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How can Safe Working Hours produce a Safe Specialist Obstetrician & Gynaecologist?

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Two articles in the current Journal highlight the issue of “Safe Working Hours”. Few will have been surprised to see that among the 49.5% of trainees who responded to the survey, there was significant concern regarding rostered hours. Although the average working week of 53.1 hours is probably not greatly different from other medical trainees, those responding to the survey perceived that fatigue resulting from long hours adversely affected their clinical performance and training. Of particular concern is that 56.1% of respondents indicated that they had experienced “dozing whilst driving” in relation to fatigue.

What are the consequences of shortening the working week?

The Royal Australasian College of Surgeons have produced a comprehensive position paper addressing the training and clinical service implications of reduced hours for surgical trainees (1). Drawing particularly on the European and North American literature, the downsides of shorter hours appear to be considerable for the surgical trainee. Obstetrics and gynaecology is unlikely to be greatly different. In fact, observing a long labour from start to finish is an essential component of obstetric training but impossible to accomplish in an 8-hour shift.

Even more concerning is the hospital administrator who, with scant regard for training, uses “safe working hours” as a pretext for limiting paid work to 38 hours (and thereby avoiding any overtime payment). The same administrator fails to ensure there is enough gynaecology training for the increased numbers of registrars required with the shorter working weeks, thereby causing gynaecological procedural numbers per trainee to be amongst the lowest anywhere. Procedural numbers are worrying low in many ITPs and likely to be contributed to by those “training” hospitals fixated on a 38-hour week. The College must progressively withdraw trainees from ITPs where trainees are being used as “cheap obstetric labour” and not adequately trained across the spectrum of obstetrics and gynaecology. The

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increased costs of alternative labour might incentivise administrative behaviours that are more sensitive to the needs of our trainees.

What is a reasonable working day and working week?

Just as training suffers with shorter hours, there can be no doubt that excessively long shifts or working weeks have adverse consequences for the training, personal wellbeing and clinical performance. But what is “excessive”? While not directly setting an upper limit, amongst 16 rostering issues in its “risk assessment tool”, the Australian Medical Association (AMA) specifies shifts of greater than 14 hours and a working week longer than 70 hours as “high risk”. The current average weekly hours for our trainees (53.1) sits at the lower end of the AMAs “intermediate risk” category of 50-70 hours per week. Each position should be judged on its merits but “targets” of a maximum shift length of 14 hours and an average week of 50 hours would seem to strike a reasonable balance between two undesirable extremes – the excessively long or unreasonably short working week.

Are there available strategies to maintain adequate training in the event of reduced working hours?

Lengthen Specialist Training? - No

The training program is already long. Graduate medical entry is now more often than not. Formal specialist training is not likely to commence until at least PGY4 followed by 4 years of core training and 2 of advanced training. One third of trainees will undertake subspecialty training (at least one additional year, more often two), occasionally 3-4 years undertaking a PhD and often parental leave with some part-time training. It is no surprise that with current training, the new Fellow may be 40 years of age before entering consultant practice. Longer training is untenable.

Streaming into gynaecological surgery during advanced training?

A focus of the “revised FRANZCOG training program” has been a recognition that not all those attaining FRANZCOG need to have consultant-level skills in all areas. Generalist, subspecialist and academic pathways focus advanced training on the intended scope of practice. Streaming even earlier may eventuate but will substantially reduce the breadth of skills of those attaining FRANZCOG.

Simulation

Simulation is an essential addition to modern training and enables the trainee to make maximal use of limited training opportunities. The College obligates some simulation training and this will have to increase. However, simulation cannot replace supervised training in the workplace.

More Training and less Clinical Service

The heavy and largely obstetric clinical service needs of our public hospitals are a long-term reality. If that “on-site” service demand continues to be met largely by FRANZCOG trainees, the gynaecological surgical training will be insufficient to reach the level demanded of a consultant obstetrician & gynaecologist. Some of the current clinical service obligation must be moved away from trainees so that trainee numbers relate to the training available rather than the “on-site” clinical service need.

Who will provide this on-site clinical service? This is likely to vary in different jurisdictions but some hospitals (particularly provincial) manage without 24-hour trainee cover of labour ward and without trainees bearing most of the antenatal clinic load. This results in the trainees usually getting considerably more gynaecological surgical training than their tertiary-based colleagues. More effective use of the prevocational workforce (“PHOs”), GP obstetricians and new Fellows are all strategies that can assist in delivering clinical service with the training numbers that a site is able to support. The “career hospitalist” may ultimately have a role but is slow to gain wide acceptance. The service role is needed now.

In conclusion, the training week requires sufficient hours for training but not so many as to compromise trainee well-being or patient safety. The optimum balance point will differ between hospitals but the available evidence would seem to point to the lower end of the 50-70 hour range. Above all, some of the heavy clinical service load must progressively move to other medical staff, so that trainees can “train”.

References

1. Appropriate Working Hours for Surgical Training in Australia and New Zealand. Position paper. Royal Australasian College of Surgeons.
2. National Code of Practice - Hours of Work, Shiftwork and Rostering for Hospital Doctors. Australian Medical Association. August 2016.