Clinical support time for public hospital doctors

2010. Revised 2019.

Definition

The AMA defines clinical support time (CST – also referred to as "non-clinical time" or "other professional duties") as the range of activities undertaken by clinicians that are not directly related to the diagnosis or management of individual patients but that are directed towards skills and knowledge development and/or teaching and training and that aim to enhance the quality of care.[1]

Clinical support roles and activities (CSR/A) include:

- teaching and supervision;
- designing work and training programs;
- preparing reports, references and rosters;
- participating in staff appraisals;
- maintaining and/or improving professional skills relative to the individual's level; and
- conducting quality audits and clinical reviews.

The purpose of this position statement is to specify a minimum benchmark for remunerated CST for all doctors working in the public hospital sector. This includes paid, protected time allocated for the completion of CSR/A.

A comprehensive list of CSR/A is at Annex A; this will assist when developing job descriptions and work schedules, and when negotiating industrial entitlements.

Background

Access to paid, protected CST is an integral component of clinical and professional practice for all doctors, including doctors in training yet to enter a specialty training program. Public hospitals depend on the CSR/A performed by clinicians to maintain their day-to-day operations and provide quality care to patients.

However, as the demand for clinical services grows, access to uninterrupted CST is being marginalised by the pressures of service delivery. This is compounded by funding deficits, an increase in the number of medical graduates, and an under appreciation of the need for protected, uninterrupted, paid time to complete CSR/A in public hospitals.

Ensuring access to uninterrupted CST is central to providing a safer, more efficient service delivery and patient care. Yet feedback suggests that many doctors currently undertake CSR/A activities in their own time regardless of CST being allocated and without which hospitals would grind to a halt.

Governments have a key role to play in ensuring that a paid, protected allocation to CST is adequately financed and supported in public hospitals, and that access to CST is monitored and linked to performance measures that serve to enhance quality, safety and accountability.

Health jurisdictions need to acknowledge the critical importance of CST to the functioning of a quality health service, recognise that CST is not optional and is in fact essential for clinicians to carry out core health service and professional development activities

Training providers can also play a leadership role by setting conditions for hospitals and health services to ensure that access to CST is provided is not merely seen as an addition to the provision of services.

Provisions for CST in industrial agreements for salaried doctors vary between Australian jurisdictions. While some agreements do include provisions for CST, others still do not explicitly recognise CST or

[1] Independent Hospital Pricing Authority. Defining TT&R and identifying associated cost drivers for ABF purposes - Environmental scan. January 2014.

specify a minimum benchmark. Where this occurs it is difficult for clinicians to access quality protected time for CSR/A and to avoid working in excess of the hours for which they are paid. It is the AMA position that employment provisions must explicitly recognise and allocate time for CSR/A not directly associated with the diagnosis or management of individual patients.

In 2009, the AMA set a benchmark of 30 per cent for CST following dialogue with the medical colleges.[2] More recently the Victorian Enterprise Bargaining Agreement (EBA)[3] agreed that a minimum of 20 per cent be allocated to CSR/A, with a minimum 50 per cent CST allocation for Unit Heads (and above with management roles). In the current environment the AMA agrees this figure is realistic and achievable and should be regarded as the minimum benchmark for CST in industrial agreements for all public hospital doctors.

AMA position

- Access to CST should be available to all doctors at all stages in their careers. Hospital departments should be adequately staffed to provide doctors with access to CST, and to provide an effective, safe and high quality clinical service.
- Doctors should be allocated at least 20 per cent of their normal weekly hours to CST duties, consistent with medical college guidelines where relevant.
- Unit Heads (and above with management roles) should be provided with a minimum 50 per cent CST allocation.
- Heath jurisdictions must have processes in place that provide access to CST through roster design and take practical measures to ensure uninterrupted access.
- Health jurisdictions should also support the inclusion of CST in job descriptions and staffing models for all posts. This will improve job satisfaction and morale in the public health sector, assist with recruiting and retaining staff and improve the efficiency and quality of care.
- Processes which measure the extent of the delivery of access to CST should be included in the performance agreements between State Health Departments and Health Services.
- Jurisdictions should have processes in place to review the current allocation of CST, assess the gap between existing and desired allocations, and develop a plan to reduce or eliminate any discrepancies.
- Each health service should establish a dispute resolution mechanism to deal with disputes regarding CST allocations, prioritisation and/or timing of allocations.
- Training provider accreditation processes must verify that trainees have access to protected teaching and training time at sites seeking accreditation and once accredited must evaluate trainees' access to CST.

A list of CSR/A appropriately undertaken during CST is at Annex A. This is not an exhaustive list but outlines some common clinical support activities.

See also:

AMA Position Statement Building Capacity for Clinical Supervision in the Medical Workforce 2017.

[2] The 30% target quoted in the AMA position statement Clinical support time for public hospital doctors – 2009 stems from a clause to that effect in the New Zealand industrial agreement. At the time the position was developed, the AMA wrote to Colleges asking if they thought a 30% target was reasonable and there were no objections.

[3] AMA Victoria – Victorian Public Health Sector - Medical Specialists Enterprise Agreement 2018-2021.

Annex A

Clinical support duties for public hospital doctors –
may include but is not limited to:

Teaching and training

For senior clinicians

- Supervision and oversight of doctors-in-training and undergraduate medical students
- Teaching activities for undergraduate, prevocational, vocational and allied health students
- Teaching activities include lectures, case presentations, workshops, grand rounds and associated preparation time
- In-training assessment activities, including feedback sessions with doctors-in-training
- Maintenance and improvement of teaching skills

For residents and registrars

- Supervision and oversight of doctors-in-training and undergraduate medical students
- Protected training time for attendance at tutorials, lectures, workshops and conferences
- Examination preparation time
- In-training assessment activities, including feedback with clinical supervisors
- Teaching activities for undergraduate and vocational students
- Teaching activities, including lectures and case presentations, grand rounds and associated preparation time

Continuing professional development

- Attendance or presentation at departmental and regional continuing education sessions
- Attendance or presentation at local and international conferences and workshops
- Journal clubs
- Peer review
- Self-directed continuous learning activities including reading and review

Maintenance of professional standards

- Specialty college activities including board, committee and examination work
- Professional body activities at state and national level
- Participation on government and non-government boards and committees

Audit & quality assurance

- Audit and appraisal activities at individual, departmental and hospital levels
- Quality assurance activities, including collection, analysis and presentation of clinical data
- Peer review
- Morbidity, mortality and critical incident review
- Clinical credentialling (delineation of clinical privileges) activities

Occupational health and safety

- Personal participation in programmes to safeguard health and wellbeing
- Development and supervision of OH&S programs for co-workers

Research

- Clinical trials and studies
- Laboratory-based research
- Reading time
- Preparation time
- Collaboration time

Health care liaison

- Non-patient contact including liaison with carers, relatives and other health professionals

Administrative

- Rostering
- Committee work at hospital, government and community levels
- Administrative paperwork and communication
- Data collection and report preparation to meet hospital or government requirements and requests

Managerial

- Human resource management
- Financial resource management
- Clinical pathway development and implementation

This is not an exhaustive list but outlines some common clinical support activities.

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