COLLEGE OF INTENSIVE CARE MEDICINE
OF AUSTRALIA AND NEW ZEALAND

21 December 2023

Victorian Department of Health
Via email: minreview.medicalstaff@health.vic.gov.au

Dear Executive Officer,

Re: Ministerial Review: Victorian Public Sector Medical Staff

The College of Intensive Care Medicine, Australia and New Zealand (CICM or the College) thanks the Victorian Department of Health for the opportunity to provide feedback on workplace systems and employment arrangements impacting public hospital medical staff and delivery of health services.

About the CICM

The CICM is the body responsible for intensive care medicine specialist training and education in Australia and Aotearoa New Zealand. Bi-nationally, we have over 1300 Fellows and over 1200 Trainees enrolled in our training program. In Victoria, we have over 200 Fellows and over 200 Trainees enrolled in our training program.

We provide continuing medical education, professional development, maintain standards and advocate to governments and the community. We provide a high-quality training program, with supervision of clinical training, administration of assessments, and a range of workshops and courses.

CICM Position

There are four key issues that the CICM wishes to highlight as part of the Ministerial Review: Victorian Public Sector Medical Staff:

1) Structured training pathway for intensive care medicine

The lack of a structured training pathway for intensive care trainees in Victoria is an ongoing issue and is potentially a deterrent for junior doctors considering a career in intensive care medicine. The CICM recommends the Victorian Department of Health works closely with the CICM and relevant stakeholders to explore viable options for how a structured training pathway for intensive care medicine might be developed, funded, and implemented.

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2) Adequate funding for training positions

Adequate funding for intensive care training positions is required to ensure an appropriately resourced and sustainable intensive care workforce. This will ensure hospitals have the capacity to train the current and future intensive care specialist workforce and trainees have a more seamless journey during their specialist training.

3) Improvements to critical care staffing in regional and rural intensive care units

Victoria's health and medical workforce is inequitably distributed across the state, with relative shortages in regional and rural intensive care units. It is vital that intensive care units are appropriately staffed at all levels (from intensive care trainees through to senior consultants) so that patients and communities have access to timely and high-quality critical care services. The CICM recommends that appropriate support and incentives to attract (and retain) intensive care trainees and specialists to regional and rural intensive care units be explored and implemented where appropriate.

4) Ensuring a representative and sustainable intensive care specialist workforce

Whilst industrial factors are not traditionally the purview of an educational organisation, the below statement is based on our understanding of the current ICU context, coupled with the feedback we've received.

To ensure the creation and sustainability of a diverse and representative intensive care specialist workforce, it is essential the challenges and barriers for the profession (including junior doctors) be explored. Intensive care is one of a small number of specialties that must provide significant staffing at both a junior and senior level 24 hours a day, and 7 days a week. Ensuring that workforce models, remuneration and support are appropriate is vital for the sustainability of critical care services.

Issues around training, rostering (high proportion of night shifts), workplace culture, career progression/opportunity, assessment and workload (part time roles with additional hours) are consistently flagged as being problematic for intensive care specialists.

Noting the above, it is recommended the Victorian Department of Health work collaboratively with the CICM and other relevant organisations to explore these key issues to provide an environment that is able to attract and retain intensive care specialists and serve the critical care needs of the Victorian community

Feedback

To contribute to this Ministerial Review, the College canvassed the views of its Victorian membership base. Direct feedback was received from a small number of specialist intensive care physicians (Fellows), Trainees and Specialist International Medical Graduates. The feedback received has been collated and summarised in themes. Please refer below to Appendix 1 to see a summary of the feedback received.

Please be advised that the feedback contained within Appendix 1 does not necessarily reflect the views or position of the College.

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The feedback has been provided on behalf of a small, motivated proportion of members working in public hospitals with the view to assist the Ministerial Review in understanding the key challenges they face and inform future health system planning.

Noting the above, the College will also use this as an opportunity to review and consider the feedback received that relates to CICM training, policy, and operations.

We hope that the information contained in our submission is helpful. The College is eager to maintain and evolve effective and constructive communication pathways for improving Victorian people's access to high-quality intensive care medical care closer to their homes, where appropriate.

Should you have any queries or comments regarding our feedback, please feel free to contact Ms Michelle Gonsalvez, Policy and Advocacy Advisor on 9514-2837 or via michelle@cicm.org.au or the Victorian State Committee via Ms Lara Ohlmus on 9514-2839 or viaviccommittee@cicm.org.au.

Yours sincerely,

Dr Rob Bevan
President

Dr Cameron Knott
Chair, Victorian Committee

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Appendix 1: Summary of CICM feedback received.

***NB Feeback contained within this summary does not necessarily reflect the views or position of the CICM. Additionally, given only a small proportion of Members responded, this feedback doesn't necessarily represent the views of the broader Victorian membership base.**

ToR 1: Recruitment, retention, supply of doctors (including local graduates and International Medical Graduates), training, training pathways and coordination of doctors across the public health sector recognising that this is a particular issue in regional and rural settings and hard to fill specialties.

Recruitment

- There should be a fair and unified recruitment pathway for Junior Medical Officers, Senior Medical Staff, and International Medical Graduates (IMGs). This could be achieved via a government-based website with several pathways depending on the career stage of the doctor (e.g. a pathway for senior medical staff, junior medical staff, and international medical graduates).

- Recruiting IMGs is an extensive and cumbersome process, particularly when initially registering with the Australian Health Practitioner Regulation Authority (AHPRA). This was particularly problematic during the pandemic where ICU capacity needed to be rapidly expanded, but IMGs were unable to enter the workforce in a timely manner due to registration delays.

- There should be more local graduate training to increase the number of doctors who graduate in Australia, and greater opportunities for international junior doctors to incentivise overseas doctors to work in Australia.

- To ensure a more equitable distribution of the intensive care workforce, there needs to be a state-wide coordinated approach to funding and recruitment, the establishment of a Single Employer model may enable this.

Training pathways

- As part of the CICM training program, Trainees are required to complete a minimum of 6-month rotations in ICU, anesthesia, general medicine, emergency medicine and paediatrics. Junior doctors are responsible for locating their placements at each hospital individually, which increases complexity and stress for ICU Trainees to individually find a placement in the appropriate specialty.

- It can be extremely difficult for Trainees to obtain one of these roles to complete their rotation particularly when a specialty is not facing a workforce shortfall: for example, Anesthesia is currently a difficult placement to attain.

- There is a lack of state-level co-ordination between Trainee rotations, which delays Trainees in completing their training, as they are yet to be accepted into the required rotation.

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There should be a statewide training pathway that selects 6-month minimum training rotations for Trainees, coordinated by the Postgraduate Medical Council of Victoria's matching system, overseen by a State CICM Statewide Training pathway team, and aligned with a Capability Framework for regional Victorian acute and critical care development.

- Hospitals are not incentivised to create more positions for these rotations. More positions would improve patient care and expedite the time it takes a CICM Trainee to attain Fellowship. A statewide Capability Framework for ICU could assist with this.

Rural/regional issues

- There is currently a maldistribution and deficit of ICU specialists in rural and regional areas; much of this can be attributed to working conditions rather than just remuneration.

- Rural ICU work can be very isolating. In smaller communities, doctors are often perceived only as their professional self, and lose their personal anonymity.

- Limited educational facilities for children, reduced social/familial support, and fewer opportunities for peer support and professional development make relocation to rural and regional areas unattractive for many ICU doctors.

- Rural ICU doctors are more likely to be working in under-resourced hospitals with less staff. This means that ICU doctors often take on more personal risk, and has negative impacts on patient outcomes, as ICU as a specialty relies on multiple doctors working together on complex critical care issues.

- It is difficult to attract trainees to work in rural/regional ICUs, which has led to reliance on locums, which are costly.

- Even when Trainees choose to work in rural/regional areas, they are often unlikely to stay due to familial and social obligations and supports remaining in Melbourne, meaning these doctors are a temporary stop-gap measure rather than a solution to rural workforce deficit. A ‘grow-your-own’ strategy for regional/rural ICU training systems can be effective.

- Due to the maldistribution of available rotations, major metropolitan hospitals employ the majority of experienced ICU trainees, meaning their patients are more likely to receive appropriate care compared to rural and regional hospitals, where the more junior ICU medical Trainee workforce is located.

- There is an opportunity for GP Anaesthetists and Rural Generalists to upskill in critical care by partnering with rural/regional ICUs; this should be facilitated through State workforce mechanisms.

- To attract IMGs to rural areas, the registration process should be more efficient, and Work-Based Assessment programs should be made available at all regional hospitals.

- Rural-metropolitan partnerships via a centralised training pathway could streamline recruitment to regional/rural hospitals and assist trainees in fulfilling all requirements of the CICM training program.

ToR 2: Adequacy of existing classification structures and exploration of future clinical management roles, including the potential of expanding the utilisation of classifications such as Medical Officers.

- Position names are less important than ensuring that the responsibilities of each role are clearly defined, and the pay scale is fair.

- There should be more opportunities for ICU Specialists to formally upskill their leadership and management abilities, for example via post-graduate education or qualifications in management. Many ICU specialists are required to act as managers with no formal training in management which can lead to incidences of harassment and bullying. Explicitly taught management skills may reduce occurrences of this.

- It is unrealistic to expect all doctors working in hospitals to agree to Fellowship and become a senior consultant. Medical Officers who have defined skills below a specialist level and are not likely to progress their career further are an essential part of the hospital workforce and should be recognised as such within the classification system – as a Career Medical Officer role within an ICU or hospital workforce.

- Clinical and administrative work are impossible to separate from each other and attempting to move either of these aspects to a "less qualified" medical officer role would result in a lower quality of patient care.

- Inefficiencies in workflows should be examined and could be reduced via technology. For example, wider use of electronic medical records (EMR), integrating a state-wide network of health data (including imaging and pathology results) and use of generative AI with documentation tasks.

ToR 3: • Exploration of the barriers to recruitment and retention of ongoing medical staff arising from different modes of employment, such as fractional specialists and fulltime specialists, and the impact of wage relativities between modes on attracting a stable medical workforce.

<u>Barriers to recruitment and retention</u>

- An organised, centralised pathway that assigns rotations to Trainees rather than expecting Trainees to find their own placements each year would make training easier and increase the retention of ICU Trainees. This would also reduce administrative burdens on ICU staff who currently perform this work.

- To prevent burnout in rural areas, health centres should be required to recruit more than one person when setting up a specialised service.

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- Accommodation should be offered as part of recruitment for rural and regional roles, and there should be more support for specialists to move and maintain their families to encourage doctors to stay and work in these areas. A 'Concierge' service to help community integration would be beneficial.

- Partial funding of roles via the Specialist Training Program, the Integrated Rural Training Program, and other such programs is not an effective recruitment method, as many rural and regional hospitals cannot afford to make up the shortfall to make the positions viable in the long-term.

Wage relativities

- The benefits of working at each hospital should be consistent so that salary is not the leading incentive for a doctor to change jobs. Wages between regional and metropolitan hospitals vary, which disincentivises specialists from working rurally and compounds the workforce shortage in rural areas. This also applies to the ability to earn a private income in a regional area.

- Regional health centres could have more remuneration than metropolitan areas to incentivise doctors to work in these areas. Currently regional and rural hospital roles are not remunerated equally to metropolitan roles.

- Much of ICU work is shift work and requires doctors to work night shifts or be on call overnight. An 'unsociable hours' contract, similar to the United Kingdom's NHS, where doctors are remunerated at a higher rate for work on weekends, public holidays, and between the hours of 8 pm and 6 am should be implemented. This would lower levels of understaffing during these unsociable hours and improve patient care.

Flexible work arrangements

- There is a lack of permanent part-time working arrangements at hospitals, which creates workforce instability and inequality. Female intensivists are often treated unfairly regarding parental leave and flexible work. Most intensive care specialists work at multiple hospitals at once, which means that despite working in the public health sector for a substantial amount of time, many intensivists do not receive an adequate amount of parental leave.

- Positions in hospitals should not only be delineated as full-time and part-time positions but should be managed on a proportional spectrum from 0 to 1 FTE.

- Older intensivists should have the option to do less on-call work and weekends to reduce burnout overtime. The longer older intensivists can work, the longer units are able to benefit from their 'in-house' experience and mentorship.

- There should be consistent clinical and administrative practices across Victorian healthcare organisations. This would increase the efficiency of onboarding and induction processes and allow for a more flexible workforce that can effectively work across multiple institutions.

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ToR 4: Rostering practices that that result in high levels of ad hoc overtime and on call that may impact the health, safety, and welfare of doctors and any alternative practices.

- Rostering depends on the number of patients per doctors, and there is no consistency across specialties what a safe patient to doctor ratio is. Introducing safe rostering rules across specialties in hospitals where there are agreed upon safe patient to doctor numbers would prevent staffing inconsistencies across departments and increase patient safety.
- ICU doctors should not have to work more than 48 hours straight on call. Some institutions still run 72-hour single consultant weekends which expose doctors and patients to risk, as tired doctors are more likely to make mistakes and adverse decisions.
- Many units rely on senior medical staff working long hours with a critical sleep deficit, with some doctors working 7 days in a row. Safe working hours should be implemented for Senior Medical Staff to reduce incidences of these situations.
- Staff shortages, particularly in regional areas, compound these issues of overwork. This leads to guidelines and procedures not being followed (due to lack of time) and significantly impacts doctor welfare, as there is less time with family, and less time to prepare for exams.
- A lack of flexible FTE arrangements means that hospitals are less able to respond to and prepare for planned and unplanned leave. Backfill of leave is often not possible.
- Hospitals often employ minimum numbers of doctors to save money, which means there is limited or no capacity to respond to unexpected emergencies.
- Ad hoc overtime is undesirable but an inevitable part of ICU work unless overtime is planned and rostered for. Work rosters often underestimate the hours of work that need to be completed. Staggering rosters throughout the day to allow for more coverage, better circadian rhythm management, and implementing flexible FTE arrangements so that more doctors are hired for a similar cost could be some strategies to limit the amount of ad hoc overtime.

ToR 5: Review the current Out of Hours arrangements for Specialists, particularly for Fractional Doctors and Doctors in Training with emphasis on how technological advances may be changing the delivery of out of hours care.

- Telehealth and telemedicine should be utilised more for out of hours care, as it improves healthcare accessibility for patients, particularly those in rural areas. However, care should be taken to ensure that telehealth does not replace in-person coverage at regional sites.

- The phone-call allowance in the Out of Hours arrangements is currently outdated as it does not include new technologies such as telehealth, telemedicine, and remote access to electronic medical records. The arrangements should be updated to reflect this.
- On-call stipends do not account for off-site supervision of registrars that many intensivists undertake, the arrangements should be updated to reflect this.

- Many doctors do too much work out of hours; safe working hours need to be mandated.

ToR 6: Exploration of working arrangements, including part time and casual employment.

- There is an over-casualisation of junior ICU consultant jobs which exposes these doctors to exploitation, as they are more likely to work undesirable hours to eventually secure long-term employment.

- There should be equal and greater access to parental leave, and part-time work. It would be more beneficial to have a larger pool of part-time FTE doctors who can work more, when necessary, rather than a smaller pool of full-time doctors who are consistently understaffed. Many hospitals recruit locums to cover gaps when flexible work negotiations fail, which is far more expensive and inefficient.

- For Doctors in-Training, part-time work may be deemed insufficient for their training, which currently negatively impacts the ability of trainees to manage their personal life. An organised, centralised pathway that accounts for differing needs in working arrangements amongst trainees would improve the welfare of trainees and improve recruitment and retention.

ToR 7: Work design which may include task allocation and support.

<u>Administrative and clinical work design</u>

- All aspects of ICU work, including administration and management should be primarily controlled by clinicians, rather than external CEOs and managers without clinical knowledge

- Well-staffed units with positive work cultures have higher rates of retention; this should be a priority.

- There should be greater support and planning for trainees, including an organised, centralised pathway, and regular structured exam teaching. At least 5 hours per week should be protected training time for registrars.

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- Despite some latent inefficiencies, it is important to maintain a clinical hierarchy to ensure appropriate supervision and delegation of tasks.

IT work design

- The variety and inconsistency of medical record systems, poorly integrated hospital IT and clinical IT result in inefficiencies. There should be more support for clinicians and administrators when implementing and optimising Electronic Medical Records (EMR), and there should be consistency in clinical informatics across institutions. Where institutions are technologically behind, minimum standard practice should be prioritised.

- Medical staff should receive education on medical administration, data interpretation, and EMR use. Technological aids such as AI could be considered.

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