

JMO Forum Report

11TH National Prevocational
Medical Education Forum

Adelaide, October 2006

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on behalf of the JMO Forum

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The 2006 National JMO Forum

The 2006 National Junior Medical Officer (JMO) Forum was held in Adelaide on the 29th of October. It was attended by over 70 JMOs from all states and territories, as well as from New Zealand. There were JMOs from all prevocational levels, from PGY1 through to PGY3+. The Forum was chaired by Dr Michael Edmonds (SA).

Four hours of this sunny Sunday afternoon were spent in heated discussion over topics important to JMOs, short listed from a wide ranging list of suggested issues. This report will summarise some of the discussion, and most importantly, the resolutions that the Forum agreed upon.

The resolutions are achievable goals and guidelines that the JMO Forum feels are important in aspects of JMO education and training. We, as JMOs, will strive to achieve these, and ask for the ongoing support from each state's Postgraduate Medical Council (PMC) in doing so. These resolutions should also be used to guide any activity or policy that will affect JMOs in Australia and New Zealand.

State Representatives

Prior to the actual Forum, each State, and New Zealand, had a nominated representative who, as a group, discussed the issues important to JMOs that were proposed for consideration. From this extensive list, the most pertinent were chosen for inclusion in the final agenda. Each state representative also supplied a brief report on the progress since last year's Forum, and any other topics that were becoming important in their state. This year's state representatives are shown in Table 1. The state representative for Northern Territory did not have the opportunity to be involved in discussion prior to the Forum, due to a breakdown of communication as a result of there being no DCT at the Royal Darwin Hospital. Reports from the state representatives are in Appendix I.

Table 1: 2006 JMO Forum State Representatives

State	Representative
New South Wales (NSW)	Marion Mateos & Anand Rajan
Northern Territory (NT)	Danni Allen
Queensland (Qld)	Matthew Peters
South Australia (SA)	Michael Edmonds & Kate Hancock
Tasmania (Tas)	Leigh Dahlenburg
Victoria (Vic)	Oliver Daly
Western Australia (WA)	Ruth Blackham
New Zealand (NZ)	Lupe Taumoepeau

Terms Used

JMO Junior Medical Officer; this is used to refer to a prevocational medical officer in the first few years after graduation

PMC Postgraduate Medical Council; this is used to refer to the bodies responsible for accrediting JMO positions in each state. These are:

State	PMC equivalent	
NSW	NSW Institute of Medical Education & Training	IMET
NT	Northern Territory Postgraduate Medical Council	NTPMC
Qld	Postgraduate Medical Council of Queensland	PMCQ
SA	Postgraduate Medical Council of South Australia	PMCSA
Tas	Postgraduate Medical Institute of Tasmania	PMIT
Vic	Postgraduate Medical Council of Victoria	PMCV
WA	Postgraduate Medical Council of Western Australia	PMCWA
NZ	Medical Council of New Zealand	

PGY Post-Graduate Year; this denotes the year level of the JMO. PGY1 is the 'intern' year, PGY2 and above are generally referred to as 'Resident Medical Officer' (RMO), 'House Officer' (HO) or 'Hospital Medical Officer' (HMO).

IMG/AMC International Medical Graduate / Australian Medical Council candidate; these terms refer to doctors who graduated from a medical school outside Australia, and may have completed the AMC exams. These doctors are often required to fill JMO positions.

Position This term is used to refer to a job description that a JMO is assigned to work in. These are also referred to as an 'attachment', 'rotation' or 'run'. JMOs tend to rotate through a number of positions each year.

Discussion Topics

A few important topics were selected through discussion between the state representatives from a large number of topics suggested to be of interest to JMOs. These were grouped into the headings below. The resolutions passed by the JMO Forum are summarised in Appendix II.

Education & Training

Education and training represent the mainstay of JMO concern, as this is the purpose of the JMO year(s). Two issues were identified as being the most important for discussion during the Forum:

1. National Curriculum Framework:

This year has seen the development of a National Curriculum Framework, which was applauded for the amount of work, and comprehensive nature of its content.

Resolution: The JMO Forum supports the concept of a National Curriculum Framework

The impending launch of this framework two days after the Forum stimulated much discussion about issues surrounding implementation & assessment, given that this document is a 'framework', and not a set curriculum, it was discussed that it would be important for JMOs to be involved in any planning or decision-making about implementation or assessment based on the Framework, as they had been during the writing process.

Resolution: That JMOs hold a position on all decision-making bodies in the planning of any implementation of the Framework

It was further discussed that not all aspects of the curriculum framework will be learnt simply through clinical attachments, and that senior clinicians may not have sufficient "spare time" to teach junior doctors during day-to-day work. The Forum agreed that there was a need to recognise and reward the teachers and trainers who provide educational opportunities. It was discussed that the emphasis of the Framework should be as a basis for ensuring educational opportunities were available for JMOs. It was suggested that the CPMEC National Training and Assessment Guidelines for JMOs may need to be updated to accommodate the National Curriculum Framework.

Resolutions: The Framework be used to guide allocation of specific and adequate funding for teaching time, facilities and learning resources, including regular, protected, paid education sessions

The priority of the Framework is to promote teaching and learning, and that the framework be used to assess teaching opportunities provided by hospitals as part of accreditation

There was a lot of discussion that there was a lot of potential for the Framework to be misused for different agendas, not beneficial to JMOs. The JMO Forum discussed the most

important ways in which the Framework could potentially be misused. These were focused around the potential misuse of the Framework as a direct assessment tool, or as a step to replacing 'core terms' with a 'competency-based' system.

Resolutions: The Framework not be used as a barrier requirement to vocational training

The Framework not be used as a "log book" or check-list for junior doctors to chase

The Framework not be a pre-cursor to a 2 year internship

The Framework not replace core terms

2. JMO Involvement in Medical School Curricula

This topic was raised after the University of Adelaide Medical School called for feedback during a review of their curriculum. A submission was entered from a JMO perspective. It was discussed that JMOs have previously identified a feeling of un-preparedness for the work required in their first years after graduation. Additionally, JMOs are integrally involved in teaching medical students; this role is under-recognised. It was discussed that JMOs can offer a realistic perspective on requirements in the workforce post-graduation.

Resolution: The JMO forum strongly encourages JMO representation on medical school curriculum committees, especially for clinical years

Accreditation

Accreditation is key to JMO training; it is the primary way to ensure JMOs have sufficient educational opportunities, and have adequate support and facilities. There remained concern within the Forum that the accreditation process was 'toothless', with little ability to enforce findings.

The PMCs have universally been diligent in accrediting PGY1 positions across all states. Since last year there has been increasing JMO involvement in the accreditation process, but this is not yet uniform.

Resolutions: The JMO Forum supports mandatory JMO representation on all accreditation visits

The JMO Forum continues to support the role of the PMCs in accrediting all PGY1 positions

There was discussion about the lack of universal accreditation of PGY2+ positions, and the subsequent problems that have been encountered. The most startling example came from Queensland, where a PGY2 was sent to a rural placement in their first week after internship, under a federally legislated programme. In this placement, this JMO was the sole doctor for an area populated with over 3000 people, and the only backup and support was a phone number. This is unacceptable. With further expansion into rural and community placements

to accommodate the looming increase in medical graduates, accreditation of existing and new positions will be required to ensure JMO requirements are being met. It was discussed that the focus of expansion should be in existing institutions and programmes. It was further discussed that there should be consideration of IMG and AMC positions in the accreditation process.

- Resolutions:
- The JMO Forum further recommends that the PMCs be responsible for accreditation of all pre-vocational JMO positions
- With an increased focus on PGY2+
 - With consideration of IMG and AMC positions
- The JMO Forum supports the exploration of new position options to accommodate the expanding workforce
- Positions should meet existing accreditation standards
 - Focus should be on expanding & strengthening existing opportunities (eg PGPPP)

Discussion also considered that a pre-accreditation survey could be a method of involving more JMOs at each institution in the process, and would allow a better snapshot of the roles and supports of JMOs. It was suggested that a snapshot may not be sufficient, and that there is a role for continual feedback to the PMCs from JMOs, with a chance to see what outcomes there were from the accreditation process. There was discussion that there was little objective evidence of PMCs enforcing their accreditation findings.

- Resolution:
- A pre-accreditation survey is an appropriate tool to involve all JMOs at an institution level
- There should be a process for ongoing feedback to accrediting bodies from JMOs throughout the period between accreditation visits
 - There be mechanisms to ensure appropriate action based on this feedback

Rural & Remote Positions

There was heated discussion about the conditions for JMOs in rural & remote positions, especially following the example from Queensland given above. It was recognised that rural & remote JMO positions are prone to a lack of supports for JMO welfare, and often are imbalanced towards service rather than education. It was felt that rural & remote positions must be clearly defined to be focused on education, not backfilling workforce shortages. It was suggested that the terms of accreditation of these positions should be valid for shorter periods to allow for the higher variability of staff and resources.

- Resolution:
- Rural and remote positions must be subject to the same robust accreditation standards as metropolitan positions

There was discussion that rural & remote positions have different welfare & educational considerations, and that targeted strategies must be developed to ensure JMO welfare in

these positions. There was recognition that many rural & remote positions would not have the same level of resources to support JMOs. It was felt that the base hospitals must be responsible for providing education and support and ensuring adequate supervision. Supervision of JMOs should be immediately available during all hours that the JMO is expected to be working. It was recognised that unique solutions would be required to achieve a satisfactory level for accreditation of these positions.

Resolution: Rural and remote positions need additional supports and innovative solutions to ensure these standards are met

JMO Welfare

JMO welfare has been a previously under-recognised issue that has been highlighted in the past year by a number of tragedies, notably the suicide of two registrars in Victoria. JMOs work in a stressful environment, and ensuring adequate supports are in place is vital. It was discussed that JMO welfare is a responsibility for all stakeholders from the top down, and should be a priority for institutions and PMCs. It was discussed that not only should it form part of the accreditation, it should be considered as part of the occupational health & safety requirements.

Resolution: That JMO welfare should form part of the accreditation criteria

There was further discussion that a significant contributor to the problem was a lack of awareness in JMOs about the problem itself, JMO rights and responsibilities, and the supports available when a problem arises. It was felt that these issues and specific lines of support should be specifically addressed during JMO orientation.

Resolution: That JMOs should be made more aware of welfare issues and what supports are available

It was discussed that JMOs often hesitate to raise issues with their clinical superiors and even the DCT due to perceptions it may adversely affect their future careers. This suggests that there needs to be a change in the culture of the medical profession. Some strategies were discussed that may improve JMO welfare, including workplace concerns (safe working hours), strengthening existing supports (the role of the MEO in welfare, mentoring) and third party supports (independent, trained and resourced JMO welfare officers, supportive GPs, anonymous helplines). It was felt that the PMCs would be an appropriate body to oversee and ensure appropriate resources are available for JMO welfare.

Resolutions: The JMO Forum supports PMCs coordination of all stakeholders involved in JMO welfare activities

The JMO Forum endorses the AMA Safe Working Hours Guidelines

Acknowledgements

The JMO Forum acknowledges the great contribution that the PMCs give to JMOs across the nation. The Forum also recognises the important role that DCTs and MEOs play in JMO education and welfare. The JMO Forum would particularly like to thank Ms Karen Grace and the PMCSA for organising this year's JMO Forum and National Prevocational Medical Education Forum.

Appendix I: State Reports

These reports were compiled by the state representatives prior to the National Forum, and were fed back to the Forum via a short presentation. The written report from the NT was compiled after the Forum, as the representative was not aware prior to the Forum; a verbal report at the Forum was given.

Report from NSW/ACT JMO Forum

Marion Mateos & Anand Rajan
(transcribed from powerpoint presentation)

The JMO Forum in IMET

- New structure
- Re-establishing role
- Report to PVTC (prevocational training council)
- Specific activities
 - Terms of reference
- Communication
 - New members
 - NSW RMOA
 - AMA DIT NSW
 - ADTOA
 - Medical students

Main challenges

- “JMO Training Project”
 - Networks
 - Recruitment
 - Length of tenure
 - Number of terms (4 vs 5)
- Our concerns:
 - JMO Security
 - JMO welfare
 - JMO sense of identity

What else is happening?

- JMO Training Project
- AMC Pre-employment Program
- Managing JMO in difficulty
- PGY2 review
- “Hospitalist”
- Centralised on-line recruitment
- Specialist training reviews
- Industrial representation (managed outside JMO Forum)

Requested topics (NSW JMO Forum)

- Increasing number of medical students
- Guaranteed employment
 - Full-fee paying students
 - Local / interstate visa graduates
 - AMCs
 - IMGs (not dealt with by IMET)

Progress around resolutions

- Accreditation
 - Continued JMO involvement
 - Both positions and hospitals
 - Surveyor training
- Training for JMOs
 - Protected teaching time on-line survey
 - Majority 1-2 hours per week, still interrupted.
 - IT resources still variable
- National JMO Charter
 - Draft form
 - Ongoing
- Being taught how to teach
 - Variable, AHS-based
- Planning for the workforce
 - Strong support from JMO Forum for guaranteed employment after graduates - ?implementation
 - Continued support for 2 generalist years, with flexibility for streaming (IMET support); full registration after PGY1
- JMO Curriculum
 - Support for National Core Curriculum Framework
 - Withdrawal of previous IMET-collated term feedback forms
 - JMO involvement in committees is strong
- Pre-intern concept
 - no specific changes, as not currently an issue

Summary

- Issues to bring to Forum
 - Medical graduate increases and guaranteed employment
 - Networks
 - Some progress around resolutions

Keen involvement in all conference activities...

NT report on resolution progress since 2005

The first thing that needs to be mentioned is that none of the current interns at Royal Darwin Hospital (RDH) were aware that the Northern Territory sent representatives to the National Prevocational Medical Education Forum in 2005, let alone that there were resolutions made about important issues that needed to be implemented/ followed-up. This highlights the most crucial factor limiting progress in such areas at RDH, which is lack of continuity of staff. The average time junior medical officers (JMOs) stay at RDH is 1 year, with few JMOs staying 2 or more years. This is largely due to the lack of adequate post-graduate training opportunities. It is very difficult to implement change in such a short time, and we understand that there has been little change in JMO education, training and welfare issues at RDH in the last couple of years.

The second issue that needs to be addressed is the lack of communication between JMOs in the different hospitals in the Northern Territory. There is currently no formal or informal communication links between RDH and other Northern Territory hospitals (Katherine, Gove or Alice Springs). Therefore, this report is limited to issues at RDH.

Despite the above barriers, there are some good things happening at RDH. Every Tuesday there is one hour of pager-free teaching time for JMOs over lunchtime, with lunch provided. The content of these education sessions is largely driven by JMO demand, rather than a well thought out curriculum. Hopefully, the implementation of the National Curriculum Framework will help guide the topic selection in the future. In the NT we are rotated through terms in true general medicine and surgery, where the breadth of human pathology is seen, including many conditions now rare in urban Australia. This provides many informal opportunities for learning and should not be underestimated.

Accreditation was recently performed at RDH. The accreditation committee must be applauded for interviewed all interns during the accreditation process. This allowed the interns to speak up about issues that might have otherwise been overlooked. However, no effort was made to interview Resident Medical Officers (PGY2 and 3) and these positions were not accredited. Furthermore, there was no JMO representative on the accreditation committee.

The principle problem impacting on education and training at RDH is the significant lack of structural support. The Northern Territory Government does not currently fund the Post-Graduate Medical Council of the Northern Territory (PMCNT). This means that at present there is no governing body to ensure recommendations from the accreditation process are implemented or to oversee education and training at RDH. Furthermore, RDH does not currently have a Director of Clinical Training (DCT), and the Medical Education Officer (MEO) is only part-time. Therefore, there is very limited people and resources to co-ordinate JMO education and training and to ensure adequate quantity and quality of teaching. For example there are no professional development programs, such as teaching on the run, at RDH. This may be in part due to the distances required for interstate convenors to travel for sessions, but it also represents a lack of government or management level commitment to education and training for doctors in the NT.

In conclusion, RDH provides excellent clinical experience, providing exposure to a vast array of pathologies and clinical situations. However, there are huge challenges in balancing service provision with education and training.

Dr Danielle Allen
Dr Kylie Gayford

QLD JMO Forum Annual Report

2006 has been a busy and productive year for the JMO forum. Housekeeping matters included a review of the committee structure and a new Terms of Reference document. Initiatives to improve JMO awareness of the committee and the PMCQ were also implemented, with the roll-out of a new JMO email address, flyers promoting the JMO forum being posted throughout hospital common rooms across the state and a new JMO forum newsletter being compiled. Several projects have been undertaken, including the Accreditation Project and the Medical Board of Queensland Intern Booklet. Representation on other forums including the PMCQ Accreditation Committee, AMAQ, and the countless subgroups investigating the impact of increased medical graduates has kept many members focused and involved throughout the year. In addition to these activities the JMO forum has been active in its perusal of the National Curriculum.

Issues of concern to members of the JMO forum mirror those felt throughout the country. These include;

- JMO welfare and stress management
- Accreditation;
 - JMO involvement (compulsory requirement but difficult to fulfil)
 - Legislation regarding removal of a units' accreditation. PMCQ relatively powerless under current legislation
 - Reporting lines; no formal structure in place to address complaints raised by JMOs regarding teaching/education/supervision concerns
 - The Accreditation Project
- The National Curriculum;
 - Support comment re 'teaching on the run' inclusion
 - Concerns regarding competency based practice
- Increased medical graduate numbers
 - Who, where, when, how...
 - Public and Private sector arrangements including GP terms
 - Registrar/consultant numbers
- JMOs in senior positions
- International Medical Graduates
 - Widespread ignorance regarding educational and cultural needs. Lack of support.

Summary of current projects/activities throughout the year

The Accreditation Project

Eighteen month project reviewing and restructuring current accreditation guidelines, standards, policies and procedures. Draws heavily on ACHS, AMC and international benchmarks. Strong JMO involvement via the focused Accreditation Project Reference Group and Accreditation Committee. Recent unveiling to interested stakeholders at two day workshop. Strong focus on RMO welfare and education/training needs. There will be much future discussion about supervision standards, one reason being increased numbers of

supervisors required for increasing numbers of interns. Malleable design with possible PGY2/3 term applicability if legislative change. Due for trial June 2007.

The Medical Board of Queensland Intern Booklet

The RMO Forum of the PMCQ undertook the task to produce an information booklet for interns, along the lines of that produced in Victoria and New Zealand. It was decided that the booklet would be more useful for interns if it has a peer-to-peer rather than an institution-to-intern tone and contains useful advice to assist and inform rather than a list of standards and prescriptions. In accordance to this principle, the workgroup set out to write a booklet that contains information about the framework of internship in Queensland, including issues of registration, expected education and training standards, description of terms and legal issues, all in an easy-to-read language with plenty of references for further sources of information and assistance. The booklet is completed and is in the phase of final comments from interested parties before becoming available to interns in a variety of physical and digital media, most likely in early 2007.

Additional medical graduates project

What is it?

QH driven group involving stakeholders from various areas including EDMS, medical school representatives, AMSA, QMSA, junior doctor representatives from each area health district, AMA, PMCQ (note the JMO Forum have not got a formal position/invitation), QPSU, ASMOFQ, College Representatives etc.

Aims?

2007 will see an increase in the number of medical graduates entering the workforce. Further significant increases are expected over the next 5 years. This project aims to address the issues surrounding the influx of new medical graduates to ensure that clinical training experiences and education is maintained at a high standard. To date QH have held 2 workshops which have involved a number of stakeholders including junior doctors.

Where's it up to?

At the last workshop it was identified that further work is required in the following areas:

- role and implementation of the national curriculum framework
- required clinical experiences vs. core terms
- teaching and assessment
- rural and regional rotations
- placements outside the public sector
- education support
- project reporting

The Ministerial Taskforce for Clinical Education and Training (MTCET) is another body looking into education and training issues that will likely result from the increase in medical graduates. It is hoped that proposals and outcomes can be collated and implemented from both groups.

International medical graduate programme

The treatment of international medical graduates (IMGs) in Queensland is highly variable. Some inner city hospitals have few IMGs, whereas more regional hospitals have IMGs as their main workforce. The issues with IMGs are:

- **recruitment:** The recruitment process is non-uniform and left to the medical administration of individual hospitals.
- **assessment and placement:** sometimes poorly matched. The AMC exams offer little indication of an IMG's knowledge and ability to function, and there are often mismatches between the IMGs ability and positions of responsibility.
- **training and supervision:** patchy. Some hospitals have excellent programs of support and training, while others have none. There are currently no standards set for IMG supervision and training (apart from those acting as interns), no body accrediting their positions, hence they are often put into places with minimal support and set up to fail.
- **advocacy:** IMGs are in a very disadvantaged position as their registration is dependent on the hospitals medical administration. This imbalance in power stops them from speaking about their issues. There are wide-spread opinions that IMGs are a disposable commodity, to be used during workforce shortages and discarded when not needed. This leaves them feeling undervalued and exploited.
- **orientation program:** There is a pre-vocational program in Queensland that introduces IMGs to the Queensland workplace, but it costs the IMGs several thousand dollars to attend instead of being paid for it, is not compulsory, does not guarantee employment, has no standards of supervision, and is abused by some hospitals for unpaid labour.

The issue of IMG supervision and training is currently not receiving much attention as Queensland concentrates on dealing with the tsunami of medical graduates. In addition, the IMGs generally are a silent group. The Medical Board of Queensland has requested a proposal from PMCQ to accredit other IMG positions in the future so we hope that attention will be focussed on IMG training and support. We will await further developments.

That's Queensland wrapped up for the year. I hope that we can offer much to the National forum.

Regards,

Matthew Peters (Chair), Joe Li (Deputy Chair), Melissa Naidoo (Committee member, AMAQ/ASMOFQ), Peter Pilouras (Committee member), Elissa Taylor (Committee member)

South Australia JMO Forum State Report



Feedback on last year's resolutions

Accreditation

The PMCSA has been active in accrediting PGY1 positions with surveys completed in 2 major teaching hospitals. There has been limited involvement in accrediting individual PGY2 positions. JMOs have been encouraged to be involved in accreditation surveys, with a JMO on the team for each survey this year. Accreditation surveyor training is being offered to all interested JMOs. A pre-accreditation survey has also been introduced to get a snapshot view of what is expected of JMOs and what is available to JMOs, and to highlight any issues for exploration during accreditation.

Training for JMOs

There remain some problems with access to sufficient pager-free, protected teaching time, but there have been improvements in a number of hospitals in this area. There have been some much awaited improvements in IT infrastructure in some hospitals.

Being taught how to teach

PMCSA continue to organise 'Teaching on the Run' courses, with increasing involvement of local facilitators, both JMO and senior staff. SA is becoming self-sufficient in running these courses now.

Planning for the workforce

The PMCSA have recently conducted a 'Developing new training positions for interns' think tank run to brainstorm ideas about new intern positions and how to implement them. This involved all levels of stakeholders.

JMO curriculum

JMOs are being more involved in curriculum issues ranging from the PMCSA education sub-committee, individual institution committees, and recent input and feedback into the medical school curriculum. There has been limited discussion about the National Curriculum Framework.

Pre-internship

The pre-internship model has been implemented by the local medical schools in final year. There have been some problems with implementation reflecting a poor understanding of the clinical environment; there is an unrecognised dependence on JMOs to teach/lead/sign off during student internships which leads to increased workload.

State specific matters

- PGY2s have been required to fill more senior registrar positions, sometimes with insufficient support. PMCSA has been looking into these.
- A shortage of JMOs, especially over the busy winter months, led to increased workload and low morale in a number of hospitals. In some cases the hospital RMO society had to devise the strategies to relieve these problems.
- There have been issues with poor IT facilities in at least one hospital

- The PGY2s generated a list of helpful tips and common mistakes learnt from their internship to pass onto the new batch of interns. This was well received and helpful
- JMOs provided feedback about the University of Adelaide curriculum and is discussing the possibility of JMO representation on medical school curriculum committees

JMO Welfare

There have been no sentinel events in SA, but welfare has been highlighted as an important issue. The recent EBA included professional leave and allowance for JMOs not in college training positions, and there have been suggestions to use this for stress management and welfare workshops as 'professional development'.

Michael Edmonds & Kate Hancock
SA State Representatives

PMIT Report for CPMEC 2006**Protected Teaching Time**

Since 2003 Interns, overseas trained doctors, and basic physician trainees have had access to protected teaching time of one hour weekly. This initiative was made between the PMIT and the individual hospitals in Tasmania rather than the Department of Health and Human Services. The agreement has allowed for increased participation in ongoing learning in JMOs. Pager-free time has been accepted well by Hospital administration but has been a difficult concept to accept by ward staff.

**International medical graduates**

The education program for IMGs has been a high point for the PMIT. Weekly tutorials are arranged for IMGs and they are provided with AMC exam based teaching both clinical and written. The PMIT, through the appointment of a clinical medical educator, has been instrumental in the early orientation of new IMGs to the various hospitals, particularly hospital culture, documentation, and the provision of clinical skills. This good work will be continued through a IMG mentoring program where IMGs who have been in the state for a year or more will orient new IMGs arriving in Tasmania. Around 30% of JMO's in Tasmania are IMGs and so the programs started in the state are quite progressive and innovative. We are looking to other states for interest in our pilot programs.

Core training

As well as regular code blue updates and Advanced life support training, PMIT has also looking to include 'Teaching on the Run' within its core training. These sessions are not just aimed at JMOs but senior staff to encourage positive models of teaching at both JMO and medical student levels. As JMOs are often responsible for medical student training, the PMIT has recognized the importance of a support program for the JMO's. In cooperation with the University Of Tasmania School Of Medicine JMOs have access to the full clinical library, online journals, and have been given the teaching on the run manual. There are two formal sessions a year focusing on practical clinical teaching sessions open to any doctors in the public hospitals.

JMO welfare

At this point there is no welfare officer for JMOs, as the MEO fulfills this role. While there have been no incidents at any Tasmanian hospitals that parallel the events in Victoria, there have been instances where a liaison officer would have been helpful. There is no service provided by the lackluster Tasmanian Medical council for doctors in trouble, nor does the government provide one. The model used in Victoria would be the best for our state.

Rural support

There are no rural relief or secondment positions in Tasmania. On the whole the rural hospitals are well resourced.

National curriculum

There has been little talk of the NC in Tasmania. We have an excellent intern curriculum at present developed in Hobart derived from the WA model. We need to see JMO input into this project which is being overtaken by the elders of the CPMEC.

Dr Lizzie Elliott Royal Hobart Hospital

Leigh Dahlenburg Royal Hobart Hospital

Victorian report to the National JMO forum - October 2006

Convenor: Dr J. Oliver Daly

The 2005 National forum was the stimulus for a lot of new activity in Victoria and we feel the National forum is incredibly important in making the JMO voice heard.

JMO representation in Victoria

- Two forums held in 2006 involving 9 and 13 JMOs each
 - First a background to JMO issues, specifically discussing
 - Resolutions of 2005 National JMO forum
 - National Core Curriculum and Medical Education
 - Accreditation
 - Rural sites.
 - Second forum. Discussed the following:
 - Role and organisation of the JMO forum
 - Resolutions
 - The role of the forum is to provide broad representation of JMOs within PMCV with a specific focus on education and training environment issues
 - Actions
 - To formalise the role of the Victorian JMO forum and request active support for forum from each hospital.
 - Improve communication amongst JMOs to raise awareness of JMO issues.
 - Develop relationships with other representative groups, AMA and RMO societies.
 - Plan to hold another JMO forum in December 2006 as follow-up to National forum.
 - National Core curriculum and medical education
 - Resolutions
 - The participants supported the concept of a curriculum framework to serve as a structure for prevocational years to develop generalist medical knowledge, skills and attitudes.
 - The practical aspects of implementation are of significant concern especially the imposition placed on JMOs.
 - There is a need for a formal structure for teaching with full planning, involvement and support of senior staff including consultants, registrars, HMO managers and MEOs.
 - MEO and JMO groups need to cooperate to support one another's efforts to improved medical education.
 - There needs to be a review of the current training and education programmes provided by each hospital
 - Actions
 - Organise a meeting between MEOs and JMOs to discuss organisation of hospital education programmes.
 - Research current training environment of Victorian hospitals.
 - Doctors health – providing a supportive environment
 - Resolutions:

- Hospitals have a responsibility for the safety and wellbeing of their staff and should be held accountable for any management decision that promotes unsafe work practices
- Senior medical staff have a direct responsibility to their junior's welfare and should be training in recognising and dealing with distressed doctors.
- Bullying and harassment is unacceptable and clear processes for dealing with such events should be available to all staff.
- Confidential, independent supports and resources should be provided to all JMOs and be readily accessible.
- Actions
 - i. Research literature and processes already available e.g. Peter Mac, RACGP booklet.
 - ii. Write letter to Hospital CEOs requesting information on OHSE policy covering JMOs including safe working hours, supervision, procedures for supporting distressed or at-risk JMOs and resources available for JMOs.
 1. anonymous phone service
 2. staff support services within hospitals e.g. senior clinical staff, HMO managers, psychologists, mentoring.
 - iii. Write submission to PMCV/VDHP to provide support for production of poster flowcharts to distribute to all hospitals identifying risk factors, symptoms and signs of stress and resources for distressed doctors (how to deal with stress, time management)
 - iv. Examine role of opportunities for clinical debriefing specifically for JMOs.
 - v. Identify means of dealing with bullying behaviour by and at JMOs.
 - vi. Promote safe hours.
 - vii. Publicise attendance at upcoming Doctors Health forum in 2007.
 1. Have one of the organisers of the Doctors Health forum in attendance at the next JMO forum.
 - Liaise with MEOs to promote educational sessions on dealing with stress, time management
- Activities
 - Doctors health forum 2007
- Medical Student influx
 - Actions: To maintain an awareness of areas where increased student numbers are impacting on the demands of the JMO workforce.

Follow-up on resolutions from 2005 National JMO forum

- Accreditation
 - There is robust accreditation process of all PGY1 and some PGY2 positions involving JMOs at every level.
 - While the accreditation process is well organised more has to be done to address issues that arise between accreditation visits and provide a means of communicating these to PMCV.
- Training vs Service provision
 - Protected teaching time is provided however is not enforced and in general rates a low priority in the consideration of JMO demands.

- Further work is continuing as above to quantify the actual amount of protected time provided at each hospital and the supports available to allow JMOs to be able to make the most of the teaching offered.
- Being taught how to teach
 - On the strength of reports from the 2005 forum, the TOTR programme has been introduced across the state with resource and support for the programme.
- Workforce planning
 - Similar issues with other states i.e. currently no guarantee that full-fee paying students will have access to an internship.
 - Significant issues with increased medical student numbers.
- National curriculum
 - As above
- Pre-internship
 - There are currently some pre-internship years rotated out of Monash.
 - Would recommend liaising with AMSA on this issue.

Other significant issues

- Consortia model
 - Similar to the NSW network model, the department of human services is planning to create groups of hospitals i.e. consortia, such that Interns will apply to a consortium and can be sent to any hospital within that consortium.
 - This model is primarily for the purpose of improving workforce distribution i.e. so rural areas are allocated enough interns.
 - There are significant concerns over support and welfare of interns being shunted between hospitals and the continuity of the JMO training environment.
 - Other states should be aware of moves of their health departments implementing these sorts of systems and to absolutely ensure JMO involvement when decisions are being made.
- Enterprise bargaining agreement
 - A great success for AMA on behalf of all Victorian Junior and Senior Medical Staff. There are particular JMO benefits:
 - Maintenance of existing conditions and pay rise.
 - \$1000 annually per JMO to cover educational expenses.
 - Hospital Consultants must have 20% of their time devoted to non-clinical tasks. How much of this goes to teaching activities will be interesting to watch.
- Within PMCV
 - Medical Education Officer programme very effective and we look forward to working closer with them this year to improve education programmes.
 - Medical Clinical Educator programme to support IMGs has been very successful.
- New medical school being opened increasing Victorian medical schools from two to three.
- MJA article on National Core Curriculum by Andrew Gleason, Ruth Blackham (WA) and myself accepted.

WA JMO Committee PMCWA - State Report

Progress on Resolutions of 2005:

- Accreditation
 - Interns and RMOs involved in accreditation process - first two site visits as observers, then deemed accreditation surveyor for future visits
 - Two JMO representatives (one JMO committee, one AMADIT representative) on accreditation committee
- Training for JMOs
 - Push for protected, pager-free teaching time ongoing at individual hospitals
 - Development of IT resources:
 - IT survey conducted over past few months re utilisation of current tools and resources, ways to improve current system, PDA usage by JMOs
 - Survey has been presented as a paper to PMCWA strategic planning meeting, poster presentation at PMEF, also for distribution to hospitals and Health Dept WA
- Being Taught how to Teach
 - TOTR program - individual articles on TOTR program published in MJA (series of topics from teaching a skill, giving feedback and the junior doctor in difficulty) combined into booklet for distribution to junior doctors from 2006 in PMCWA satchel
 - Continued support for TOTR program to be attended by JMOs as PDL leave conducted by each hospital
- Planning for the Workforce
 - Continued qualified support for increase in intern and RMO positions for 2006 (ensure adequate positions, however without allowing unaccredited positions or purely service rotations for interns)
 - Fremantle Hospital
 - Royal Perth Hospital
 - Sir Charles Gairdner Hospital
- JMO Curriculum
 - JMO representation on PMCWA Committees - Executive, Workforce, Accreditation, Education
 - Aiming to create positions for JMOs on Postgraduate Medical Education Committees at a hospital level - committees currently exist with local decision on junior doctor involvement; aim for representative from JMO committee to be able to inform and influence within DPGMEs

State-specific issues:

- Standardised terms
 - Current plan is for standard 5-terms across all three adult tertiary hospitals in WA for 2006
 - Other ideas mooted - 2 block plan (each block consists of 6 months, which can be divided into 2 or 3 terms, allowing for 4, 5 or 6 terms per year with a common dividing point) or 6 terms per year allowing for intern relief positions to accommodate increase in numbers whilst allowing each intern to do ED/gen med/gen surg/specialty med/specialty surg
- Pharmaceutical sponsorship of JMO functions

- Recent call for state-wide PMCWA policy on this issue for adoption by hospitals; variety of standpoints to be discussed
- Planned JMO viewpoint including feedback from committee (bi-monthly meeting) and forum (all JMOs in WA) for combining with PMCWA policy document - with integration of RACP, RACGP ethics codes
- Risk management
 - Letter to DPGMEs to survey current teaching at each hospital of patient safety/risk management/clinical governance/medicolegal issues
 - Discussions with DoHWA safety & quality in health care representative at JMO committee
 - Increasing need for raised awareness by JMOs of medicolegal issues - for further discussion with MDOs and hospitals; full support from Exec, Education committee
- Satchel! PMCWA satchel for all interns starting 2007 with included TOTR teaching tips for clinicians booklet

Accreditation: Current accreditation ratings in WA

1. Three-year Accreditation (Full) is granted when the organisation/unit/department demonstrates compliance with all of the accreditation criteria.
 2. Three-year Accreditation (Provisional) indicates substantial compliance with the majority of the accreditation criteria. PMCWA will require verification by the date determined by the lead surveyor that the organisation/unit/department has addressed recommendations raised by the survey team. Full accreditation will then be granted following receipt of confirmation.
 3. One-year Accreditation is granted when the organisation/unit/department meets many of the standards but there are deficiencies warranting attention. One year accreditation requires written confirmation by the Director of Postgraduate Medical Education (DPGME) of attention to the deficiencies and will require a survey in twelve months.
 4. Six-month Conditional Accreditation is granted when the organisation/unit/department requires immediate action to correct deficiencies. The organisation/unit/department will be re-assessed for continuing accreditation before the expiry of the accreditation period so granted.
- Terms which fail to achieve accreditation status after appropriate review will not be considered suitable for employment of pre-vocational trainees until corrective action is taken.
 - It is a requirement of the Medical Board that all placements for interns be accredited by the PMCWA.

JMO supports:

- Hospitals - MEO, DCT, term supervisor, individual psychological counselling sessions available to JMOs (eg. ITIM - 4 counselling sessions for all staff)
- Medical community - Colleague of first contact, own GP

*Dr Ruth Blackham
Chair, JMO Committee PMCWA, 2006*

NEW ZEALAND REPORT

Accreditation

- Accreditation in NZ is undertaken by the Education Committee of the Medical Council of NZ. 2 JMO representatives are appointed to sit on the committee as “Consumers of Education”. This position has a 2 year tenure. During this time, the JMOs are involved in setting & reviewing accreditation standards/criteria and participate in visiting hospital accreditation teams. They are also invited to sit on panels involved in the reaccreditation review of the vocational scopes of both medical and surgical colleges.
- Wider JMO involvement in the accreditation process occurs in the form of answering a pre-accreditation survey and meeting with the visiting accreditation team to give feedback regarding various aspects of their clinical experience.
- The survey is distributed to all interns a few weeks before each visit, and covers many areas:
 - Run objectives & feedback
 - ED & night cover supervision
 - Meeting facilities
 - Medical library facilities
 - Computer access
 - Support for clinical teaching
 - Leave
 - Informed consent
 - Cultural competence issues
 - Continuity of care
 - Implementation fo the RMO handbook
 - Clinical staff attitudes to teaching
 - Health maintenance for interns
 - Quality assurance activities for interns
- Attendance at these meetings by JMOs is variable throughout the country. This is an area in which support from employers is important to encourage more JMOs to take part in this process.

Training for JMOs

- Weekly ‘pager-free’ protected teaching time is achieved well in most areas within NZ.
- IT resources are generally well developed throughout NZ hospitals. Electronic discharge summaries and ward round notes, although somewhat labour intensive in their implementation in certain areas (especially for the 2-finger typists among us!), these measures have helped free time for educational activities. On-line journals, text books and other resources are also readily available. Unfortunately, problems with slow or lack of computer workstations in some hospitals can be a limiting factor.

Being Taught how to Teach

- Teaching methods are not currently a mandatory part of the Intern education program.

Planning for the Workforce

- Currently, medical training in NZ is based on a 6 year undergraduate model plus 1 year clinical experience or pre-registration year. This is currently under review by Council, with the proposal to increase the internship period, and move to a 5 year undergraduate plus 2 year clinical experience model.

Pre-intern concept

- The trainee intern (TI), or equivalent pre-intern role in NZ has traditionally been a shadowing year, where students are expected to take on 1/3rd of the JMOs workload. This is a very well supported year with clear run objectives and an emphasis on education and broadening clinical experience.

Interestingly, JMOs commonly feedback that greater and earlier exposure to the ‘paper work’ of JMOs during the TI year would ease the transition from the pre-internship.

Lupe Taumoepeau
NZ Representative

Appendix II: Summary of Resolutions

Education & Training

National Curriculum Framework:

- The JMO Forum supports the concept of a National Curriculum Framework
- That JMOs hold a position on all decision-making bodies in the planning of any implementation of the framework
- The Framework be used to guide allocation of specific and adequate funding for teaching time, facilities and learning resources, including regular, protected, paid education sessions
- The priority of the Framework is to promote teaching and learning, and that the framework be used to assess teaching opportunities provided by hospitals as part of accreditation
- The Framework not be used as a barrier requirement to vocational training
- The Framework not be used as a “log book” or check-list for junior doctors to chase
- The Framework not be a pre-cursor to a 2 year internship
- The Framework not replace core terms

JMO Involvement in Medical School Curricula:

- The JMO Forum strongly encourages JMO representation on medical school curriculum committees, especially for clinical years

Accreditation

- The JMO Forum supports mandatory JMO representation on all accreditation visits
- The JMO Forum continues to support the role of the PMCs in accrediting all PGY1 positions
- The JMO Forum further recommends that the PMCs be responsible for accreditation of all pre-vocational JMO positions
 - With an increased focus on PGY2+
 - With consideration of IMG and AMC positions
- The JMO Forum supports the exploration of new position options to accommodate the expanding workforce
 - Positions should meet existing accreditation standards
 - Focus should be on expanding & strengthening existing opportunities (eg PGPPP)

- A pre-accreditation survey is an appropriate tool to involve all JMOs at an institution level
 - There should be a process for ongoing feedback to accrediting bodies from JMOs throughout the period between accreditation visits
 - There be mechanisms to ensure appropriate action based on this feedback

Rural & Remote Positions

- Rural and remote positions must be subject to the same robust accreditation standards as metropolitan positions
- Rural and remote positions need additional supports and innovative solutions to ensure these standards are met

JMO Welfare

- That JMO welfare should form part of the accreditation criteria
- That JMOs should be made more aware of welfare issues and what supports are available
- The JMO Forum supports PMCs coordination of all stakeholders involved in JMO welfare activities
- The JMO Forum endorses the AMA Safe Working Hours Guidelines