SESSIONAL CONTRACT OVERVIEW

CONTEXTUAL OVERVIEW TO BE READ IN CONJUNCTION WITH SESSIONAL CONTRACTS FOR VISITING MEDICAL OFFICERS

Sessional contracts for visiting medical officers contain clauses which prescribe contractual arrangements and provide a basis for an equitable and mutually rewarding relationship between the hospital or area health service and the visiting medical officer in the future.

However, it is important that several contextual issues are clearly stated and understood by the parties.

1. Role of the Visiting Medical Officer.

Because of their training, expertise and experience, senior medical staff have the ultimate responsibility for patient care. This central role also necessitates continued leadership in

- planning the clinical activities of hospital departments,
- maintenance of high clinical standards,
- introduction of new technology and new methods of patient care,
- meeting the challenge of efficiently utilising limited hospital resources for the greatest benefit to the community.

Visiting medical officers, together with their academic and staff colleagues, provide essential expertise in all of these matters and their continuing involvement is vital.

Visiting medical officers are and will remain independent contractors, but in facing such complex matters as waiting lists, budget allocation and the like, there should be a team approach in which visiting medical officers and other senior medical, nursing and allied health staff work with the management of hospitals and area health services to achieve the best possible result for patients.

2. Review and Updating Mechanism.

Both the Australian Medical Association (New South Wales Branch) and the Health System acknowledge that a suitable process has to be developed by the parties aimed at reducing the need for long and complex arbitration in relation

to visiting medical officer issues.

A process which is suitable for adoption is that the Australian Medical Association (New South Wales Branch) and representatives of the Health System meet to discuss issues periodically with the object being to implement a package of agreed variations each two years.

The discussions will address any matters that need revision, including the question of levels of remuneration. If this process leads to an agreement between the parties, then it can be submitted to the Arbitrator on a consent basis.

Whilst every effort should be made to achieve agreement between the parties, it is recognised that there may be the need for the involvement of a mediator, if agreement is not achieved. The objective of the mediation process is to reach agreement on all matters, or as many matters as possible, prior to either party making a decision to take an issue or issues to arbitration.

At the conclusion of the mediation process, a total agreement could be submitted to the Arbitrator. However, either party could reserve its right to take matters to arbitration if consent arrangements were not achieved.

It is anticipated that the above process of consultation and, if necessary, mediation would be conducted over approximately two months.

3. Clinical Privileges.

Recognition of the kind and extent of work that visiting medical officers may undertake in hospitals is safeguarded by the essential role of credentials committees of peers (set up under existing agreed by-laws) to advise Boards on clinical privileges and their inclusion (as required by existing regulations) in appointment agreements. A flexible dispute resolution procedure with an emphasis on resolution being achieved at the local level, in addition to statutory appeal provisions in the Public Hospitals Act, ensures fairness.

4. Maintenance and Enhancement of Skills.

When clinical privileges are determined and facilities are made available, recognition will continue to be given to the need to maintain the special skills of visiting medical officers and to facilitate the development and use of new skills. This will occur through the reasonable availability of study and conference leave and the fostering of an atmosphere which is conducive to improvements in expertise and quality.

5. Senior Specialist Status.

There is an understand that existing senior specialists will retain that classification and that future promotion will be based on peer review through a credentials committee.

6. Total Service Structure.

A new clause 5 headed "Services" amplifies the way in which agreement is reached on ordinary hours of service and different methods of remuneration. In the new clause 5 there are now 3 options available to the visiting medical officer which can be used in establishing ordinary services and hours and their remuneration.

An explanation of each option is set out below.

Option 1 - Budgeted Actual Hours Remuneration.

This option involves payment for ordinary hours as worked within an agreed annual plan for services and payment. Call-backs are, of course, additional.

A process to calculate services to be provided is best developed in consultation with individual visiting medical officers at the local level.

A suggested method is as follows:-

Step A - an annual services plan is drawn up and agreed between the visiting medical officer and the relevant clinical head, including the number and nature of services and all known factors (eg relieving, annual leave, Christmas activity levels, etc). The planned services would include direct patient care, postgraduate teaching, approved committee attendance etc;

Step B - these services are converted to agreed annual hours;

Step C - claims and payments are made each month in accordance with actual hours worked to the limit of the agreed annual hours;

Step D - hours worked are compared to budget each 3 months to ensure that budget will be achieved. Where a material trend either way is detected, consultation with the visiting medical officer should take place to ensure that the end of year outcome is appropriate. This may involve an amended plan of activity or funding which gives appropriate consideration to the needs of patients and the day to

day practice of the visiting medical officer. If the agreed annual hours are exhausted prior to the end of the period and arrangements are not in place to vary the hours in accordance with an amended workload plan, provided adequate notice is given, the visiting medical officer may request to proceed on unpaid leave, and approval of such leave is not to be unreasonably withheld; and

Step E - on-call is separately arranged by means of a roster developed in consultation with the clinical head of department.

Option 2 - Specified Procedures Remuneration.

This option is designed specifically for visiting medical officers who primarily undertake surgical or other procedures. Procedures converted to hours are paid for when performed (up to budget limit). There is an agreed service plan and budget with periodic review. Agreed hours are paid each month for non-procedural work. Call-backs are, of course, extra.

The following are suggested steps and could be varied by local consultation but consistent with the terms of the contract:-

Step A - the visiting medical officer and the clinical head and/or medical administrator develop a plan of the types and numbers of particular procedures expected to be performed in the year;

Step B - each type of common procedure is converted to an agreed number of hours based on an assessment of the average time taken by surgeons for the procedure, including pre and post-operative care, eg, Cholecystectomy - x hours, Hemi-Colectomy - y hours. The average should be calculated over a significant number of procedures to minimise variations and should be reasonable taking into account the facilities and staff available;

Step C - claims and payment are made each month in accordance with actual procedures performed (converted to hours in accordance with the agreed assessment), to the limit of the agreed annual procedures;

Step D - Procedures performed are compared to budget each 3 months to ensure that budget will be achieved. Where a material trend either way is detected, then consultation with the visiting medical officer should take place to ensure that the end of year outcome is appropriate. This may involve an amended plan of activity or funding which gives appropriate consideration to the needs of patients and the day to day practice of the visiting medical officer.

If the agreed annual hours are exhausted prior to the end of the period and arrangements are not in place to vary the hours in accordance with an amended workload plan, provided adequate notice is given, the visiting medical officer may request to proceed on unpaid leave, and approval of such leave is not to be unreasonably withheld;

Step E - a plan is developed for other work including that of a non-procedural nature or procedural work which does not lend itself to an assessment under step B and these hours are similarly agreed - this will include hours for outpatient clinics, postgraduate teaching, committees, consultations, etc;

Step F - these other hours are then divided into either 12 equal instalments or seasonally adjusted as agreed and paid in the same way as option 3; and

Step G - on-call is separately arranged by means of a roster developed ion consultation with the clinical head of department.

Option 3 - Agreed Hours Remuneration.

This option involves agreement as to the ordinary hours to be paid each month. Call-backs are, of course, extra.

The following are some suggested steps, but implementation would be a local process and varied accordingly within the principles in the contract:

Step A - the hospital extracts the previous year's, including ward rounds, consultations, operating theatre sessions, other procedures and outpatient clinics (all for public patients only);

Step B - hours spent on postgraduate teaching, approved committees and any other agreed services are added;

Step C - the annual hours calculated are varied for known changes from last year, eg, additional theatre hours, less relieving, additional approved committees, etc, and giving consideration to available funds etc;

Step D - the annual hours are then divided into either 12 equal instalments or seasonally adjusted as agreed; and

Step E - on-call is separately arranged by means of a roster developed in consultation with the clinical head of department.

7. Negotiation of Variations in Hours.

7.1 Unexpected material variations in workload.

Establishing the annual agreed ordinary hours on a fair and firm basis should overcome the need to continually review and amend the hours. However, it is acknowledged that, from time to time, there will be an unexpected and material variation. This may be an isolated and temporary thing or it may be a clear trend. When either occurs, the hospital and the visiting medical officer should examine the facts and the reason for the variation, and equitably negotiate changes in hours.

7.2 Extra attendances - special consideration for one year only.

It has also been agreed that for the first twelve months of the new contract, a record will be kept of and payment made for extra attendances which are:

(a) additional to those taken into account when determining agreed hours; and

(b) self-generated and non-routine in nature; and

(c) after hours; and

(d) not a call-back; and

(e) not of a pattern.

In the next year these extra attendances will be one of the factors considered in establishing routine hours.

8. Accountability.

It is recognised that in claiming for work performed visiting medical officers, as professionals, are accountable for the efficient and effective use of public monies. This is a key principle in the provisions set down in the contract, specifying the nature of record keeping.

In terms of clause 12(2) of the Determination, it has been agreed that examples of the information acceptable in lieu of the full name or medical record number of the patient are theatre lists, outpatient clinic lists, minutes of committees and notations in the medical record. Visiting medical officers are advised to keep personal records of attendance, in the event that such documentation is

inadequate to support claims.

It is expected that where additional information is required under clause 12.3 of the Determination to support payments to be made under a sessional contract the situation shall be evaluated after 3 months. If over that 3 month period those additional details have been satisfactorily provided by the visiting medical officer concerned, then it is expected that such additional details will no longer be required, and record keeping requirements will revert to those outlined in clause 12.2

9. Insertion of Additional Clauses.

The Determination will form the major part of the actual contract, but, by agreement with the individual visiting medical officer, it is possible to insert additional clauses which are not inconsistent with the Determination itself.

10. Ongoing Consultative Process.

It has been agreed that an ongoing consultative process between the Australian Medical Association (New South Wales Branch) and New South Wales Health will occur. This will facilitate:

(a) the continuing improvement of relationships between the two organisations; and

(b) effective communications; and

(c) involvement of visiting medical officers in contributing to management decision processes.

In particular, at the expiration of 12 months from the commencement of the new determination there will be a review of its operations by the Australian Medical Association (New South Wales Branch) and the New South Wales Health. It is expected that through this process any perceived difficulties will be resolved.

11. Training and Education.

The need for training and education for all concerned in matters arising from this new contract, is recognised. Suitable training and education to meet this need will be provided as required.

12. Anaesthetic Services.

For anaesthetists, where it is agreed that is locally required, routine anaesthetic sessions should be allocated to anaesthetists after consultation with the department or section of anaesthetists.

In relation to Option 1 - Actual Hours and Option 2 - Specified Procedures, where a session is cancelled with less than 28 days notice, the visiting medical officer should be paid for that portion of the list that might have been expected to be of a public patient nature. Payment would be on the basis that the visiting medical officer:

(a) attends the hospital for a period equating to the payment claimed; and

(b) partakes in such other professionally related anaesthetic responsibilities as may be allocated by the hospital. These may include, but not be limited to:

(i) assisting other anaesthetists; and

(ii) partaking in quality assurance or peer review activities; and

(iii) undergraduate or postgraduate education.

13. Calculation of Hours.

It is recognised that the hospital records pertaining to procedures may understate the total time taken in providing the services in some circumstances. Where this is likely to occur it would be advisable for visiting medical officers to maintain a personal record of actual time taken.

It is understood that there is a proportion of "down-time" in completing the total work. The proportion of public and private work undertaken in a "session" should be apportioned across this "down-time" in calculating hours spent on public patients. This includes operating and anaesthetic sessions and ward rounds.

It will always be in the best interests of visiting medical officers to have personal records that can support reviews of hours if they are dissatisfied with the extent of hospital records.

14. On-call and Call-back.

The definition and accompanying clauses are to provide for a "call-back" to be

paid if a visiting medical officer receives a request to attend a "call-back" and returns. This clause also provides that where a visiting medical officer is not on the roster but responds to a request to attend then a call-back is payable.

It is recognised by the parties to the mediation that not all circumstances can be covered in the determination and accompanying documents. It is expected that visiting medical officers and managers will look to the circumstances in determining whether duties are of a routine nature or of such an urgent nature and outside routine practice that they may legitimately be regarded as resulting in a call-back.

It is understood that in the total professional environment of the practice of medicine, some routine services are delivered "after-hours" and equally some call-backs are delivered during a routine day.

Any dispute should be settled expeditiously at a local level.

15. Termination.

In relation to termination of appointment of a visiting medical officer, this should be dealt with fairly, and, where appropriate, provide the affected visiting medical officer with an opportunity to present his/her case.

Where termination is effected, the reasons for such termination should be provided to the visiting medical officer if he/she so requests.

Termination of a visiting medical officer's appointment is, of course, subject to a right of appeal under Part 6B of the Public Hospitals Act.

16. Dispute Resolution Process.

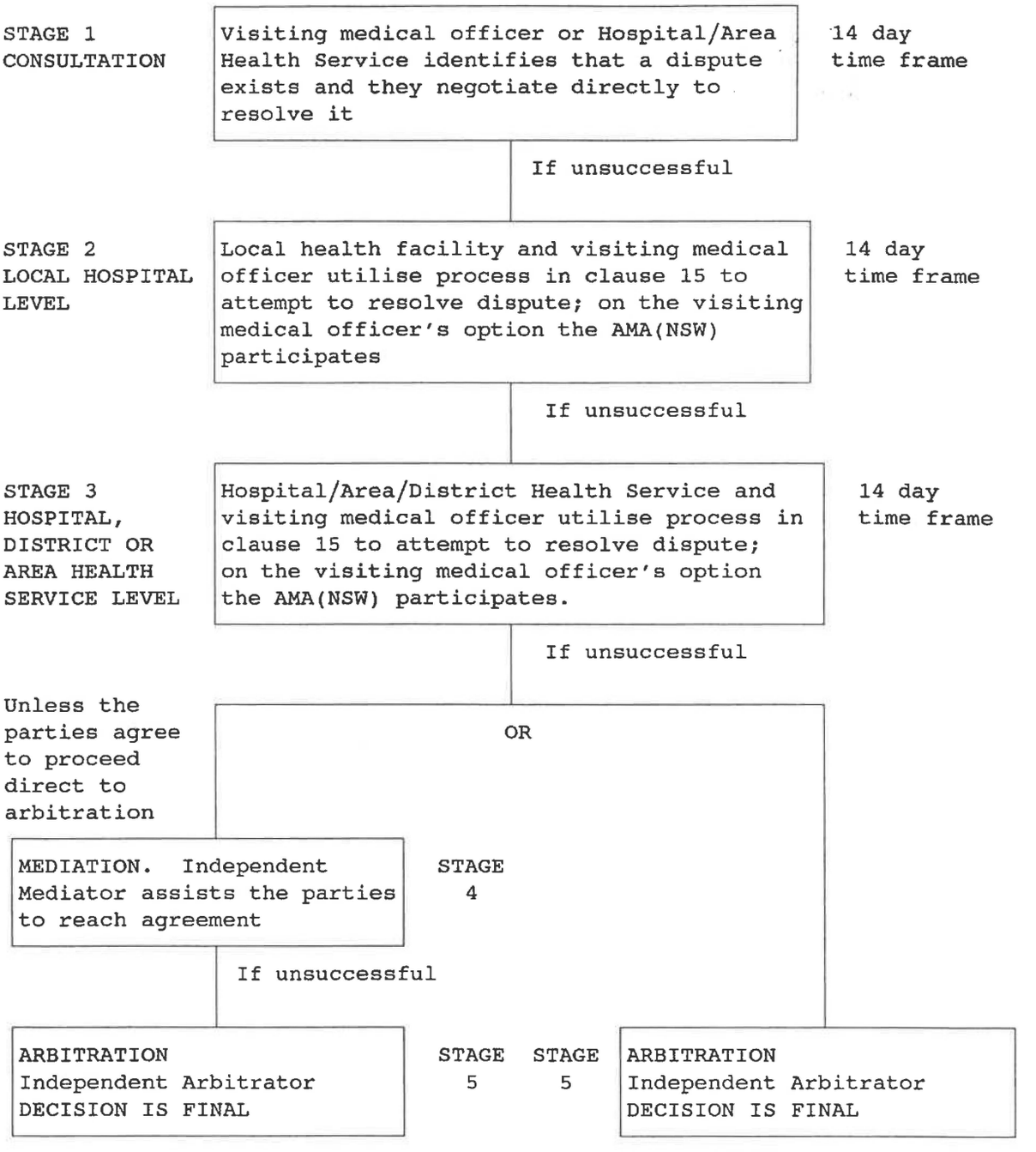
The objective of these provisions in the contract is to achieve a fair and equitable result for visiting medical officers and hospitals and area health services. It may take the form of a mediation or other process designed to resolve disputes or differences in an effective and expeditious manner.

The individual visiting medical officer and the hospital or area health service have the option of agreeing on a mediator or arbitrator and in the absence of agreement a person appointed by the President of the Law Society of New South Wales. To assist parties to disputes a list of suitable mediators and arbitrators will be agreed upon by the New South Wales Health Department and the Australian Medical Association (New South Wales Branch). However, the individual and the Hospital or Area Health Service have the option of agreeing

on a mediator or arbitrator not included in the list.

Whilst the words in the Determination may appear complex, schematically represented, the process is as follows:

DISPUTE RESOLUTION PROCESS



AS AN ALTERNATIVE TO THE ABOVE
THE VISITING MEDICAL OFFICER AND HOSPITAL OR AREA HEALTH SERVICE MAY AGREE TO ANY MEANS OF DISPUTE RESOLUTION AT ANY TIME

17. Guidelines for Completion of an Individual Contract.

(a) The parties to the contract.

The contract is between the Hospital or Area Health Service Board and individual visiting medical officers. Discussion and agreement in regard to each contract will, however, occur on a local hospital basis involving, as appropriate, medical department heads and medical management.

(b) The term of agreement.

The individual agreement can be for up to 5 years. Usually the agreement would be arranged to cease at the same time as the expiry of the visiting medical officer's periodic appointment. It can, of course, be for any shorter period.

(c) Schedule 1 - Hospital names and services provided.

This is a list of hospitals and health facilities at which services are to be provided under this contract.

This schedule may also include services to be provided at each hospital if the visiting medical officer and hospital or area health service agree that these should be recorded in detail in the contract in addition to the information recorded for clinical privileges.

If it is desired to specify the general nature of services to be provided, or to separately identify the committees, clinics, on-call or other particular functions which it is agreed are to be remunerated, these may be recorded in this schedule.

(d) Schedule 2 - The determination.

The determination is attached as the second schedule of the contract.

(e) Schedule 3 - Ordinary hours of services.

The agreed annual hours of services and the method of remuneration should be stated here.

When agreeing on ordinary hours, visiting medical officers and medical managers should have full access to any helpful information held by the hospital, such as past claims, summary data on hours paid, hospital computer print-outs of patients treated and theatre utilisation information, where available and relevant.

All components of non-private work in the hospital are to be taken into account, including ward rounds, operating theatre, other procedures, outpatients, teaching,

and approved committees.

On-call pay and call-backs are not part of ordinary hours. They attract extra payments. All work other than call-back (including extended sessions and any out of hours work that is not a call-back) should be taken into account in agreed ordinary hours.

Current hours being claimed need to be considered along with all the above factors when determining agreed ordinary hours.

(f) Schedule 4 - Classification.

It is necessary to indicate the appropriate classification so that the correct hourly rate is paid.

Choice is between three grades of general practitioner, and specialist and senior specialist.

It is also necessary to specify anaesthetist, physician or surgeon for the purposes of background practice cost payments. Obstetricians and gynaecologists are regarded as surgeons for this purpose.

(g) Schedule 5 - Clinical privileges.

Clinical privileges written in the contract should be as delineated by the board after advice from a Medical Appointments Advisory Committee or Credentials Committee.

There may be general privileges and often special or specific privileges.

General privileges are those that generally apply to members of a particular specialty. These will apply to individuals of a specialty at this time unless otherwise specified, for example, "general surgery" or "consistent with the usual practice of orthopaedic surgery".

Many hospitals, through their Medical Appointments Advisory Committees or Credentials Committees, have identified a range of special privileges which have not been granted to all members of a particular specialty and have been delineated separately. For example, for general surgeons these specific privileges may include lasser surgery, endoscopy, or laparoscopic surgery, for gynaecologists there may be specific privileges to undertake endometrial ablation and for general practitioners, defined obstetric privileges etc. Where these have been delineated separately they should be stated.
