Appropriate Working Hours for a FRANZCOG Trainee

Acton et al (2016) reported that the average working week for FRANZCOG trainees was 53.1 hours, not dissimilar to the 54-hour average for hospital doctors reported by the AMA (2011).

The Medical Trainee Survey (2020) reported that RANZCOG trainees work 50.2 hours a week, compared to 45.6 hours a week for the national average. Fifteen per cent of trainees worked 24 hour shifts with median sleep times of only 1-2 hours during those shifts.

In the 2016 AMA survey, Obstetrics & Gynaecology fared only marginally better than Surgery for "at risk" working hours as judged by the AMA points system. For Obstetrics & Gynaecology, 42%, 40% and 18% were judged as low, significant and high risk respectively. For Surgery, the corresponding rates were 28%, 53% and 20% (AMA 2017).

Adverse consequences of training week with excessive working hours

Equally well documented are the adverse consequences of excessively long hours, both for patients and trainees. Higher stress rates and substance abuse by doctors and increased adverse incidents for patients (Baldwin 2004).

Tucker et al (2016) concerningly revealed that 56.1% of trainees indicated that they had experienced "dozing whilst driving" in relation to fatigue. The mean working hours in this group was 53.3 hours compared to 51.0 hours in those reporting 'never dozing while driving'.

Minimising fatigue is obviously critical but more complex than working hours alone. Petrie et al (2020) assessed mental health issues amongst junior doctors in Australia in relation to working hours. Whilst the average working hours per week were just over 50 hours, there was a doubling in serious mental health concerns in those working over 55 hours per week in comparison to those working 40-45 hours per week.

Factors to consider in determining if Working Hours are excessive

The total hours worked represent only one of many factors that may contribute to workplace stress with potential adverse consequences for patient and trainee. Factors to be considered include (AMA 2011):

1. Total hours worked
2. Presence of shifts in excess of 14 hours (so that not reliably achieving eight hours uninterrupted sleep each day).
3. Days off per fortnight and month
4. Workload when at work
5. Presence of on-site assistance: a) at a more senior level; or b) at a more junior level
6. Opportunities to sleep when working either: a) at home ("on-call"); or b) within hospital provided facilities
7. Assets of the workplace e.g. quality of training, workplace culture

Adverse consequences of training week with inadequate working hours

There are cited cases of hospital administrators who, with scant regard for training, use "safe working hours" as a pretext for limiting paid work to "normal hours" in order to avoid any overtime payment. Unfortunately, the highest priority for a hospital administrator may be financial – ahead of excellence in patient care and the high quality training for its staff. Note that this is not necessarily the "fault" of the hospital administrator but a consequence of the health system in which he/she works.

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 (RACS). Drawing particularly on the European and North American literature, the downsides of shorter hours appear to be considerable for both the surgical trainee and surgical patients (de Blacam et al, 2016).

1. Reduced surgical training

   This reduction of training opportunities is not only a consequence of fewer hours of exposure, but also a result of the total number of training procedures remaining constant while the number of trainees required increases. Simple arithmetic mandates fewer procedures per trainee. In obstetrics & gynaecology in Australia and New Zealand, gynaecological major surgery procedural numbers are worrying low in many ITPs, exacerbated by those "training" hospitals fixated on a 38-hour week.

2. Reduced continuity of care

   Surgical trainees have noted reduced continuity of care with reduced training hours (de Blacam et al, 2016). Obstetrics and gynaecology is unlikely to be different. Observing a long labour from start to finish is an essential component of obstetric training but impossible to accomplish in an 8-hour shift.

3. Increased stress and workload

   A simple reduction in working hours without a corresponding increase in staffing, may mean that the trainee must do the same amount of work in fewer hours (Clarke et al, 2014). For example, six trainees doing a 1 in 3 roster, with two on call after hours would need to do twice as much work if it became a 1 in 6 roster with only one on-call after hours – with the added stress of being the only registrar. A roster with reduced working hours does not always mean less stress for the trainee (and in some cases can mean more).

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 of trainees. 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 (50-55 hours) 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 working week of 50-55 hours would seem to strike a reasonable balance.

It should be noted that:

1. Considerably shorter working hours are appropriate where "workplace stress" is excessive by virtue of a poor workplace culture or excessive workload. With respect to the latter, the registrar should always be supported by a junior colleague after hours where births are in excess of 2000 annually and a second registrar, senior registrar or continuously 'on-site' consultant should be present if births are in excess of 4000 annually.
2. In hospitals birthing less than 1000 annually, it may be reasonable to be rostered for longer hours providing sleeping accommodation is provided or "on-call" occurs from home. In such circumstances, the average

number of hours of uninterrupted sleep should be considered along with other factors in determining whether the working hours are excessive.

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, then gynaecological surgical training opportunities will be insufficient for trainees 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 determined solely by 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".

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