The University of Sydney

Curriculum Matters

Office of Medical Education Newsletter

DECEMBER 08, ISSUE 5

IN THIS ISSUE

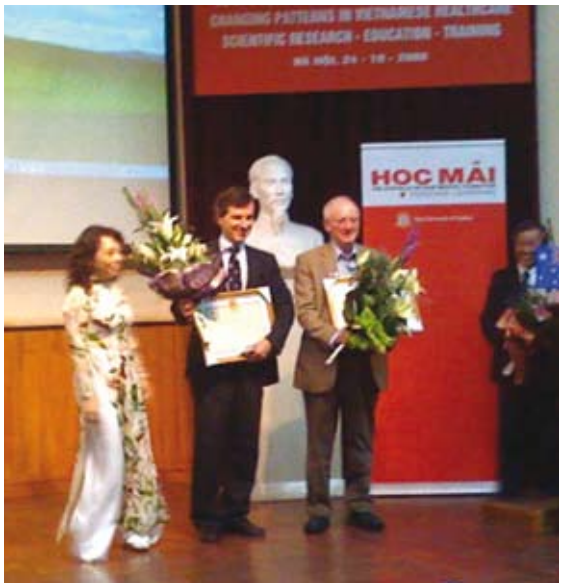
A visit to Vietnam

Professor Bruce Robinson

A group of 28 Faculty staff, Hoc Mai Board members and supporters visited Hanoi and Ho Chi Minh City (HCMC) recently to contribute to the activities of Hoc Mai.

FROM LEFT: PROFESSOR KIM OATES, DR HAI, PROFESSOR BRUCE ROBINSON, PROFESSOR DANG VAN DUONG

The cornerstone of the visit was a conference on Education in Medicine, Nursing, Public Health and Research which was held at the Viet Duc Hospital in collaboration with Viet Duc and the Hanoi Medical University. The conference was attended by Professor Nguyen Thi Kim Tien, Vice Minister of Health and Professor Nguyen Tien Quyet, Director of Viet Duc Hospital, as well as many academics and students from Hanoi Medical University.



FROM LEFT: PROFESSOR NGUYEN THI KIM TIEN, PROFESSOR BRUCE ROBINSON, PROFESSOR KERRY GOULSTON

Presentations from both sides indicated the need for change in the educational approach. Our Vietnamese colleagues welcomed assistance in implementing change in their medical and nursing and midwifery curricula and embraced the support being offered by Professor Kerry Goulston and Professor Kim Oates from the Faculty of Medicine and Professor Jill White, Dean of Nursing and Midwifery. Young researchers were also keen to examine the Australian model of PhD and Master's degrees. In all areas plans were made to develop these ideas into specific projects for which funding will be sought.

The delegation also visited a number of teaching hospitals in Hanoi and met with two new universities in HCMC; the University of Medicine and Pharmacy and the Pham Ngoc Thach University. Both universities are keen to join the Hoc Mai student exchange scheme and will take students for placements in 2009. In Hanoi and HCMC, we interviewed over 70 excellent candidates for Hoc Mai AusAID scholarships in medicine, nursing and public health. We hope to be able to fund half of these people to come to Australia in 2009.

Vietnam is a country of immense charm and great opportunity, in great part due to the warmth and friendliness of its people. Professor Dang Van Duong, our Hoc Mai co-ordinator in Vietnam again demonstrated his critical role in introducing us to outstanding members in his team.

Too many doctors

Do we have too many "doctors in the house"?

Professor Stephen R Leeder

In May this year I gave the inaugural lecture in the new medical school at Deakin University in Geelong. It brought back wonderful memories of my experience of helping open the new medical school in Newcastle 30 years ago and the feel of fresh beginnings when we commenced the graduate program here twelve years ago.

After the lecture I was besieged by students (Unusual!! I cannot have spoken about public health, could I? No!) who wanted to discuss the question: "Where are we to find places as interns when we graduate?" Their concern is a real one, because medical education has blown out in recent years and the numbers of new doctors are rising steadily. What is going to happen to the new students at Geelong – and to you, dear reader? Let's rehearse the facts.

It is true that the federal government, which controls the number of medical students, permitted a dramatic increase in the number of Australian medical schools, from 12 in 2004 to 19 in 2008. A big increase in the number of medical students graduating in the next ten years will follow this action. Yet, although this increase intuitively makes sense, whether the resulting number of medical practitioners is right, too few or too many, is really hard to know. Why that is so I shall explain in a moment. First, note this.

PROFESSOR STEPHEN LEEDER

Australia imports several hundred doctors each year to fill vacant hospital positions and to assist with general and specialist practice in rural and remote Australia. Overseas-trained doctors may be required through provisional licensing arrangements to work in areas of workforce shortage for up to ten years. Many of these doctors are from economically less advanced nations and choose to work in countries with advanced health systems, such as Australia. Yet they are often from countries whose health systems and patients desperately need them. There are compelling ethical reasons why, given its wealth, Australia itself should train sufficient numbers of doctors for its own needs, and then some. So if, for whatever reason (and I believe there will be several reasons), the number of imported doctors falls, there will be plenty of work for our new graduates if we bring all hospitals into the training pool.

Earlier this year, the University of Melbourne and University of Queensland jointly established the Australian Health Workforce Institute. Let us hope that this Institute can get things straight as there are serious curves in the road to navigate as we progress into the future of our health care system.

What makes workforce planning so hard in medicine?

First, there is the problem of the 10 years that separate turning the tap on or off and the supply of practising doctors, which is a long time in politics and even longer in terms of technological change. We are now on the verge of the nanotechnological and genetic revolutions, which will radically alter medicine. Not only will our diagnostic labels change to reflect new genetic insights, but so too will our treatment alter in an age of tailored, personalised medicine. How many doctors, equipped with what skills, will we need for this new age?

Second, we have a declining and ageing community of general practitioners. Their numbers were 104 per 100,000 population in 2001, decreasing to 98 full-time practitioners per 100,000 in 2005. This means fewer than ten doctors for every 10,000 people. Put seven of those ten in inner urban areas, two in inner regional areas, and share the last one between outer regional and all remote Australia and you see the problem.

Third, workforce development is not simply a question of numbers of doctors. The rise and rise of the allied health professions and their growing interest in territory once considered to be exclusive medical turf means that assumptions about the future roles and responsibilities of medical practitioners and health teams must change. For example, we have an increasing number of older people in whom once-fatal conditions, such as coronary artery disease, have become chronic disease. To respond to these changes appropriately, doctors must work with the other health professionals to determine who is best at doing what. There are now opportunities for nurses, physiotherapists and others to help achieve continuity of care which once might have fallen almost entirely upon the general practitioner. How many GPs will we need? Hard to tell.

Even harder when you think that generational changes in our society are altering the idea of what it means to be a doctor. Graduate entry to medical school brings with it new types of students whose experience of life and education is broader than previously. Many have partners and children, and most have to work while studying. They (you!) will graduate with debt.

Female students now represent close to 50% of all medical students in Australia. Research shows that approximately 80% of female doctors will take time out of the workforce, and more than 30% plan to work part time. Similarly, 20% of male doctors now intend to take time out. Perceptions are also changing. Many students say quite frankly that they are unimpressed with old notions of a family-less and selfless dedication to medicine. They are looking to build lives in which their profession is not their sole, exclusive, dominating, exhausting definition of identity. We may need to train more medical students simply because the doctor of the future will work fewer hours per week.

Where does this leave us?

The arithmetic may be impossible to get right. We should make the best guess we can as to how many doctors we will need in ten years' time, and then add a margin for error and international demand. Our estimate should take (cont'd overleaf...)

Northern exposure

account of the diminishing hours that doctors will wish to work.

To deal with the distributional challenge – too few in Broken Hill, too many in Rose Bay – we need to pay doctors for the services that we know people will increasingly need, like the detailed listening, education and skill adjustments required for care of people with chronic diseases such as diabetes and heart failure. We need to pay specialists to work, at least for a time, in the areas where our population lives, which may not be where they live. Perhaps this means flying specialists in for two days in ten. We must equip our doctors with the skills of intellectual agility that are needed for them to adjust to big changes in medical knowledge and practice. In the midst of all of this, we need to retain the central humane purpose of medicine and medical education - to relieve human suffering due to illness and injury.

To conclude – watch this space. I do not believe we are training too many doctors, but we do need to be sensitive to their changing role and lifestyle, and get smart about matching work opportunities to what they and the community that they serve want. If you find yourself without a job, just tell me!

Northern exposure: an experience of medicine in the Top End

Dr Narelle Shadbolt

Borroloola, with a population of about 800, is located 954 km south-east of Darwin, 380 km from the Stuart Highway and about 50 km from Gulf of Carpentaria. It's a place of contrasts: red dust and low scrub savannah against the deep-green Macarthur River, lined with lush trees and cycads; dry heat followed by the wet with spectacular thunderstorms; beautiful bright-eyed children affected by rheumatic heart disease, glomerulonephritis and painful skin conditions; and world-famous Aboriginal artists whose families have died young from the complications of diabetes, heart disease and alcohol.

FUN IN THE WEARYAN RIVER

The population is mainly Aboriginal. Borroloola is the home of a number of very different Aboriginal communities – the Yanyuwa, Mara, Karawa and Kurdanji peoples all live around the town. In addition, there is a big itinerant population, drawn by vast cattle stations, the best barramundi fishing on the Gulf and giant crabs at King Ash Bay.

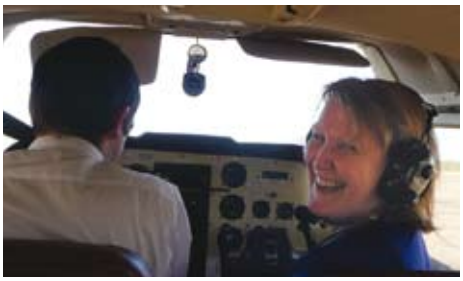
I had the great privilege of working there as one of a group of GPs who each go to Borroloola for a month. I was welcomed by the communities, the Aboriginal health workers and the clinic staff. Having been an urban GP for 20 years, I arrived with my heart in my hands because I was way out of my comfort zone. But the experience reminded me of why I did medicine in the first place. We should all give time to serve as doctors in remote areas. The clinics at Borroloola, Robinson River and Kiana are staffed with remote-

HUNTING AND FISHING DAY - TALKING ABOUT GOOD FOODS FOR DIABETES

International students

(cont'd) An experience of medicine in the top end

area nurses and Aboriginal health workers plus the GPs. Really busy clinics and on-call time were interspersed with fishing, bush-tucker days and visits to the amazing secrets of the Top End – spectacular rock gorges, hot springs, cycad forests and billabongs full of water lilies.



FLYING OUT OF ROBINSON RIVER

It was a steep learning curve. Rheumatic heart disease, renal disease, diabetes, skin conditions and infectious diseases affect a huge proportion of the population. The things that we take for granted in urban practice are often unavailable or accessible only on a limited scale. Pathology results take a week to come back, and pharmacy supplies take a week to arrive. X-ray facilities are very limited and ultrasound is unavailable. No physiotherapy or other allied health services exist. I certainly encountered a lot of medicine. I also learned that clinical skills are really important – skills that are sometimes put aside in settings where high-tech diagnostic tests are readily accessible.

I'm not sure I made a difference to the huge public health problems of the Indigenous communities – lack of housing, poor access to fresh food, and almost no access to dental and other basic health services. But I know I have learned something about the human condition that will make me a better doctor.

A BORROLOOLA SUNSET

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International Students in the University of Sydney Medical Program

Dr Lyndal Trevena

The University of Sydney Medical Program accepts 35-50 international students each year. They bring with them a diversity of experience and a high level of motivation to become medical practitioners. Taking on substantial financial and personal risks, they choose to study medicine in our Faculty. So who are they? Why do they come to study medicine with us?

The majority of our international students are from North America with a further core of students from Singapore. Others come from a range of countries including India, China, Taiwan, Germany, United Kingdom, Timor-Leste, Indonesia, Japan, Nepal, Pakistan, Fiji, Morocco, Korea, Malaysia, Kenya, Zimbabwe and more, varying from year to year.

In 2006, and again in 2008, we surveyed international applicants at the Multi-Mini Interviews (MMIs) and found that the most common reason for applying to study outside their own country is the experience of studying and living abroad. Clearly, our international students are an adventurous group with much to offer.Furthermore, the main features that attract our international students to the University of Sydney Medical Program are the graduate-entry education, the early clinical experience and the outstanding international research reputation of our Faculty.

Like our local students, the international students are actively engaged in research in our centres and institutes and this brings great potential for future international research collaboration as our international alumni develop their careers.

International student-driven research projects are currently under development looking at support needs and career paths of our international students and alumni.

We know anecdotally that our international graduates have gone on to take up residency positions in top programs at prestigious universities, but we hope that, for the first time, we will learn more systematically where our internationals go and how they get there. What choices do they make and how can we, as a Faculty, work in partnership to achieve the best for our graduates?

Our international students are also actively engaged in new global health programs. They are embracing opportunities to experience more of the Asia-Pacific region, setting up options and electives and working alongside our local students in global-health advocacy student groups.

The University of Sydney Medical Program runs the 'Postcards' series, in which students and staff give 'snapshot' presentations on their recent experiences of working in medicine overseas. The 'Postcards' series also gives international students an opportunity to share information about their home countries' health status, health systems and cultures.

As a top-ranking international medical faculty, we need to continue to work closely with our international students and foster their enormous talents. We can learn much from each other and should continue to build these relationships as our graduates pursue their medical careers around the world.

Curriculum

A new medical imaging syllabus

PROFESSOR SHIH-CHANG (MING) WANG (FRACR) PARKER-HUGHES CHAIR OF DIAGNOSTIC RADIOLOGY

If curriculum contents reflect medical knowledge requirements for new graduates, the current University of Sydney Medical Program curriculum suggests medical imaging is of (very) minor importance in clinical practice.

The reality is that imaging is an essential component of diagnosis, treatment and management across all of medicine. Yet, we teach little of it, and there is no consistent or systematic approach. This is of concern, as imaging is one of the fastest rising cost areas in healthcare, is the main source of ionising radiation exposure with potential for real harm, and is frequently misused or inappropriate.

The 10-year review of the medical program revealed one of the greatest deficiencies was medical imaging education. In response, under Dr. Noel Young, the Discipline of Imaging developed an imaging syllabus with the input of several radiologists and nuclear physicians. A chair of Diagnostic Radiology was appointed from July 2008 to continue this development.

The new syllabus, including defined learning objectives, will be implemented in 2010, with Imaging expanded and integrated into teaching blocks. Core imaging will be brought into anatomy and pathology in stages 1 and 2, and integrated with blocks for stage 3. Students may take advantage of ultrasound training and integrated attachments. Assessment of Imaging will be based on the learning objectives. Finally, the appropriate use of imaging, rather than the simply image interpretation, will be taught. Although less than 1% of graduates become radiologists, most doctors use imaging clinically.

These goals cannot be achieved in one fell swoop. The new syllabus requires phased development and enrichment over time, but should result in a high quality educational experience for our future students.

caption corner winner

Our caption corner winner is John Dodson with:

Michael Field says... "These are silk gloves, not rubber, but when the students arrive..."

John won a $50 book voucher. Congratulations!

Raising the profile of Pathology

CLINICAL PROFESSOR EVA RAIK (AM, FRCPA, FRACP)

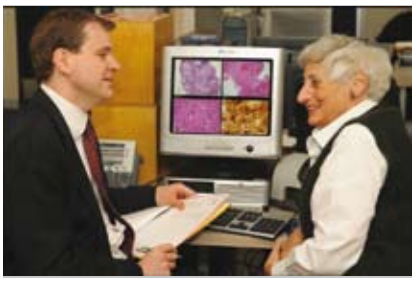
As recommended by the curriculum review of the University of Sydney Medical Program, the enhancement of the pathology component of the curriculum is progressing well. Both academic and clinical staff have given strong support and encouragement.

There will be more microbiology, biochemistry and tissue pathology in Stage 1 in 2009. There will also be a haematology assessment at the end of block 4 (trialled at the Northern Clinical School with excellent positive feedback), and a tissue pathology assessment toward the end of Stage 1.

In Stage 2, all students will be able to observe autopsies at the City Morgue. It has been difficult for students to attend autopsies in the hospitals as few are performed in that setting nowadays. Students will be expected to report on two observed autopsies.

The time-honoured clinicopathological conference will be re-introduced into the curriculum in Stage 3. Students will be required to participate in the presentations on a rotational basis and attendance will be compulsory. Relevant clinical and laboratory staff will attend and facilitate the presentations. Students in Stage 3 will also be able to visit a state-of-the art pathology laboratory.

The ultimate aim of the increased emphasis on pathology is to ensure the graduating doctor has a good understanding of the basis and mechanisms of disease processes as well as an appreciation of the role of laboratory investigations, knows which investigations to request, can interpret the results, is cognisant of the costs and knows how these costs are met in the Australian health system.



CLINICAL PROF EVA RAIK WITH DR ANTHONY GILL PLANNING THE FORMAT OF THE PROPOSED CPCS

Patient safety & PPD news

Associate Professor Merrilyn Walton

The WHO Patient Safety Curriculum Guide

In 2008, the World Health Organization (WHO) supported the development of a world-wide patient safety curriculum guide for medical schools.

Associate Professor Merrilyn Walton from the Office of Postgraduate Medical Education (OPME), led a team of patient safety practitioners in developing the curriculum guide for the WHO. A comprehensive curriculum and a teacher's guide were completed in May and circulated to the WHO Expert Group for consultation. The Expert Group endorsed the curriculum at a meeting in Geneva in June 2008. The Curriculum has been through the WHO production process and will be ready for piloting in 2009.

The University of Sydney will be one of about 12 medical schools from around the world selected to pilot the new patient safety curriculum.

FROM LEFT: PROFESSOR JORGE CÉSAR MARTINEZ (DEL SALVADOR UNIVERSITY, SCHOOL OF MEDICINE), A/PROFESSOR MERRILYN WALTON, PROFESSOR BRUCE BARRACLOUGH (CHAIR WHO EXPERT GROUP)

For more information on the WHO Patient Safety Curriculum Guide for Medical Schools, visit the WHO website (http://www.who.int/patientsafety/activities/technical/medical_curriculum/en/) or contact Associate Professor Walton's office by calling 02 9351 4542.

The OPME is planning a one-day Symposium on Patient Safety Education on Monday, 9 March 2009. The symposium will cover patient safety education at all levels of medical education. Anyone interested in attending can register by calling 02 9351 4542.

Patient Safety Topics in the WHO Patient Safety Curriculum Guide

- What is patient safety?
- What are human factors and why are they important to patient safety?
- Understanding systems and the impact of complexity on patient care
- Being an effective team player
- Understanding and learning from errors
- Understanding and managing clinical risk
- Introduction to quality improvement methods
- Engaging with patients and carers
- Minimising infection through improved infection control
- Patient safety and invasive procedures
- Improving medication safety

The new PPD program

Overview of PPD Aims in the University of Sydney Medical Program

- Commitment to compassionate, ethical professional behaviour.
- The ability to work cooperatively as a member of a team, accepting and providing leadership as appropriate.
- Recognition of the inevitability of decision making in circumstances of uncertainty and the capacity to make rational and sensitive decisions based on the best available evidence.
- The ability to recognise his or her personal, physical and emotional needs and responses to stress, and openness to assistance in times of need.
- Ongoing commitment to the advancement of learning within the medical community.
- Commitment to maintaining professional standards and obligations.
- Commitment to improving the quality and safety of health care.

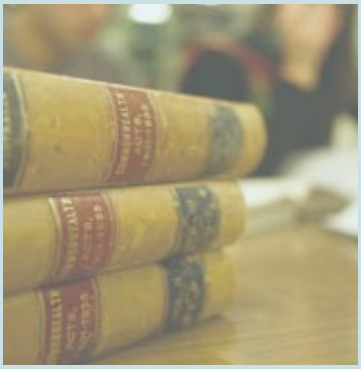
The review of the University of Sydney Medical Program in 2007 offered a unique opportunity to implement a new Personal and Professional Development (PPD) curriculum that incorporates areas such as patient safety and professionalism. The PPD program is a four year program that begins in the first week of Stage 1 with the PPD Intensive.

The Stage 1 PPD Intensive is a two day workshop where students meet experts related to the PPD theme, hear patients' stories and work through case studies in small groups. The Intensive helps students to grasp important aspects of health care, and exposes them to the range of qualities inherent in PPD.

The new PPD curriculum includes PPD Intensives in stages 1,2 and 3 (Year 4) as well as PPD components in the PBL blocks, lectures and student activities during years 3 and 4. The PPD Theme is assessed and medical students are required to compile two PPD portfolios during the University of Sydney Medical Program. The new PPD program starts in Stage 1 with the provision of foundational knowledge which underpins PPD learning in the later stages.

OME Update

Student Initiative: Medical books for Iraq



As highlighted by the Iraqi Ambassador to Australia at a recent University of Sydney seminar 'Medicine in Conflict - Iraq', Iraqi medical schools need to update educational materials in order to educate the next generation of Iraqi doctors. The most recent textbooks available in Iraqi medical schools were printed in the early 1980s.

The aim of our group is to collect current medical textbooks and to distribute them to selected medical schools in Iraq. This will give our fellow Iraqi students access to current educational materials and help them to become competent doctors who will serve the healthcare needs of the Iraqi people into the future.

For more information please contact Basim AlAnsari under mbalansari@med.usyd.edu.au or call 0422 893 018.

The Launch of the new Stage 3

Associate Professor Chris Dennis, Ms Jaime Comber and Dr Elizabeth Bassett

A lot of exciting changes will be introduced into Stage 3 of the University of Sydney Medical Program in 2009. The Office of Medical Education (OME) and the Clinical Schools are working hard to ensure that the changes take place smoothly and further improve the Program. Here is a sneak preview of what students and staff can expect in 2009.

The old Stages 3 and 4 will be merged to form one bigger, better Stage 3, which will span two years. The new Stage 3 will encompass four Core Blocks, four Specialty Blocks, an Elective Block and a Pre-Internship Block. The Core Blocks will replace the Integrated Clinical Attachments and the Specialty Blocks will replace the Specialty Rotations. Each of the Blocks will be of eight weeks' duration. Students will be divided into four Streams, and each Stream will take the Blocks in a different order. As a result, students will benefit from increased interaction with clinicians and a more intimate learning environment.

The Problem-Based Learning (PBL) cases are being updated for 2009, and the Clinical Disciplines are working on interactive Clinical Reasoning Sessions to replace the Stage 3 PBLs in 2010. In each Clinical Reasoning Session, students will interview patients face-to-face and get to observe the realities of many clinical conditions.

Meanwhile, the University of Sydney Medical Program website for Stage 3 is being completely revamped, incorporating new information on the Core and Specialty Blocks. The new website has greater capacity for on-line information, and we are working hard to utilise its capacity with exciting new computer-based resources.

Other significant changes will be made in Stage 3. Teaching in the PPD and Population Medicine themes will introduce innovative learning methods. A new Clinical Skills curriculum is being developed help students gain and retain the skills that they will need throughout their clinical careers. New learning objectives are also being collated for each Discipline. These will provide a clear guide of what students need to know, and will enhance their self-directed learning.

By means of all of these exciting changes, we hope to strengthen the University of Sydney Medical Program, produce even better trained doctors, and make the Program even more interactive and enjoyable. We in the OME look forward to introducing the new Stage 3 in 2009.

caption corner

WIN $50 book voucher!

Can you think of a suitable caption? To enter this competition, please email your caption by 15 January 2009 to curriculummatters@med.usyd.edu.au.

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