

The Symbiotic Experience: Medical training in the private sector

Dr Saxon D Smith MBChB MHL MAICD

Australian Private Hospitals Association Congress

18th October 2010

Disclaimer

- My brief is to provide the trainee perspective and experience of private sector
 - Based on personal experience with private sector training in Dermatology and ICU.
 - Conversations with colleagues who have experience with other private sector specialty training, including Orthopaedic surgery, Urology, etc

Outline

- Introduction
- 6 key advantages to specialty training in the private sector
 - To the community
 - To the trainee
 - To the provider (hospital or private practice)
- 4 potential disadvantages to specialty training in the private sector
- 3 important trainee focused questions to be considered when creating private sector specialty training positions

Introduction

- Data from the former National Health Workforce Taskforce suggests that there is now a shortage of approximately 6300 medical practitioners across the country¹.
- By 2014, domestic medical graduates will grow to 3108pa from 1287pa in 2004².
- The Commonwealth has committed \$640m to support a significant expansion in GP training positions as well as additional training positions in the private sector.
- Funding does not necessarily equate with actual positions.
 - In 2009 there were 2243 intern places in Australia, which falls short of the >3700 positions required by 2014³.
 - 1st year vocational training positions have grown around 8.2%pa since 1999, but falls well short of the expected growth in graduate numbers with an additional 1200 positions required by 2015³.

1. Health Professions Entry Requirements, 2009-2025. Macro Supply and Demand Report. National Health Workforce Taskforce. 2009

2. Medical training Review Panel, Thirteenth Report April 2010.

3. AMA Medical Training Summit Joint Statement. Action of Medical Training. Australian Medical Association, 29th Sept 2010

Advantage 1

- Capacity building
 - Making room for 'square wave' shift in medical graduate numbers
 - Specialty specific capacity to fill identified areas of need
 - Anaesthetists
 - Pathology
 - Dermatology

Advantage 2

- Potentially more reflective of actual medical practice in the future
 - Orthopaedics
 - Psychiatry
 - Dermatology

Advantage 3

- Potentially more flexible training
 - Capacity for part-time and job sharing roles
 - Split public-private training

Advantage 4

- Exposure to private practice setting
 - Structure
 - Practice structure
 - Solo practices
 - Share practices
 - Co-located practices
 - Time management
 - The business of medicine
 - Public hospital mentality not continuing reality
 - Medicare
 - Private health insurance

Advantage 5

- Better multidisciplinary connectivity
 - Opportunity for clinical communication and fostering of relationships across allied health professionals
 - Instead of the professionals operating in silos within the public sector intersecting adhoc through the notes
 - Hand surgeons
 - Dermatology
 - Also reflective to the push to coordinated MDT settings for pt car in private practices

Advantage 6

- May provide better structure for patient care in private hospital setting
 - Earlier and coordinated ward rounds
 - Trainee as alternative contact point for patient care questions
 - Potentially better medical documentation
 - Medicolegal risk management

Disadvantages 1

- Glorified surgical assistant or scribe
 - Especially in surgical based specialties
- “to be seen and not heard” is not medical training
 - Stagnation of medical knowledge and decision making skills

Disadvantage 2

- Impact on the private practice
 - Things take more time
 - For the consultant to review patients
 - Especially with junior registrars
 - Irrespective of counterargument of “being able to book more pts in as two people seeing them”
 - Slower surgery if performed by the registrar
 - Experience of the operator registrar
 - Education as case proceeds, aka “teaching on the run”
 - Cost to practice
 - Extra consulting rooms, offices, etc

Disadvantage 3

- Change in a fundamental cornerstone in private health
 - Patients autonomous choice of doctor
 - They do not get to choose their registrar
 - May lead to a potential blurring of what 'public' and 'private' health means

Questioned to be asked 1

- Funding models of training
 - Partnerships/MOU between public and private entities
 - Rotational basis
 - Trainee attached funding
 - Trainees have the 'cost of their funding' attached to the individual rather than the position
 - Potential for external trainers
 - But who would control the administration of funds
- Single funder model
 - Who purchases training placements at accredited institutions
 - State Health dept/College's/3rd party entity
- Medicare billing funded models
 - Eg GP registrar model

Questioned to be asked 2

- Employee entitlements to follow trainee as they transition through both public and private settings
 - Maternity leave
 - Sick leave
 - Annual leave
 - Long service leave
 - Industrial representation
 - Because work places are not always perfect

Questions to be asked 3

- Medical indemnity insurance
 - Is the trainee covered?
 - Is the consultant covered?
 - Is the private hospital/practice covered?

More questions than answers.

But the answers exist

My vision:

Specialty training occurring jointly in public and private settings through memorandum's of understanding between these two entities, allowing for flexible and responsive education of the trainees for the betterment of the community's healthcare as a whole.