician counterparts - 39 hours compared to 51.4 hours for males.

In addition to a shortage of junior doctors, most hospitals also report a shortage of consultant staff able to train junior doctors employed at the hospital. This shortage led, in turn, to administrative restrictions on the structure of junior doctor rosters.

Hospital administrators report that employing overseas-trained doctors was not an effective solution, as they often encountered significant and potentially expensive problems with overseas-trained doctors that had led them to be very cautious in using them in their hospitals.

In this context administrators pointed to poor English language skills resulting in serious communication breakdowns, a failure to understand Australian laws relating to doctor/patient confidentiality resulting in possible liability exposure and differing skill levels often resulting in overseas-trained doctors requiring significant supervision.

Shortage of Funds

A number of stakeholders report that a shortage of funds prevents them from implementing family friendly and flexible workplace initiatives. The most common initiatives cited for which funds are unavailable are childcare facilities and adequate support staff/data managers for senior clinicians.

A hospital administrator commented that a major reason hospitals are unable to provide flexible work arrangements is the administrative burden placed on senior consultants. In addition to their clinical and training duties, consultants are required to manage a vast amount of paperwork and data that could readily be managed by an administrative assistant or "data manager". The volume of data provided to consultants has increased with the development of electronic communication. Much of this information is irrelevant to the consultant's immediate practice. It was felt that the provision of data managers to senior consultants with training duties would be of significant benefit to both the senior consultant and the junior doctors under his/her supervision.

Initiatives such as the provision of childcare facilities are also frequently mentioned as not falling within current budgets. It is clear that benefits would accrue to both junior doctors and other staff were such facilities to be made available. The New South Wales Government has recently responded to this issue, announcing that an additional 945 childcare places will be made available to doctors, nurses and other health professionals in the next five years. This decision demonstrates both an acceptance of the public policy benefit that is likely to result and the ability of state health services to enhance the flexibility of the medical workplace through targeted budget increases.

Career Medical Officer

The most common solutions volunteered by stakeholders to the problem of lack of resources are both an increase in funds and an increase in junior doctor numbers. The second most common response was a restructure of the role of Career Medical Officers (CMOs) within the hospital system.

Hospital administrators all indicated an awareness of the reasons behind the restriction on the number of junior doctors entering medical schools and consequently in the hospital system and vocational training programs. A majority of stakeholders felt, however, that widespread flexible working arrangements could only be provided if more doctors are employed to cover shifts and increase the total number of "doctor hours" available to the hospital.

Many stakeholders are of the opinion that an increase in the number of CMOs in the hospital will provide the necessary "doctor hours" to create more flexibility in the rostering of all doctors.

Flexible working arrangements are currently widely available to CMOs, however, it is generally acknowledged that the current career model for

CMOs is unsatisfactory, and without restructure, it is unlikely that a significant number of doctors will be attracted to the role.

The current structure of the CMO role in Australia, and the focus on specialisation, appears to have also created a negative attitude to the role in the mind of some senior doctors. One stakeholder expressed the view that CMOs are:

"not good doctors, have no ambition, have a go-nowhere attitude, are dead weight and are striving for nothing."

Suggestions for restructuring the CMO role, and giving it a higher status, centred on the provision of further education and career development opportunities for CMOs. The provision of further university education options to CMOs is seen as essential. A CMO model incorporating a masters degree in clinical medicine was widely perceived as an initiative which would provide CMOs with the career development currently unavailable to them.

Most stakeholders accept that programs of this nature will provide positive changes to the medical workplace. Another suggestion which is widely supported is that CMOs could be given the role of providing significant education and training to junior doctors in their post graduate years 1 and 2 (PGY1 and PGY2). This would provide CMOs with further opportunities for career development and counter the "lack of trainers" problem reported by many hospitals.

Most stakeholders felt that the sub-specialisation evident in medicine today leads to a regrettable extinction of the generalist within broad disciplines of medicine. It is felt that initiatives focusing on the development of CMOs within those broad disciplines will have the added advantage of reintroducing an important component of a high quality medical system.

All the suggested improvements to the CMO role target opportunities for academic advancement and career development. The creation of a hospital generalist/specialist medical educator role is seen as an attractive and flexible career path with the potential to attract a large number of doctors and help ameliorate the current resource problem facing hospitals.

The success of any initiative to enhance the role of CMOs will require additional funding and also willingness by hospitals, Colleges and consultants to acknowledge the further education and experience of CMOs and the important contribution they will make to the development of junior doctors. Another important suggestion, aimed at targeting the current status issues associated with the CMO position, is to change the name of the position to "general hospital practitioner" or "hospitalist".

Previous Research into the Role of the Career Medical Officer

The CMO role has previously been investigated in this context. The AMA's Alternative Non-Specialist Hospital Career Options project undertaken in the mid-1990s investigated options for the restructure of the CMO role, aimed at improving recruitment and retention for hospitals. The then Commonwealth Department of Health and Family Services', Hospital Pilots Restructuring Program also investigated some similar issues, although focused more on operational issues at individual workplaces than a significant restructure of the CMO role.

Various reports and submissions were produced under these programs, notably the AMA commissioned paper by Brennan and Williams: "*Non Specialist Hospital Careers Project*". The recommendations for enhancing the CMO role arising from that report were not taken forward due to cost restrictions. The majority of the papers prepared for the project reach similar conclusions to those set out in this report.

The Schools of Medicine at the University of Queensland and the University of Newcastle developed a proposal for a Masters of Clinical Medicine targeted at CMOs and submitted it for Commonwealth funding in 2000. The proposed course was designed to combat many of the problems inherent in the CMO career pathway as it is currently structured that are outlined above and was intended to be adoptable by universities in each state. The proposal was not funded in 2000 but the Universities intend to resubmit it for funding in the near future.

Workforce flexibility and quality and safety considerations both require that the workforce shortage be addressed. An investigation of the role of CMOs and possible enhancements to that role and the contribution CMOs can make to medical care in Australia is warranted. Much work has already been done in this area and nearly all stakeholders viewed it as an important issue and possible agent of change. Accordingly, stakeholders felt that federal and state governments should provide the required funds to enable the necessary work in this area to be completed.

Nurse Practitioners

A similar response to the issue of resources was made by several hospitals currently exploring the development of the nurse practitioner role. The objective of these hospitals is similar to the objective of the enhancement of the CMO role - the creation of a skilled workforce able to take pressure and workload off the current clinical staff.

Nurse practitioner initiatives appear to be effective in areas where a threshold number of nurse practitioners were recruited, however nursing is facing severe recruitment difficulties and, accordingly, not many hospitals have the sufficient numbers of nursing staff to achieve a successful program.

In addition, nursing stakeholders suggest that the development of a nurse practitioner role has not been effective in encouraging more individuals to train for a career in nursing, nor enticed former nurses back into the field.

Summary

A shortage of resources, both financial and human, is the most significant barrier to the development and implementation of flexible working arrangements for doctors in Australia. Stakeholders considered that this problem can only be addressed by an increase in funding and an increase in junior doctor numbers or the development of a skilled workforce of hospital generalists and/or nurse practitioners able to share the workload of the current clinical staff.

Education and Training

A majority of stakeholders identify positive workplace changes that could result from a review of the current medical education and training model. Most stakeholders note that it would be impossible to identify the perfect model and that “no one size fits all”. There is also general agreement that the “apprenticeship” system currently used in Australia is the most appropriate method of training junior doctors. However, within that broad framework several areas with the potential for change were identified.

It is important to note that extensive work has been done in the areas of undergraduate, pre-vocational and vocational medical education and training. Restructuring of university courses to focus on problem based learning, the introduction of personal development units and a new emphasis on well rounded education are important changes in the undergraduate curriculum.

Many medical Colleges have undertaken, or are about to undertake, a significant review of the way in which they structure their training and examination programs. The emergence of postgraduate medical education councils in each state and territory is having a significant impact on the quality of training delivered to pre-vocational doctors, and ensures that more structured on-going training is provided in the hospital environment.

Despite the significant advances in medical education that have been achieved, stakeholders still identify areas where they feel improvement is necessary or the practical implementation of initiatives is being thwarted by funding and resource issues. Stakeholders feel that positive initiatives are often not properly implemented because of the practical tension in the hospital environment between service provision and training.

Key issues for review raised by stakeholders include: the time required to complete training under the current model; the lack of emphasis placed on the “values of medicine”; teaching of appropriate clinical skills; and the concentration of a significant proportion of training years in the hospital environment.

Length of Training

The length of time currently required to complete training has a profound impact upon the lifestyle of a junior doctor. This impact is detailed in the TQA Report and ranges from curtailing social life and affecting relationships to delaying child bearing until the end of training. The length of time required to complete training is also often cited as one of the principal reasons for working long hours, as junior doctors attempt to balance gaining experience, building a profile they perceive is necessary to enable them to secure a place in a training program and study for exams.

Several stakeholders indicate that it might be possible to reduce the length of time taken to complete an MBBS by one year without the need to make major changes to the current curriculum. A more radical overhaul of the MBBS, and a significant reduction in the volume of information taught to students, is generally perceived to be a bad idea. Several stakeholders note that the majority of university courses have been overhauled in the past few years. The introduction of the UMAT and GAMSAT tests and a move to a problem solving, team based learning model being the most significant changes.

Stakeholders did indicate that it might be possible to shorten the length of time required to complete vocational training. The issues discussed in this context are outlined in the section on vocational training below.

Values of Medicine

A significant number of stakeholders observed that, in addition to more modern attitudes to work and flexibility, many junior doctors appear to have developed a disappointing attitude to the practice of medicine. Stakeholders feel that many junior doctors do not appreciate the privileged position held by a doctor, and the dedication a doctor traditionally feels towards

providing a service to his or her patients. The concept of loyalty to institutions is no longer a commonly accepted principle.

Various stakeholders feel that medical students are not given a proper education in the "values of medicine" and the nature of "professionalism". Whilst accepting an urgent need for reform of the medical workplace, these stakeholders note that medicine is not able to be as flexible as many other professions.

Accordingly, they state that universities should provide pre-vocational career information, focussing on the likely impact of a medical career on lifestyle and techniques to manage this issue. The inclusion of education relating to the special privileges and obligations of doctors, the required "sense of service" and pride in the profession is also mentioned as a necessary addition to the MBBS curriculum.

Hospital Skills

Many stakeholders state that a majority of university graduates do not have appropriate clinical skills for their intern year. In addition, the transition from university to the intern year and PGY2 is currently unnecessarily stressful - there is no well-structured "bridge" between these years. These stakeholders feel that this is a contributor to the lack of flexibility, stress and long working hours experienced by doctors in the PGY1 and PGY2 years.

Stakeholders acknowledge that much work has been done in this area and that the introduction of Medical Education Officers often results in improvements. Stakeholders also acknowledge that more structured training is now being offered to PGY1 and PGY2 doctors in many hospitals in Australia. However, stakeholders who commented on this issue stress that more work is required to bridge between the university experience and the pressures of the intern year.

Solutions suggested by stakeholders focus on the inclusion of more hospital based clinical skill training either in the medical degree curriculum, or as a bridging course between graduation and the intern year. This training would include communication skills in addition to basic clinical skills. Stakeholders feel that specific training in these skills would improve the effectiveness and safety of the junior doctor in their early years of hospital work, facilitate their understanding of procedures and communication in the hospital environment and accordingly, improve the quality and flexibility of their working day. Several stakeholders note that their junior medical officer training already included training in communication and management issues, however the majority of hospitals report that they either do not have these programs, or that they are poorly attended.

One important point made by a stakeholder in relation to the flexibility available to interns relates to the legislative obligation on medical boards to ensure that interns have achieved a basic level of competence to practice. In order to comply with this requirement, and gain a full range of clinical exposure, it is necessary for interns to experience both weekend work and night shifts. While this requirement is undeniable, some stakeholders feel that hospitals and medical boards should make every effort to accommodate the reasonable requirements of doctors with children or other responsibilities when rostering intern shifts, or considering proposals for part time internships.

Vocational Training

The TOA Report reaches extensive conclusions regarding junior doctors' attitudes towards vocational training. The majority of stakeholders concur with the finding that:

"Lifestyle and work practices have the greatest impact on vocational choice."

Most College stakeholders indicate an awareness of this issue and point to their policies and initiatives regarding part-time and flexible work arrangements. Many Colleges have, in recent years, taken a more pro-active approach to this issue in order to attract more junior doctors into their programs.

Following publication of the *Trainee Selection in Australian Medical Colleges* (Brennan Report) on trainee selection commissioned by the Medical Training Review Panel, all medical Colleges formalised policies allowing vocational trainees to undertake at least part of their training on a part time basis. Most Colleges also permit a break from training to be taken and usually refer to maternity leave when discussing the circumstances in which that break will be permitted.

Other initiatives being undertaken include the Royal Australasian College of Surgeons job share register, the Royal College of Pathologists of Australasia mentoring program currently in development and the work being done by many Colleges in relation to curriculum and learning goals in preparation for accreditation by the Australian Medical Council.

Notwithstanding these initiatives, stakeholders recognise that the pressures on junior doctors during vocational training are, in general, severe. The principal reason for this outcome, cited by most stakeholders, is the tension between service delivery and training created by the current system.

The majority of vocational trainees work in hospitals and provide a vital element of the staffing requirements of hospitals. Consequently, stakeholders note there has been a gradual decline in the time and energy devoted to providing quality training during these years and an emphasis placed on provision of services to patients. As a result trainees do not necessarily receive the quality of training and study time they should during these years, and a stressful “cramming” situation is created when preparing for exams.

This tension is also the most common reason stakeholders believe there are areas for improvement in medical training and education, despite the many advances made in the area over the past few years. This situation has, in the main, been the result of the lack of adequate staffing in hospitals referred to in the previous chapter.

Several stakeholders suggest that this problem could be ameliorated if Colleges engaged in more consultation with hospitals regarding the structure of vocational training, exam schedules and associated matters. The New South Wales Government has recently established the Medical Education and Training Council to facilitate communication between Colleges and hospitals and improve the efficiency of medical training in New South Wales. The progress of this initiative should be closely monitored.

An interesting point made by many stakeholders is that most vocational trainees are training in public hospitals which, in today’s medical system, do not provide them with a comprehensive education in their area of specialty as the vast majority of patients in hospitals are acute cases. Many stakeholders are beginning to question the focus of vocational training in hospitals, a view which may ultimately further impact on the shortage of hospital staff. This issue has been recognised by the Australian Health Ministers’ Advisory Council, which has released a discussion paper on the matter.

Many stakeholders also suggest that a failure to properly define training outcomes and competencies and to examine issues such as the relationship between volume and competence in designing training programs, is a major contributor to the inflexible and demanding nature of vocational training. Several Colleges have begun inquiries and research into this issue. Based on the comments of a variety of stakeholders closely involved with training medical students and junior doctors, it would seem appropriate for a major, cross discipline study to be undertaken regarding the value of competency based training and the relationship between volume and competence. The results of such studies could have a significant impact on the vocational training model, and may alter current perceptions that training part-time must necessarily take twice as long.

At a minimum, more clearly defined training outcomes (pass marks/competencies) are likely to have a beneficial effect on junior doctors, who will no longer feel compelled to work unsafe hours and compromise family/personal life as they strive to surpass mysterious “bars”. The finding in the TQA Report that junior doctors feel pressured into selecting their specialty too early is supported by most stakeholders, however, most also believe that there is little that can be done owing to the already lengthy qualification processes.

Several stakeholders stressed that basic training in all disciplines should be made as modular and transferable as possible, and that all Colleges should be prepared to recognise at least a proportion of basic training in another discipline. This measure would give more flexibility to junior doctors, enabling them to more easily move between training programs if necessary.

Skills Centres

The majority of stakeholders feel that the use of skills centres will significantly increase the quality and safety of vocational training. In addition, the use of a skills centre as an integral part of training curricula will have a significant impact on the flexibility of training. Trainees will have the ability to structure training sessions around their personal and childcare commitments, instead of waiting for patients to present at hospital. This can reduce the length of training and will enable trainees who may have otherwise had to train part-time to move closer to a full-time equivalent.

Most stakeholders acknowledge that large skills centres, such as the Centre for Medical and Surgical Skills in Perth, are very expensive. However, many stakeholders are so convinced of the clinical and work/life benefits provided by such centres that they consider state and federal governments should fund at least one centre for each state. Other stakeholders, such as Royal Adelaide Hospital, point to the similar training benefits that can be achieved by establishing smaller and much less expensive skills centres within available resources at individual hospitals.

Summary

Although most stakeholders believe that the current education and vocational training model is highly effective most agreed that, within the broad structure of the model, there is significant room for investigation of improvements. Targeted research into the curricula offered in undergraduate levels, PGY1 and 2 and vocational training programs is regarded as desirable. It is important that there be an investigation of whether training could be made more effective, and perhaps less time intensive, by reviewing our understanding of the relationship between volume and competence. It may also be necessary to investigate whether junior doctors receive the best preparation for independent practice completing the majority of their training in public hospitals.

In addition, it is regarded as important that universities, hospitals and Colleges work together to address issues related to the education of junior doctors in all aspects of medicine. Suggested improvements include: units related to the "values of medicine"; units heavily focused on hospital competencies including navigation of administration and communication skills; and devoting funding to the development of skills centres and their use; particularly in vocational training programs.

Culture

Although the majority of stakeholders reject the finding that the mind-sets of consultants, medical Colleges and hospital administrators are the greatest barrier to implementing change in the medical profession, stakeholders do recognise that a major cultural change will be required before the medical workplace embraces flexible work practices.

Stakeholders believe that only a minority of consultants have an attitude consistent with statements reported in the TQA Report such as:

“In my day we had to wake up before we went to sleep.”

To the extent that consultants are perceived to be opposed to the introduction of flexible working practices, stakeholders believe that the majority are in fact concerned about the potential impact on quality and safety. Accordingly, any attempts to combat this resistance should focus on that aspect of the issue.

Leading by Example

An overwhelming majority of stakeholders feel the most effective way to combat health and safety based consultant resistance to the introduction of flexible working practices is to lead by example. The introduction of workplace flexibility “champions” is a widely supported suggestion.

Several stakeholders have already begun initiatives focusing on combating quality and safety based resistance to flexible working practices. The West Australian Pre-Vocational Training and Accreditation Committee (PTAC) claim considerable success in this area. PTAC is rigorous in ensuring that each pre-vocational position it accredits is compliant with a range of important factors, including reasonable hours of work and other conditions consistent with flexible workplace arrangements.

PTAC report initial consultant resistance to many of its demands relate to hours of work and flexibility, however, notes that this resistance is eroded by a combination of effective communication and demonstrated maintenance

of quality and safety standards. In fact PTAC report that, after observing the success and workability of flexible arrangements for junior medical staff, many senior consultants implemented more flexible work arrangements for themselves.

A complementary issue raised by most stakeholders is that consultants are, in general, highly influenced by their peers. Accordingly, the identification of consultants willing to be “flexibility champions” and the active support of Colleges would be vital components of any strategy aimed at achieving cultural change and targeting quality and safety based resistance to flexible work practices.

All stakeholders who report successful implementation of flexible working practices indicate that a vital component of the success was effective communication between hospital administration, consultants and junior medical officers regarding rostering and work arrangements. Merely ensuring that all participants are aware of arrangements is widely

regarded as insufficient. All participants are required to actively contribute to the creation of rosters and arrangements to ensure that the particular requirements of individual positions and needs are accommodated and agreed arrangements are genuinely considered and accepted by all parties. Stakeholders stated that the key elements of this process are communication, articulation of clear expectations and support.

Training Compact

Many stakeholders accept the need for open and active communication regarding the structure of rosters and work arrangements, but note that junior doctors are often intimidated by the subject of work arrangements and are unlikely to initiate or properly participate in such discussions. One group of stakeholders suggests that a device such as a “training compact” might be an effective method of addressing this problem.

The proposed “training compact” was envisaged as a document (separate from any employment contract) setting out the hospital’s undertakings in relation to the training that would be provided, the way in which the hospital intended to provide it and the consultants who would be likely to provide the training. The document would also set out the junior doctor’s undertakings in relation to the way in which they would approach their training.

This document is not envisaged as a binding legal document, but rather as an effective communication tool for setting clear expectations, involving consultants and providing a platform from which a discussion of work arrangements would be actively encouraged for junior doctors. For example, hospitals could make commitments to junior doctors in this document about the way in which protected study time (provided under most employment contracts, but not generally well observed) will be provided.

This document may also provide an effective means of giving hospital administration and consultants a forum to make clear their expectations regarding the level of commitment to quality work and training expected from the junior doctor. In this way hospital administrators might also be able to make a clear statement about the inadvisability of “moonlighting” - a junior doctor practice mentioned by most hospital administrators as common, extremely vexing, detrimental to effective training and destructive of practical implementation of Safe Hours principles.

Quality and Safety

To effectively counter quality and safety based resistance to flexible workplace arrangements many stakeholders feel it will be necessary to improve certain hospital competencies designed to facilitate such workplace arrangements. The most important of these hospital competencies, and the one with the most power to change workplace arrangements, is clinical handover.

The TQA Report indicates that one of the principal objections to the introduction of flexible workplace initiatives in hospital settings is the issue of continuity of care:

“The provision of continuity of care and the inability to simply leave mid consultation are also perceived as a barrier to greater training and workplace flexibility.”

The issue of continuity of care is supported by various stakeholders as a vitally important and real barrier to workplace flexibility or dismissed by stakeholders as a spurious excuse for not implementing change. Different opinions on this matter were held within each of the major stakeholder groups (hospital administration, government and College) and particular themes could not be attributed to any of those groups. One matter on which most stakeholders agree, is that continuity of care will not be significantly affected by part-time work, job sharing or other flexible working arrangements if handover procedures were improved.

It is generally accepted that, particularly in medicine and surgery, handover procedures are neither well taught nor well practised. Most stakeholders agree that handover is done better in emergency departments, but still feel that there is room for improvement.

Most stakeholders point to the poor record keeping skills and written notes made by both junior doctors and consultants. It is generally agreed that both oral and written communication regarding patient conditions is significantly worse than it was 20 years ago. Most stakeholders believe that any increase in adverse events as a result of handover is a result of the poor processes currently employed, rather than resulting directly from the handover itself.

Stakeholders are divided on the question of why clinical handover techniques for medical staff had experienced deterioration in the past 20 years. Some stakeholders attribute this decline to the increased likelihood of litigation, others to the failure of the education institutions to teach proper clinical skills.

Stakeholders are clear on one fact; the development and introduction of best practice clinical handover guidelines would be a significant positive step for both the care of patients and the introduction of flexible arrangements in hospitals.

Summary

Although the “dinosaur” attitude that medical training has always been, and must remain, inflexible and excessively demanding is largely rejected by stakeholders, other cultural issues are identified. Stakeholders feel that remaining cultural resistance to flexible workplace arrangements is rooted in concerns regarding quality and safety. Accordingly, stakeholders suggest that such resistance could best be overcome by demonstrating that quality and safety will not be compromised by the introduction of flexible working arrangements. This “example” will be facilitated by the introduction of “flexibility champions” and the facilitation of pro-active communication on the issue among all involved persons.

Importantly, the development of best practice clinical handover guidelines is identified by stakeholders as an essential initiative to address the quality and safety concerns of consultants in relation to workplace flexibility. The introduction of agreed clinical handover guidelines is seen by many stakeholders as a prerequisite to greater workplace flexibility.

Workplace Organisation

Many stakeholders indicate that, notwithstanding the necessary changes noted above, many positive changes are achievable within the current system. The following sets out suggestions for change, many of which are already being implemented in various institutions around the country.

Junior Doctor Coordinators

An important consideration raised by some stakeholders is that administrators directly responsible for junior doctor rostering and entitlements should be persons likely to empathise with the experience of a junior doctor. One hospital reports that the recruitment to such positions of relatively young coordinators, who had recently completed medical training, has resulted in a higher level of happiness among the junior doctors.

A similar initiative, Medical Education Officers (MEOs), has been implemented in many hospitals. The introduction of MEOs responsible for ensuring appropriate training is provided to doctors in PGY 1 and 2 has resulted in some positive changes. MEOs can be used to ensure that training time is protected - one stakeholder reports that MEOs collect junior doctor pagers prior to training lectures to ensure protection of training time.

The introduction of MEOs appears to usually be in conjunction with the provision of a more structured training and orientation program for junior doctors. MEOs are able to give issues such as communication and management training, mentioned in preceding sections as vital, the time and attention they deserve.

Initiatives such as these, designed to improve junior doctor access to appropriate quality advice and training from individuals empathetic to their needs, are an important and achievable step in the move to a more flexible workplace.

Smarter Rostering

The opportunities for improvements in rostering practices leading to greater flexibility, even within existing workforce and resource constraints, was raised by a number of stakeholders. Resource materials and training on best practice rostering for staff involved in setting doctors' rosters could significantly enhance the scope for introducing more flexibility, while improving roster design, involving junior doctors and moving towards "Safe Hours" compliant work schedules.

Orientation Programs

Nearly all stakeholders agree that comprehensive orientation programs can significantly improve a junior doctor's work experience. Most stakeholders agree that to be properly effective orientation programs should be 2 - 4 days in length and should ensure that junior doctors are introduced to nurses and other staff with whom they will be working and are properly instructed about administrative procedures.

In addition to making junior doctors more comfortable in their workplace, good orientation processes can reduce the time spent at the workplace by junior doctors by making them aware of and encouraging them to effectively use streamlined administrative procedures. Early awareness of these procedures can also significantly reduce junior doctor stress levels.

Job Design and Support

Many stakeholders report an increase in junior doctor happiness and flexibility resulting from a more effective allocation of administrative staff. These stakeholders report that a review of their processes have made clear that junior doctors are often being used to complete administrative tasks where there is no clinical nor training benefit to be gained.

One stakeholder reports that the employment of a “gopher” in the orthopaedics ward to collect X-Rays and perform other routine tasks previously allocated to junior doctors had resulted in reductions in junior doctor hours, stress and resentment. Other stakeholders report success with similar trial schemes.

The redesign of junior doctor jobs and the shedding of non-medical functions is seen by a number of stakeholders as offering an important opportunity for creating greater workplace flexibility. Similarly, the redesign of other work systems, including data collection forms and administrative procedures, offer further opportunities for improving workplace flexibility for doctors.

Technology

Various stakeholders are of the opinion that many of the inefficiencies currently evident in hospital medical practice will be resolved with the introduction of technologies making clinical pathways, decision support systems and documents such as test results available electronically to a hand-held device used by doctors. Several stakeholders report that they will be commencing trials with these new technologies in the near future. Clearly, this type of advance would require additional funding.

Information for Managers

Many stakeholders indicate that they have already completed extensive policy reviews in the area of workplace flexibility and point to well developed policies on the issue. A majority of these stakeholders, however, note that the uptake of benefits was slow, and not widespread among medical staff. These stakeholders identify a need to create work/life resource kits for medical managers and consultants and to provide those managers and consultants with training and advice about employer obligations and the business/clinical case for providing more family friendly/flexible work options to medical staff.

Physical Facilities and Support

Other initiatives reported by stakeholders to enhance flexibility and which have a beneficial effect for junior doctors are: the provision of rest rooms or beds for doctors; the provision of taxi vouchers to doctors finishing work late at night and the provision of childcare facilities. Access to medical libraries “after hours”, access to the internet and the provision of work stations and study facilities are also seen by stakeholders as enhancing flexibility and reinforcing the “learning environment” by providing the necessary physical facilities.

Flexibility Network and Job Share Register

The creation of an internet based “flexibility network” to share information and success stories, establish e-mail groups and chat rooms, provide ready access to College and hospital flexibility policies and provide an online resource, is seen by stakeholders as an achievable objective with the scope to advance the flexibility agenda.

The establishment of an internet based job share register, with the support of all key hospitals, medical Colleges, pre-vocational training bodies and medical associations, is identified by stakeholders as a practical step that could be taken within existing resource constraints to maximise access to flexible work and training opportunities.

Define and Audit Flexibility

Stakeholders identified the development of a common understanding over what constitutes a flexible medical workplace and the creation of tools for the assessment and audit of flexibility initiatives as a potentially useful initiative. Such an initiative would serve to identify an inventory of flexibility options available to medical workplaces and provide a solid basis for the adoption of flexibility programs consistent with industry best practice.

Employment Issues

Some stakeholders identified the need for changes to employment arrangements, such as the introduction and/or expansion of paid maternity leave, as offering further opportunities for flexibility. Improved employment security for junior doctors, particularly in part time and job share positions and support with obtaining suitable ongoing positions after periods of flexible work and training are also seen by some stakeholders as important to facilitate greater flexibility.

Summary

There are many positive initiatives in the area of workplace flexibility for medical staff being implemented in hospitals around the country. These initiatives are an important part of the cultural shift to a greater acceptance of flexible work practices for junior doctors. A number of these initiatives, such as the web based job share register, could readily be expanded to apply across the junior doctor workforce with the support and participation of both hospitals and training providers.

Next Steps

The quality of input from stakeholders provided through written submissions, face to face meetings and policy discussion groups has been extremely high. Input has been received from all the major stakeholders in each state and territory, including from hospitals, medical training organisations and health administrations. The time and effort put into the consultations by stakeholders demonstrates a genuine commitment across the medical and hospital sector to effecting positive change.

The outcomes of the policy discussion groups at the national forum, "The New Medical Workforce - Options for Change", reflected and augmented the earlier consultations and confirmed that the change process had commenced.

The next steps for all stakeholders necessarily involves closely examining this report, identifying those elements that fall within their capacity to influence, establishing priorities and establishing a program for promoting the expansion of flexible medical work and training practices in their organisation.

Many issues and initiatives can be progressed at the individual workplace, hospital and College level, but a number require political and resource commitments by state and federal governments. Others, while not requiring significant additional resources, require coordination across hospitals, Colleges and other stakeholders. Not all the opportunities identified in this paper can be pursued simultaneously, nor can a number of impediments be immediately removed.

The AMA, as part of its ongoing Work Life Flexibility project, will identify those initiatives in this paper that it can usefully progress. This will involve further consultations with stakeholders on industry wide issues, facilitating progress on specific initiatives requiring a coordinating role and maintaining a broad industry change program on this important issue.

All stakeholders are invited to comment to the AMA on this report and to indicate areas of activity they consider they can usefully progress. Feedback should be provided to:

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Attachment A

Stakeholders Involved in Consultations and Forum

Adelaide to Outback GP Training Program, SA
Alice Springs Hospital, NT
Angliss Hospital, VIC
Austin & Repatriation Medical Centre, VIC
Australasian College for Emergency Medicine
Australasian Society of Career Medical Officers
Australian & New Zealand College of Anaesthetists
Australian & New Zealand Intensive Care Society
Australian Centre for Industrial Relations Research and Training
Australian Council for Safety & Quality in Health Care
Australian Council on Healthcare Standards
Australian Divisions of General Practice
Australian Health Ministers' Advisory Council
Australian Medical Association (NSW)
Australian Medical Association (Victoria) Limited
Australian Medical Association (WA)
Australian Medical Association Council of Doctors-in-Training
Australian Medical Council
Australian Medical Students Association
Australian Medical Workforce Advisory Committee
Australian Nursing Federation
Australian Salaried Medical Officers' Federation
Australian Society of Anaesthetists
Bankstown Health Service, NSW
Barwon Health, VIC
Bayside Health, VIC
Beachport Medical Services, SA
Bendigo Health Care Group, VIC
Bunbury Health Service, WA
Committee of Deans of Australian Medical Schools

Committee of Presidents of Medical Colleges
Commonwealth Department of Health & Ageing
Commonwealth Office of the Status of Women
Council for Early Postgraduate Training of South Australia
Department of Employment and Workplace Relations, ACT
Department of Health & Human Services, TAS
Department of Human Services, Victoria
Faculty of Medicine and Dentistry University of Western Australia
Faculty of Medicine Nursing and Health Sciences, Monash University
Faculty of Medicine University of New South Wales
Faculty of Medicine University of Sydney
Faculty of Medicine, Dentistry and Health Sciences University of Melbourne
Flinders Medical Centre SA
General Practice Partnership, SA
General Practice Registrars' Association
Group of Australian Society of Anaesthetists Clinical Trainees
Health Department of Western Australia
Health Services Association of NSW
Hornsby Hospital, NSW
Human Rights & Equal Opportunities Commission
Internal Medicine Society of Australia & New Zealand
King Edward Memorial Hospital, Perth
Latrobe Regional Hospital, VIC
Launceston General Hospital, TAS
Lyell McEwin Health Service, SA
Macquarie Hospital, NSW
Maroondah Hospital, VIC
Mayne Health Pathology, VIC
MDA National
Medical Board of South Australia

Medical Board of the Australian Capital Territory
Medical Training & Education Council, NSW
Mercy Hospital for Women, VIC
New England Area Health Service, NSW
New South Wales Medical Board
Newcastle Mater Misericordiae Hospital
Northern Territory Postgraduate Council
NSW Health
Office of the Minister for Health, SA
Postgraduate Medical Council of New South Wales
Postgraduate Medical Council of Victoria, VIC
Queen Elizabeth Hospital, Adelaide
Queensland Branch of Australian Medical Association
Queensland Health
Repatriation General Hospital, Daw Park, SA
Royal Adelaide Hospital
Royal Australasian College of Physicians
Royal Australasian College of Physicians - Australasian Faculty of Public Health Medicine
Royal Australasian College of Physicians - Australasian Faculty of Rehabilitation Medicine
Royal Australasian College of Physicians (Paediatrics and Child Health)
Royal Australasian College of Surgeons
Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Royal Australian & New Zealand College of Ophthalmologists
Royal Australian & New Zealand College of Psychiatrists
Royal Australian & New Zealand College of Radiologists
Royal Australian College of General Practitioners
Royal Brisbane Hospital
Royal Children's Hospital, Parkville, VIC
Royal College of Pathologists of Australasia
Royal Darwin Hospital

Royal Hobart Hospital
Royal Melbourne Hospital
Royal North Shore Hospital, NSW
Royal Prince Alfred Hospital, NSW
Rural Doctors Association of Australia
School of Medicine Flinders University
School of Medicine University of Queensland
Sir Charles Gairdner Hospital, Perth
South Australian Department of Human Services
South Eastern Sydney Area Health Service
Southern Health, VIC
Strategic Planning Group for Private Psychiatric Services,
Sunshine Coast Health Service District, QLD
Sunshine Hospital, VIC
Sydney Children's Hospital, Randwick
Tasmanian Department of Health and Human Services
Territory Health Services, NT
The Canberra Hospital
The Postgraduate Medical Education Committee Queensland
United Medical Protection
University of Melbourne
Victorian Hospitals Industrial Association
Western Australian Prevocational Training and Accreditation Committee
Women's and Children's Hospital, SA
Work Life Resources, VIC

Attachment B

Possible Flexible Work Practices

Regular part-time work

A regular part-time employee:

- is a permanent employee;
- works less than full-time hours;
- has reasonably predictable hours of work; and
- is entitled to employment entitlements associated with permanent employment such as sick leave and annual leave (on a pro rata basis).

Job-sharing

Job-sharing is an arrangement in which two or more people share one full-time job, each working part-time on a regular on-going basis. Job-sharing may be a viable option when a position needs to be filled on a full-time basis, but not necessarily by one person.

Teleworking

Teleworking (also known as home-based working) is when an employee works on a part-time or full-time basis away from the workplace. Typically teleworking is done from a home-based office with remote access to the workplace network. A typical teleworking arrangement will involve a combination of work from home and at the office.

Parental leave

Men and women are able to take time off work to care for their child during the first year of its life. Federal workplace relations legislation entitles parents to 52 weeks unpaid leave on a shared basis to care for their newborn or adopted child.

Carer's leave

Carer's leave (also known as family leave) enables employees to take time off work to care for and support an immediate family member who is sick.

Career breaks

Career break schemes allow employees to negotiate a fixed period (up to several years) away from work. The employee is guaranteed a job at the end of the negotiated period.

Child care

The availability of affordable, quality child care is an important issue for employees with children. Employers can offer a variety of child care initiatives to support employees. These could include:

- advice and referral services - offering assistance in finding appropriate child care;
- organising school holiday care;
- before and/or after school care - either providing this service in the workplace, or arranging transportation for children to get to and from the child care centre;
- sponsoring Family Day Care places; and
- establishing a child care centre within the workplace for children of employees.

Family rooms

Employers can set up an office within the workplace that has, in addition to a workstation, facilities such as a bed and/or cot, TV and video etc. Family rooms provide a safe location where staff can carry out regular duties while ensuring that dependants are cared for where alternative arrangements are not available. Family rooms can serve a number of functions:

- Emergency child care
- Longer term child care (such as vacation or after school care)
- Care for elderly or disabled dependants
- A private place where breastfeeding employees can express milk or feed babies at work

Flexibility of working hours/weeks

- **Flexitime** - allows employees some freedom to vary their start and finishing times, with nominated core times that they are required at work.
- **Purchased leave** - enables employees to accept a reduced salary over the year and take longer periods of leave at that agreed salary.
- **Compressed weeks** - working full time hours but over fewer days in a week or for night.

For more information visit the Work and Family Unit website of the Department of Workplace Relations at:

<http://www.workplace.gov.au/workfamily/>

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