Setting the scene: Training/trainer perspective

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Background

- College perspective
  - Already at capacity
  - No where else to train

- NMTAN perspective
  - Too many doctors
  - Maldistribution
  - Nexus between staffing public hospitals and training positions

“Unintended” consequences

- Dermatology modeling
  - Unfilled training positions every year
  - Shortage of dermatologists (**40-60** by 2030)
  - Need to increase intake by ~5/pa
  - Expanding GP role in skin cancer treatment

“Unintended” consequences

- Emergency modeling
  - Oversupply of ~**2000** emergency physicians
  - Drops to ~900 if reduced hours and intention to retire
  - Assumes no restriction in intake (which has already changed)
  - Assumes supply/demand for FACEMs was in balance in 2016…

  - Did ACEM just end up with the “leftover” trainees?

“Unintended” consequences

- Trainees who want work-life flexibility during training and post-fellowship

- Trainees who want career flexibility
  - Geographic
  - Clinical
  - Academic

Special Skills

- Retrieval medicine
- Toxicology
- Medical education
- Trauma
- Administration
- Palliative care
- Paediatric emergency medicine
- Paediatric critical care
- Research
- Medicolegal
- Geriatric emergency medicine
- Hyperbaric medicine
- Wilderness medicine
- Sports medicine
- Indigenous health
- Public health
- International emergency medicine
- Infectious diseases and tropical medicine
- Disaster medicine
- Drug and alcohol/addiction medicine
- Forensic medicine
- Eye/ENT
- Rural and remote health
- Simulation medicine
- Women’s Health

Case

- PGY4
- Working in ED part-time and completing PhD
- Had hoped to apply for ENT training but hasn’t been able to secure the prerequisite 10 week ICU term
- 1 child and hopes for another;
- realized that may EM was their calling when they were looking forward to working NYE overnight in a very busy metropolitan ED…

Paradox

- Too many doctors yet every year we are short and desperately appealing to the UK's lack of sun…
- Not enough training capacity, yet very few part-time or job-sharing trainees
- Disincentive to stay in service roles when college selection processes favour PhDs and other higher degrees

Other considerations

- Industrial implications
  - Hospitals don’t like part time employees
  - How do we pay non-registrars working in middle-grade roles?
- Supervision implications
  - Colleges and supervisors often don’t like part-time trainees
- Jurisdiction concerns
  - Significant demand for PGY2-5 to staff hospitals; reliant on IMGs (not just regional centres)

Some questions…

- Does every doctor in training want to be a specialist?
- Would more doctors work part time if given the opportunity?
- How can we make working in regional/rural Australia more attractive (rather then punitive)?
- How do we model for complex careers and anticipate career planning