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