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Overwork - Medical Legal Risk: Real or Perceived?

Scott Chapman

Good evening, ladies and gentleman. I'd like to welcome you to tonight's presentation. I'm Scott Chapman, the Legal Vice President of the Society. Dave Gronow, our President, is on special assignment. Welcome to *Overwork - Medical and Legal Risk: Real or Perceived?* Phil Truskett will kindly introduce both speakers for us. Dr Rosa Canalese and Sian Gilbert. I get the great task of telling you that you can't use your mobile phones while we're in here. Can you switch them off? Or put them on silent, or do whatever it is you need to do with them. But apparently, there are booths here that you can go and take – make phone calls, but could you just switch them off, that'd be great. So, I'll hand over to Phil. We'll have questions at the end of both presentations. Phil will cover all that off, but it'll be questions at the end, and then the usual questions again afterwards. Thank you very much. Enjoy the evening.

Phil Truskett

Thank you, Scott. I'd like to welcome you all, and this is a really topical topic, *Overwork - Medical Legal Risk: Real or Perceived?* There's a lot of stuff in the literature about this at the moment, and we're now talking in terms of joy of work, and all sorts of interesting words of wellbeing, that I don't think you would have seen in medical literature ten years ago. We talk about work/life balance, it seems to imply that work is antithesis to life, which is probably not entirely true, and there are issues that are very much true about the quality nature and nurture of the work that you do, and not that it's a fact that you're working. So, I think it's a really topical area, and an area that's changing its appearance quite importantly. So, we have two really good speakers on this, and Dr Rosa Canalese's going to take off. She's a Senior Medical Advisor for Avant, and has a 25 year history with engagement with general practice, teaching and of education, and also medicolegal aspects. So, she's devoted countless hours to developing and teaching medical students, and also curricular. So, she's a very apt person to speak on the medical side, in relation to work, and what it means to us all.

Rosa Canalese

Overwork - Medical and Legal Risks: real or perceived? I'm going to actually concentrate the talk around hospital based doctors, and predominantly our junior doctors, doctors in training. As Phil said, there's a lot in the media about it, and it has focused a lot more on the hospital based doctors, and their experience of their workplace. I'm going to look at some of the literature around that. I'm going to contrast some of the data around that, and then leave it to the audience to decide whether the risks are real or perceived.

Sunday papers, the other week. Burn out now recognised, it's under the ICD as a syndrome. Interestingly, I did a talk on burnout, probably around 1998, to a group of GP registrars, and surprisingly enough, the Sunday papers ran an article around that time too. It must just be

serendipity, but it featured a person on a gurney being wheeled down the corridor going, “Is your doctor sicker than you are?” And, it was a topic on burnout, and I think the sad thing is, is that here I am now in 2019, and things haven’t changed that much. And Simon Willcock, made a similar reflection in the MJA recently, that ran a series of articles on overwork and resilience training, and doctors now in the work place, and made a similar reflection, as Simon did a lot of work around junior doctors, and stress and burn out and depression and anxiety. And, 20 years on, the work place doesn’t appear to have changed that much, and that in itself, is a concern. This is what the ICD described the syndrome as ’feelings of energy depletion or exhaustion, increased mental distance from one’s job, feelings of negativism, cynicism, related to your job, and reduced professional efficacy.’ And there are probably moments in every day, where we all feel like that at work. So, it has been recognised now as a syndrome, and got a classification. Whether it leads to a mentally diagnosable illness, that’s a different classification, and a different matter in terms of compensation, health work compensation, which Sian will touch on.

I thought I might start because, I don’t necessarily want to assume that everybody knows how you end up as a junior doctor in this country. So, I just wanted to quickly run through, the pathways to actually getting into the hospitals and being a junior doctor. So, this is Australian trained on this side, so they’ll have come through medical school. Most of the medical schools these days are graduate entry, which means they’ve done a prior degree. So, often by the time they’re finished medical school, they’ve done seven years plus of University, depending on how long it’s taken them to get into medicine. They then move into an internship, hospital based year. It’s now called PGY1, but internship, PGY1, JMO, they’re often used interchangeably, but they refer to those very early years of doctor training. That is a provisional registration year, they’re not fully medically registered. They have to work under supervision. There’s parameters under the AHPRA registration for that year. Then if they successfully complete that year, they move onto full medical registration, and then work through whatever training, speciality, whether they stay in the hospitals, whether they go out into community based training. For overseas trained doctors, there’s an extra step. So, overseas trained doctors have qualified in an overseas country. Often, they’ve been a specialist in that country, so they may not necessarily have done general training, they may have actually fully qualified as a surgeon, or an ophthalmologist or any other speciality. They have to do the Australian Medical Council exams, and passing those exams, they’re clinicals and writtens. This is the standard pathway. They get provisional medical registration, and have to do a PGY1 equivalent. So, for those doctors, the challenges are even more so, because they’ve often done many, many years as a doctor in their country, and they are treated as interns. So, as junior doctors, in a junior doctor year, and then they move through full medical registration.

So, what are the pressure points and stressors for our doctors? Competitiveness of securing positions, that’s both hospital positions, and then subsequent training positions. Financial stressors. Many of them are graduating with a lot of debt. If you’ve done seven years of University, you’re graduating with a lot of debt. Accessibility and quality of the senior supervision and support that they might get in those junior doctor years. The balance between being a service provider and delivering workforce in the hospital, versus education and training and accessing education and training. Expectations, both personal expectations and organisational expectations, of what a junior doctor year should look like. And, the

workplace environment and culture. There's probably a lot of non-doctors in the audience going, "So what? Every graduate from University faces those sorts of stressors. Nobodies guaranteed a job in their first year after Uni. A lot of those stresses apply to many professions." I guess, the key difference, is that when doctors get stressed, and don't work effectively, patients die, and I think that's probably one of the key differences. And ultimately, a lot of these things impact on patient safety, where you've got a lot of competing tasks and ultimately, doctors working in a stressed environment, where they're not getting the supervision and support they need, ultimately impacts patient safety, and there's a lot of data that supports that. I've put down there, just in the corner of the culture and medical profession, and I will come back to that.

Okay, so I want you to meet Dr Roy, start with a story. Dr Roy's an intern in his second – I use intern, I'm old, PGY1, and he's in his medical term, he was a hot shot medical student. He went to the best medical school, graduated with honours, got the plum intern position, at the best teaching hospital, and he's a go getter sort of intern, happy to jump in there. Edna comes in, she's an 86 year old, and she's got a lot of fluid on her chest, and it needs draining. And Doctor Roy's medical registrar says to him, "Do you want to do it Doctor Roy?" His eyes light up. "You've done them before, haven't you?" Doctor Roy doesn't want to miss the chance. Hasn't really done one before, but he's seen a lot of them. Happy to give it a go, what could go wrong? There's so much fluid there, what could I hit? Anyway, he looks at the YouTube video, on how to put in a chest drain, and "Right, I've got this." Okay. Anatomical landmarks, check. Local anaesthetic, check. Guides the tube in. Edna's not feeling very well. "I don't feel very well, Doctor Roy." Then she passes out. He looks down, and there's blood draining from the tube. MET call. Everybody gathers, Doctor Roy looking forlornly. Medical registrar, "What did you do? You idiot. You told me you've done these before." 48 hours later, Edna dies in ICU. What could happen to Doctor Roy? Well, he got suspended pending further investigation. There was a root cause analysis. There was a complaint, there was a coronial, and then there was civil proceedings. The impact, mostly in terms of his career, well, he went onto a risk assessment performance program within the hospital. His full medical registration got delayed, 'cause he had to do a couple of remediation terms, and had a longer provisional registration period. So, all in all, not a great end to an intern year for our hot shot, Doctor Roy. So, what went wrong? Okay. Junior doctors – there's an organisation in NSW called HETI, the Health and Education and Training Institute, and they're there to look after junior doctors, and to ensure that they get teaching, training, supervision. And there's a document called, the Compass, or the guide to the junior doctor years, and I've taken some excerpts from this HETI Compass. And, the HETI Compass book says, "As an intern, you will work under supervision. There are always going to be more senior doctors supervising you. They're ultimately, the ones responsible for patient safety. When you're on duty, you must always have access to the advice and support, of a more senior clinician. You should get orientated to each term. Written term description, work expectations, rostering, including overtime. Learning objectives for the term. Departmental clinical guidelines, and know the roles of all the team members. Education forms a large part of your job. Your hospital network should provide you with a formal education program. It's also supposed to assist you getting to it, as well. Your term supervisors should work with you to achieve the objectives for the term, and your mid and end of term assessments are opportunities to learn." There's also a paragraph on support for your well being. "Look after yourself. You should have access. Identifiable structures for where you can take grievances or concerns. All JMO's need to have a

supportive and safe working environment." So, this is what HETI tells them. So, is it unreasonable that that's what they expect? Okay. This is advice to new doctors. "You're not expected to manage seriously unwell patients. Notify senior staff, as soon as you expect a patient is unwell. Be clear to that senior staff member, that you need advice and support." This is an interesting paragraph. These are people that have just finished medical school. They're going into their internship. "If you don't feel comfortable with the advice given to you by your registrar, ask them to see the patient with you. If you're still not comfortable with the plan, consider calling a consultant. Use a graded assertiveness approach, and always prioritise patient care."

Maybe bolshie Doctor Roy, but look what happened to him. There might be a few interns, junior doctors, who would feel comfortable challenging a registrar, or calling a consultant over a registrar's head, or maybe even have heard of what a graded assertiveness approach is. But, you know, it is very hard. So look, you're going to get all the support, and teaching and it's all going to be nice, and we're all going to look after you, but look, if you get into strife, just tell them you don't agree with them. It's a really bit of a hard situation for a junior doctor with a power imbalance there. Okay. On the wards, this is sort of a blog type website, that was developed by doctors for doctors. So, it's sort of, lots of articles, lots of helpful information, it's free access for doctors. But on the wards, has a section on burnout in junior doctors, and they describe burnout as emotional exhaustion, depersonalisation and reduced personal accomplishment. Which is very similar to the syndrome features that we looked at earlier on. 79% of doctors were concerned about their own health, and the majority had low job satisfaction. So, this is based on the AMA survey report. It's old data now, but I think it's been reproduced in more recent surveys as well. 69% reported feelings of burnout. 54% reported compassion fatigue. Burnout in doctors we know, increases medical errors, and delays and also impairs decision making. So, that actually has dire consequences for patients, because errors happen, and mistakes get made and people die.

The mismatch, the expectation mismatch. I've said previously, what the junior doctors goes in expecting. This is a study that predominantly, it was done with GP registrars, but it was GP registrars doing their hospital based training. So, first part of GP training happens in hospitals. So, this was looking at GP registrars who are doing that at that second RMO year. The Australian doctors are stressed and report has high rates of burnout. They have the highest rates of stress, and more attempts at suicide, than the Australian population. That's a very alarming statistic. Junior doctors who report burnout, are more likely to report increased absenteeism, depression, have more self reported errors, and engage in risky alcohol use, and probably risky drug use as well. And, this is what's been described as the contributing factors. Job demands, patient loads, long working hours, disproportionate on call, out of work hours, and difficulty maintaining work life balance. There's that word again. So, what they're experiencing is, a little bit of a mismatch to what they've been told to expect in those junior years. So, this study was a qualitative study, and interviewed large number of doctors. So, the theme set emerged out of the study, with first of all, the expectations of self. So, limitations in their own knowledge and ability. And this was exacerbated in times of uncertainty or unfamiliar situations, and they found that it was intensified, if the personality style the doctor was perfectionist and high achieving. And those quotes, I'll let you read them, but those quotes were actually quite good, because I think they do point out that mismatch, you know? "I thought there would be support. I felt that I would get help, and it wasn't there, and it's not

what I experienced." This doctor here, pointed out that they were a bit of a perfectionist, but again, that work load, those expectations, and I think when you go into a year thinking, "Well, we're going to get supported. It's going to be teaching. It's all going to actually be a well supervised year" and that's not what they experience. I think that heightens that perception of stress, and makes it more likely that they are going to crash and burn, because it's just such a mismatch to what they were expecting.

Expectations and the response of others. The expectation of the junior doctor was that they would be working in a safe environment, supported by their direct supervisors, teams, hospitals, colleges or colleagues. And, that is not unreasonable, given that's what they got told. The working environment has been identified as a clear stressor for both hospital and general practice registrars, with the long hours. An interesting comment that medical administration was uninterested and unhelpful. You know, that support network that you're supposed to have identified, the people you can go to. A lot of the doctors said, "Unhelpful, not interested." And, there's some more quotes from the study. And, the medical administration just giving up. The second one was an interesting one, going, "I don't mind doing the work, I just don't want to do it on my own." "Had meetings with consultants" so, you know, chose that path of talking to the consultant, but they didn't really feel that they were going to be supported. And that's interesting, for some of the senior clinicians had forgotten what their early training years were like, and that goes a little bit to the medical culture, which I'll talk about. And then self care. So, the interesting thing in this, is all the participants were aware of self care, and I think that this is probably a feature of the junior doctors coming through. They really, really do want to try and achieve a balance. A lot of them, because it's taken them seven years or more to get into medicine, they often have already married, and have families. So, they're not necessarily single doctors, that can necessarily work all those long hours, and not have outside interests. And even if they're not married with family, I think coming through, a lot more of them are having outside interests. More of them want to work part time, much to the lament of their senior colleagues. And so, although not being paid for doing after hours is a stressor, I think a lot of the junior doctors would probably say, "I would actually rather not have to do the long hours, even if you did pay me" because they don't want to get that burnt out. It's interesting the comment, and I'll talk to some of the strategies that have been implemented, but resilience training has been one of the strategies that some of the area health networks have implemented, and it's an interesting comment by the junior doctors, is that they thought that was a cop out. Which, you know, is interesting that that's a perception, but I think it is an important part of howwe might need to address this issue. So, what the authors identified, the themes that came through, were these expectations of self, expectations response to others and self care. And what they identified is, if the doctor had problems in two of the areas, they experience stress. If they have problems in three of the areas, then it led to burn out. So, this was an article again, in MJA in 2018, and I think it was reflecting on, it's time for the profession to step up. There is a little bit of "When I was boy, you know, we did these hours, it toughens you up, you know, it's just to be expected. You've got to, you know, see one, do one. You got to hit the ground running." And all of those sort of concepts, and often if that's what happened to you, that's what you do to the doctors coming through, because if you haven't been taught to properly train, supervise, teach, if the way you learnt was through see one, do one, or hit the ground running and see what happens, then that perpetuates through the system. So, yes, work experience, work hardening is necessary, but it's not the only solution to it. So, these are some strategies that are being

used to address the issue of burnout. , resilience training and resources. So, resilience training is important, there's a concept called Grit, which is, you know, your ability to persevere and to get on with it, so you get a GRIT score, a GRIT rating. . So, they talk about people with high GRIT scores, are much more resilient and are much more likely to be able to deal with it. Developing support networks basically within the hospital, the doctors themselves, organisations, as I said, like on the wards and other groups like that that support junior doctors and have resources. The medical indemnity organisations as well have resources that they can access. The colleges have a role to play. I think that they need to have strategies for their doctors in training, and looking at the issues and addressing those. The training organisations as well, so the GP training organisations need to have a pastoral care role, and are factoring in that, because it is the future generations that are coming through their profession. And of course, there needs to be system change. It's not all about, you know, it's easy to blame the system, it's easy to blame the doctor, but it needs all of it to actually have effective change, that's going to actually look after the doctors. So, we're going to actually hold out to questions until the end, so I'll hand over to Sian.

Phil Truskett

Thank you, Rosa. That was a really great platform to start from. There's never been more of intersection between the profession of medicine, and also the law in this context. You will be well aware of the fact that Yumiko Kadota, a young unaccredited plastic surgeon registrar, had a very public meltdown towards the end of last year, and she in fact is taking, understandably, legal action against her employer. I found out recently from ASMOF, ASMOF, those at the know, is the union, the Australian Salaried Medical Officers. They're currently gearing up to do a class action for all residents, for un-rostered over time, whoever worked for the Department of Health. That would be billions of dollars, and would probably bring the healthcare to its knees, and that currently is being considered very strongly. So, it will be very timely to have the legal aspect of what this means, and I'd like to introduce Sian Gilbert, who is a partner with HWL Ebsworth, who has extensive experience in this space.

Sian Gilbert

Thank you very much. Thank you, Rosa, and thank you to the Association for extending an invitation for me to present tonight. So, my task tonight, is to analyse the motion of overwork, through the legal prism, or through the prism of the various legal structures and concepts, that we have that deal with overwork. And I hope I don't put you to tears in introducing that concept, because whilst they sound fairly dry, in this particular area, and in my area of employment law, and in Work Health and Safety, there's always a human element, and that makes it important, and makes it critical, and in my view, makes it really interesting. I'm aware that, well I think I'm talking tonight to a combination of people with a combination of interests. People who may act as employers, or sit on boards, who are exercising responsibilities as officers, for example. Conversely, people who are employed in the medical profession, and who are employees or workers, if you like. And on top of that, a layer of legal professionals, who'll be providing advice one way or the other about risks and liabilities. So, I hope I can adequately address each of those interests. The thesis that I'll be prosecuting,

well not prosecuting so much, but the conclusion that I have reached is this one, in terms of our subject matter. Overwork, is it a real or perceived risk? It's a real risk. It's certainly a real risk, analysed through the legal prism, particularly given examples and comments that we've discussed already tonight. Are there measures that you can take to control the risk, either as an employee or an employer? Yes, there are. There are triggers that we can be aware of. There are mechanisms, that we can put in place to control these risks, and from my point of view, that's what my role is all about, and that's certainly where I wish to start tonight. One of the most underlying principles of the work I do in workplace relations and safety, is safety legislation. So, that's where I intend to start. We'll look at Work Health and Safety. I then propose to look at an employment law analysis, of the overwork issue, and then look at it from a contract law and common law point of view. As I said, I don't intend to put you all to sleep, I do hope to bring interesting and enlightening examples to the table tonight. But I want to put it in context, first of all. And as a good safety lawyer, presented or prepared a little bit of a risk analysis. I've given a citation at the bottom of this slide, and the next slide has some further citations which are available at the end of the presentation. But I don't think anything that I'm about to say, would come as a surprise to anyone in the room, nor do I think that anything I'm about to say, is a point of controversy at all. So, just looking at some of these available statistics, or information if you like, which I've gleaned from the Human Rights Commission, which is a commission that I work in frequently, particularly dealing with discrimination issues. So, relevantly, sex discrimination, disability discrimination, how work life balance actually works in practise. So, just looking at some of those statistics. As I said, not controversial I wouldn't have thought. Overwork and work stress, are related to psychological illness. There can be no doubt that there is a connection between those concepts. Stress related workers compensation claims have doubled in recent years, costing over 10 billion dollars each year. A survey of over 5,000 workers indicated, that 25% took time off each year, for stress related reasons. That's a lot of people. That's one in four of us in this room. That's one in four of your staff. That's one in four of people that you work with. That's a lot of people, and I'm not suggesting that all stress related conditions are caused by overwork, but there's certainly some connection in those themes. In relation to psych injury claims, work pressure accounts for about half of all claims, and harassment and bullying for another quarter. And again, a financial note, preliminary research shows that Australian businesses lose over 6.5 billion dollars a year, failing to provide early intervention and treatment, for workers suffering with mental health conditions. Some further context, if you like, from a risk analysis point of view, there is research available to support each of these propositions, not all related propositions, but interesting propositions. Again, I don't think controversial. Long work hours are implicated in a range of mental health problems, including stress, depression, anxiety, high blood pressure and insomnia. Long work hours, and this is particularly relevant given what Rosa has addressed us on earlier this evening, long work hours, particularly in care based professions, such as nursing, are associated with a deleterious impact on competence. I might then jump down to the final point on the slide, which might look like a little bit of a curve ball, but compare that to this point. Output per hour rapidly declines after 50 hours of work per week. Essentially, rendering anything after 50 hours of work per week, ineffective. And I think, when you combine that with that second point, about care based professions and competency based KPI's, if you like, that's very concerning. That's very concerning to me. And again, not controversial at all. Sociologists have implicated long work hours, and the emerging care deficit in developing countries, when

we look at time spent with our children and our elderly. Perhaps not a work related concern, but nonetheless, a concern. So, as I said earlier, the first point, or where I start in my professional interest, is as a safety lawyer. And what we have in each jurisdiction in Australia, we have it in NSW, we have it on a Commonwealth basis, we have safety law. And there can be no doubt, no doubt at all, that the intention of Work Health and Safety legislation is to provide the various regulators with a very, very big stick. It sets the highest bar, that you could possibly set, in terms of intentions to provide safe work places, for those in our care, and those who we work with. The primary duty, as I've set out, is for PCBU, that's a person conducting a business or undertaking. That's every hospital, that's every medical practice, that's every doctor in a partnership, for example. Every PCBU must ensure, so far as is reasonably practical, the health and safety of workers engaged in the business. And relevantly, there's a lot of descriptions in the Act, that talk about plant and equipment and construction, none of those relevant for tonight's purposes, but relevantly, that includes providing safe systems of work. And that of course, raises the question, of whether a work system that causes burnout, or requires excessive hours to be performed, is in fact, a safe system of work. And the Regulator, in my view, has a lot of work to do in this area, and has actually been doing some work in this area. Now, I apologise in advance, if there's anyone here from K&L Gates, the law firm, I didn't mean to single anybody out with this slide, but it was widely reported they were one of a number of firms, who were the subject of interest from the Regulator last year, and I think this is topical and interesting. It goes to what Rosa said so very well, about the incidents of these kinds of problems in medical students, and junior medical officers. Law firms are not immune from that at all. And that came to a very big head last year, when there was a royal commission, as we all know, into banking, and there were complaints from graduates and junior lawyers, that they were essentially working around the clock. They were sleeping in the office, they were over worked, and one made a complaint to the Regulator, it was in Victoria, and the Regulator took action. And it was to my mind, or to my knowledge, the first time that there'd been a overwork intervention, from any Safety Regulator. And I raise it as a pertinent example of this subject, that as I said, there is work to be done by the Regulator in this particular area, and they're starting to do it. It resulted in the Regulator issuing infringement notices to, not just K&L Woods, sorry I said K&L Gates, not just to that law firm, but to a number of law firms, requiring them to implement safe systems of work. They had to give assurances to the Regulator, that they had appropriate rostering systems, they had appropriate measures in place, so that people weren't sleeping under their desk. To the extent that people did have to work overnight, which can be required in extreme litigation, and can be required, I imagine, in extreme circumstances in the medical profession, that there were appropriate measures in place to ensure that the health and safety of those employees, was a factor that was considered in that particular system of work. Just on that, the powers of the Regulator are fairly, I wouldn't say extreme, but they're certainly powerful, because they can do things, and they can make an employer do things, that might be very inconvenient for an employer. They can attend your workplace, they can inspect your records almost at will, that includes of course, rosters or grievance records. They can issue infringement notices, so a notice to say you've got an unsafe system of work, you need to fix it. More importantly, they can issue a prohibition notice, saying your system of work is unsafe to these graduates who are sleeping under their desk, we're shutting you down until you fix it. And of course, they can initiate prosecutorial proceedings. And there are massive penalties that are available. 1.5 million dollars

maximum, for a corporation in the event of a breach likely to cause serious illness or death. And $500,000 for any other breaches.

Moving on through, I'm a little bit conscious of the time. So, looking briefly, a legislation governing working hours, we do actually have legislation about this, and it may come as some surprise to people who regularly work more than 38 hours a week. But the Fair Work Act, the Federal piece of legislation says this. It's says, "There is a maximum amount of hours, that an employee can be required to work. And the maximum in any one week, is 38 hours." Put up your hand if you've worked 38 hours anytime in the last week. Nobody. And the reason for that is this, where I said the Work Health and Safety Act is a very, very big stick, the Fair Work Act is like a wet leaf. There's really not much that can be done. So, you can make a complaint to the Fair Work Ombudsman, or an employee can make a complaint to the Fair Work Ombudsman, good luck if, as an employee, you want the Fair Work Ombudsman to intervene or prosecute, because the theory is this, and we have some High Court authority about this. The theory is this, is that contracting parties, who enter into an agreement, and who are asked to perform reasonable additional hours, which the Act does provide for, and who agreed to perform those reasonable additional hours, for recompense. So not for free, so not someone who's just getting paid, for example, nine to five, but someone who's on a salary usually, doesn't really have any comeback to then say, "I was asked to do the extra hours. I didn't really want to. I felt like I had to, but now I've done it." "Did you get paid for it?" "Yes, I got paid for it." There's not much sympathy. There hasn't been much sympathy, I should say, historically from the courts about that. Subject to what I'm going to conclude on about reasonable foreseeability, and hopefully tying in with what Rosa has said earlier.

Just briefly, is there a little bit of assistance in what I've described as the wet leaf of legislation of the Fair Work Act? There is a little bit. There is a right to request, flexible workplace arrangements, only some people have the right to request flexible workplace arrangements. Those people are set out on the slides. So, the parent of a school aged child, a carer, a person with a disability, a person who's over 55 years old, and the most recent amendment to the Fair Work Act, a person experiencing violence from a member of their family, or caring for a person who's experiencing violence from a member of their family. So, those classified classes, if you like, of employee, have the right to request flexible work place arrangements. What happens on request, it extends to a right to request change of hours, so typically right to work part time. Patterns of work or the location of work. The request can be refused on any reasonable business grounds. And after the request is refused on reasonable business grounds, there's no right of recourse after that. It may transfer into a claim, in relation to discrimination, if it's, for example, being refused because of a disability, or caring responsibilities for children, but as I said, it's a little bit of a toothless tiger.

Moving briefly to the conclusion of this aspect of tonight. So, from a contract law analysis, in terms of overwork, and whether the legal risks are real or perceived. There are expressed terms in contracts of employment. So, Rosa referred to contractual terms, that said as a JMO, you will be supervised, or as a JMO, you might only be required to work reasonable business hours, or reasonable work hours, sorry. Is that an enforceable contractual right? My view is, only if there's any provable damage or loss, flowing from either the absence of supervision, or not working reasonable hours. And to revert to the example of our hot shot intern, was his failure to perform that procedure, a result of lack of supervision, or having to

work excessive hours? Or was it, the result of him lying, and saying that he was comfortable performing that procedure? That's how that legal angle would play out, and you can see that there are arguments on either side of that. And I think, they'd probably both have a role to play in that analysis. Just briefly, implied terms. Generally, it would be agreed there's an implied term to be provided with a safe place of work, so that goes to where I started out from. Safe work places are something that every person is entitled to. Again, on a contract raw analysis, how do you sue over that? You've got to show that the loss of damage flows from the unsafe work place. I've put trust and confidence with a question mark. That argument was killed essentially by the high court a few years ago. It was a very popular argument, when people were prosecuting claims, including of overwork, but essentially over stress claims, where there was a lack of trust and confidence. That's no longer an implied term. Just briefly, the importance of workplace policies, I cannot emphasise enough, how important it is, for any work place. I wouldn't even say any sophisticated work place, but for any work place, to have policies that mandate how people are to be treated, what's acceptable workplace conduct, and importantly, what steps can be taken, in the event that someone is aggrieved, or someone is suffering. The early signs of stress, or needs assistance in the performance of their duties, such as the hot shot intern. I'm a very advocate for the notion, that if people are supported through early signs of stress, then that's exactly what support networks and EAP, and the provision of leave, is about. Is it's to nurse people back to, getting to a good place, so that they're working at 100% and supported, and able to be working at 100%. Just very briefly to conclude, the common law analysis is really where I want to finish up tonight. When I said that the theory I wanted to not prosecute but pursue, is one about there being a real risk, not just a perceived risk. It's on this analysis. It's on the common law analysis. These are the essential elements. So, there has to be a duty of care. I think it's fairly widely accepted and acknowledged; any employer will owe a duty of care to any employee, generally. There has to be vicarious liability, which is associated with that. There has to be evidence of an injury that's different to the safety analysis that I talked about before. Safety is about risk of injury. You don't need evidence of an injury. Common law is about evidence of an injury, but this is the point here. There has to be a reasonably foreseeable risk of injury, and this is where I think we've moved on. So, picking up where Rosa left off, on the acceptance of burnout as a syndrome. On the acceptance of the notion, that work place stress can turn into a psychiatric injury or illness. Acceptance of the notion, that we're very much on notice and aware, that because we're all working longer hours, bigger hours, we're all contactable 24 hours a day, there is a link between, what that might result in, in terms of somebody's mental health or psychiatric health. And I think we have to make the connection with reasonable foreseeability. I think we're at a point now, that we can probably say, without too much controversy, and it depends on certain other conditions, which if I have time, I'll address very briefly based on one case. But I think it depends on, us being able to safely say, has hot shot intern said to somebody, "My hours are too extreme. I'm not coping. I'm finding this really difficult." If the response to that is, "Thank you for raising that. We're going to take steps to try to monitor and make sure you're not in a position of performing a risky procedure, that you probably shouldn't be performing" compared to a position of "Go away, not interested, tough luck. That's what we all had to go through. You're no different to anybody else." Then I think, once that risk is notified, once we're on notice of that risk from someone who is claiming to be suffering from burnout, claiming to be suffering from overwork, and the very visible and sometimes palpable consequences of overwork. And I think, we are

in the territory of reasonable, foreseeable risk of injury. I think we've got enough data these days, to be able to say that. Now, of course those claims are defendable, because of course, a person who's in that position may have all sorts of other matters going on in their private life. May have all sorts of matters going on, to do with their competence or their own behaviour. But as I said, the theory that I was not prosecuting, but led myself to in my reading and research, in preparing this presentation tonight, is that thesis. That is the risk real or perceived? It's a real risk, but it's a manageable risk. And as sensible prudent employers, litigators, employees, you look at risk management structures, and you look at ways to ensure that you've got policies and procedures in place, to manage those very risks, that I'm talking about.

I had included two extra slides, just on a case on that, but I think I've essentially covered what I wanted to say. Just for the sake of closure, it's where I've said, there was actual notice of the conduct said to be causative of the injury, so somebody says, "I'm tired, I'm over worked, I'm stressed, I've had too much." And the injured party had a propensity or was developing symptoms. So, where you could see or a reasonable person could see, that that is a person suffering from stress or fatigue, or a combination of those kinds of symptoms. That is where I propose to conclude this part of the session, and I think we're now opening for questions.

Phil Truskett

Thank you, Sian. I want to invite you two to sit on the couch, because it probably be closer to the microphone. Or sit here, which ever works out best. We'll open for questions. I know there will be, "That's not the way when I was a boy" but I just want to tell you I was speaking to three PGY2's yesterday, who told me that PGY1 year, that they were working with 50 patients in their service each. They would start ward rounds at 6:00 am in the morning, being told they weren't allowed to, and their registrars were in theatre all day. So, imagine the stress that that must bring. I'd also like to tell you that I visited a hospital two days ago, that had a wellness room in the library, which was stocked with bean bags, and mindfulness colouring books. And the resident staff were very pleased by that. So, there is a process going on. So, I'll now, on that note, ask any questions.

Q& A:

Neil

When you consider there's a problem with overwork from the junior doctor's point of view, if you're in hospital, you've got an amount of money that you can spend, you've got an enormous requirement of services, and people will be charging through the door, day and night. So, you've got a problem in that, you can only have so many residents. You really need to double the amount of residents, and if you take the hospital that I worked in until 2015, we had 12 fellows. These are surgical registrars, who have got all their degrees, and they're doing advanced training for one or two years. When they finish, they had to move along. Some got positions in the hospital as junior staff specialists some 8 didn't, and they're looking elsewhere. So, you know, this is a very difficult career structure, and it's brought with

a lot of pain, and they say administrations are well recognised. Basically, they don't care, because the trouble is, they can't care, not that they don't care.

The question is, what do you do about it?

Phil Truskett

Well Neil, to add to that comment, there are now six thousand doctors in Australia who are not vocationally registered. Six thousand, and we import two thousand IMG's per year, most of whom go and work in the metropolitan areas. So, there's a huge disconnect, and the other bizarre issue is, and it's NSW and QLD, there's a shortage of interns. Work that out. I might ask you Rosa to talk on. I mean, the career path thing is difficult, but I guess part of the question is, how can we arrange our resources, in order to fulfil what Sian and you both have talked about, is there a balance of work and the pressure and stress?

Rosa Canalese

I don't think anybody likes the stress of a medical administrators job and it's sort of, my slide that talked about that balance of service provision. Yes, if you want a service that needs to be provided. But you don't achieve that by overworking your junior doctors, because that doesn't address the problem at all. One of the additional problems that has occurred, because there were more interns going through, there's a lot of medical schools started up with more interns, and I understand now, they're not guaranteed their first year either. But the difficulty was, was that NSW Health guaranteed – for a period of time, all domestic trained graduates, an internship. But that didn't go with extra money to the hospital. They had to find the positions, but didn't get extra funding, or they didn't get sufficient extra funding. So, what the hospitals did, was they compromised by not having the senior doctors. So, they lost their Career Medical Officers, they lost their more senior positions. Once upon a time, you could get two, three, four years in the hospital, just getting general senior training, and there were positions for that. And those doctors acted as supervisors for the junior doctors. But even though they're more expensive, so the hospitals got rid of those doctors, because they had to employ the interns. So, you end up having a whole lot of junior doctors, without the layers of supervision, expecting that the consultant, the VMOs, the specialists who are going to, you know, come up to the plate and be the supervisor for doctors. And the reality of that, none of that happened. So, the problem was, is that you have a lot of junior doctors. And the fact in that, the stress levels, the long hours, but the lack of supervision. So, it's not just the long hours per say, I think it's the over work because it is very, very stressful to constantly feel, that you actually cannot do your job, that you actually don't have the skills. You don't have the knowledge; you don't have the required competency to do your job. That is an extra stress too. I know how to do my job, I just need more hours, versus, I actually need more hours, but also too, I don't have the skills and actually that is very stressful.

Neil

So, there's not the back up?

Rosa Canalese

There isn't the back up, there isn't the support needed for supervision. But the junior doctors are told that they're supposed to get that. That's the difficulty.

Phil Truskett

And there's also a loss from that perspective of peer support. In days gone by, you could talk to your colleagues if you were in trouble, but they're too busy too. So, there is no time to devote to those sorts of cultural issues. Sian, do you have a comment from the Regulator perspective?

Sian Gilbert

Yes, I would just make one additional comment, and I appreciate it's a different industry, being private sector, compared to largely public sector in health, but for example, the law firms I spoke about, who got into all sorts of trouble with the Regulator, found some more grads quick smart, to alleviate the pressure.

Neil

I had to fire my secretary.

Sian Gilbert

So, they were able – as I said, the Regulator had some work to do in this space, and they did it. Can you do that in the public sector? Probably not as readily, because we're all bound by people setting budgets above, and potentially your area of control. But that's how it can be resolved, in the private sector. That's probably all I could add to it, because I don't have the specialist knowledge.

Neil.

I'm also a member of the Fellowship Services Committee, which is actually looking at it now. The reality is, it doesn't matter how many hours you do, what you need is somebody to back you up. Somebody that you can pick up the phone, and say "Somethings happened to me, what do I do about it?" And that's probably the most fundamental thing that we could provide at senior level.

Phil Truskett

Yeah, you could, but the hours seem not as important as whether you're nurtured by support. It's a surrogate measure to easily measure, but it's not the measure that's important.

Richard Jones

I have a few questions. One is, can you be discriminated against on the basis of incompetence? It's fascinating to see your slide, which showed the helpers can be the hospital, in another slide, it said that the medical administrators weren't interested. I was fascinated, but I just wondered how you envisage the hospital helping, because I found that the hospitals were not.

Rosa Canalese

I'll answer that one. In terms of the junior doctors, each hospital is supposed to have an appointed positions called the DPET, the Director of Prevocational Education and Training, and that person's role or part of their role, is to oversee the junior doctors and be that helper.

So, they sit within medical administration, so unfortunately often they get lumped into being medical administrators. But each hospital that takes junior doctors, it's a requirement of them being accredited to take junior doctors. So, hospital's actually have to get accredited, to be able to have junior doctors. But the requirement is, that they have this individual, they have this position of a DPET, who is responsible and the go to person for the junior doctors as their first point of call, when they've got stressors. The difficulty of course is, that it's not particularly a popular role, and the DPETs, it varies from area to area, but the DPET's don't get particularly trained in how to provide supervision support with constructive feedback, and do all those sort of things. They're often doing it in addition to whatever their hospital job is as well. So, it's not usually an exclusive role.

Phil Truskett

They're usually junior staff specialists or VMO's

Rosa Canalese

Staff specialists or someone within the hospital, or in addition to their role. So, in terms of – that's how the hospital is expected to help, but I think it very much relies on that individual, and because again, that job is to how well that works out in the hospital. Can you be discriminated through incompetence?

Sian Gilbert

On a national level, it's unlawful to discriminate against a person on the base of their race, sex, disability or age. So, unless incompetence is related to any one of those factors, in the mind of the discriminator, no.

Richard Jones

How do you cope with people who are incompetent?

Sian Gilbert

That could be another hour seminar. So, there are processes that have to be put in place, for managing poor performance, or what you perceive as poor performance.

Rosa Canalese

And for junior doctors, well those first two years they are supposed to be training you, there's actually supposed to be a program in place for monitoring their performance, their competence, their objectives. There's actually a junior doctor curriculum that covers those first two years, and it has a set of expected competencies to be achieved by the end of that year. And a hospital that takes on junior doctors, is supposed to commit to helping the doctors achieve those competencies. So, that's that whole thing that comes back to your Term Supervisor, is supposed to help you achieve those learning objectives. There is supposed to be somebody that is monitoring you at mid term and end of each term. They're supposed to get constructive feedback, and help you work towards achieving those competencies. So, the way you mange it, is you manage it proactively. So, you identify initially, what competencies the doctors really don't have, and then you put in place steps to help them achieve. And that's supervision, support, helping doctors understand. The interns like Doctor Roy, they're confident, they're not necessarily competent, and so there's somebody there that

actually can check competence, and that there are processes in place to ensure that doctors aren't doing procedures, and the old see one, do one, teach one, that shouldn't exist anymore. I know a lot of us got trained that way, but there's actually graded ways – staged ways of actually training someone to be competent. But the problem is, is a lot of the doctors that do supervision, don't get opportunity to be trained to be a trainer and to be a supervisor. So, often don't get that skill set training, to teach somebody how to this well.

Phil Truskett

And sadly, see one, do one, teach one's, been replaced by "I saw on YouTube."

Rosa Canalese

See one, do one.

Phil Truskett

That's what happens.

From the floor: Question - do they have any observations about stress related issues concerning self-employed people – the extras in private practice? Likewise lawyers and barristers?

Phil Truskett

Sounds like you Sian.

Sian Gilbert

You're certainly correct in identifying the fact that there's not as much of a legislative protection for anybody who's self employed. So, a person whose self employed on my analysis, if you look at the safety analysis, is a PCDU. I'm a partner in a law firm, I'm a person conducting business. I undertake in a whole conglomerate of persons conducting the business or undertaking. So, I think, the regrettable answer to your question, as you're all on your own sometime. People who are self employed, certainly don't have the same level of protection legislative or otherwise, when it comes to the consequences of overwork or workplace stress.

Rosa Canalese

So, it might be a case that, I guess, you don't have the protections under the law but, I guess, under the Code of Conduct Medical Practice, an expectation and that as a professional, you will implement strategies of self care, and that you will be mindful of this professional requirement. I mean, it's all nice in writing, but that you will be mindful of, that you are starting to lose interest in your patients. You're losing interest in providing good care. Your patients are potentially suffering, or a colleague that pats you on the shoulder, and draws your attention to that, then you respond to that appropriately, in terms of looking after yourself, and providing yourself of your support with work, your own health professions, and looking after yourself. There some of the professional expectations that you do that, with non legal ones.

From the floor: I was under the impression, that the working conditions of junior doctors, in terms of hours worked, number of shifts, and time between shifts was nearly better, in terms of getting bored. I think in 2010, I thought the conditions were going to get better and when

thinking, stress, burnout with hours worked, and I wondered why we are doing that if the conditions – the hours worked for example, had improved, why has stress been on the rise?

Sian Gilbert

It's part of that analysis, which was a little bit simplistic in following the more practical view, but there's not much that can be done by way of complaint. So, awards are routinely reviewed, and there's a wage case before, whichever before the Federal Commission of NSW Commission, and there are aspirational statements and submissions made, which is fantastic, and those generally made by the Union and other interested parties, on behalf of the JMOs. And so, you have a set of standards, if you like, put into an award. But people are not motivated to agitate, if it's not adhered to. And that goes to the question earlier about the young lawyers, the young graduates. There's a certain pride in working the long hours, and the presenteeism and always being there late at night. Not me, but for juniors. And I've seen people on Facebook half the day, so they could be there late at night when they think that's when they need to be seen, to be there. I think it's part of that culture, but yes, you might have the award, but try enforcing it, that's the issue.

Phil Truskett

And having said that, the award is fairly silent. It just talks about how you should be paid when you do it. There's not a lot of regulation in it.

Rosa Canalese

Just to that point, I think the hours are better, I think the roster is better. I think it varies from local healthcare work. I think that it depends on your staffing as well. So, I think that while the hours of the award might be better, I think there are still a lot of doctors that are working longer hours. But part of it also is too, I think it also goes to that lack of supervision and support. Maybe working longer hours, they're actually not as able to do their job, so they don't have the skills then to do their job. There might be an expectation, an unwritten expectation, that you're on the ward at 7:00 when the surgeon gets there, and then you're there when they're coming out. So, I think, yes, there's an award and the hours are probably getting better, but I still think there's a whole lot of those other cultural things and services where it is still not an issue.

Bruce

Do you think there's a role for mentoring?

Rosa Canalese

Yes. It depends, I guess, on what you mean by a mentor, because I think, generally the term mentor, is a more senior experienced colleague, who just wants to ensure that the best happens for you. They may not necessarily be someone who's in the workplace, who's there when you need assistance with a skill, or with a competency. So, mentorship, yes, might help, in terms of more general discussions and career path and career direction. But I think for that, being 'johnny' on the spot, "I need help with this skill, I'm out of my depth, I need

someone to assess a patient" that probably requires more on the spot supervision. So, I think there is a role for mentorship, but I think it has a different role, to what stressors the doctors are experiencing, which is that on the spot, "I need help."

From the floor: I'd just like to ask what you think about the bridge gap, between what's on the website. You know, we encourage our staff to ask for help. What we all – I'm assuming we all know is reality, you just don't put your hand up, particularly as the job not as supportive, but I wouldn't recommend it. So, what can be done by employers to try and measure their people to stop the hand fight, when you're having problems?

Sian Gilbert

I'm happy to make a comment about that. That is all about culture here. It's all about culture. I don't have the direct experience in the medical environment, but for example, part of my area of expertise, is in sexual harassment, and that's been under the lens for the last 18 months in the media. And there have been all sorts of questions raised about, why don't people make complaints? Why don't people speak up? And usually, the answer is, because it's too difficult. Because it's too difficult, and you're getting punished, and your singled out, and your treated differently. That, is about culture. And the only way you can change that, is leadership from the top. So, the example I just spoke to anecdotally about presenteeism, that's about you as a senior medical professional, for example saying, "You don't need to be seen to be here at nine o'clock at night." "In fact, I would prefer it, if you were really efficient, and got your work done, in this particular timeframe, so that we can all go home and have time with our families, or go to your soccer game or do this." The only answer I can give you, is about culture and leadership from the top.

Rosa Canalese

And I'd echo that. I think, if somebody experiences a friend or a colleague who's spoken up, and seen that they have been treated appallingly, then they won't speak up. So, it is about that leadership. That way if somebody does put their hand up, that it's seen that they are taken seriously, that it is addressed, and that it's managed appropriately, and they are not the scapegoat, or the ones that have been wronged. So, I think it is that leadership, and then I think, if the culture is supportive of, "Yes, we do want to hear from you, and when you do speak to us, we will take it seriously and the appropriate steps will be taken." And I think in the absence of that, you won't get that open culture and supportive environment.

Phil Truskett

Thank you for that. I'd like you all to join with us, and thank Rosa and Sian. I think they tackled a very difficult subject, with great elegance and a fabulous way of putting things together. So, I really thought you did a great job, both of you. Thank you.