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Invited Commentary

Why working expectations need to change to protect doctors and the quality of patient care: A perspective from down-under

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There is a slow cultural change in doctors' working hours throughout hospitals in Australia. As a result of negotiation of working conditions through doctors' unions, the impact of staff furloughs during COVID and burnout on staff leaving the workforce, the expectations on doctors to work long hours of unpaid overtime and sacrifice their work-life balance is slowly shifting.

In Australia, each state has a different Enterprise Bargaining Agreement (EBA) between doctors and health services, so working conditions and salaries vary. In Victoria, where I work, the base hours of work for a registrar/doctor-in-training are 43 hours per week, including five hours of training time. 'Safe working hours' clauses stipulate that a doctor cannot work more than 140 hours in a two-week period and should not be scheduled to work for more than 14 hours in a day. Doctors should have a break of ten hours between shifts. On-call provisions are a little less clear and are at risk of contributing to fatigue and unsafe working hours. The Victorian EBA states that a Health Service must "*develop a procedure that addresses how occupational health and safety considerations are addressed where they arise (which may include but not be limited to later starting times, earlier finishing times, additional breaks) and expressly encourages Doctors to contact the relevant manager where they have not received a 10-hour break and it may impact on occupational health and safety.*" *([1], p49)*

There is a long-standing culture of junior medical staff working un-rostered overtime, with multiple class actions/lawsuits currently underway with health services across Victoria. Junior doctors are claiming they have not been paid for countless hours of un-rostered overtime. Health services are countering that the overtime was not approved, and so challenging whether it was valid [2]. However, junior doctors argue that they were discouraged from claiming overtime or told to improve their time management if overtime was required [2]. Some health services are actively encouraging staff to claim their overtime and bypassing direct supervisors to help remove barriers to claiming. This data is then being used as a business case to support employment of additional staff.

During the COVID-19 pandemic, many health services faced staff shortages due to mass furloughs caused by illness or contact isolation. In some hospitals, this meant remaining staff had to pick up the slack. In others lucky enough to have access to staff, rostering was designed to buffer the expected sick

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leave. The expectation to call in sick to protect your colleagues and patients, as well as the knowledge that your absence would not result in additional workload for co-workers, helps undermine the culture of soldiering on and working through illness. As special provisions for COVID sick leave disappear and isolation rules are relaxed, it is hoped that the culture of looking after oneself will be sustained.

The health system in Australia is currently facing a mass exodus of doctors and nurses due to burnout [3]. Many doctors are seeking more flexible working arrangements and are less prepared to work excessive hours, with many taking time off or choosing to work part-time. Last year saw a health service where I have worked offer multiple positions as 'job-share' or flexible working arrangements to recruit staff. Every day I receive offers of locum work to fill gaps in rosters either from sick leave or staff unexpectedly leaving roles. This is challenging as it is often more remote hospitals outside major cities that face the brunt of staff shortages. There are increasing numbers of patient presentations through emergency departments post-lockdowns, with increasing pressures, worsening wait times and concerns about the impact on patient care. This then risks compounding the effects of burnout on remaining staff.

Several prominent doctors have spoken out about their decision to step away from clinical work to manage burnout, describing moral distress due to the impact these pressures are having on patient care [4, 5]. It is my hope that we can find a way forward where health services can be staffed adequately, and safely, to ensure the care of both their patients and those who provide this care.

Conflict of interest

The author has no conflicts of interest to report.

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