

### Outline

- Getting in to the specialist system
- Initial issues and support
- Ongoing CPD and support
- Mentoring

---

---

---

---

---

---

---

---



### Recruiting rural specialists

- Proposal to use a standard entry exam for all—including a broad AMC exam
  - Australian candidates don't have to pass it
  - Specialists who haven't done surgery for years and won't ever, will have to spend time/energy/money revising material...for what?
  - A basic level specialty exam would be more appropriate (e.g. ABIM 1 day recert exam)

---

---

---

---

---

---

---

---



### Registration/Application for Fellowship

- Several rural physicians have not understood the differences and issues around "area of need" registration, "specialist registration" and Fellowship
- E.g. they apply for AON and have 2 years peer review, then they apply for Fellowship and are told they need to reapply, take exams, etc. when their performance has been suitable for Fellowship
- Recommendation: Flow diagram, streaming

---

---

---

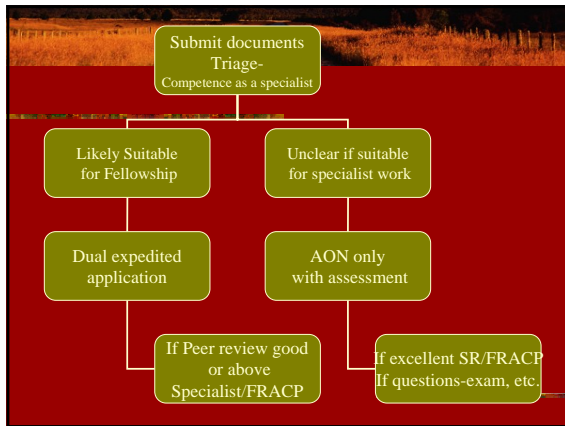
---

---

---

---

---




---

---

---

---

---

---

---

---

### Overall support

- Orientation to major issues
- Clarify registration/specialist processes
- Consider supporting OSPs to work in medical units in metro centres for 1-2 weeks so that they can understand the system
- Offer/mandate refresher ACLS course or simulation skills training as part of that 1-2 weeks
- The logistics of this are an issue (housing, etc.)

---

---

---

---

---

---

---

---

### Registration hurdles

- I made 5 trips (5 hours RT) to Melbourne over 3 months to get state, HIC, etc. registration accomplished
- Facilitate single 2 day visits to do all document sitings, etc. in each capital city or in Sydney associated with the college (would be problematic with state reg?)

---

---

---

---

---

---

---

---

### Two week orientation-plus weekend on call (day rounds, etc)

| Mon                         | Tues                        | Wed                                    | Thurs            | Fri                         |
|-----------------------------|-----------------------------|--|------------------|-----------------------------|
| REG/Doc<br>ument            | Hospital<br>unit-<br>Rounds | Hospital<br>unit-<br>Rounds            | Clinics<br>day 1 | Hospital<br>unit-<br>Rounds |
| Hospital<br>unit-<br>Rounds | Hospital<br>unit-<br>Rounds | PBS/Me<br>dicare-<br>reg issue<br>time | Clinics<br>day 2 | Clinical<br>skills day      |

---

---

---

---

---

---

---

---

### Australian hospital contracts

- Two specialist physicians were hired by a hospital on contract
- Contracts were difficult to interpret
- The specialists later discovered that they were being paid less than 30% of the rate local VMOs were earning for the same work on call weekends
- New OSPs need counselling available re fairness of hospital contracts and how to work in the Australian hospital system
- Previously DIMIA required a single employer and would not allow dual contracts (e.g. with a hospital and RCS)—this has now been overcome on special occasions

---

---

---

---

---

---

---

---

### Medication issues

- Learning proprietary names and which drugs are available/not available in Australia is relatively straightforward if time consuming
- I work in two clinics and was/am much faster in the clinic that has "Medical Director" because of the prescribing support
- Understanding "restricted", "authority" and SFX scripts, etc. took some time
- Recommend e-MIMS or equivalent to all specialists (handheld products avail)

---

---

---


---

---

---

---

---



## Language and scientific units

- Language, abbreviations and spelling are an issue (GORD vs GERD, bung, etc)
- Units/result interpretation not a huge issue except for speed and possible mistakes—but despite improved laboratory notification of abnormal results and provision of reference ranges this might be an issue for some
- All specialists should provide normals (e.g. on echo reports provide normal PA pressures, AS gradients, etc)

---

---

---


---

---

---

---

---



## Accessing Metro Consultants

- Huge issue-not knowing people and the alternatives slows me down significantly
- I mainly rely on ringing the hospital/registrar but this takes a lot of time and effort when you don't know specific people
- Recommend : College put together or maintain a book/webpage for each capital city? Is this too complicated/expensive?
- Recommend: Central referral systems (as for paediatrics) would be enormously, enormously helpful

---

---

---


---

---

---

---

---



## Initial collegial support

- Continue current peer review processes
- Conflict of interest with support role
- Assign separate mentor/support person
- Recommend UpToDate© to all newly rural specialists
- Ask candidate and mentor to assess for procedural revision needs, e.g. to revise central lines or intubation
- Provide opportunities, mentoring for such activities
- Require CPD points for AON/specialist positions for Fellowship

---

---

---

---

---

---

---

---



## College meetings

- Invite new rural specialists at registrar rates to the college meeting in their first 2 years in Australia
- Have special sessions for new rural docs
  - Advanced skills-portable simulation
  - Practice and information support
- Advantage to college- builds membership and collegiality
- Consider 1 rural specialists meeting every 2 years at an RCS

---

---

---


---

---

---

---

---



## Challenges for learners

|                   | Average Retention Rate |
|-------------------|------------------------|
| Teach others      | 80%                    |
| Practice by doing | 75%                    |
| Discussion group  | 50%                    |
| Demonstration     | 30%                    |
| Audiovisual       | 20%                    |
| Reading           | 10%                    |
| Lecture           | 5%                     |

National Training Laboratories, Bethel, Maine, USA

Engage students

---

---

---


---

---

---

---

---



## CPD for rural specialists-1

- Conferences are valuable for networking and doctors prefer to go to meetings than to do videoconference sessions (Gjerde, Acad Med, 1999)
- Didactic conference sessions do not change practice (Wolf, JAMA 2002)
- Recent studies show that interactive web sessions and virtual patient sessions with asynchronous discussion are as effective in pre-post test settings as traditional methods (Midmer, JCEHP 2006; Curran, Acad Med 2006; Coma del Corral, MIME 2006)
- No long-term outcome studies exist

---

---

---


---

---

---

---

---



### CPD for rural specialists-2

- Teaching enhances the effectiveness of CPD! (Flores, Fam Med, 2006)
- Teaching improves outcomes on registrar exams in the UK (RACP keynote 2004)
- Recommend providing 1 teaching (especially) EBM workshop per year at RACP to give rural specialists teaching and EBM skills—could we recognise with double CPD points?)

---

---

---


---

---

---

---

---



### Mentoring

- The RACP rural registrar mentoring program should be expanded to rural specialists because of conflict of interest between peer reviewers (with potential competency threat/competition for patients—probably not real but definitely perceived)
- Program should be supported and evaluated
- Could be annual meetings at RACP—"one on one mentoring" (or one on 2) sessions over lunch, etc.
- Match before meeting

---

---

---

---

---

---

---

---



---

---

---

---

---

---

---

---