

## Medical Education and Training Summit Day 2

The 2008 Medical Education and Training Summit was designed for the assembling of key internal and external medical stakeholders, all with differentiating thoughts and perspectives to offer and express.

The 100 nominated medical delegates, representing a wide range of stakeholders across Australia all gathered with the same purpose and goal: “To ensure the future management of medical education and training for the Northern Territory medical workforce”. Delegates were selected for their vast knowledge and expertise in their chosen profession.

The 2-day program offered a platform for invited guest speakers to elaborate and expand on their nominated topic and to offer their ideas and in some way influence the development of an improved coordinated and integrated approach to medical education and training across both the NT and the health sector.

Below were the topics presented on the first day (see attachments). Following the completion of each presentation, an open discussion occurred allowing questions and points of view from all delegates to be heard;

- **An Overview of the NT Medical Education and Training Review** - Dr Janie Smith
- **Medical Students** – Professor Michael Lowe
- **Pre Vocational Training** – Dr David Chapman
- **Post Graduates Medical Council** – Professor Peter Roeser (no speech notes)
- **International Medical Graduates** – Associate Professor Alan Ruben
- **Vocational Training** – Professor Michael Kidd, Associate Professor Richard Murray  
Dr Phil Carson, Dr Stephen Brady & Dr Emma Spencer
- **Continuing Professional Development** – Dr Charles Kilburn, Dr Leonie Katekar,  
Professor John Wakerman
- **Indigenous Doctors** – Dr Latisha Petterson

Whilst it was recognised that we all have different experiences and that it is not always possible or even desirable to all agree on the same topic or subject, there was respect for conflicting ideas and the realisation that in coming together to discuss topics and ideas, we can endeavour to attain the best possible solutions and outcomes for the NT’s medical workforce.

## TOPICS

Day 2 commenced with delegates breaking into 7 pre-selected groups, representing the 7 topics discussed on Day 1. The reasoning behind the selection for the groups was based on level of knowledge, current occupancy and degree of interest in topic. To the best of the Facilitators and the Summit coordinators ability, co-workers or delegates from the same organisations were kept separate.

The following reflects topics discussed, group recommendations and thoughts.

### ***Medical Students***

#### **Priority Issues:**

1. Commitment to the full continuum of medical training in the NT taking account of context and demography, such as need to train more indigenous health professionals;
2. Commitment to excellence in areas of strength and need – Indigenous, community-based training, remote, public health, as might be defined through appropriate feasibility studies etc;
3. Commitment to vision of continuum of training both vertically and horizontally.

#### **Linkages:**

- Recognise the importance of pathways for indigenous students into medicine and allied health;
- Medical training must emphasise coordination across the health professions.

#### **Actions:**

- Establish a working party to develop a business case for the NT Medical School, drawing on the strength of CDU and Flinders University's programs, involving other partners and noting the benefits to the NT and Indigenous populations of such a school;
- Move to single agency to coordinate and place all medical students in the NT and coordinate with agencies placing other health profession students with a view to a single integrated agency for all placements;
- Develop infrastructure, training resources and time for release of practitioners from clinical duties sufficient to train students across hospital and community settings. This will involve added rewards for private practitioners, appropriate administrative support and attention to models of training;
- Models of teaching and learning be explored that recognize the value of students in the workforce, that integrate learning and teaching across levels of training and different learning groups, and that explore efficient use of flexible and remote learning resources.

**Resources & Funding:**

- Explore NT-sponsored cadetships in later years;
- Free up NT scholarships;
- Explore Commonwealth funding for infrastructure.

## ***Pre-Vocational Training***

### **Priority Issues:**

1. Fragile Accreditation Status;
2. Overwork – Trainees & Supervisors & IMG issues;
3. Orphan status & integration, networking and coordination issues.

### **Linkages:**

- Linked to the education and training continuum – vertical and horizontal;
- Medical student to vocational;
- Links to undergraduate, postgraduate and IMGs'.

### **Actions:**

- Immediate – Teaching as core responsibility – funding needs to be clearly articulated;
- Longer-term – More intern places (double)/workload/workforce;
- Longer-term – Network coordination training/education/placements/recruitment, integration.

### **Resources & Funding:**

- Commonwealth – can link into commonwealth programs;
- NTG – More FTE and \$ from DHCS for more intern places, require approx 30% more funding in order to fund this which includes the resources required for training/supervision/the directorate model;
- Private;
- Other – Possible resources are already there, just need to identify.

## ***Post Graduates Medical Council***

### **Priority Issues:**

1. Establishment
  - Function and mission appropriate to the Territory
  - Structurally independent
  - Appropriate governance and secretariat
  - Adequate funding
2. Prevocational and IMG
  - Accreditation, education and training
3. Broader agenda
  - Integration with undergrad and vocational training
  - CPD
  - Resource efficiency

### **Linkages:**

- Sharing administration support;
- Collaboration with medical schools and colleges;
- Broader agenda for educational coordination and input;
- NTRMET Model;
- PMC needs to be independent;

### **Actions:**

#### Immediate:

- Establishment of the PMC by June 2008;
- NT Medical Board and DHCS to develop a statement of support and core values with endorsement from NT Minister;
- Project Officer to support establishment of the PMC;
- Funding for JMO Forum in September 2008.

#### Longer term

- Accreditation of ALL prevocational and IMG positions;
- Collaboration the medical schools and colleges to support transitioning;
- National projects;

- PMC needs to be independent;
- Monitoring the outcomes;
- Need to separate the management of the NT Directorate AND the PMC;
- Council of Medical Education rather than Directorate;
- PMC representation;
- MET requires further discussion;
  - Role and function
  - Working relationship with PMC
- Collaboration with PMC Queensland and CPMEC;
  - Dual funding is ideal
  - \$300,000 (+ rent) estimate
- NT Medical Board – increasing medical board fees.

**Resources & Funding:**

- Collaboration with PMC Queensland and CPMEC;
  - Dual funding is ideal;
  - \$300,000 (+ rent) estimate
- Department of Health and Community Services (DHCS);
- NT Medical Board – increasing medical board fees;

## ***International Medical Graduates***

### **Priority Issues:**

1. Recruitment
2. Ongoing Supervision and Assessment
3. Training and Support

### **Actions:**

- Pre-employment clinical interview (currently IMG PAC for GPs, but will need to be expanded for other high risk areas);
- Accredited recruitment panel comprising GPs and hospital specialists;
- DHCS Network recruitment (all five hospitals & rural medical practitioners);
- Capacity for day-to-day supervision:
  - DHCS (hospitals & RMPs);
  - Support supervisors with MEOs / administrative staff;
  - GPs;
  - Expand GPR program to include IMGs;
  - Explore increasing use of telemedicine;
- Panel of accredited, paid assessors from General Practice & hospitals:
  - Dedicated MEO support for IMGs;
  - Family-inclusive cultural orientation;
  - Expand GPR program to include IMGs;
  - Integrated with other JMOs/GPRs but, where necessary additional
  - In DHCS through NT Directorate of Clinical Training, in community through GP education organisations.

### **Resources & Funding:**

- National average \$8000 per year per IMG to recruitment (excluding relocation), supervision, assessment, training & support
- Need to consider additional costs due to “tyranny of distance”
- A conservative estimate might be \$10,000 per year per IMG.
- The investment now creates a sustainable future

## ***Vocational Training – Generalist Specialist***

**Vision: By 2018 we will have a unique model of generalist training across and within all craft groups with a strong primary and population health focus.**

### **Priority Issues:**

1. Lack of training and educational delivery infrastructure. No coordination within and across craft groups, institutions, vertically and horizontally (hospitals, community, ambulatory etc)
2. Inadequate educational Milieu (context is stretched, stressed service delivery system).
  - Physical infrastructure (consulting rooms, accommodation Planes, trains and automobiles etc)
3. Human resources:
  - Supervisors - multiple other roles, lack quarantined time for training self and others, support for coordination,
  - Trainees - multiple other roles, lack quarantined time for training self and others, support for coordination, coordinators;
  - Personal resources- preparedness for work in NT environment- social isolation, high-stress with limited support, clinical governance/ quality assurance; research;
  - Technological infrastructure e.g. internet, e-health including tele-radiology, tele-health, videoconferencing;
  - Increased graduate numbers- competition for time
4. External players:
  - Colleges (and NT PMC?) have own requirements, which we may or not be able to meet. Can't meet standard or standard inappropriate.

### **Actions:**

1. Lack of education infrastructure:
  - Map existing training infrastructure/positions and learning resources;
  - Define gaps/duplication and future needs (short term);
  - Plan and implement over-arching training network (within 3 years);
  - Appoint Directors of training - pre-vocational and vocational, medical education officer and admin support;
  - Active co-ordination of training- all levels.
2. Training settings:

- Map current education inventory including IT, resources (include “hardware”);
- Define deficits/duplication;
- Work smarter e.g. non-clinical support to free up consultant;
- Remediate or drop where deficits exist;
- Examine Access to other funding sources e.g. ESTP (short term);
- Human resource support

### 3. External players

- Flexible training- colleges
- Innovative supervision models
- Cross-jurisdictional co-operation (especially Northern Australia)
- Accreditation
- Horizontal integration- cross-specialty as well as other disciplines
- Strengthen links between specialties specific to NT e.g. public health, primary care etc

### **Resources & Funding:**

- Within 1 yr: Project funding with project tasks to do mapping;
- Within 3yrs move to Northern Australia medical training network.

## ***Continuing Professional Development***

### **Priority Issues:**

1. Prevocational Gap – CPD compulsory for medical students, but not JMOs
2. Provision and resources limited and not locally centralised – 37 providers
3. Interdisciplinary CPD opportunities: Venue, delivery, remote supervision and delivery

### **Actions:**

- Urgent creation of centralised local directorate to coordinate multiple service providers and standards;
- Coordinate multiple (37) current providers rather than new organisations;
- Australian Curriculum Framework for junior doctors has professional requirements;
- Interdisciplinary and local context more effective than generic national standards – this is currently available;
- Continuing process rather than one off 'check list';
- Recognition of prior learning for PGY1+ when commencing vocational training;
- Infrastructure – who is in charge? What is the curriculum? How is it implemented? Where is it implemented? Funding – sponsorship? Commonwealth? Charity?

### **Resources & Funding:**

- Financial and time barriers addressed by recent study allowance in the NT;
- Fantastic human resources already exist. Fill in gaps – training venues an issue;
- Access to university, NTCS, NTGPE resources, which have already been set up. Microsoft has offered to set up a 'studio' in conjunction with library.

## *Indigenous Doctors*

### **Priority Issues:**

1. Medical School
2. Models of healthcare and education and training
3. Role of indigenous workforce in all health disciplines

### **Actions:**

1. NT Clinical School - Centre of Excellence
  - Focus on: tropical health, indigenous health, international health, multi-disciplinary teamwork, traditional healing, cross-cultural safety/security training and understanding (international and indigenous);
  - Flexible Curriculum to be NT appropriate rather than driven from an interstate university.
2. Recruiting students (Indigenous, international, national.)
  - Feeding in students in a flexible fashion
  - Appropriate environment for NT students with adequate support
  - Programs. Bridging courses.
  - Lobbying around primary school education (see below under NT Health Education Council).
3. Recruiting teachers:
  - DHCS needs to have a commitment to academia;
  - Needs academic base;
  - Use the draw-card of research to attract people (eg Menzies and CRC-AH);
  - Administrative support to free-up time to do the training;
  - Flexible employment arrangements;
  - Rotations to other regions within the NT and supported outreach (needs admin support);
  - Work with Aboriginal Community-controlled health organizations.
4. MET Directorate = Post-Grad Medical Council could do this. Call it:
  - **NT Health Education Council**
  - A site that collects information and informs people.
  - Encourage recruitment to health professions. Crosses agencies within government. Education, etc.
  - Deals with flexible entries, bridging courses, etc.
  - Needs to report to NT Chief Minister, not DHCS.

- Helps integrate across IMG's, junior doctor training, multi-disciplinary training across professions.

### **Resources & Funding:**

- Cost effective in the long run by setting all this up.
- Pay-feeing international students would contribute;
- Link with 'Close the Gap' movement and funding;
- Current lecturers already in NT – eg Menzies, CDU, Centre for Remote Health, etc.
- Seeding funding to set up the medical school;
- Bridging courses;
- IT support;
- Admin support to current providers;
- Money from interstate university.

## FURTHER CONSIDERATION

Training programs don't necessarily meet the specific needs of NT

- What is the plan for the NT in the next 10 years;
- Specific nature of rural/regional practice;
- Will still need IMGs to support small hospitals;
- Rural generalist/proceduralists;
- Specific training for supervisors especially in remote context
- TEACHING PEOPLE TO TEACH

College accreditation requirements for training

- Only 4 programs are able to provide all training in NT (psych, GP, Public Health and Pathology);
- Some e.g. (RACP, ED) can do most except 6-12 months in NT;
- Service jobs exist but not accredited for training;
- Few colleges mandate rural/regional training;
- Lack of flexibility in training/employment (administration of training usually state-based, accommodation, relocation etc).

Recruitment, Retention, Return

- At all levels;
- Loss of entitlements when leave territory for training;
- Constraints around movement within territory/country;
- Value of teaching/training;
- Human Resources;
- Time- supervisors and trainees.

## POSSIBLE SOLUTION

- 'Novel' training environments (accessing ESSTP/OMSTP= ESTP);
- Increased flexibility in training e.g. modules, CPD;
- Consideration of alternative models for training;
- Contracts to enable trainees to leave NT and return with guaranteed employment;

- Rural/regional background of doctor, regional university training, rural/regional post-graduate training;
- Employment for spouse, Schools and support for family etc;
- Flexibility in training, employment - ensuring that at end of training you will be able work wherever you want;
- Training to meet the needs of NT e.g. chronic disease in ambulatory setting vs acute care needs.