An Overview of the NT Medical Education and Training Review
Dr Janie Smith – Director RhED Consulting Pty Ltd

THE BRIEF
- Map current providers and activities:
- Provide an analysis of the efficiency, effectiveness and appropriateness of current education and training programs:
- Recommend options for a more cohesive and coordinated approach:
- Key roles and responsibilities:
- Development of clearer pathways between hospital and community training institutions.

WHAT WE DID – METHOD
- Literature review
- Mapped the providers – 37
- 106 interviews stakeholders
- 2 focus groups
- 3 case studies
- Survey 14 feeder universities – students
- Strategy workshop
- Written report, recommendations.
- 9 months ago……..

NT CONTEXT
- Small population
- Dispersed geographically
- Highest Indigenous
- Exceptionally high CD
- Small medical workforce
- Small specialty silos
- 5 hospitals
- High IMG numbers
- Attractive to students
- No medical school
- High interprofessional needs
- Everyone knows each other – many hats
- Under resourced
WHAT DID WE FIND?

- Passionate committed workforce – 440
- Challenging multicultural workplace
- Fascinating medicine
- Good educational experiences
- Some fantastic teachers
- ‘Tsunami’ of medical students
- Real opportunities for innovation
- It’s different

WHAT WORKS?

**Top 5 strengths of current NT medical education & training**

<table>
<thead>
<tr>
<th>Strength</th>
<th>Number of respondents (n=126)</th>
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<tbody>
<tr>
<td>Fascinating medicine</td>
<td>50</td>
</tr>
<tr>
<td>Good educational experiences</td>
<td>50</td>
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<tr>
<td>Fantastic teachers</td>
<td>30</td>
</tr>
<tr>
<td>NTGPE</td>
<td>10</td>
</tr>
<tr>
<td>Other</td>
<td>10</td>
</tr>
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</table>

Number of responses (n=126) in total
WHAT DID WE FIND?

- Structure built for NSW
- 37+ providers for 440 doctors (excl GPs+AMS)
- Disciplinary Silos
- Poor coordination information flow
- No existing hospital accrediting structure
- Affecting intern training + retention
- Poor IMG support – based mainstream
- Significant recruitment and retention issues
- Focus on workforce not populations needs
- No clear leader

WHO IS THE LEADER?

WHO is ultimately responsible for medical education and training in the NT?

<table>
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<tr>
<th>Number of responses (n=40)</th>
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WHAT STUDENT ISSUES DID WE FIND?

- Multiple providers for very small numbers
- 2 clinical schools
- 30ish students; 38 staff; 4 funding streams;
- + UDRH – CRH
- 14 feeder universities co-ordinated by NTGPE
- 370 students, 6 funding streams
- More demand vs supply supervision
- Placements very confusing + other disciplines
- Imprint is like a watermark
- Flinders determine the structure!
PGY1-2 WHAT DID WE FIND?

- No PGMEC for 2 yrs
- Provisional accreditation RDH
- 25 recommendations to implement by Nov 07
- No DCT

Issues
- Poor quality and coordination of training
- Lack of release time for training
- Insufficient training budget
- Poor focus on education vs recruitment
- Dissatisfaction re pay and conditions
- Junior doctor curriculum – poor understanding
- No structure IMG support or system – 33%

VOCATIONAL TRAINING

- 9 generalist and specialist colleges
- All separate accreditation requirements
- Small numbers of registrars
- Largely hospital based 3-20 av 10
- GP registrars 47
- Supervision – every layer teaches every layer – burn out consultants
- Some good educational activity – RDH-ED+ NTGPE
- Real opportunities for the generalist spec and innovation and interprofessional learning e.g. cross cultural

CPD WHAT DID WE FIND?

- 3 Divisions GP groups!
- 4 GP / rural medicine groups
- 7 specialist colleges
- + Govt, unis, AMSs + pharmaceutical companies
- Some good educational activity
- Could be more innovative and cross disciplinary
Where are the gaps? (n=55)

- PGY1+2 training + support: 22 responses
- IMG support + training: 12 responses
- Access training + remote: 11 responses
- Can't complete VT pathway NT: 3 responses
- Other: 6 responses

The 7 greatest barriers to cohesive training

- Workforce no's, support & resources: 25 responses
- Lack of coordination of training: 20 responses
- Low priority of education & poor vision: 18 responses
- Distance: 15 responses
- Funding: 12 responses
- The silo mentality: 11 responses
- Others: 7 responses

WHAT DOESN'T WORK?
DUPICATION?

WHAT NEEDS TO CHANGE?

### Where is the duplication? (n=43)

- **Student placements**: 20
- **CPD**: 10
- **Cultural awareness**: 6
- **Post graduate sector**: 5
- **Other / Don't know**: 2

### Top 7 priorities for change (n=72)

1. **Increased funding**: 26%
2. **Dedicated education provider & roles**: 22%
3. **CPD**: 18%
4. **Student placements**: 15%
5. **Cultural awareness**: 10%
6. **Post graduate sector**: 8%
7. **Other / Don't know**: 7%
SPOTLIGHTING AREAS OF RESPONSIBILITY

- Model that recognises difference and builds on the existing strengths
- Remote, Indigenous, infectious + tropical diseases
- Alternative medical school model
- Hosp Generalist specialist
- Interprofessional learning – cross cultural
- Model that meets populations health care needs
- Placements that value add- IPL
- Links with SE Asia
- Training pathway for IMGs
- A model that could lead Australia in innovation

IN 2018
- Where will you be?
- What will you be doing?
- What we do today will leave the footprint for those undertaking our roles in 2018 …lets focus on the best structure for them
NT Medical Student Education
Dr Michael Lowe - Clinical Dean, NT Clinical School, Flinders University

CHAOS OR COMPLEXITY? - THE RHED PERSPECTIVE:

AND COMMON CHALLENGES...

- Students to have NT & Aboriginal Health experience
- Students to return to intern and practice in the NT
- Enhance job satisfaction & retention of staff
- Good teaching recruits good students
AND COMMON CHALLENGES...
- Increasing need for student placements
- Teaching infrastructure
- Clinical Supervisors
- Rural and remote health
- Changing patient care needs

TWO ORGANISATIONS: COMPLEMENTARY PROGRAMS

**NTCS**

**Flinders Y3 (16 full yr):**
6/12 in RDH, 6/12 in community/rural

**JCU Yr 5 (8 full yr):**
RDH/GP

**Flinders Y4 and electives (200 places)**
RDH/ASH 6 wks

**NTGPE**

**JCU Y6 (8 full yr):** RDH/WA
Students from across Australia

**RUSC (~110 places):**
rural/remote plcmt 4-6 wks (incl elective placements)

**John Flynn (~60 places):**
rural community 2 wk/yr for entire course

THE AUSTRALIAN SITUATION

AUSTRALIAN MEDICAL GRADUATES
HOW THE NTCS IS ADDRESSING THIS CHALLENGE

- Expanding teaching settings
- Community (including Super clinic)
- Private sector
- Rural/remote (including Gove)
- Coordination across different levels of teaching
- Greater emphasis upon multidisciplinary teaching/learning

NEW NTCS EDUCATIONAL MODELS

- Rural Clinical School
  - GP-based
  - Katherine/ Gove / Alice
  - 8-16 NTCS student placements per year (1 semester each)
  - Commonwealth funded
- CBME
  - GP based - Darwin urban
  - C4 program – community based health providers (e.g., Family Planning, skin clinic, diabetes educator)

“The most rewarding experience [of the CBME program] has been being able to take responsibility for my own patients in the GP clinic. I have found procedures such as suturing and corneal foreign body removal interesting and enjoyable. The opportunity to visit other providers in the community and gain a holistic understanding of continuity of care has been invaluable”.

CBME student, 2008

ABORIGINAL HEALTH PLACEMENTS

- Laynhapuy Homelands
- AMSs
- Tiwi Islands
- Dedicated stream of curriculum
THE FUTURE - THE MEDICAL WORKFORCE PIPELINE

LEAKS IN THE MEDICAL WORKFORCE PIPELINE

(Where/why losing potential NT health workforce?)
<table>
<thead>
<tr>
<th>Program</th>
<th>Apply</th>
<th>Acceptable</th>
<th>Recruited to NT</th>
<th>%</th>
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<tr>
<td>NT School Leavers for undergrad med</td>
<td>60 (UMAT)</td>
<td>16</td>
<td>4-6 (JCU)</td>
<td>25%</td>
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<tr>
<td>NT Graduates for Grad entry medicine</td>
<td>25 (GAMSAT)</td>
<td>13</td>
<td>8-10 (Flinders)</td>
<td>62%</td>
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<tr>
<td>NTCS Grads for intern</td>
<td>24</td>
<td>10-14</td>
<td></td>
<td>55%</td>
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<td>NTGPE Elective for junior docs</td>
<td>18</td>
<td>7</td>
<td></td>
<td>38%</td>
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<tr>
<td>Intern for PGY2</td>
<td></td>
<td></td>
<td></td>
<td>50%</td>
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<tr>
<td>PGY (N) for PGY (N+1)</td>
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Table 3.10  Primary care medical practitioners states and territories 2000

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<th></th>
<th>Male</th>
<th>Female</th>
<th>All</th>
<th>% female</th>
<th>Practitioners/100 000 population</th>
<th>Population/Practitioner</th>
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<td>2 325</td>
<td>7 145</td>
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<td>111</td>
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<td>5 275</td>
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<td>1 215</td>
<td>3 401</td>
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<td>7 152</td>
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</table>

Source: AIHW (2003a)
THE RESULT: MEDICAL WORKFORCE SHORTAGES

HOW TO KEEP THEM HERE? THE EVIDENCE SAYS

Why they left:
“…Those who moved to the NT as a result of financial incentives or who had strong expectations that working in the NT would be an exciting, novel experience tended to stay for no more than 5 years, often leaving because they found the work environment too stressful.”

Why they stayed:
“In contrast, those who stayed longer came because they had existing social networks and were familiar with the NT environment…”

NTCS STUDENTS RETURN TO THE NT FOR INTERNSHIP:

<table>
<thead>
<tr>
<th>Position</th>
<th>Location</th>
<th>Type</th>
<th>Closing Date</th>
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<tr>
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<td>Kalkarindji</td>
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<tr>
<td>7%</td>
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<td>4%</td>
<td>61%</td>
<td>2%</td>
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<td>4%</td>
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<td>8%</td>
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</table>

Totals: 33 | 65 | 17 | 231 | 14 | 14 | 21 | 57 | 452
Train doctors from the NT, in the NT = Keep doctors in the NT

**BLOCKING THE LEAKS IN THE MEDICAL WORKFORCE PIPELINE**

Full medical training in the NT
NT school leavers should be able to train in Medicine in NT:

- B Med Sci CDU (1st 2 yrs)
- Year 1 and 2 of Flinders course on CDU/Menzies campus (NTCS)
- Yrs 3 and 4 with NTCS, with extra students from Flinders and JCU joining them at start of year 1 and start of final 2 years.
- Commitment to collaboration – Flinders/CDU/other partners
- Funding
- Commonwealth
- NTG
- Affirmative policies for Indigenous/Territory entry
- Any program must place Aboriginal Health at centre
- Curriculum, governance, collaboration.

**WHAT I WOULD LIKE FROM THIS SUMMIT:**

- Commit to training our workforce locally
- Include NT Flinders/CDU School –
- Commit to retention of NT workforce and potential NT workforce
Pre-Vocational Training – The View from the Swamp
Dr David Chapman, Acting Director of Clinical Training, Royal Darwin Hospital

INTERESTING TIMES
Medical Education & Training Review
Medical Education & Training Summit
Despite irreverence, flippancy and cynicism, there is a sense of action, anticipation & excitement.

WHO'S WHO & WHAT'S WHAT OF PRE-VOCS
• Post Graduate Year 1 (PGY1) - Interns
• PGY2 – 4 Resident Medical Officers (RMO)
• PGY2 – 8 International Medical Graduates (IMGs) in RMO positions

WHERE DO THEY FIT IN THE CONTINUUM?
• Interns: 1st year after graduation with conditional registration
• 48 weeks of service in an accredited hospital.
• Terms in General Medicine and General Surgery + 2 electives
• Dedicated training and supervision

AND THEN
• On successful completion: Full Registration
• RMOs and currently not required to participate in formal training and supervision
• May remain “undifferentiated”, or prepare for a specialist training program

THE CHANGING PROFILE OF PRE-VOCATIONAL TRAINEES
• Increasingly older, more experienced & in a hurry
• Often parents and partners, not partying backpackers
• Expecting workplace flexibility
• Expecting relevant & professionally delivered training
WHERE ARE THEY?

<table>
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<tr>
<th></th>
<th>RDH</th>
<th>ASH</th>
<th>KDH</th>
<th>GDH</th>
<th>TCDH</th>
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<td>0</td>
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<td>10</td>
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<tr>
<td>PGY &gt;4 IMG</td>
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<td>4</td>
<td>8</td>
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<tr>
<td>Total</td>
<td>66</td>
<td>36</td>
<td>9</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

The equivalent of a moderately large metropolitan hospital spread over an area equal in size to France, Italy and Spain combined (olé)

WHAT DO WE DO IN PRE-VOCATIONAL TRAINING?

- General Training: 1.5 hours across a lunchtime
- Pager protected & “compulsory”
- Clinical scenario based,
- Adaptable to the changing needs of the Hospital AND of JMOs.
DIVISIONAL & DEPARTMENTAL TRAINING

- Grand Rounds: the theatre of the intellect
- Radiology meetings: fuzzy pictures of peoples’ insides
- The Consultant Round: “The Medical Student Inquisition”
- Teaching on the Run: peripatetic quiz night
- See One, Do One, Teach One: learning by anxiety
- Handover: “grilling the Registrar”

SPECIAL COURSES

- Advanced Life Support Courses
- National Trauma Centre Short Courses (incl EMST etc)
- Occasional Registrar/Senior RMO Development Courses “bought in” (PDRP)

THE CURRENT LOCAL CONTEXT

- An imperative to attract & retain suitable Medical Officers
- NT sandwiched between WA & Qld – the Scylla of Salary and the Charybdis of Conditions
- Attraction is not just $$ - reputation matters

THE EMERGING LOCAL CONTEXT

- Uncertainty in supply of IMGs
- Competition for vocational trainees: a need to “grow our own”
- A renaissance of a learning culture

THE CURRENT & EMERGING NATIONAL CONTEXT

- The “Tsunami”: quality versus quantity?
- Not pick & choose, but compete or capitulate
- Taking the Baden Powell approach: “Be Prepared”
- PGY 2 & beyond – the “forgotten ones”
  - Currently perceived as service providers rather than trainees
  - Supervision to become more aligned with PGY 1?
  - Hospital accreditation for PGY 2 & above to come?
- The Australian Curriculum Framework
  - Exemplifying the spiral curriculum
  - A shift in emphasis: professionalism
  - Supervision & assessment: increased rigour
• International Medical Graduates (IMGs)
  o “It isn’t only culture”
  o Serious supervision

• Early specialisation
  o Early choice or accelerated training?
  o The benefits of generalist pre-vocational training
  o Service or training: apprentice or student?

• Early streaming
  o Speeding the process or limiting the experience?
  o How much diversity equals generalist training?
  o Enabling choice

• Role substitution: “see one, do one…if you’re lucky”

• Models of training:
  o Simulation versus “the real thing”
  o Apprentice versus student

WHAT SHOULD BE OUR VISION?
• “The Bees Knees in Medical Education & Training”
• To ensure all JMOs have access to a standard of training that enables them to realise their full potential as Doctors

WHY?
• To enable the Territory to provide a cost effective and excellent standard of health care appropriate to the needs of its population

HOW DO WE GET THERE? - STRATEGIES
• Aggressively promote renaissance of a culture of learning and self evaluation = return to the future
• Develop local capacity & fruitful collaboration = excellence, relevance and cost effectiveness
• Pursue the widest scope in participation in training = attraction, retention & cost effectiveness
• Adopt a network focus = improved health services, greater capacity for managing staffing and greater opportunities for training

HOW DO WE GET THERE? - TACTICS
• Establish an independent Postgraduate Medical Council with a network focus
• Articulate forcefully the benefits of balance between service and training: - equally to government, bureaucracy and practitioners
• Local or network – but not both? -
• Appoint a Medical Education Team with Director Clinical Training (DCT), Medical Education Officer (MEO) & Medical Education Assistant (MEA)
• Appoint Medical Administration staff to facilitate the training vision through recruitment, placement & rostering
• Collaborate in development & delivery of training with the Northern Territory Clinical School & Rural Clinical School, and Northern Territory General Practice Education
• Collaborate in developments with the Postgraduate Medical Council of Queensland (PMCQ)

WHAT MIGHT WE DO, SPECIFICALLY?
• Local capacity: PMCQ delivered Train the Trainer courses for Teaching On The Run and Professional Development of Registrars Program
• Locate that capacity within the consortium of training providers: NTCS, NTRCS, NTGPE, NTC
• 5 terms in pre-vocational years (with constrained choice for PGY1), and integrate relieving into rotations
• Plan & provide balanced & guaranteed pathways to vocational training from PGY 1 onwards
• Development & marketing of PGPPP placements & pathways to GP training
• PGY 1 & 2 rotations through District Hospitals with a supervision & teaching infrastructure in parallel with Medical Student and GP Registrar placements
• Network recruitment & placement independent of Hospital administrations
• Electronic tracking of JMO careers
• Professional Training Allowances paid to all JMOs under an agreed performance plan

WHAT ARE THE IMPEDIMENTS?
• Staffing
• RDH Accreditation report
• Prof Smith’s Med Ed Report
• Department of Medicine Review
• Infrastructure:-
  o Accommodation
  o Travel
  o Training Delivery
  o Supervision
• Structural change within hospitals
  o Macro: Patient flow
  o Micro: Staffing “buffer”
    ▪ Rostering practices
    ▪ “take” days

ABOVE ALL
• An articulated vision and a champion to sustain & realise it
• Government & bureaucratic will to fund, fight for and facilitate the vision
International Medical Graduates
Dr Alan Ruben – Paediatrician and Public Health Physician
Associate Professor, NT Clinical School
IMG Training Coordinator, DHCS

Recommendation
That the NTDHCS, through the Directorate of Medical Education and Training and in collaboration with the Colleges and other providers, develop a career pathway for NT IMGs that places value on the contribution they are making.

That the model developed:
- provides clear training and career pathways for IMGs
- considers the potential changes by the AMC in their introduction of the competent authority and the standard pathways
- includes pastoral care, family support, and professional support mechanisms
- is a package that assists IMGs in overcoming the barriers to staying, and places value on the contribution they are making
- explores the option of having joint training standards with other countries such as the UK, to enable IMGs to have their training time in Australia counted in the UK
- considers supervision training, arrangements and support
- identifies sources of funding to support and implement this initiative.

International Medical Graduates (IMGs) make up over 33 per cent of the workforce in the NT and in smaller regional hospitals they can make up almost the entire medical workforce.
TOP END
Royal Darwin Hospital

- 49 of 140 (36%) of registrars/RMOs are conditionally registered IMGs, over 50% of the total staff are IMGs

Katherine and Gove Hospitals

- All (100%) the staff at Katherine Hospital are IMGs (although short term locums are often Australian trained).
- Over half the staff at Gove Hospital are IMGs.

Royal Darwin Hospital

Without IMGs the Emergency Department would lose 60% of its staff, only 1 of the 5 Obstetricians would remain, there would be no Oncology service, there would be no ophthalmology service and no specialist facio-maxillairy or specialist trauma surgeon.

CENTRAL AUSTRALIA
Alice Springs Hospital

- Of the 40 specialists, 27 (68%) are IMGs
- Of the 27 IMG specialists 9 (33%) are conditionally registered
- Of the 59 registrars/RMOs, 21 (36%) are conditionally registered IMGs

Tennant Creek Hospital

- Mainly staffed by short term junior doctors from interstate
- “Inadequately trained and supported”

GENERAL PRACTICE

- 260 GPs in the NT
- Unknown number of IMGs
- 25 IMG GPs are being mentored through the “5 year scheme”
- In this year’s cohort of GP Registrars only 8 of 20 places have been filled, none are IMGs
- One IMG is in among 4 new GPRs under a new GPR scheme currently being trialed

Sources:
Primary Health Care Research and Information Centre - http://www.phcris.org.au
General Practice and Primary Health Care NT
Northern Territory General Practice Education Ltd
CURRENT SYSTEM:

General Registrants:
- AMC Part 1 (MCQ)
- AMC Part 2 (Clinical)
- 12 months minimum of supervised practice

Specialist Registrants:
- As determined by AMC and Colleges

NEW SYSTEM
The AMC allows workplace assessment, whether the employer be a Health Department or General Practice; supervised by the Medical Board and AMC.

1. An eligible IMG can opt to enter the “Competent Authority” Pathway (CA) - workplace assessment
2. Other non-specialist IMGs must remain in the “Standard Pathway” (SP), currently exam based but will become workplace assessment at discretion of the AMC. From 1 July 2008 all new registrants who are not CA eligible must have passed AMC MCQ exam.
3. An IMG can opt to stay in the old system

“COMPETENT AUTHORITY” PATHWAY
Eligibility restricted to doctors who are unconditionally registered in the USA, UK, NZ, Canada and Ireland
They must apply for a Certificate of Advanced Standing from the AMC.
The criteria are:
- A primary medical qualification or pass in the licensing exam in one
- of those countries, and
- At least 12 months supervised practice in an accredited hospital
"The Competent Authority pathway is a workplace based assessment of their adjustment to the Australian health system, not a clinical skills assessment, as clinical skill has already been assessed by the original Competent Authority."

**STANDARD** PATHWAY

Currently Examination based with a minimum of 12 months supervised practice

Will change to workplace based assessment, after completion of AMC1, when AMC completes standards and accreditation procedures

From 1 July 2008 all new IMGs who want to participate in the 'Standard Pathway' will have to have passed the AMC Part 1 before they can be conditionally registered/employed.

This is the case for all Australian States and Territories

**STEPS IN NEW PATHWAYS**

1. (Pre-employment Clinical Interview)
2. Orientation
3. Induction
4. Supervision
5. Assessment
6. Remediation
7. Reporting
8. Registration

<table>
<thead>
<tr>
<th>Competent Authority Pathway</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registration division</td>
</tr>
<tr>
<td>Registration renewal</td>
</tr>
<tr>
<td>Further assessment</td>
</tr>
<tr>
<td>(AMC accredited provider)</td>
</tr>
<tr>
<td>Registration renewal</td>
</tr>
<tr>
<td>including compulsory CQD</td>
</tr>
<tr>
<td>Supervision</td>
</tr>
<tr>
<td>Orientation</td>
</tr>
<tr>
<td>Registration</td>
</tr>
<tr>
<td>Clinical Assessment</td>
</tr>
<tr>
<td>Experience / suitability</td>
</tr>
<tr>
<td>Basic competence</td>
</tr>
<tr>
<td>Applicant / Position</td>
</tr>
</tbody>
</table>

24
TO DATE, IN DHCS HOSPITALS:

- Interviewed 70 IMGs employed by DHCS across the NT
- Trained 43 Specialists (including 15 GPs) in IMG assessment with another session this week in Alice Springs, thereafter training sessions as required.
- Enrolling 31 eligible IMGs in Competent Authority Pathway
- Ready for Standard Pathway when AMC allows
- Organising AMC MCQ tutorials to commence in June
- Conducting AMC clinical exam preparation workshop in June
TO DATE, IN GENERAL PRACTICE:

- Preparations for CA pathway not commenced
- 5 year scheme is continuing.
- GPs have been trained in IMG assessment as per previous slide.
- Introduction of CA pathways are an employer responsibility
- NTGPE has run two clinical bridging courses, one each in 2007 and 2008, 25 participants from hospitals and General Practice, 10 have sat the AMC clinical exam and all passed.
General Practice Vocational Training
Professor Michael Kidd
Professor of General Practice, The University of Sydney
Past President, The Royal Australian College of General Practitioners

GENERAL PRACTICE VOCATIONAL TRAINING
- Largest specialty medical training program in Australia
- 600 registrars entering training each year
- 56 registrars currently with NTGPE
- Registrars enroll in the Australian General Practice Training (AGPT) Program
- Coordinated by the Australian Government’s General Practice Education and Training

2008
- Now two vocational recognition qualifications offered to all registrars enrolled in AGPT program
  - FRACGP
  - FACRRM
- April 2007, Australian Government amended the Health Insurance regulations to also recognise Fellows of ACRRM as general practitioners under Medicare
- GP registrars can choose to train towards FRACGP or FACRRM or both
- Registrars training towards FRACGP can also undertake the RACGP Fellowship of Advanced Rural General Practice as an additional rural qualification
- Training based on the curriculum prescribed by the RACGP and by the ACRRM
- Require at least one year of hospital experience before commencing training
- Able to apply for AGPT in intern year
- Registrars select to train in the general pathway or the rural training pathway
- Applicants affected by the “10 year moratorium” are required to join the rural pathway

TRAINING TOWARDS FRACGP
- YEAR 1: Hospital term
- YEAR 2: GP terms
- YEAR 3: GP terms and sit FRACGP examination
- YEAR 4: Optional extra year of Advanced Rural Training leading to RACGP Fellowship in Advanced Rural General Practice
TRAINING TOWARDS FACRRM

- YEAR 1: Core clinical training (hospital)
- YEAR 2: Primary Rural and Remote Training
- YEAR 3: Primary Rural and Remote Training
- YEAR 4: Rural Specialised Training
- Assessment across all four years leading to award of FACRRM

General practice training is coordinated through regional training providers around Australia

The regional training provider for the NT is NT General Practice Education (NTGPE)

NTGPE was established in 2002 by consortium of partners including Flinders University, Charles Darwin University, GP Divisions of NT, Aboriginal Medical Services Alliance NT, ACRRM and RACGP

- NTGPE has responsibility for:
  - Community based primary care placements of medical students from across Australia (up to 170/year through RUSC and 61 with JFSS)
  - Prevocational General Practice Placement Program (24/annum)
  - Vocational training of GP registrars (up to 20 new GP registrars/annum)
  - CPD for GPs and IMGs
  - Cultural awareness training

REMOTE VOCATIONAL TRAINING SCHEME

- Separate GP training scheme, run in partnership by a company established by ACRRM and RACGP and funded by Australian Government
- Training for doctors already working in remote locations who wish to train to attain the FACRRM and the FRACGP
- Supervision is provided remotely
- Suitable model for further consideration in the NT, especially for some IMGs

DON'T DISMISS THE IMPACT OF SHORT TERM COMMUNITY PLACEMENTS

- Over 600 medical students from The University of Sydney have taken part in clinical placements and as John Flynn Scholars in the NT over the past 15 years
- All have described the remarkable experience
- This training does have an impact
- Many have returned as interns and/or registrars
- Many have returned as qualified GPs either full time or as locums
Producing Specialists for the North
Assoc Professor Richard Murray
Dean of Medicine, James Cook University

OVERVIEW
• The northern Australian context
• Generalism vs subspecialisation and the needs of regional Australia
• The specialist link to the regional pipeline
• Intellectual content of northern specialities
• The research, workforce & quality nexus

Population 949,819
~1/3rd of total OR/R&R pop
138,201 Indigenous pop
(14%, 30% national total)
The Rural Medical Generalist
- Nurses
- AHWs
- Allied health
- NPs, Pharmacists, Physician Assistants, etc

The vacated ground of medical generalism

The Generalist Specialist
- Medical specialists

PUBLIC MATERNITY SERVICES CLOSED SINCE 1995 IN QUEENSLAND

PREDICTORS OF RURAL VOCATIONAL CHOICE IN MEDICINE
- Rural origin (and spouse rural origin)
- Rurally focused curriculum
- Rural clinical exposures as a student
- Regional medical program
- Regionally-based vocational training
MEDICAL TRAINING PIPELINE?

- Variable policies and infrastructure for selection between Colleges
- Problems with centrally administered 'merit-based' systems for regional Australia
- Regional planning should be based on community need & training capacity
- Little formal role for Universities / RCSs / UDRHs in supporting viability of regionally-based specialist training

REGIONAL ACCESS TO SPECIALIST TRAINING

The General Specialist as it applies to the Training & Practice of Surgeons
Assoc Professor Phillip Carson
Associate Professor of Surgery, Royal Darwin Hospital and Flinders NT Clinical School
THE CURRENT MACRO CLIMATE
• Long and accelerating trend towards increased specialisation
• Dominant model of delivery of specialist services involves increasing specialist numbers
• Royal Australasian College of Surgeons is largely following and supporting this trend

TRAINING PATHWAYS FOR SURGERY
• General Surgery (breast, endocrine, upper GI, hepato-billiary, colorectal, oncology, trauma,)
• Orthopaedics (Spine, hands, feet, joints, sport)
• Otolaryngology/ head and neck
• Plastic and reconstructive
• Vascular
• Pediatric
• Urology
• Cardio-thoracic
• Neuro

NEW DIRECTIONS AND NEW PROBLEMS
• New SET (surgical education and training) program shortens training at the expense of generalist skills
• There is a current crisis in providing emergency care, especially in the biggest hospitals
• The western world is grappling with exponential increases in the cost of health care

WHAT THE PEOPLE NEED IS ACCESS TO HIGH QUALITY SPECIALTY SERVICES – NOT NECESSARILY SPECIALISTS
• NT, by necessity has developed innovative working models for delivering specialty care
• Jon Wardill/ Jim Scattini servicing surgery in Katherine
• Visiting neuro-surgeons/ local general surgeons covering head injuries for the Top End

ESSENTIALS OF THE MODEL
• Well and broadly trained generalist
• Supportive, non-competitive specialist
• On going open communication and patient sharing

WIN FOR GENERALIST
• Working at capacity
• Expanded capacity-in a supported environment
• Expanding capacity- development/CME
WIN FOR SPECIALIST
- More interesting and challenging cases
- Secure in ongoing care
- Decreased workload
- Expanded experience by proxy

WIN FOR PATIENTS AND THE STATE
- Constant local cover
- Audit and accountability built in
- Attractive careers= enhanced recruitment and retention
- Decreased economic and social disruption for patients and employers
- Decreased costs

PROVIDING SPECIALTY VS. SPECIALIST SERVICES
- Developed by necessity in rural and remote areas
- A viable “new” model for tertiary health care delivery in the western world
- Cost efficient
- Continuous elective and emergency cover in the local area

NT SURGERY’S CONTRIBUTION TO TRAINING GENERALISTS AND APPROPRIATE SPECIALISTS
- Participate in national and regional training of specialists (SET)
- Expose and train students and junior doctors to the generalist model
- Equip GPs with surgical skills
- Retrain/orientate appropriate IMG’s
- Value add to and broaden recently qualified specialists
NT TRAINING STRENGTHS
- Broad experience
- Excellent environment for training those with Rural/remote, emergency, military, cross-cultural and tropical surgical needs
- Developing and demonstrating alternative pathways in the delivery of Specialty services

PROVIDING SPECIALIST SERVICES THE SPECIALIST
Sees all cases
Follow-ups and chronic disease
Intermittent service
Patients travel to base institution
Majority become routine cases

PROVIDING SPECIALIST SERVICES THE GENERALIST
Sees less
Does less
De-skilled
Emergencies evacuated or done less well
No CME, development or audit
Non-viable, may leave

PROVIDING SPECIALIST SERVICES THE PEOPLE AND THE STATE
Some will get better care
Some, with complex problems get worse care
May be less accessible and intermittent
Quality of emergency care decreases
Costs - community and personal - increase

PROVIDING SPECIALTY SERVICES
Tertiary Referral
Mutual support and arrangements
Joint clinics/procedures/aftercare
Shared Care
Ongoing links and consultation
More discussion, teaching, skill transfer
The Physician
Dr Stephen Brady – Alice Springs Hospital

What is a Physician?
Physicians are often called medical specialists. They are doctors who have completed an extra eight years or more of training after their initial university medical training. Physicians are generally referred to as physicians or specialists by a general practitioner seeking experienced medical advice.

Physicians often choose to specialize in a particular area of medicine. You may know physicians by their main area of specialty such as cardiologists, oncologists, gastroenterologists, general physicians, occupational physicians, rehabilitation physicians. The College trains physicians in all of the following areas:

<table>
<thead>
<tr>
<th>Cardiology</th>
<th>Diseases of the heart</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Genetics</td>
<td>Diseases of the genes</td>
</tr>
<tr>
<td>Clinical Pharmacology</td>
<td>The effects of drugs and management of drug therapy</td>
</tr>
<tr>
<td>Community Child Health</td>
<td>Social and physical environmental factors affecting the growth and development of young people whether sick, ill, impaired or disabled, generally in community-based or government child health services</td>
</tr>
<tr>
<td>Paediatric Medicine</td>
<td>Diagnosis and management of acute and emergency paediatric problems</td>
</tr>
<tr>
<td>Radiology</td>
<td>Disorders of internal glands and hormones, including diabetes and thyroid disorders</td>
</tr>
<tr>
<td>Gastroenterology and Hepatology</td>
<td>Diseases of the gut, liver and associated organs</td>
</tr>
<tr>
<td>General Medicine</td>
<td>Diagnosis and management of conditions that may be complicated, difficult to diagnose or involve multiple organs and systems of the body</td>
</tr>
<tr>
<td>Geriatric Medicine</td>
<td>Management of illness and maintenance of health in aged people</td>
</tr>
<tr>
<td>General Paediatrics</td>
<td>Diagnosis and management of infants, children and adolescents with undifferentiated and complex conditions</td>
</tr>
<tr>
<td>Haematology</td>
<td>Diseases of the blood</td>
</tr>
<tr>
<td>Immunology &amp; Allergy</td>
<td>Diseases affecting the immune system</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>Diseases caused by infections</td>
</tr>
<tr>
<td>Intensive Care Medicine</td>
<td>Management of critically ill patients</td>
</tr>
<tr>
<td>Neonatal/Perinatal Medicine</td>
<td>Care of the fetus, the premature and ill newborn</td>
</tr>
<tr>
<td>Nephrology</td>
<td>Diseases of the kidneys</td>
</tr>
<tr>
<td>Neurology</td>
<td>Diseases of the nervous system, including the brain</td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td>The use of radioisotopes for diagnosis, and occasionally, the treatment of illness</td>
</tr>
<tr>
<td>Oncology</td>
<td>Management of patients with cancer and tumours</td>
</tr>
<tr>
<td>Paediatrics &amp; Child and Adolescent Psychiatry</td>
<td>Diagnosis and management of children and adolescents with psychological difficulties</td>
</tr>
<tr>
<td>Paediatric Rehabilitation Medicine</td>
<td>The management of disability and handicap arising from impairments in children and adolescents</td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>Management of people with terminal illnesses; emphasizing the quality of life</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>Management of joint, muscle and soft tissue disorders</td>
</tr>
<tr>
<td>Sleep Medicine</td>
<td>Diagnosis and management of sleeping and breathing disorders</td>
</tr>
<tr>
<td>Thoracic Medicine</td>
<td>Management of lung disorders</td>
</tr>
</tbody>
</table>

PHYSICIAN TRAINING
- 3 years basic physician training
- Examination
- 3 years advanced training
- ASH accredited for 12 months basic training (level 1 hospital)
- RDH accredited for 12 months basic training (level 2 hospital)
- Advanced training in general medicine, infectious diseases, endocrinology, cardiology, nephrology (RDH).

PHYSICIAN TRAINING IN ASH
- 3, 6 or 12 month hospitals
- 3 month rotations from 3 hospitals in 2 states
- Locals, IMGs and trainees from other colleges
- Advanced training – the next frontier
Clinical Workforce in Internal Medicine and Paediatrics in Australasia | 2003

The Royal Australasian College of Physicians

Australia

Key points

5 The 2003 workforce of 4,371 Fellows of the College clinically active in internal medicine within Australia comprised 501 General Consultants, 651 Specialist Consultants in adult medicine, 3,091 Specialist Consultants in paediatrics, and 645 Specialist Paediatricians.

6 The average annual workforce growth rate from 1991, when the College began monitoring the workforce, to 2003 was 3.8% as compared with a growth rate of 1.3% per annum in the Australian population over the same period.

7 Between 2001 and 2003 the workforce in adult medicine grew by 5.1% per annum whereas the paediatric workforce grew by 2.2% per annum. During the same period Australia's total population was projected to grow by only 0.9% while the population aged 0-14 was projected to decrease.

8 The ratio of the total population of Australia to all clinically active Fellows was 4,630:1 in 2003 compared with 7,490:1 in 1991.

9 In 2003, the ratio of population aged 0-14 to General Practitioners ranged from 4,630:1 in the Northern Territory up to 11,730:1 in Western Australia whereas for Specialist Paediatricians it ranged from 6,280:1 in South Australia up to 25,490:1 in the Northern Territory. In Austria as a whole the ratio was 9,220:1 for General Practitioners and 7,390:1 for Specialist Paediatricians.

10 In adult medicine, the ratio of population aged 15 years and older to General Consultants ranged from 22,140:1 in South Australia up to 40,310:1 in New South Wales with an overall Australian ratio of 31,630:1, whereas for Specialist Consultants the ratio ranged from 3,040:1 in the Australian Capital Territory up to 11,370:1 in the Northern Territory with an overall ratio of 5,150:1.

11 In 2003, women formed 21% of the workforce as compared with 16% in 2001. Women were most strongly represented among Specialist Paediatricians (37%) and least among General Consultants (19%).

12 The overall age distribution ranged from 30 to 72 years with a mean of 48 years and 49% aged 50 or older. 44% of the age group 30-64 years were women as compared with 13% or less in the age groups over 65 years. General Consultants, with a mean age of 52 years, were older than other practitioners, although this gap is narrowing. Apart from a general bias towards younger ages in the Northern Territory and older ages in Tasmania, there was relatively little variation among the states and territories in age distribution broken down by type of practice.

13 For Specialist Consultants, cardiology and gastroenterology were the two most prominent fields, followed by respiratory medicine, neurology and endocrinology. For Specialist Paediatricians, neonatal pediatrics was the most prominent field followed by developmental and behavioural pediatrics, respiratory medicine and paediatric haematology/oncology.

14 The age structures within specialties were similar to the overall age distribution, though some fields were notable for their relative youth (infectious diseases, medical oncology and emergency medicine).

15 The ratio of population aged 15 years and older per General Consultant was 3,160:1 for Australia as a whole, varying between 24,900:1 in the Northern Territory and 40,300:1 in New South Wales. The ratio of population aged 0-14 per General Consultant was 5,200:1 overall and varied from 4,650:1 in the Northern Territory up to 11,700:1 in Western Australia.

16 Ratios of population per specialist varied widely among specialties, between adult medicine and paediatrics, and between the states and territories. The Northern Territory, Tasmania, Queensland and Western Australia were poorly represented in several fields.

17 87% of Fellows were involved in care of patients in public hospitals and 79% had some private practice. Involvement in community clinics was uncommon (8%). Undergraduate or postgraduate teaching was undertaken by 71%, and research by 54%, 4% had an administrative role and 10% were engaged in some other professional activity.

18 2% of the workforce did not hold an appointment (paid or honorary) at any type of hospital, 17% did not hold an appointment at a teaching hospital.

19 80% of the workforce was located in the state capital cities, 8% in other large cities (Newcastle, Wollongong, Geelong, Canberra), South Coast/Gold Coast/Coffs Harbour) and 12% in regional centres (includes Blue Mts and Central Coast, NSW, and Darwin because of its population size). 230, per cent of the workforce was female in the state capitals and 14% in the large cities and regional centres. The proportion of Fellows without a hospital appointment of any kind was uniformly low across all three categories of location (2%).

20 The average total working week for all types of professional activity was 52.5 hours. 12% worked less than 40 hours a week and 19% more than 60 hours.

21 The average time spent in clinical practice was 30.4 hours per week. General Consultants spent the most time in clinical practice (mean 42.2 hours) while Specialist Paediatricians had the lowest mean (33.3 hours).

22 The average time spent in clinical practice varied from 36.3 hours per week in the Northern Territory to 40.0 hours in Queensland. Fellows in the state capitals had the lowest average (38.1 hours) while those in regional centres had the highest (45.5 hours).

23 For General Consultants and Specialist Consultants in all states and for General Paediatricians in New South Wales and Victoria the average clinical workload in regional centres was greater than in the state capitals and other large cities and sometimes much greater.
Ratio of Australian population aged 0 - 14 years per paediatrician (●) and ratio of population aged 15 years and older per consultant in adult medicine (■).

PREVALENCE ESTIMATES BY NT REGION, ABORIGINAL POPULATION IN REMOTE AREAS, 2005

Sources: NT Chronic Disease Register, NT Hospital Morbidity data and ABS National Health to 2005 NT Indigenous
REMOTE INDIGENOUS COMMUNITIES, 300+ PEOPLE

RACP 2006 advanced trainees by specialty and state/territory

<table>
<thead>
<tr>
<th>Specialty</th>
<th>NSW</th>
<th>Vic</th>
<th>Qld</th>
<th>SA</th>
<th>WA</th>
<th>Tas</th>
<th>NT</th>
<th>ACT</th>
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<td>Neurology</td>
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<td>8</td>
<td>6</td>
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<td>306</td>
<td>120</td>
<td>86</td>
<td>80</td>
<td>14</td>
<td>12</td>
<td>16</td>
<td>974</td>
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<tr>
<td>%</td>
<td>34.7</td>
<td>31.4</td>
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<td>9</td>
<td>8.2</td>
<td>1.4</td>
<td>1.2</td>
<td>1.6</td>
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</table>
Speciality of those awarded FRACP's 2000-2005

<table>
<thead>
<tr>
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The IMSANZ/RACP joint position paper “Restoring the Balance”* discusses these topics in more detail, but the key issues can be stated as follows:

- There is a significant deficit in the number of physicians with general medicine skills in Australia to undertake the service requirements in acute general medicine units.
- The lack of general physicians in many (tertiary) training institutions exacerbates the problems in providing adequate training opportunities, supervision and mentorship of trainees in general medicine.
- Trainees specialising in general medicine have difficulty accessing both general medicine and other specialty training posts.
- The inequities in remuneration and employment conditions (rostering, workloads, training and service requirements) have resulted in a negative impact on the uptake of general medicine as a desirable and rewarding career choice.
2.3. The Way Forward

The College recognises that, at least in the immediate future, there will be shortages in all disciplines of the health workforce. This submission focuses mainly on consultant physicians and paediatricians, but workforce issues affecting the faculties of the College also need to be recognised.

The College recognises that it will be some time before the Australian medical workforce is self-sufficient and is thus playing a substantial and increasing role in the assessment of overseas trained physicians, and is paying greater attention to recognition of prior learning in these situations. However, it believes that there should be a balanced distribution of the current Australian medical workforce between general practitioners, “generalist” specialists and sub-specialists, between states and territories, and between rural and metropolitan areas. The College wishes to work with governments to ensure that the lack of access to specialist physician and paediatrician care does not disproportionately affect the elderly and those with lower health status, particularly those living in rural and remote areas.
Physician Education
Dr Emma Spencer, Director of Physician Education – Royal Darwin Hospital

FACTS
- Medical education has improved
  - Let's get some historical perspective
- Quality training opportunities are inextricably linked to adequate workforce numbers
- Administration is a significant diversion of clinicians non-clinical time
  - and always will be
- ‘Silos’ exist for (some) very good reasons
  - natural evolution
  - Maintenance of professional standards
  - Practicality of peer review
  - Process of creating a governance structure

PHYSICIAN TRAINING RDH
- Accredited training for 2 years of basic training
- Structured program of terms
- Grand rounds
- Chart review / infectious diseases teaching
- JCs (ID gen med pall care endo haem)
- RACP
  - Curriculum/ Mini CEX
- Physicians clinical exams ‘Bulldogs’
- Advanced training in renal IFD haematology (clinical and Lab) general medicine cardiology palliative care endocrinology ICU
- Annual Scientific meeting

PREVOCATIONAL TRAINING
- Medical administration
- Office of DCT
- Articulated philosophy
  - Alice Katherine Tennant Kunnunurra remote area etc to broaden the access
Accommodate a small number
  - Practical assistance
  - Cannot completely retrain

Differing standards of basic medical education
Different cultural values
  - Understanding of patient advocacy
  - Understanding of patient focused care
  - Understanding that in Australia the boss in not always right

Need to STRENGTHEN existing structures

PREVOCATIONAL TRAINING AND LEADERSHIP
Gap between reality and expectation
  - Requires leadership
Broad and deep exposure
  - ‘clinical weight’
  - Consequences of shorter work hours
Process of clinical and personal maturing
Not comfortable
Intellectual independence and self direction
  - Without the rigid structure of the eternal childhood of medical school
Protected Teaching Time’
  - Not the panacea

PHYSICIANS - WHAT WE NEED (RACP)
Appropriate FTE - 0.3 in addition to clinical FTE
  - DPEs and DPPEs Alice and Darwin

Competent administrative support
  - Able to facilitate communication between ASH+RDH
Secretarial role PLUS++++
Support college activities/engage with college
Engage with trainees
  - Assist with college processes
Run scientific meeting
IT support/advertising/raising profile
Advocacy college training
PHYSICIANS - WHAT WE NEED (HOSPITAL BASED)

- Competent hospital/departmental administrative support
  - Fulfill basic administrative functions
  - Advertising
  - Registrar recruitment processes
  - Setting up interview times…
- IT support/facilitating teaching sessions
- Positive engagement re prevocational access to medical terms

DEVELOPMENT

- Allow flexibility
  - Practical administrative SUPPORT!!!
- Support clinicians
  - With time and money
  - They do the teaching (usually for free and usually in their own time)
  - Understand the value of bedside teaching
- Strengthen the basic tenants of medical education in Australia
  - Patient advocacy
  - Patient focused care
  - Clinical governance
- Don't reinvent the wheel
Continuing Professional Development
Dr Charles Kilburn

REGULATORY REQUIREMENTS OF CPD

- Model of medical regulation
  - 19th century
  - Initial registration requirements
  - Annual fee
- Inadequate for 21st century

Continuing Medical Education

Under the new Medical Practice Act 2004 s38 (2) (b) a registered person must in each calendar year on a date fixed by the Board pay an annual practice fee fixed under this Act and complete a renewal form approved by the Board, containing all information requested including the undertaking of any course of continuing medical education (CME) by the person during the preceding year. The 2005–2006 renewal form will require applicants to complete this section. Please note registration will not be refused in the absence of any evidence of continuing medical education; however, practitioners should note that this will be subject to future Board determination following further discussion with the relevant parties.
REGULATORY REQUIREMENTS OF CPD

MEDICAL BOARD OF WESTERN AUSTRALIA
ABN: 25 171 511 367

STATEMENT OF ACTIVITY

An Application for Resumption of Registration is required to be completed if the registration status of the applicant was that of Not Practising/Occasional for a duration of greater than two years and the applicant seeks to resume Occasional Practice/Practising in Western Australia. Please include attendance at any educational institutions, and explain any periods where you were not practising medicine.

No requirement for CPD

MEDICAL BOARD OF THE AUSTRALIAN CAPITAL TERRITORY

Are you able to provide evidence of recency of medical practice in the past five years? Yes No

If you practise in a private capacity, are you currently covered by a policy of medical indemnity insurance at an appropriate level? Yes No

Are you able to demonstrate ongoing professional development? If yes and you are participating in a program, list the title of the program:

Provided by: Yes No

No clear requirements for recency or CPD on application forms
The College Council has mandated compulsory participation by Fellows in the MOPS program. Fellowship is not a time limited qualification therefore the Council does not have the right to take the Fellowship away from Fellows not participating in the program.

Certain medical boards currently require that enrolment in a MOPS program be confirmed when seeking medical registration. It is expected that all medical boards will introduce this requirement in the near future.

**Participation**

Only registered medical practitioners are eligible to enroll in the ANZCA CPD Program. Enrolment is not necessary for Fellows and there is no fee. Fellows who wish to participate in another CPD program *in lieu of* the ANZCA program need to contact the College for guidance. Anaesthetists who are not Fellows of ANZCA are welcome to participate, for which a fee will be payable. Although at present not all jurisdictions require participation in CPD for Recertification, the forthcoming Australian single national registration to be implemented by the Council of Australian Governments (COAG), heralds mandatory participation.
The Maintenance of Professional Standards (MOPS) Program was implemented in 1994 as a strategy to promote continual professional development. The MOPS program provides Fellows of the College with a way of formally documenting their participation in a range of continuing education and quality assurance activities.

Voluntary, not linked to fellowship or re-certification

Royal Australasian College of Surgeons
The CPD Program is conducted over a triennium, currently 2007–2009. All active Fellows in medical, surgical or medico legal practice have a requirement to participate.
The CPD Program provides flexible requirements according to type of surgical practice.
Voluntary, not linked to fellowship or re-certification

Introducing the 2008–2010 RACGP QA&CPD Program
The Royal Australian College of General Practitioners (RACGP) is pleased to introduce the Quality Assurance and Continuing Professional Development (QA&CPD) Program for 2008–2010. Since being established in 1987, the QA&CPD Program has been continually evaluated and updated. The new triennium program aims to ensure all GPs are provided with opportunities to participate in high quality educational activities that emphasise patient safety. Modifications for 2008–2010 enhance the program's depth, flexibility and standard, thus increasing the educational benefits general practitioners (GPs) receive for the valuable time they invest and, ultimately, improving patient outcomes.
• The RANZCOG continuing professional development (CPD) program is designed to facilitate three endeavours: training, continuing education and review.

• In 1986, RANZCOG Fellowship became linked to a mandatory program of continuing education and recertification. The New Three year Continuing Education Program was approved by Fellows of the College on 3 March 1999. Fellows must obtain 150 points over the three-year cycle of this program.

• Inconsistent from jurisdiction to jurisdiction

• Inconsistent between Colleges

• No clear responsibility between Boards, Colleges and employers

• Inadequate

• National consistency required by 2010
Australian Indigenous Doctors
Dr Latisha Petterson

WHO WE ARE
• Over 120 Indigenous medical graduates (doctors) working across the country
• Over 120 Indigenous medical students studying in medical schools across Australia

We work as
• Medical Officers
• General Practitioners
• Surgeons
• Cardiologists
• Obstetricians and Gynaecologists
• Physicians
• Psychiatrists
• Public Health Physicians
• Medical Educationalists
• Researchers

WHAT WE DO - 1
AIDA advocates for improvements in Indigenous health in Australia and encourages Aboriginal and Torres Strait Islander people to work in medicine by supporting Indigenous students and doctors.

AIDA incorporates the philosophy that Life is Health is Life in its policy and advocacy work, encouraging equitable health and life outcomes for Aboriginal and Torres Strait Islander people throughout leadership and in the spirit of cultural integrity.

AIDA is a not-for-profit, non-government organisation dedicated to the pursuit of leadership, partnership & scholarship in Aboriginal and Torres Strait Islander health, education and workforce.

WHAT WE DO - 2
AIDA works with governments at all levels, health organisations and medical schools to promote Indigenous health and to provide policy advice to:
• Department of Health and Ageing
• Medical Deans Australia and New Zealand
• National Aboriginal and Torres Strait Islander Health Council (NATSIHC)
• Australian Medical Workforce Advisory Committee (AMWAC)
• Aboriginal and Torres Strait Islander Health Workforce Working Group (ATSIHWWG)
• General Practice Education and Training Aboriginal and Torres Strait Islander Reference and Consultative Groups (GPET)
• National Aboriginal and Torres Strait Islander Health Council (NATSIHC)
• Royal Australasian College of Physicians Aboriginal and Torres Strait Islander Health Advisory Committee (RACP)
• Royal Australian College of General Practitioners Joint Consultative Committee for Aboriginal and Torres Strait Islander Health (RACGP)

and others

WHAT WE DO - 3
AIDA provides support to our members through
• Mentoring
• Representation on advisory and selection committees e.g. – Puggy Hunter Memorial Scholarship Scheme
• Advocating for better recruitment, support and retention of Aboriginal and Torres Strait Islander students and staff
• Advocating for institutional change on Indigenous health issues

WHAT WE BRING AS INDIGENOUS DOCTORS
• Spiritual, Cultural, Emotional and Physical understanding
• Holistic approach to health
• Tradition of healing
• Trust, Respect and Connection to Community
Acute Care Division
Mr Peter Campos – Assistant Secretary, Dept of Health & Community Services

HISTORICAL ARRANGEMENTS
• Flinders University – NT Clinical School
• Supports teaching in the NT Hospital Network

BENEFITS
• Contribute to national effort
• Training our “own”
• Specialist training has increased at Royal Darwin Hospital and Alice Springs Hospital

CHALLENGES
• Recruitment and retention of medical staff
  o Nationally
  o Remote areas

FOR THE FUTURE
• Enhance focus on Teaching, Research & Clinical Practice
• Demand for medical staff across Australia over the next 20 years
• Encourage generalist rather than sub specialties except where critical mass exists in the NT
• How to include International Medical Graduates
• Sustainability of services
• Establish NT wide hospital network rotations and links into community training
• Establish medical training links with:
  o Kimberley and Top End Queensland
  o East Timor and Indonesia

NTG/BIITE PARTNERSHIP AGREEMENT
Schedule 6 Early Childhood
Schedule Leaders:
• Lyn Fasoli (BIITE)
• Jenny Cleary (NTG)
Health Services Division
Ms Jenny Cleary Assistant Secretary, Dept of Health & Community Services

OVERVIEW OF HEALTH SERVICES DIVISION

NT’s unusual PHC sector:

- Health Services Division as direct service provider
- Long standing participation in medical training (preceding NT-based med trng/support agencies)

- Community and public health services:
  - Education, prevention, early intervention, assessment, treatment and support services

- Program areas:
  - Health Development/Oral Health, Remote Health, Community Health (Urban), Environmental Health, Disease Control

- 840 Staff (approx), includes 40 Doctors

REVIEW INDICATES

- Complex medical training environment (37 direct stakeholders)
- Important to develop the NT medical workforce locally
- Critical and urgent need to streamline the current mix of arrangements
- Acknowledge recent work:
  - Amalgamation of TEDGP, CADPHC and GPPHCNT
  - Collaboration between DHCS / TEDGP on placement of medical students
  - Education stakeholders contributing to planning for the Palmerston Superclinic
  - Strong links between Rural Clinical School and NTGPE for coordination of student placements
  - NTGPE and DHCS collaborating on clinical supervision

FUTURE MEDICAL WORKFORCE NEEDS

- Community-based practitioners:
  - interest in Public Health issues and practices
  - flexibility and innovation
  - willingness to explore new models through team-based practice
  - willingness to work within clearly defined protocols (CARPA); and willingness to share their expertise

- Hospital-based doctors:
  - awareness of socio-economic-cultural history of their clients
  - awareness of the realities and challenges of...
delivering services in NT urban and remote communities; and
  o preparedness to support seamless client-focused services beyond the hospital

NEED FOR COORDINATION

• What do we mean by coordination?
  o Planning student numbers by site and supervisor
  o Balancing undergraduate and post-graduate placements
    • Positive client balance of registrars
  o Coordination of learning outcomes
  o Coordination of communication with medical schools/providers
    • Reporting demands
    • Student support
  o Other health professional training

• How?
  o Training institutions in competition with one another

CURRENT ENVIRONMENT

• Public health physicians- critical leaders across NT health system
• Inter-dependence, inter-relationships in service provision (benefits and challenges)
• Training and education delivered locally:
  o challenging and complex
  o limitations result in diminishing capacity; opportunity costs of diverting existing specialist services

ISSUES FOR RESOLUTION

• Health centers are not ‘swamped’ with students from various providers
• Aims and objectives of the placement are understood by the placement supervisor
• Effective and appropriate supervision
• Student housing and travel support
• Increasing rigor and cost of accreditation
• Coordinated, innovative support for students and registrars in our urban community-based settings

CONCLUSION

• DHCS is committed to providing safe, effective, enjoyable, memorable placements for medical students in urban and remote settings
• Improved planning, coordination and re-sourcing needs to be from a national perspective
• Optimism re common ground, shared goals