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Comment

The paper is broad and helpful as a basis for further consideration of this important subject.
I offer the following opinions based on extensive experience as a medical clinician, private and public hospital manager and Health Services consultant across Australia and New Zealand. I am still actively employed in senior management for both acute health and aged care.

Culture and Social Context

The past twenty years have seen major changes to the behaviours of doctors in regard to lifestyle, hours of work, shared responsibility for family and home duties. Some of the factors promoting change include the following:-

- Equal opportunity for women;
- Anti discrimination e.g. Disability, aging & retirement;
- Two income households;
- Increased disposable wealth;
- Safe hours;
- Reticence to do on-call work;
- Major increase in female medical graduates;
- The heightened threat and cost of litigation;
- Multicultural society with differing values for family and society in general;
- Availability of carers for kids, sick and elderly.

The above list is not in any order of priority

These factors have underpinned major changes to the availability of doctors and their willingness to work. The following observations are universal throughout Australia:-

- Many women doctors work part time and balance the duties of motherhood and parenting;
- The partners of such women are often doctors or other health professionals and are expected to be supportive of mutual responsibilities and individual career ambitions;
- Doctors of all ages can afford and are prone to take holidays or attend conferences far more than in earlier years;
- No one partner in a relationship or marriage can take a dictatorial approach to the choice of a practice location or housing location;
- Access to private schools child minding, grand parents and established friendships are relevant to the choice of where to live and practise;
- Domestic responsibilities impact the availability and flexibility to participate in on- call rosters for emergency services, obstetrics and anaesthetics;
- The “Safe Hours” program sponsored by the AMA has been effective in achieving shorter working hours for doctors in training. This has the flow on for the younger doctors who are unprepared and unwilling to work the long hours that have been traditional for specialist medicine and Rural Medicine for all disciplines;
- Reduced hours for doctors in training is leading to a lessened breadth and quality of experience and understanding of the lifecycle of developing diseases;
- Litigation is driving change to reduce the long hours for surgeons and anaesthetists with an evident danger of more mistakes to be made. This is prompting shorter hours of work per day and the need to take a morning off if recalled for duty overnight;
- Anaesthetists are being paid for on call and recall to cover private hospital duties, particularly the obstetric rosters. This is an unsustainable paradigm for the medium to long term;
- The heightened level of income of many doctors, particularly specialists means that there is more freedom to give priority to lifestyle. E.g. Ten years ago most obstetricians earned less than $2,000 for a delivery. Nowadays it is not that uncommon for a charge of $6,000 to apply for a private patient and some of

the popular doctors deliver more than 400 babies in one year. Gynaecology income is additional to that. The HIC could give accurate information on this topic. It is recognised that obstetrics carries a burdensome impact on lifestyle and therefore it may not be the best example.

This litany of observed changes will not revert to ways of the past. It is important therefore that the anticipated further change and consequences are considered in the Review of the Health Workforce.

This paper is written as a prompt to consider some practical realities that are of serious concern because they are creating change that planning has not addressed.

The author would be happy to expand on the matters raised here if the Commission would be assisted by such work.

Author: