The Northern Territory

Junior Medical Officer (JMO)

FORUM

4-5th of October, 2008

Darwin

Report compiled by Cecelia O'Brien
(NT JMO Forum Chair)

Kindly Sponsored by:
NTGPE
Alice Springs Hospital RMO Association
Royal Darwin Hospital RMO Society

Abbreviations

JMO	Junior Medical Officer
RDH	Royal Darwin Hospital
ASH	Alice Springs Hospital
NT	Northern Territory
IMG	International medical graduates
DoHCS	Department of Health and Community Services
EBA	Enterprise Bargaining Agreement
AMC	Australian Medical Council
CPMEC	Confederation of Postgraduate Medical Education Councils
PMC	Postgraduate Medical Council
MEU	Medical Education Unit
DCT	Director of Clinical Training
ACF	Australian Curriculum Framework
GCTC	General Clinical Training Committee
MAC	Medical Advisory Committee

Background

The inaugural Northern Territory (NT) Junior Medical Officer (JMO) Forum was held in Darwin on Saturday 4th and Sunday the 5th of October, 2008. There were 9 representatives with 3 attending from Alice Springs and 6 from the Royal Darwin hospital. The range of postgraduate years of those attending included one PGY1, five at PGY 2 and two at PGY3+. Apologies included the AMA DIT Chair (Alex Maxwell), NSW JMO Forum Chair (Florian Honeyball), WA JMO Forum Chair (Ruth Backham), past president of the NSW JMO Forum (Stephanie Arnold), the RDH International Medical Graduate Representative (Sarah Jolly).

Until this year, each RMO Association had been responsible for advocacy and representation within individual hospitals. There were only two national representative roles through the AMA Doctors in Training and no Territory based approach to JMO issues.

The 2007 National JMO Forum expressed significant concerns regarding the conditions under which the NT JMOs were working and issued a set of strong recommendations. These included the urgent re-establishment of the NT PMC, to recruit and retain clinical specialists and called upon the CPMEC and state PMCs to assist the Northern Territory in developing safe conditions for junior doctors and their patients.

Since the start of the year, there have been significant developments in the Northern Territory including:

- The re-establishment of the PMC
- The recognition of Medical Education and Training as the NT Government's core business
- The NT Medical Education and Training Review and Summit in April, 2008
- The appointment of the DCT at ASH and RDH, the new Medical Education Unit at RDH and appointment of the Medical Education Officer.
- The successful implementation of the new competent pathways for IMGs
- The implementation of changes to the EBA agreement including the professional training allowance

There has been positive movement forward, however, significant concerns remain with regard to chronic workforce shortages and high workloads that directly affect the education, training, supervision and welfare of JMOs in the Northern Territory.

Definition and Aims

DEFINITION of JUNIOR MEDICAL OFFICERS (JMOs): includes but is not necessarily limited to, doctors in training, from PGY1 through to PGY5. This definition includes all international medical graduates and junior medical officers on remote and community placements.

DEFINITION of the NT JMO Forum: A representative body consisting of JMOs (as defined above) from all over the Territory, who advocate and work with Territory and hospital stakeholders for safety, education, training, supervision and welfare for junior doctors in the Northern Territory.

AIMS of the NT JMO Forum:

The aims of the NT JMO Forum were set out at the 1st Forum and are as follows:

1) Facilitate discussion regarding JMO safety, education, training and supervision between JMO representatives from across the Northern Territory

2) Work collaboratively and in partnership with the new NT PMC, hospital administration and NT government along with other stakeholders to address issues affecting junior doctors and assist in planning for the future

3) Ensure collaborative Territory wide approach to advocacy and change for junior doctors

4) Ensure representation for JMOs at the Territory level and at National meetings such as National JMO Forum and Council of Doctors in Training

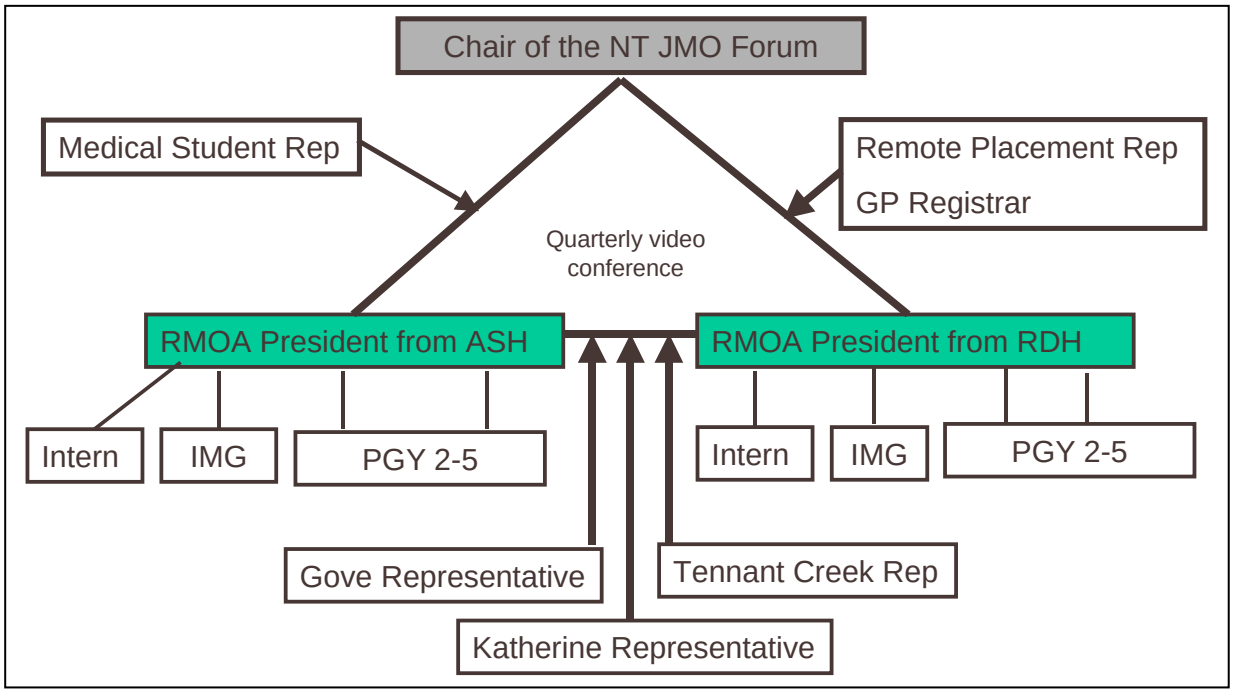
5) The Forum will represent and advocate for International medical Graduates representatives who comprise 33% of the NT workforce. Medical students who are currently studying through the NT Clinical School will be invited to participate in the Forum.

Structure of the NT JMO Forum

The structure of the NT JMO Forum was discussed and set out at the inaugural meeting. There will be a rotating Chair of the Forum, shared between Alice and Darwin on an annual basis. Both RMO Association Presidents at ASH and RDH will then elect an intern, IMG and two PGY 2-5 representatives at the start of the working year. These subcommittees will meet on a regular basis. There are to be quarterly meetings via video conference including all representatives, RMO Association presidents, representatives from the district hospitals (Katherine, Gove and Tennant Creek), medical student representatives from ASH and RDH and remote placement junior doctor and registrar representatives. The Forum will be held twice a year and will rotate between Alice and Darwin.

The Chair will represent the Forum at the NT PMC meetings, meet regularly with DoHCS and attend National JMO Forum meetings. The role of the Chair will be to facilitate discussion between JMO representatives on a regular basis, organise and co-ordinate the biannual Forums and quarterly teleconference meetings and formulate reports and statements on various issues affecting JMOs.

The Presidents from each RMO Association will be responsible for attending regular meetings with their various hospital administration bodies, along with electing members of the JMO Forum and meeting regularly to discuss hospital specific issues.



C/- Cecelia O'Brien, The Registry, PO Box 41326, Casuarina NT 0811, Email: cecobrien@gmail.com, Phone: 0414602853

Key Recommendations and Discussion points

1) Governance

Dr Elizabeth Chalmers from the NT PMC, attended the morning session of the JMO Forum and outlined the role of the PMC, composition of the council and representation of JMOs. The office of the NT PMC is in Darwin City, 5th Floor Officer Tower, Holiday Inn, 116 The Esplanade, Darwin. Shirley Bergin has been appointed the General Manager and Sophie Henry has been appointed the support officer. The first meeting of the NT PMC will be in the middle of November. Letters of appointment and terms of Reference have been sent out to Council Members at the start of October.

Resolutions: The NT JMO Forum

- Supports the re-establishment of the NT PMC and acknowledges with appreciation the 2 positions for junior medical officers on the council.
- Supports the inclusion of PGY2 in the subsequent accreditation processes and encourages the future accreditation process to be extended to include all prevocational medical officers.
- Recommends that the PMC be informed of the current inpatient statistics from the RDH and ASH, in order to assist in monitoring workload for accreditation purposes.

2) Accreditation

The Accreditation of the RDH was discussed in depth at the JMO Forum in October and subsequently via the RDH RMO Society working party. There is the RDH RMO Society position statement and recommendations that were developed in response to the NT JMO Forum and in preparation for the up and coming accreditation committee visit at the end of October (See Appendix One). In comparison with other states, accreditation is in the process of moving to accreditation of PGY 1 and 2 and in discussion with Dr Elizabeth Chalmers, this will be achievable in the Northern Territory.

Resolutions: The NT JMO Forum

- Recognises that while the RDH may meet the accreditation criteria as outlined in the Accreditation report; there are still chronic workforce shortages, high workloads and systemic problems that impact greatly on patient care, junior doctor safety and the delivery of education, training and supervision.
- Recommends that the RDH Accreditation Committee consider assessing each Division or Department (Medicine, Surgery, Emergency, Orthopaedics and Psychiatry) to identify those Departments that remain problematic, while rewarding those departments that have made significant effort and have been receptive to change.
- Supports the NT PMC in the plan for accreditation of both PGY 1 and 2 in the future.

- Emphasises that the Alice Springs Hospital must prioritise preparation for re-accreditation for 2009, in light of the current issues facing the Royal Darwin Hospital.

3) Safety of Junior Medical Officers in the Northern Territory

While there have been significant changes this year, chronic workforce shortages and high workloads have not been addressed adequately, continuing to impact on patient and JMO safety. The discussion on safety centred around the workloads per team, overtime, rostering, supervision and support for JMOs and subsequent affect on reduced education (practice based and access to rostered teaching) and poor supervision (due to heavy workload of the clinicians and surgeons).

Resolutions: The NT JMO Forum

- Acknowledges that in the NT, patient and Junior Medical Officer (JMO) safety is compromised.

- Ensure that any new doctor to the Northern Territory is NOT rostered on a relief term or ward cover, evenings or nights for at least 4 weeks.

- Recognise that every Junior Doctor in the Territory should have mandatory ALS (Advanced Life Support) certification once a year at a minimum. Also to enforce that no junior doctor should do ward cover or district hospital rotation without ALS certification.

- Advises that Royal Darwin Hospital reverse the current weekend **Ward Cover** rostering practices to ensure interns work Saturdays, which are regarded as less complex compared with Sunday.

- In line with the RDH RMO Society and the Medical Registrars, support an additional night RMO position to ensure patient and JMO safety.

4) Workload

At the ANZMET Conference last year, 16 patients per intern was defined as the upper limit for safe practice, ensuring safe working hours and enabling access to education. The average workload in Surgery at the Royal Darwin Hospital has been reported up to three times that the National standard.

Resolutions:

- The NT JMO Forum holds grave concerns about the imbalance between workforce and workload impacting on patient safety and junior doctor medical education and training. This will be exacerbated by the impending population growth and apparent lack of forward planning in the medical workforce.

- Specifically, the NT JMO Forum recommends the:
    - Implementation of a 5th medical team at the Royal Darwin Hospital to reduce the workload of our current medical teams, improving patient safety
    - Unfilled positions in the Territory be filled as a matter of urgency
    - Division of Surgery at the RDH immediately addresses consistently dangerous workloads and chronic workforce issues, which is compromising patient and JMO safety.

C/- Cecelia O'Brien, The Registry, PO Box 41326, Casuarina NT 0811, Email: cecobrien@gmail.com, Phone: 0414602853

- The efforts of the Division of medicine at the RDH are recognised for implementing cultural change in relation to junior doctor and patient safety and education, despite limitations and a paucity of resources.

5) Education and Training

This year, the Northern Territory Government recognised that Medical Education and Training comprised part of their core business. The Department of Health and Community Services and new CEO, Dr David Ashbridge, commissioned an external review and subsequent Summit to examine Medical Education and Training in the NT. One of the most important points highlighted by the review and summit is that high workloads and an inadequate workforce present significant barriers to the delivery of adequate prevocational education and training. Peter Boyce from the DoHCS attended the morning session of the Forum and will be kindly forwarding the formal outcome report from the summit.

The Australian Curriculum Framework was discussed with the recommendation that there needs to efforts made for curriculum development using the framework. Innovative approaches to ACF implementation were discussed including web based intranet curriculum and resources that all JMOs in the NT can access.

Resolutions: The NT JMO Forum

- Congratulates the NTG for recognising Medical Education and Training as its core business. We also note the recent appointments of DCTs, an MEO at RDH and look forward to an MEO in Alice Springs.

- Supports the Emergency rotation as a mandatory core term in PGY1 within the Territory.

- Supports the development of a Territory wide Junior Medical Officer curriculum using the ACF.

- Supports and encourages the implementation of an NT wide medical education and training network utilising information technology to ensure continuity of education and access. This is will reduce replication and system inefficiency.

- Strongly supports the introduction of medical education registrars to contribute to junior doctor education and training at the RDH and ASH.

- Recognises that every Junior Doctor in the Territory should have mandatory ALS (Advanced Life Support) once a year at a minimum. Also to enforce that no junior doctor should do ward cover or district hospital rotation without ALS certification.

6) Supervision

Service delivery has dominated practice in the Northern Territory due to the escalating workloads, inadequate workforce and significant population growth in the last 10 years. As a result, supervision, education and training have been adversely affected. Due to the nature and structure of the Surgical terms, supervision remains a major issue. Registrars have many roles and are expected to be in theatre, clinics and admitting patients, often at the same time. This means that interns are often completing ward rounds alone and managing patients on their own without adequate supervision on the wards.

Resolutions: The NT JMO Forum

- Recognises that workload impedes adequate supervision and support and until this is addressed, inadequate supervision will remain a major accreditation issue.
- Recommends that there needs to be structured supervision with frequent monitoring of JMO rotations.
- Recommends that the supervision role and responsibilities should be updated to include registrars in the assessment of JMO competencies.
- The relief term remains problematic and unsupported. This term needs to be addressed as a matter of urgency to provide improved supervision and monitoring to ensure junior doctor and patient safety.

7) Assessment and Evaluation

Term assessment and evaluation have been less a priority in the Northern Territory due to the domination of Service delivery.

Resolutions: The NT Forum

- Recommends that formal assessments with clinical supervisors for every JMO are mandatory and need to occur at the start, middle and end of the term.
- There needs to be a structured assessment form and pathways to assist JMOs who are not meeting requirements or who are performing poorly.

8) Representation

Clear and defined roles were set for the NT JMO Forum along with introducing and strengthening partnerships with key stakeholders. The key role of the NT JMO Forum is to enable a united Territory voice and representation, consultation and collaboration. Peter Boyce from the DoHCS attended the forum and supported the institution of regular meetings with the JMO representatives.

Resolutions: The NT JMO Forum

- Supports the collaborative partnership and consultation with JMOs through:
    - Quarterly meetings with the Medical Superintendent
    - Quarterly meetings with Dr David Ashbridge and Peter Boyce (DoHCS)

- Recommends that a JMO representative is required for the following committees:
    - JMO Administration
    - PMCNT - 2 representatives are on the Council
    - Hospital Administration
    - General Clinical Training Committee (GCTC) – 2 already in place
    - Medical Advisory Committee (MAC) – 1 representative is in place

9) EBA for Junior Medical Officers

The EBA was outlined and its applications to monitor and ensure standards for patient and doctor safety were discussed. Salary issues were raised as important issue affecting doctors Territory wide including the delayed payment of overtime and penalties along with the frequent errors and difficult interpretation of the NT pay slips. Leave entitlements, the professional training allowance were also discussed. The access to myHR to for overtime approval was recommended (currently JMOs use paper overtime forms, requiring consultant signatures for approval) in line with other public service employees in the Territory.

Resolutions: The NT JMO Forum

- Demands an audit of the payroll system to address persistent errors in pay and entitlements as outlined in the EBA.

- Supports the implementation of a pay system that is clear, accurate and auditable.

- Recommends further investigation for lack of pay progression for IMG doctors past Level 4.

- Requires equity in access to 'myHR' to enable electronic rosters, time variance and leave application to be granted to JMOs to be in line with the rest of the public service in the NT.

10) JMO Administration including Term allocation, rostering, welfare, support and recruitment

The lack of a functional JMO Administration unit and support staff, particularly at the RDH is significant. In other states, the JMO Unit monitors and regulates JMO working hours and is responsible for an equitable roster, monitoring shift swaps and overtime. In relation to term allocations and applicability to career pathways, there were no defined or transparent processes and allocations are often inequitable. This was highlighted as an important barrier to the retention of our junior doctors in the Territory. Pathways into generalist and specialist training are not well defined and complicated by high workloads and service delivery rather than focus on education and training. A recent report from Cam Bennett regarding the RDH Medical Roster Review was welcomed and supported. Discussion surrounded the potential of electronic rostering and supported the common rostering through the JMO Unit rather than individual departments.

Resolutions: The NT JMO Forum

- Congratulates the introduction of the 'Critical Care Year' at the RDH
- Recommends that the JMO Administration Unit is responsible for and oversees all JMO rostering, welfare, recruitment and term allocation. Electronic rostering will facilitate this.
- Recognises the importance of JMO welfare and plans to adopt programs from other states.
- Demands equity and transparency with the term allocation for junior doctors along with the consideration of career pathways and pre-requisite training requirements.
- Avoid BIAS and inequity for JMOs who want to undertake a generalist pathway compared with specialist pathways. In addition, vocational status and international medical graduates should not affect the equity of term allocation.

11) IMG specific issues

Two IMG representatives were present at the NT JMO Forum, Dr Perthidia Mango from ASH and Dr Emily Elwell from the RDH. Dr Sarah Jolly who was the IMG representative was unable to attend. Through the efforts of Dr Alan Ruben and his team, the Northern Territory is a leader in the implementation of the new AMC pathways and in the supervision of IMG doctors. Discussions centered around the safety for IMGs and equity of training opportunities. The Forum are concerned that IMGs often arrive from overseas and commence work on nights or relief terms with little to no orientation to the hospital.

Resolutions: The NT JMO Forum

- Congratulates the NT on the proactive approach to the IMG registration
- Advocates for timely and adequate orientation and safety of rotations that precludes relieving from being the first rotation.
- Requests the assessment of the adequacy of supervision under the new AMC arrangements.

- Ensures that there is equity in training opportunities compared with Australian graduates.

12) Orientation

Orientation is an important part of initial intern and resident training and its role in accreditation was discussed.

Resolutions: The NT JMO Forum

- Advocates for increasing the involvement of PGY2-5 in the development, applicability and running of the orientation program for all new JMOs.

- Recognises that the majority of our patients come from an indigenous background and the current cultural orientation does not adequately prepare junior doctors for this. We need a high quality and more intensive cross-cultural program, involving indigenous stakeholders.

13) District hospitals in the Northern Territory

District hospitals provide JMOs with a unique experience with a strong emphasis on understanding and appreciating the culture of a small indigenous community. However, there are significant concerns regarding poor supervision, clinical guidance, governance and support. Unfortunately, representatives who have worked in Gove and Tennant Creek were unable to attend. However, Katherine District Hospital was discussed with concerns regarding supervision, clinical governance and implications of a poorly supported system complicated by the lack transport of acute patients at night.

Resolutions: The NT JMO Forum

- Holds significant concern for JMO rotations to peripheral hospitals in the absence of clinical support and governance structure.

- Opposes the proposal of interns rotating through the district hospitals to alleviate the chronic shortage of doctors.

- Recommends that JMOs rotated to peripheral hospitals should be at least PGY2 or greater and have completed, as a minimum, an ICU or anaesthetic term AND an Emergency term. Current ALS certification should be mandatory.

- Recommends that IMGs complete a minimum of one rotation at RDH prior to district hospital allocation.

14) The Vision for the Future

Dr David Chapman (DCT at RDH) was invited to speak about the 'Vision for the Future' for the Northern Territory. The RDH has added four additional intern full time places in order to gradually adapt the infrastructure to accommodate the new wave of medical graduates in the next 5 years. Other challenges include the uncertain supply of IMGs, particularly with the new guidelines and change in structure of assessment. Ideas from the discussion included the electronic tracking of JMO careers and the impact of changing to a five term year.

Resolutions: The NT JMO Forum

- Supports the additional increase in intern places at the RDH in preparation for the future increase in medical graduates.

- Supports the up and coming review by Professor Roeser with regard to the infrastructure and preparation required to accommodate the influx of new medical graduates over the next 5 years.

Appendix One

Royal Darwin Hospital

Resident Medical Officers' (RMO) Society
PO Box 41326
Casuarina, Northern Territory 0811

Until the chronic workforce and workload issues are resolved, the RMO Society can not support the full 3 year accreditation of the Royal Darwin Hospital for Postgraduate year one.

INTRODUCTION

On behalf of the Royal Darwin Hospital (RDH) Resident Medical Officers' Society, we would like to thank you for this opportunity to submit our response and recommendations for Intern Accreditation.

The Northern Territory (NT) remains a popular destination for junior medical officers (JMOs) due to the geographical challenges in delivering healthcare, tropical medicine and infectious diseases, unique case mix of patients and pathology, indigenous health and welfare issues and the national role of the Royal Darwin Hospital in trauma and disaster management for Australia and surrounding countries.

In recent years, escalating patient loads without a concomitant increase in medical officer staffing levels or improvements within clinical and administrative systems, the reputation for prevocational training excellence diminished substantially. This trend first became evident in 2003 with the RDH for the first time being granted conditional registration in light of concerns with regards to workloads and supervision within particular Divisions. The loss of the Northern Territory Postgraduate Medical Council (NT PMC) in 2004 contributed to the inadequate governance required to implement the accreditation recommendations. The degree to which prevocational support and training had deteriorated was highlighted in 2007 by the NT Medical Board limiting intern accreditation to conditional one year.

Since the 2007 accreditation report, there has been significant effort put forth to address many of the highlighted deficiencies. The RDH RMO Society acknowledges that the RDH has made substantial steps within the boundaries of limited resources.

These improvements include:

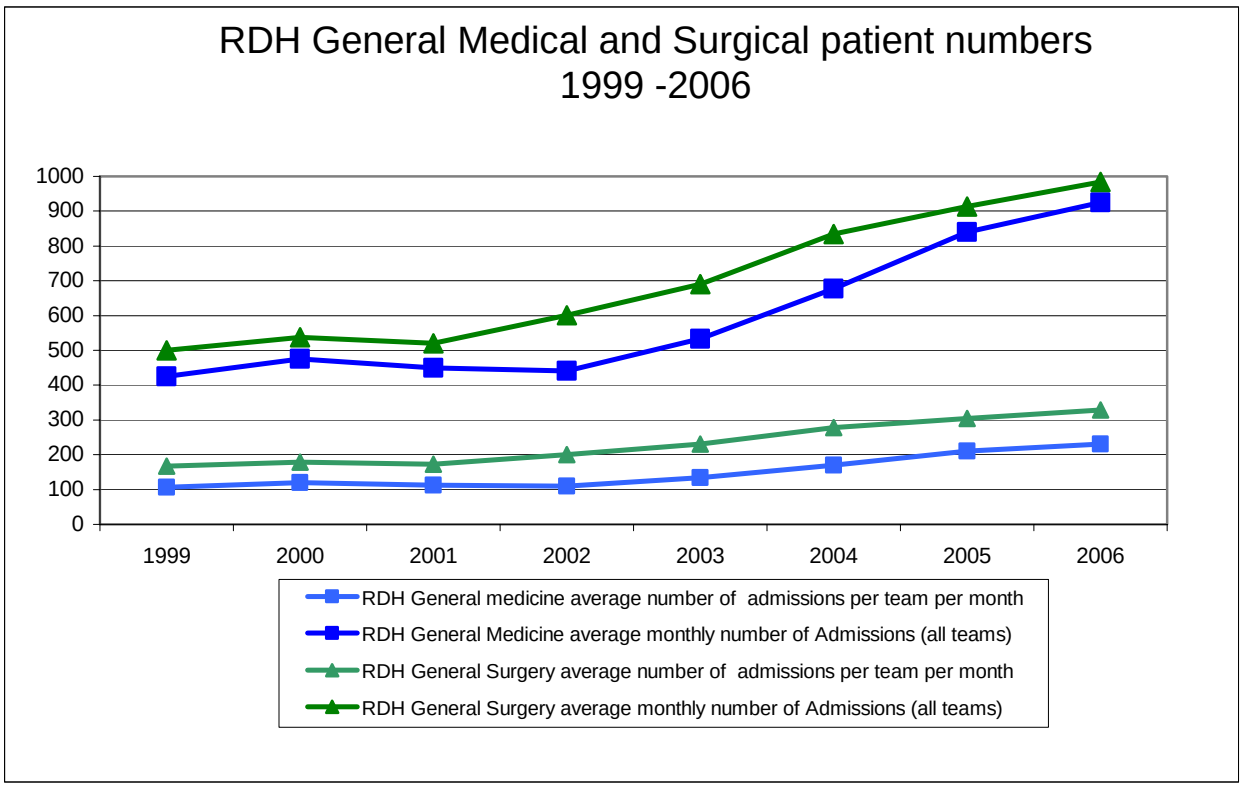
- The particular departments and consultants who have maintained or improved conditions pertaining to intern accreditation.
- The work and enthusiasm for the upgrading of JMO education and training facilitated by the DCT and the newly established Medical Education Unit (MEU) and medical education registrars.
- The establishment and operation of the IMG AMC accreditation pathway in the Northern Territory.
- The provision of professional training allowances in the recently agreed upon enterprise bargaining agreement.
- The acknowledgement of Medical Education and Training as part of the NT Government's core business

WORKLOADS AND STAFFING

In spite of the numerous improvements over the past 10 months, there has been a fundamental failure to address the workload issue. This issue was raised in the 2003, 2006 and 2007 accreditation reports along with Cam Bennett's report on rostering, the 2007 internal review of the Division of Medicine and the NT Medical Education and Training Review. Due to the ongoing high workload and chronic workforce shortages, patients and staff are being placed in increasingly difficult and dangerous situations.

We maintain that the high workload both directly impairs the ability of medical staff to provide safe and effective patient care while also undermining the ability of the hospital system to achieve ideal education and training outcomes. Senior clinicians are unable to dedicate time to training and JMOs find themselves unable to attend teaching sessions due to clinical responsibilities.

The graph below depicts annual monthly patient separations for the RDH General Medical and Surgical units from 1999-2006. This data was obtained from the NT Government health database in 2007. It illustrates the marked increase in workload over the past number of years.



Repeated attempts made by the RDH RMO Society to obtain updated workload data to present in this report were impeded. It is the opinion of the RMO Society that an open and transparent approach to monitoring workload levels is the only way to ensure ongoing patient and medical officer safety.

Without the provision of additional resources and staff, there are serious concerns regarding the sustainability of many of the recent positive changes at the RDH. In light of these concerns, the RMO Society can not support the full, unconditional accreditation of the Royal Darwin Hospital.

DIVISION AND DEPARTMENT ACCREDITATION

At the recent NT JMO Forum, the JMOs discussed the conditions of relevant divisions or departments individually. Due to quite significant disparities, there was a consensus to make accreditation recommendations on a divisional or departmental level. This would allow future scrutiny to be applied to the areas of greatest concern.

1. **Department of Emergency Medicine – consistently the most organised, well supervised term at RDH**
    a. Supervision directly with consultants and registrars
    b. Excellent teaching program on Thursday morning – 4 hours protected with a mixture of Consultant, Registrar and resident teaching along with skills sessions and simulation.
    c. Rostering – frequent modifications and evaluation
    d. Appointment of a Medical Education Registrar to commence in 2009, which we strongly support.
    e. Achieved a good balance of service and training requirements with ongoing resource constraints.

2. **Division of Medicine – marked improvements made in the last year**
    a. Successful implementation of its policy equalizing patient numbers across the 4 medical teams with average patients per team to be between 15 and 20.
    b. JMO training and support has improved significantly with commitment made to upgrade and solidify training during the medical rotations.
    c. URGENT need for additional 5th medical team and at least two JMOs per team as recommended by the internal review in 2007
    d. Increasing need for additional administrative support
    e. Ongoing rostering issues which have recently been discussed and proposal for One Staff is being investigated.

3. **Orthopaedics – improved since 2007**
    a. We would like to acknowledge the efforts of Dr Mehta, who has made marked improvements to the term.
    b. Our concerns relate to the non-sustainability in maintaining these standards in view of significant senior staff shortages and ongoing high workloads.
    c. Good orientation and formal teaching
    d. Supervision is reportedly good: registrars usually easily contactable via the afternoon clinics
    e. Practice based learning with supervision in clinics (but remain busy)
    f. Ward workload significantly high but shared effectively between the interns
    g. Ongoing variable support and supervision on the wards, particularly with regard for medical issues

4. **Department of Surgery – remains poorly supervised with unsafe, high workloads**
    a. Increase opportunities in trauma related surgical training and the improved access and organisation of courses such as EMST, EMSB, short course in Trauma and the MIMMS.
    b. Many JMOs are concerned for patient safety, are over stretched and feel incompetent as a direct result of management issues and inadequate supervision
    c. Excessive and unsafe workload – frequently 40 patients per intern and wide variation between teams
    d. Ongoing staffing shortages at all levels
    e. Supervision - Consultants infrequently visit the ward and registrars are frequently unavailable to give assistance and maybe caught up in theatre for extended period of time
    f. Floating RMO position was created to assist interns with their daily tasks. However interns have made complaints to senior staff that these residents are frequently in theatre or acting as junior registrar rather than doing supporting the interns on the wards, also there are concerns that these residents have not always shared work equally between teams.
    g. Poor Management - Registrars maybe required in theatre, at clinic, and on a post take ward round simultaneously. Invariably, ward work that is compromised and supervision of interns drops. Another factor that reduces registrar supervision in surgery is the cycle of nights that constantly takes two registrars from different teams, also schedule leave leads to their being effectively only a little over one registrar per team at any one point in time (recently changed to 2 registrars per team).

5. **Psychiatry and Pediatrics**
    a. No concerns were raised

Our Recommendations for Divisional Accreditation

- **Emergency**
    a. Full accreditation for 3 years
- **Division of Medicine**
    a. 2 years accreditation based on the improvements made over the past year and ongoing concerns regarding high patient loads and inadequate staffing at all levels.
- **Orthopaedics**
    a. 1 year accreditation based on the fact there is only now two consultants to supervise, educate and train JMOs and registrars
- **Department of Surgery**
    a. 6 month provisional registration
    b. Changes to be implemented prior to the start of 2009 intern year with 6 monthly assessment points
    c. Immediately address workforce shortages in Surgery, which are impacting on high workloads and are compromising patient and junior doctor safety as a result.
        - Additional 2-3 registrars (one extra night Registrar to cover RAPU and ward), one relieving and one permanent night Registrar on roster
        - At least an Intern and Resident on each of the 4 surgical teams
        - Consultant recruitment

C/- Cecelia O'Brien, The Registry, PO Box 41326, Casuarina NT 0811, Email: cecobrien@gmail.com, Phone: 0414602853

Accreditation Recommendations from 2003-2007 and the current status at Royal Darwin Hospital

This table highlights the opinion of the RDH RMO Society with regard to the current status regarding each accreditation recommendation

Category	Year	Accreditation Recommendation		Comment
Hospital Orientation	2006	The hospital should ensure that all JMOs receive a comprehensive orientation regardless of when they commence at the hospital.	✓	Good improvements – formal program that was well received this year. Many residents started on nights or relief without formal orientation throughout the year. Often IMGs without specific orientation, start nights or relief terms. Deficits – cross cultural session, myHR, IMG and mid term program for new JMOs
	2006	Orientation content should be developed for the specific needs of the IMGs.	✓	Acknowledge that Alan Ruben has done a lot of work with implementing the new competent pathways for AMC along with changes made to the orientation program.
	2006	A follow-up orientation meeting should be held to allow questions to be answered.	✓	Occurred this year
Term Orientation	2006	Term orientation should be provided at the commencement of all terms.	✓	Highly variable Medicine and ED have an orientation packs, formal 4 hr program in ED Surgery – poor Ortho – apparently thorough
	2006	Term orientation should be the responsibility of term supervisor (a senior consultant doctor), but if delegated to other staff the content of the orientation should be determined by the term supervisor.	✓	
	2006	The hospital should establish a process for skill verification at the commencement of each term with a special focus on skills particular to the term.	✓	Surgery implemented skills verification but there has been no acquisition of new skills when comparing start and end of term skills.
Supervision	2006	The hospital should regularly review and assess the adequacy of supervision and take appropriate action to rectify any deficiencies identified.	✗ Due to	Surgery remains poorly supervised in conjunction with very high workloads. Emergency – good supervision. Medicine – well supervised. Paediatrics,

	2006	The hospital should ensure that a culture of supervision is engendered amongst senior staff, in particular at the registrar level.	Surgery	Psychiatry and have good supervision and support pathways. High workload is impacting on ability of seniors to adequately supervise interns.
	2006	The hospital should help JMOs to identify their limitations and to acknowledge when help is required.	✗ Due to Surgery	Surgical interns know their limitations but ask for help from other residents and Medical Registrars due to poor supervision. Repeatedly complaints of high workloads and poor skill development are not addressed.
	2007	RDH must urgently make its own review and assessment of the adequacy of supervision and take appropriate actions consequent to the assessment to ensure the adequacy of JMO supervision.	✗ Due to Surgery	Dept of Surgery has been contacted on many situations regarding the poor supervision and workload impact.
Balance of Service and Training	2006	The hospital should monitor and evaluate training and workload in and across all terms and take appropriate action to rectify any inequities identified.	✗	There has been little progress in this area and we attempted to include up to date workload figures in this report, which was fraught with difficulty.
Formal Educational Programs	2006	The hospital should evaluate the adequacy and effectiveness of the formal education program in meeting the educational needs of all JMOs and take appropriate action to rectify any deficiencies identified.	✓	80% aligned with the ACF but there has been little curriculum development and content change to date. The RDH ED training program continues to be of high standard.
Practice-Based Teaching	2006	Practice-based teaching in the surgical terms needs to improve.	✗	For interns on surgical teams is sparse and irregular. There is little to no theatre experience for interns.
	2007	The hospital must evaluate the adequacy and effectiveness of practice-based teaching across all terms and take appropriate action to rectify any deficiencies identified.	✗	No formal evaluation process
Clinicians as Teachers	2006	The hospital needs to ensure that all doctors who are responsible for teaching are aware of this responsibility to provide effective clinical teaching.	✗	Highly variable and restricted by the high workload at RDH.
	2006	The hospital should train and evaluate doctors in their role as teachers.	✓	There has been a course this year for train the trainers aimed at clinical staff, registrars and JMOs. There is no evaluation structure.
Assessment and Feedback	2006 and 2007	The hospital should ensure that all term supervisors provide formal assessment and feedback using the agreed form at mid-term and at the end of the term. This recommendation and the comments in the previous report are still relevant. There was no evidence of any change since the review in October 2006. The provision of assessment and feedback remains	✗	Feedback remains variable and frequently mid term and end of term assessments are done together at the end of term. Some Consultants are proactive with the assessments processes whereas others require juniors to remind them several times that assessment forms need to be done. Not all Consultants use the

		inconsistent across the terms and within the terms. This needs to be addressed.		opportunity to provide feedback constructively.
Junior Medical Officer Management	2006	The hospital needs to ensure that claims for payment of un-rostered overtime are paid in accordance with the award instrument.	✗	Payment of unrostered overtime has generally increased. JMOs pressured by senior not to submit claims in some units, and therefore we are recommending to use the online unrostered overtime submission rather than the current paper trial with interns having to find and individually hand in their claim.
	2007	The hospital must urgently staff and implement the proposed medical administration structure and assess it for effectiveness.	✗	No significant change to Medical Administration and Dr Vino remains part time. Implications for leave/rosters and recruitment are currently under discussion.
Junior Medical Officers with Special Needs	2006	The hospital should identify the needs and provide support for JMOs with special needs, especially the IMGs.	✓	Implementation of new competent pathways has occurred and the is NT leading the way in this area
Junior Medical Officer Advocacy	2006	The hospital should review and amend the processes for JMO representation appropriate to the needs of the JMOs and the needs of the hospital.	✓	NT JMO Forum established and first meeting on 4-5th of October. MAC rep, AMA DIT, 2 JMO positions on the NT PMC. Rep on RDH general training committee. Advocating for more representation with DoHCS and Hospital admin
Director of Clinical Training	2006	The hospital must appoint a new Director of Clinical Training (DCT) as a matter of high priority.	✓	This role has been place for one year. Due to amount of work needing to be covered, and for availability for JMO's to access DCT this position needs to be full FTE
	2006	The hospital should review the adequacy of the secretarial, administrative and financial support for the DCT and take appropriate action to rectify any deficiencies identified.	✓	A new administrator officer has been appointed recently from NTG.
Supporting Junior Medical Officers	2006	The hospital should review the effectiveness of its support programs and take appropriate action to rectify any deficiencies identified.	✓	There are some support pathways that exist for JMOs outlined in orientation. Semi-structured meetings with DCT but many interns feel that this method of feedback and support is inadequate.

Physical Amenities	2006	The adequacy, comfort and privacy of the overnight accommodation should be assessed and improved.	✓	Accommodation remains poor however NTG has recently committed to improving the staff accommodation. Adequate overnight accommodation/rest facilities are not available for staff on night shifts.
	2006	The adequacy, comfort and general amenity of the long-stay accommodation should be assessed and improved.	✗	The staff village stipulates only a 3 month stay for JMOs although the registrars have long stay options
	2006	The hospital should review the rule that excludes some NT Clinical School JMOs from living in the 'village' to ensure equity of access to accommodation.	✓	As far as we know this occurs sporadically.
	2006	The hospital should provide a dishwasher in the Noonan Room.	✓	This was fitted in 2006.

Appendix Two – Terms of Reference

Purpose of the Committee

- Facilitate discussion regarding JMO safety, education, training and supervision between JMO representatives from across the Northern Territory

- Work collaboratively and in partnership with the new NT PMC, hospital administration and NT government along with other stakeholders to address issues affecting junior doctors and assist in planning for the future

- Ensure collaborative Territory wide approach to advocacy and change for junior doctors

- Ensure representation for JMOs at the Territory level and at National meetings such as National JMO Forum and Council of Doctors in Training

Role and Responsibility

Advisory functions:

- To work in collaboration with NT PMC and work in partnership and in consultation on relevant issues affecting prevocational training and education.
- To liaise with other States on National issues affecting prevocational training and education and advise the NT PMC on these issues
- Advocate for the interests of JMOs and promote training and disseminate information from teaching bodies.

Operational Functions:

- To promote awareness of JMO Forum issues to all Territory JMOs and external organizations
- To action the National JMO Forum resolutions

The Forum will represent and advocate for International medical Graduates representatives who comprise 33% of the NT workforce. Medical students who are currently studying through the NT Clinical School will be invited to participate in the Forum.

Membership

The JMO Forum will consist of the two RMO Association Presidents at ASH and RDH and an intern, IMG and two PGY 2-5 representatives will be elected at the start of each calendar year. There will also be representatives from Gove, Tennant and Katherine District hospitals.

Terms of Appointment:

This is a one year appointment for the Chair with extensions available. Each calendar year, elections for each Forum position will occur via each RMO Association. The intern position will be elected during Orientation. The IMG, 2 positions from PGY 2-5 will be elected at the Annual General Meeting of the RMO Association each year. Expressions of interest will be sent to the District hospitals.

Meeting attendance expectation:
The Forum will be held twice a year and will rotate between Alice and Darwin. Teleconference arrangements will be made for those who are unable to attend. In the event of a representative is unable to attend a meeting, a proxy from the same Network must physically attend in their place and will have equivalent voting rights at that meeting. There are to be quarterly meetings via video conference including all representatives, RMO Association presidents, representatives from the district hospitals (Katherine, Gove and Tennant Creek), medical student representatives from ASH and RDH and remote placement junior doctor and registrar representatives. The subcommittees from each hospital (as shown in the Diagram from the report on page 5) will meet regularly in association with the RMO Society.

Chair Appointment:
The election of the new chair will occur by the Forum at the 1st annual meeting at the commencement of each calendar year. The Past Chair is also invited to remain on the Forum for one year. If the Chair is unable to attend a NTPMC meeting, the corresponding RMO President is required to attend on place of the Chair.

Name and Position	Dr Cecelia O'Brien
Appointed	February, 2008

Responsibilities include: elected as a representative on the NT Postgraduate Medical Council for the duration of their term as Chair.

Support Officer:
The NT PMC is responsible for providing secretariat support to the NT JMO Forum. This role includes preparation and distribution of documentation for each meeting, liaise with members as required, overseeing the documentation of minutes meetings.

Name	Sophie Henry at the NT PMC Office
Appointed	October, 2008

Conduct of Meetings

Quorum	is 50% + 1 in attendance
Voting	As necessary

Where a proxy attends the meetings on behalf of a full member, the proxy will be entitled to the same voting rights as the member.

Rules
- Where the Chair resolves to hold a vote in order to clarify the resolution of the Forum, the Chair is to vote only when a vote is required.
- The Chair will declare to the Forum that the vote is tied that they will exercise a casting vote

Frequency of meetings	Twice a year
Location	NT PMC Office 5th Floor Officer Towe, Holiday Inn

116 The Esplanade, Darwin

In Alice Springs – TBA

Standing Agenda Items

1. Procedural Business
   1.1. Apologies
   1.2. Conflict of Interest
   1.3. Confirmation of Minutes
   1.4. Business arising
   1.5. Standing items
   1.6. Current Major Issues affecting Education and Training
   1.7. NT PMC update
2. New Business
3. Other Business
4. Meeting Closed
5. Next Meeting

Reports
Reports from the Forum Meetings will be provided to the NT PMC, Forum members, National JMO Chair and accessible to other organisations advocating for JMOs issues such as AMA CDT and RMO Associations.

Distribution of minutes
Minutes and action notes will be distributed via email to all members within two weeks of the meeting.

Action notes will be documented within the minutes and those responsible for actions will be recorded and be expected to undertake the agreed actions.

Record Keeping
Minutes will be taken by the NT PMC will hold a complete set of all documentation for 7 years.

Committee Formally reports to:
The JMO Forum is an official body of the Northern Territory Postgraduate Medical Council (NTPMC)

Evaluation of Committee and Terms of Reference

Frequency of Evaluation
Terms of References to be reviewed annually and as required.
Date of Last Evaluation: October 4-5th, 2008
Date of Next Evaluation: February, 2009

For information, please contact the NT JMO Forum:

Cecelia O'Brien
Resident at RDH
NT JMO Forum Chair

The Registry
PO Box 41326
Casuarina, NT 0811
E: cecobrien@gmail.com
P: 0414602853

Dr Sam Goodwin
Resident at ASH
AMA DIT Representative
RMO Soc Co-convenor

Dr Paul Secombe
Resident at ASH
RMO Soc Co-Convenor

Dr Rob McNamara
Resident at RDH
Past AMA DIT Rep
RMO Society Vice President

Dr Daniel O'Neill
Intern at RDH
AMA DIT Representative

Mike Purvis-Smith
GCTC Rep
President of RDH RMO Society

Dr Emily Reid
Resident at RDH
Acting Treasurer of RDH RMO Society

Dr Samantha Bigg
Resident at RDH
GCTC Representative

Dr Perthidia Mango
Resident at ASH
IMG Representative at ASH