



## Overtime contracts and salaries: a personal view

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*The commuted overtime system is so out of touch with reality that it cannot be implemented without widespread fraud.*

In December 2004 a memo from the CEO to the senior medical staff told us to complete new annual commuted overtime contracts. It turned out to be a red herring – the contracts must be *reviewed* rather than *renewed* – but it made me read the contract and take a good look at my work. I started clocking myself in and out. I am now convinced that our work contracts are unfair and so flawed that they cannot be implemented without committing fraud.

### What the documents say

The overtime contract [HD 4/2] specifies a range of categories for commuted overtime (COT) remuneration. I, and most senior doctors on joint UCT/Provincial conditions of service, fall into Group 3. This specifies COT of 13-20 hours a week and pays us for 16 hours at 1,3 times our basic salaries. Our basic salaries are based on a mythical 40 hour working week. Thus, COT accounts for one third of our income. It is non-pensionable, and is taken away during sick leave.

PGWC Circular H95/2004, *Consolidation of prescripts for commuted overtime*, clarifies aspects of the COT contract. The circular makes it abundantly clear that '... on call (standby duty) is not regarded as overtime ... and may not be taken into account' in the calculation of COT [paragraph 7.2]. This is elaborated further under *Control Measures* in Section 9, with underlining for emphasis: 'Commutated OT can only be earned when performing actual patient related clinical services at the workplace' [9.2.6]. Furthermore: 'It must be emphasised that ... the heads of clinical departments/ supervisors will take responsibility & accountability should any malpractice be identified with compliance ...' [9.3].

The COT contract makes it clear that 'the Western Cape Department of Health reserves the right to claim back any monies which are incorrectly paid or which cannot be justified by periodic audit.'

### The reality of work

Comparing the contract to the realities of my job was an alarming exercise. To illustrate, let me describe my last weekend on call in the ICU.<sup>1</sup>

The Friday ward round starts, like any other weekday round, at 7:30 and continues till 11:30. It involves a multidisciplinary team of specialists, therapists and nurses. The children are critically ill. We review each patient and plan management for the day. Our tools include mechanical devices and powerful drugs that support vital functions, and antibiotics. Our decisions have life-changing implications. The potential to do harm is enormous, the responsibility overwhelming. The buck stops with me.

After the round, team members implement the decisions, continuously monitoring changes in the patients' conditions. Meanwhile new admissions arrive: children who have had major operations, critically ill children with medical conditions.

The afternoon round starts routinely at 4:30. On this Friday night it ended after 7 pm. I went home at 8:57 pm after updating my notes and discussing a child's condition with her family, leaving two registrars to cover the night. Later, during the night I had 6 phone calls from the registrars to discuss patients.

On Saturday morning I was called in to see a child at 7:26, an hour before the routine 8:30 round. I left the hospital for lunch shortly after 3pm. I was called in again at 5:40 and was busy till 9:30 pm. On Sunday the routine round started at 8:30 and lasted until 14:18. I came in at 10pm to help sort out a problem, returning home at 10:40pm. During the night I had 2 phone calls for advice on patient management.

All in all, from Friday at 5 pm, my weekend call took up 62 ½ hours including the handover round on Monday morning. About 17 hours consisted of

<sup>1</sup> This was a typical weekend with one difference: because of nursing staff shortages we are limited to 16 beds instead of 22. This makes the ward round a little shorter, but it adds to the stress levels by forcing us to turn some patients away, against their best interests. Alas, there seems to be no end to the nursing crisis in the foreseeable future.



regular work,<sup>2</sup> 4½ hours of emergency work on the premises, and 41 hours of being on call from home.

In the 6 consecutive weeks since the start of February, I spent an average of just under 53 hours a week on hospital premises. Of these, 47.6 hours consisted of regular work, and over 5 hours of emergency weekend and after-hours work. In addition, I provided an average of 18 hours a week on call from home.

### Problems with the contracts

The clocking-in exercise confirmed my suspicions: in terms of my contract, around 7 and a half hours of routine work and 5 hours of emergency out-of-hours work a week counted as no work at all! So did 18 hours of being on call from home (having to turn down dinner invitations and opportunities for mountain walks and exercise, being woken up regularly at night and generally being stressed wondering when the next child somewhere is going to be struck by a car or fall into a swimming pool). The truth is that I fall short of the commuted overtime contract's definition of overtime which requires me to spend 56 hours a week on the premises -- an average of 8 hours a day, 7 days a week, year in and year out.

Now, since I spend more time here than many of my colleagues, the same applies to them, only more so. Furthermore, I am convinced that the vast majority of heads of clinical departments, medical superintendents, and senior officials in the Health Department are fully aware of it. Yet we get paid commuted overtime.

How do we manage this? We simply complete monthly forms (duly signed by clinical heads and superintendents and CEOs who you would think should know better) stating that we comply with the contracts.

Technically this is fraud. I don't know how much this kind of fraud costs the fiscus; this would depend on how many are overpaid in relation to the service they deliver. Speaking for myself, I don't feel overpaid. Still, whatever the drain on the health budget, fraud is fraud. And fraud is corruption.

<sup>2</sup> By 'regular work' I mean the ordinary, routine daily work that is necessary to do one's job. In our case this extends to weekends – routine decisions made on Friday morning cannot stand till Friday night, let alone Monday.

### Is the problem with us or with the contract?

In my opinion, these contracts are fundamentally flawed. This system is so out of touch with reality that it cannot be implemented without resorting to fraud. The central problems are that the definition of overtime is untenable, the value of on-call time is negated, and our basic contracts for 40 hours have no basis in fact.

#### *The definition of 'overtime'*

Overtime is 'the time during which a person works at a job in addition to the regular hours'.<sup>3</sup> My own regular hours amount to between 45 and 50 hours a week. But my basic salary is for a 40 hour week; the remaining 5 – 10 hours are classified as overtime. Overtime is, or should be, necessary in unusual circumstances only. The very idea that part of one's *regular* work, the work that is necessary for normal operational requirements, can be classified as overtime is a negation of basic labour principles.

#### *The burdens and benefits of on-call time are negated*

Time spent 'on call/standby' may not be counted as overtime unless you are 'performing actual patient related clinical services at the workplace'. This assumes (a) that our being on call or on standby constitutes no burden to us and is of no value to the health department and (b) that all forms of call or standby are equally unburdensome and valueless. Both these assumptions are wrong.

There are several levels of burden in being on call. My own periods on call are extremely demanding, even when I am not on the premises and make decisions on the basis of clinical information or laboratory results given to me telephonically. But, however I make my decisions, I must assume full responsibility for them, their implementation and their consequences.

The burden goes beyond mere clinical decisions, however. In many cases the child's illness is sudden: it may be due to a car crash, the birth of a baby with severe congenital abnormalities, near-drowning, or an acute, fulminating disease. Death is not unusual. We are involved in difficult end-of-life decisions almost every day. All of these entail immediate, extensive, emotion-laden and

<sup>3</sup> Concise Oxford Dictionary



highly complex communications with parents, extended families, other health professionals.

This is onerous work. To the Health Department, however, it has no value at all unless we spend 56 hours a week in the hospital buildings. As regards benefit, the standards of care that sick children get 24 hours a day every day of the year, in this hospital at least, are as good as is humanly possible within the limits of available resources. The Health Department knows this.

Whilst all calls are burdensome, those done by some of my medical colleagues are less onerous than mine. Yet we are all paid the same overtime allowance: all forms of call are regarded as of equal value. Consequently, the distribution of benefits and burdens is unfair.

### **Fair, transparent working conditions are essential**

My intention here is to bring attention to some of the flaws in the current contracts of health professionals in the public sector. As public sector health professionals we account for a large slice of the people's health budget. We are paid with public money. Our working conditions and salaries must stand up to public scrutiny.

This system shows how banal corruption can be and how easy it is for good people to be complicit or turn a blind eye. But corruption, even on a small scale, insidiously poisons institutions and has a way of becoming assimilated into their culture.

I found myself asking how such a system can survive at all, let alone be so resilient. It seems to have a life of its own. Perhaps this is so because it is so convenient. It suits doctors, at least in the short term, because their monthly salaries seem reasonable; it suits administrators because they don't have the energy or the skills to negotiate decent contracts; and finance departments because of all the money they can save on pensions.

### **The COT system cannot continue as it is**

The fact that so many of us are working on the basis of such flawed contracts is simply untenable. This is a matter of great urgency.

We work in the public sector because we believe that all children, including the poor and indigent, have a right to the best possible health care. Most of us reject the option of limited private practice [Remunerative Work Outside the Public Sector – RWOPS] because our work is demanding and leaves no time for private practice.

We expect nothing more than fair working conditions that are not damaging to our own health and well-being. The precise details should be subject to negotiations. In principle we are entitled to basic contracts that pay fair salaries for the type of work we do, with fair compensation for regular work that falls outside normal office hours, on-call times and emergency work on site. Since all these are essential for normal operational requirements they should form part of a salaried package. None of it should be seen as overtime. Overtime should be seen as exceptional work that is needed in exceptional circumstances such as epidemics, mass casualties or national disasters.

Meanwhile, at a personal level, I find it intolerable to have to comply with fraud in order to be paid for my work.