Confederation of Postgraduate Medical Education Councils (CPMEC)

Report to MTRP
23 February 2012

CPMEC would like to highlight the following developments since the last MTRP meeting.

1. National Internship Standards

In our previous report to the MTRP we had noted that that the Medical Board of Australia (MBA) had circulated a draft registration standard for granting general registration on completion of the intern year. The draft standard was developed by an AMC working party which includes representatives of the Board and CPMEC.

The registration standard stipulated 47 weeks of equivalent full time experience in an accredited intern position within a 2 year period, including a minimum of 10 weeks exposure to medicine, 10 weeks exposure to surgery and 8 weeks exposure to emergency medical care. The draft standard attempted to move away from compulsory 'general medicine' and 'general surgery' rotations and focus on the type of experience obtained. It also included explicit allowance for part time internship and for part of the internship to be completed outside Australia. A minimum of eight weeks experience in 'emergency medical care' was proposed, rather than a rotation that had to be completed in an Emergency Medicine department.

Following their initial consultations, in November 2011 the MBA released a second draft standard for general registration for Australian and New Zealand medical graduates on completion of intern training. CPMEC consulted with its member Postgraduate Medical Councils (PMCs) for inputs and comment. Briefings on the initial consultations on the draft internship standards had also been provided by Dr Stephen Bradshaw on behalf of the MBA at the 16th Prevocational Forum in Auckland in November 2011 and the annual CPMEC Advisory Council meeting.

In its submissions on the second draft standards, there was acknowledgment of the changes made to the original draft standard and the MBA comments regarding additional work including; *setting learning objectives for PGY1, Intern assessment and sign off, National framework for intern training accreditation process and definition of mandatory term requirements*.

CPMEC made the following additional observations and recommendations:

- MBA (and the AMC) should build on existing documents and frameworks where available, including the *Australian Curriculum Framework for Junior Doctors* (ACF) and the *Prevocational Medical Accreditation Framework* (PMAF).
- Concern that the second draft continued to lack any specific reference to educational requirements, as the purpose of intern year is stated as allowing *"medical graduates to consolidate and apply clinical knowledge and skills while taking increasing responsibility..."*
- That the proposed standard should include a requirement for attendance at mandatory intern education sessions.
- That more details of requirements for part time, interrupted and deferred internship are included.
- That there are clear statements on deferral of internship, recency of practice, and the minimum continuous time required in a term.
- That the standard clearly stipulates the requirement for successfully completing internship.

It is pertinent to note that junior doctors have continued to emphasise the need to maintain mandatory terms in emergency medicine. They also generally agree on the desirability of all

junior doctors having the opportunity to experience supervised general practice or community placements irrespective of their subsequent specialisation.

2. 2011 Prevocational Forum

The 16th Australasian Prevocational Medical Education Forum was held in Auckland, New Zealand from 6-9 November 2011. This was the first Forum held outside Australia, and the Medical Council of New Zealand's Education Committee is to be congratulated for putting together a highly successful Forum which received extremely positive feedback. CPMEC liaised closely with the hosts to ensure that the event was a truly trans-Tasman affair.

Preceding the Forum, there were a number of special interest group meetings involving Directors of Clinical Training, Medical Education Officers, Junior Medical Officers, Prevocational Accreditation staff, and personnel involved with intern matching and allocation processes. CPMEC also had its Advisory Council meeting with key external stakeholders on 6 November 2011.

A copy of the resolutions adopted by the 2011 JMO Forum is attached to this report.

3. National Audit of Multiple Job Acceptances

A national audit of multiple intern job acceptances by final year medical students was conducted again in 2011 under the auspices of the National Intern Allocation Working Party (NIAWP) chaired by Professor Geoff Thompson of South Australia. All students who accepted more than one intern position were contacted by the audit project administrator to encourage a quick decision so that health services were given adequate notice of vacant positions.

The total number of duplicate acceptances identified was double that of 2010 with 80 applicants accepting 2 positions (versus 40 applicants in 2010). Two applicants had accepted 3 positions (1 applicant in 2010). Most of those holding multiple acceptances had decided which position they would accept by late September 2010.

In addition to identifying medical graduates holding multiple job acceptances, the NIAWP has also been working to achieve greater consistency in national intern allocation priority rankings, and intern application opening and closing dates. A national application process has been discussed. Members of the NIAWP have also been involved in discussions with Health Workforce Australia to develop a national response to provision of internships to international full fee paying students graduating from Australian medical schools. HWA has entered into an arrangement with NSW Health Education Training Institute (HETI) to undertake a manual vacancies support system for unallocated Australian trained medical graduates. HETI is undertaking the task with the support of the NIAWP.

4. HWA

CPMEC has been exploring with the HWA ways of working collaboratively to maximise the quality and efficiency of prevocational education and training. Further meetings are scheduled in the next few months to this end.

Since the conclusion of MTRP funding for priority projects in prevocational medical education and training, the capacity of CPMEC and PMCs to undertake innovative activities to promote the quality of prevocational training has been severely constrained. MTRP funding significantly lifted the profile of prevocational training through initial funding to establish Postgraduate Medical Councils and subsequently providing grants for national projects aimed at improving early postgraduate medical education and training. These projects included the

Australian Curriculum Framework for Junior Doctors; the *Prevocational Medical Accreditation Framework*; and the *Professional Development Program for Registrars,* each of which has been extensively utilised and referenced.

Currently CPMEC is working with CPMC and the Medical Deans on a joint Supervision project funded by the HWA.

5. Collaboration with AIDA

CPMEC and PMCs will set up support and mentoring programs for Indigenous medical graduates in conjunction with Australian Indigenous Doctors Association (AIDA) to help manage their transition through the prevocational training and provide career guidance on vocational training opportunities. As in other areas, PMCs have been mindful of their significant resource constraints in developing this collaboration agreement,

6. Prevocational Accreditation Matters

Prevocational Medical Accreditation Framework (PMAF)

CPMEC developed the PMAF to promote greater national consistency in prevocational medical accreditation policies and practices in Australia. It was based on extensive consultation with PMCs and external stakeholders. The final version of the PMAF was signed off by member PMCs in October 2009. All PMCs are now using the PMAF to review standards and policies. A CPMEC survey undertaken in March confirmed the value and utilisation of the PMAF as a unifying national framework.

CPMEC has been promoting the PMAF to the AMC working party established to develop a national framework for intern accreditation processes. A consensus statement agreed to by all PMCs emphasises the work undertaken in the development of the PMAF as a national framework and its utilisation by all states and territories to guide prevocational accreditation practices.

Streamlined Approach to Accreditation of General Practice Training

Following discussions and a national meeting involving CPMEC, PMCs, General Practice and Education Training Ltd (GPET), the two General Practice Colleges (RACGP and ACRRM) and Regional Training Providers, it was agreed to consider a more streamlined approach to the accreditation of general practices with regard to prevocational and vocational training posts.

GPET convened a workshop in Melbourne on 19 May 2011 to discuss the issue. Subsequently, it was agreed between GPET and CPMEC to undertake a limited number of pilot surveys that would allow for a joint survey of both PGPPP and vocational training posts. PMCs in Victoria, Northern Territory and Western Australia have agreed to undertake these pilot surveys in conjunction with their relevant Regional Training Providers. GPET is funding these pilots and project completion date is August, 2012.

Each of these PMCs is in the process of setting up a project plan and the first meeting of the Project Steering Committee, comprising key stakeholders in prevocational general practice accreditation, is scheduled for early March 2012. Prof Rick McLean is the Chair of this Steering Committee.

7. Professional Development Program for Registrars (PDPR)

The PDPR is now a nationally accepted program aimed at building clinical supervisory capacity for registrars who are increasingly responsible for the teaching and supervision of prevocational doctors. CPMEC General Manager, Dr Jag Singh continues to deliver the

PDPR and a Trainer Accreditation Program with the support of clinicians. Indeed, the latter has been a strong feature of the PDPR. In 2011, 11 PDPR programs and 2 Trainer Accreditation Programs were delivered by CPMEC. This excludes programs delivered directly by accredited trainers. Evaluations for both programs continue to be extremely positive.

8. CPMEC Administration

Effective from 6 November 2011, I have taken up the CPMEC Chair role for the next two years. Prof Geoff Thompson from South Australian Institute of Medical Education and Training is Deputy Chair. CPMEC has also launched a new logo and is currently in the process of reviewing its website.

Prof Simon Willcock
Chair, CPMEC
8 February 2012

CPMEC

CONFEDERATION OF POSTGRADUATE MEDICAL EDUCATION COUNCILS

Australasian Junior Medical Officers' Committee (AJMOC)

201I Australasian Junior Medical Officer Forum (AJMOF) Resolutions

Introduction

This report outlines the resolutions adopted at the 2011 Australian Junior Medical Officer Forum (AJMOF) which was held at the Sky City Convention Centre in Auckland, New Zealand on 6 November. The meeting was attended by more than seventy junior doctors, representing all states and territories in Australia, and New Zealand. AJMOF is now a major annual training and education event for junior doctors and is held in conjunction with the annual prevocational medical education forum. This year was the first occasion that the Forum was held in NZ and it was jointly steered by the Australasian Junior Medical Officers' Committee (AJMOC) members representing both Australia and New Zealand. In addition to the resolutions, this report outlines the process used in their development, and also provides a brief description of the rationale for each of the 2011 resolutions.

Development of 2011 AJMOF Resolutions

The development of the 2011 (AJMOF) resolutions began with a face-to-face meeting of the AJMOC in Melbourne in April 2011. AJMOC comprises the Chair of each state and territory Junior Medical Officers' Forum in Australia and a junior doctor representative from the Medical Council of New Zealand's Education Committee. Key current issues in prevocational medical education were identified as the basis for the development of the 2011 resolutions. Consideration was also given to progress made on the resolutions adopted at the 2010 AJMOF meeting. Following the April meeting a sub-committee of AJMOC developed a first draft of resolutions which were subject to further discussions and revisions through a series of trans-Tasman teleconferences. Arising out of these consultations, a final draft set of resolutions was finalised for discussion and adoption by the 2011 AJMOF in Auckland on Sunday 6 November.

The final draft resolutions were considered by all the JMOs who attended the 2011 AJMOF meeting which was jointly chaired by Dr. Josh Savea (New Zealand) and Dr. Munib Kiani (Western Australia). After outlining the resolutions to the AJMOF plenary session, AJMOC members facilitated group discussions to obtain feedback on each of the resolutions. The resolutions were refined over the next two days by AJMOC and other JMO volunteers and then presented to the full plenary session of the 16th Prevocational Conference on Tuesday 8 November 2011 (Day 2 of the Conference). It was very gratifying for AJMOC that a number of key stakeholders who attended the presentation at the Conference commented on the high quality of the resolutions that were adopted by the 2011 AJMOF meeting.

2011 AJMOF Resolutions

The 2011 AJMOF resolutions have been grouped into eight areas as follows:

- *Internship and Prevocational Training Standards*
- *The PGY2 year*
- *Prevocational Accreditation*
- *Training Capacity Expansion*
- *Innovation and Work Reform*
- *Education, Clinical Supervision, Teaching and Assessment*
- *Workplace Flexibility and Doctors' Health*
- *Consultation with JMOs*

1: Internship & Prevocational Training Standards

An emergency department (ED) term provides a unique experience where junior doctor autonomy is maximized but senior input is readily available. AJMOF submit that few other specialties offer such qualities and an emergency medical term in an emergency department provides a learning experience for which there is no substitute. AJMOF acknowledges that while the Medical Board of Australia cannot mandate something which jurisdictions do not yet have the capacity to provide, namely an ED term for every intern, junior doctors believe that this is something that we should work towards. AJMOF also believes that while junior doctors must not be compelled to complete a general practice or community term, all junior doctors, regardless of their career trajectory, would benefit from such a placement. Furthermore, the Forum noted that the Australian Curriculum Framework for Junior Doctors (ACF) had provided a vehicle to make significant improvements to the educational aspects of prevocational years and that it should guide the clinical experience, learning objectives and appraisal processes in these years.

Resolution 1.1

The Australasian Junior Medical Officers' Forum (AJMOF) calls upon the Medical Board of Australia (MBA) to ensure that the national intern registration standard mandates that interns complete core terms in medicine, surgery and emergency medicine of a minimum of 8 weeks clinical exposure within that unit. AJMOF defines an emergency medicine rotation as one that is conducted in an emergency department.

Resolution 1.2

AJMOF considers it desirable but not compulsory for all junior doctors to have the opportunity to experience supervised GP or community practice irrespective of their subsequent specialisation.

Resolution 1.3

AJMOF calls upon MBA and the Australian Medical Council (AMC) to adopt the Australian Curriculum Framework for Junior Doctors (ACF) as the educational framework for all prevocational doctors.

2: The PGY2 Year

AJMOF acknowledges the efforts of health services to institute streaming of terms for PGY2 to assist junior doctors to fulfil college requirements and gain further experiences in a particular field e.g. medicine or surgery. However the Forum noted that there were a significant proportion of junior doctors who did not make their career choice until much later in their prevocational training. AJMOF believes that these undifferentiated doctors should have flexibility in their training programs to facilitate this process.

Resolution 2.1

AJMOF calls upon health services and colleges to allow flexibility in selection of PGY2 terms, noting that some junior doctors may make early choices about future speciality while others prefer to take a more general path in their prevocational training.

3: Prevocational Accreditation

AJMOF believes that prevocational accreditation plays a vital role in ensuring that junior doctors have high quality learning experiences with adequate support, education, supervision and welfare. It is the key instrument that allows for independent quality assurance of training, education and support provided to junior doctors.

Noting the need to develop a nationally consistent framework for prevocational accreditation, AJMOF urges the Medical Board of Australia and the Australian Medical Council to recognise the work already done by the Confederation of Postgraduate Medical Education Councils (CPMEC) in consultation with numerous stakeholders to develop and implement the Prevocational Medical Accreditation Framework (PMAF) as a unifying national framework. This framework has helped to increase consistency across the jurisdictions in accreditation policies and practices; align prevocational accreditation practices with other appropriate local and international benchmarks; reduce work required in each PMC (or its equivalent) to develop and review standards from scratch; and provided increased transparency and knowledge sharing of prevocational accreditation practices.

As junior doctors are directly impacted by the prevocational accreditation practices, there is a need for the continuing involvement of JMOs in the accreditation process to ensure that their unique perspective as consumers of prevocational training is considered in all accreditation visits.

AJMOF also believes that all prevocational training positions should be accredited. The Forum acknowledges the progress made in some jurisdictions in this regard to accredit all PGY1 and PGY2 positions but notes that some jurisdictions are still resistant to extending the scope of prevocational accreditation.

To ensure that prevocational accreditation activities are maintained and strengthened, there needs to be long-term funding commitments by jurisdictions and the MBA to Postgraduate Medical Councils, or the equivalent agency responsible for prevocational accreditation.

Resolution 3.1

AJMOF calls upon all Postgraduate Medical Councils (PMCs) or equivalent to accredit all PGY1 and 2 positions.

Resolution 3.2

AJMOF endorses the adoption of the Prevocational Medical Accreditation Framework (PMAF) as the national framework for accreditation of prevocational education and training.

Resolution 3.3

AJMOF reaffirms the continuing need for PMCs or equivalent to include at least one junior doctor in each prevocational accreditation survey. Surveyor training should be provided to junior doctors for this purpose.

Resolution 3.4

AJMOF calls upon the state and territory governments to provide stable and equitable long-term funding to all PMCs or equivalent to undertake accreditation.

4: Training Capacity Expansion

AJMOF notes that expanding training capacity is necessary if Australia is to meet its stated target of reaching self-sufficiency with regard to its health workforce requirements and meet the healthcare needs of a growing and increasingly diverse population. The Forum acknowledges the significant level of effort and resources being expended and notes the contributions that junior doctors can make through their active engagement by the major stakeholders in shaping policy. Junior doctors are at the 'coalface' of healthcare and can make important contributions on the nature and size of the future medical workforce.

Of most immediate concern to junior doctors is accessibility to vocational training places because of the increased flow of medical graduate numbers. AJMOF notes that this bottle-neck could significantly reduce the effectiveness of newly realised workforce gains, and limit career advancement for many capable

doctors. The Forum also called upon authorities to find ways of finding internships for all Australian medical graduates through a balanced approach that did not place unfair burdens on particular jurisdictions. At the same time AJMOF wished to highlight the ongoing contribution of international medical graduates who provide much needed health services in rural and remote regions.

Resolution 4.1

AJMOF calls upon Health Workforce Australia (HWA) to ensure ongoing junior doctor involvement in the National Training Plan pipeline analysis relating to the medical workforce of Australia.

Resolution 4.2

To prevent career bottlenecks for junior doctors, AJMOF calls upon all key stakeholders in medical education and training to ensure that the number of vocational training positions is increased and that the quality of training is maintained.

Resolution 4.3

AJMOF calls upon HWA to ensure that all prevocational trainees are able to easily access simulated learning environment (SLE) projects.

Resolution 4.4

AJMOF believes that all medical graduates of Australian universities should be provided internships, and calls for governments, HWA and universities to reach a sustainable solution on this issue.

Resolution 4.5

AJMOF recognises the contribution of international medical graduates (IMGs) in meeting Australian medical workforce shortages and calls upon the AMC, Australian Health Practitioner Regulation Agency (AHPRA) and health services to adopt consistent, efficient and transparent processes for supervision, registration, ongoing employment, and professional support.

5: Innovation & Work Reform

AJMOF recognises the importance of developing leadership skills among junior doctors including active encouragement to access best practices from beyond the clinical context. The Forum noted that leadership and professionalism are routinely demonstrated in the clinical context, but may not be specifically targeted as learning objectives by supervising clinicians. AJMOF believes cultivation of leadership skills through leadership experiences, training courses, and mentoring will be supplemented by self-directed learning.

AJMOF applauds the improvement of health service delivery and medical education using technology. Investment in technological infrastructure will be best realised through appropriate consultation with stakeholders and up-skilling to optimize implementation and ongoing use of new or improved systems and tools.

AJMOF also recognises the integral role of senior clinician teaching in the medical education of junior doctors. Prevocational trainees receive much of their education through clinical exposure with opportunistic teaching from consultants and, increasingly, registrars. AJMOF recognises the vulnerability of informal teaching opportunities between junior doctors and senior clinicians to ward demands and restructuring of the clinical unit.

With regard to a national intern application process, AJMOF acknowledges that a shift away from state-specific application systems to a national process could occur in the future. While debate exists regarding the impact of this system reform on junior doctors, junior doctors are unanimous that applications should remain free of cost to the applicant.

Resolution 5.1

AJMOF calls upon HWA, health services and jurisdictions to provide appropriate access for junior doctors to leadership development programs.

Resolution 5.2

AJMOF supports the use of technology to increase the capacity, efficiency and effectiveness of medical work practices. It is the expectation that training and infrastructure will be provided to support these changes, and that this will be done in direct collaboration and consultation with junior doctors.

Resolution 5.3

AJMOF calls on State and Territory Health Departments and workforce agencies to acknowledge and enumerate the impact of the introduction of new health professionals, such as physicians' assistants, on junior doctor training and take steps to ensure training is not compromised.

Resolution 5.4

AJMOF supports a national intern application portal which allows jurisdictions to retain control over the processing of applications. Applications should be processed at no cost to the applicant.

6: Education, Clinical Supervision, Teaching and Assessment

AJMOF recognises the important role clinical supervisors play in the teaching and supervision of junior doctors. To ensure that they continue this highly

valued role, the Forum believes that health services should support their clinical supervisors through protected time, appropriate rostering, and access to professional development programs.

To ensure the sustainability of a teaching culture within the wider healthcare sector, with increasing graduate numbers, junior doctors should be provided with training in teaching and supervisory skills at an early stage in their careers.

AJMOF recognises the role of interprofessional learning (IPL) in the distribution of senior clinician supervisor burden, and in enhancing the understanding of the roles of other health professionals to improve collaboration and the quality of patient care. However, AJMOF believes that junior doctor teaching should be primarily given by senior medical staff, but supplemented only where appropriate, with nursing, allied health and other teaching. These concerns are primarily to prevent de-contextualising the medical aspects of doctor training

AJMOF also believes that assessing junior doctors based on a list of individual competencies may be useful in assessing qualities such as proficiencies in procedural skills; however, it does not assess the higher order judgement required by junior doctors to provide comprehensive patient care.

AJMOF believes that junior doctor education is a priority and believes that this should be uninterrupted by pagers and the like, to ensure an optimal learning environment. The health service can enforce protected teaching time through holding pagers and/or having an administrative person answer pages, divert/ physically hand pagers to registrars, and make this explicit to all senior medical staff, nursing and allied health staff through announcements and/or other appropriate advertising.

AJMOF also believes that there is an unmet need for training and education of a significant number of prevocational doctors, as they do not fall under the ambit of a college registration. Ideally, all postgraduate doctors who have not completed vocational training qualifications should be in a clearly articulated training pathway.

Resolution 6.1

AJMOF reaffirms its call for health services to ensure protected time for clinical supervision and teaching of supervisors. The role of clinical supervisors must be formalised in rosters, job descriptions and relevant policies. Key performance indicators should emphasise and recognise the teaching and educational obligations of health services.

Resolution 6.2

AJMOF supports the development of a national framework for clinical supervision and calls upon key stakeholders (State and Territory Health Departments, PMCs, HWA's integrated clinical training networks and health services) to ensure continuing support for all junior doctors, registrars and directors of clinical training (or equivalent) to attend professional development programs.

Resolution 6.3
AJMOF supports the incorporation of teaching and supervisory skills into junior doctor and registrar training. Integral to this is access to programs such as 'Teaching on the Run' and the 'Professional Development Program for Registrars'. AJMOF supports the assessment of these non-clinical skills.

Resolution 6.4
AJMOF supports the majority of formal teaching to be given by medical staff with relevant input from allied health, nursing and other disciplines. AJMOF encourages policy makers and funding agencies to facilitate this.

Resolution 6.5
AJMOF recognises that assessment of junior doctors should not solely be competency-based due to its limitations. AJMOF calls upon the AMC, HWA and jurisdictions to recognise this in any policies that will impact on medical education and training.

Resolution 6.6
AJMOF reiterates the importance of pager-free protected teaching time for junior doctors at all levels. AJMOF believes health services should take appropriate steps to enforce this.

Resolution 6.7
AJMOF calls upon all relevant stakeholders to provide education and training opportunities to prevocational junior doctors beyond the PGY2 year.

7: Workplace Flexibility and Doctors' Health

Transition to being a doctor can be a very challenging and stressful period for prevocational doctors. AJMOF considered it imperative that strategies for managing work stress and maintaining work-life balance form an important part of support available to junior doctors, as well as access to the benefits of confidential doctors' health support services.

Resolution 7.1

AJMOF supports the proposal by the MBA for part-time or deferred internships. The proposed time frames could be extended for exceptional circumstances on a case by case basis.

Resolution 7.2

AJMOF calls upon the MBA and State and Territory Health Departments to ensure the ongoing resourcing and implementation of confidential doctors' health services including counselling programs. This information should be included as part of the orientation program.

Resolution 7.3

AJMOF calls upon relevant stakeholders to ensure that Australian prevocational standards include the requirement for adherence to accepted evidence-based safe working hours.

8: Consultation

The ongoing developments in education and training with regard to junior doctors require more than token consultation. JMOs should be consistently and appropriately engaged in development of relevant standards. AJMOF also acknowledges that there are a number of representative bodies and individuals throughout Australasia making contributions to this process on behalf of junior doctors. AJMOF believes that JMOs would be best served by transparent communication and collaboration between all these parties in order to share knowledge and ensure appropriate stakeholder consultation.

This resolution reaffirms the belief of junior doctors on the need for more transparent communication between policymakers, other stakeholders and junior doctor groups themselves.

Resolution 8.1

AJMOF calls upon key stakeholders to ensure JMO forum representatives are actively involved in the development and implementation of prevocational education and training standards.

Resolution 8.2

AJMOF resolves to improve communication and collaboration between relevant JMO representative bodies involved in advocacy through an agreed framework for cooperation.

Thanks

AJMOC acknowledges the contributions of all junior doctors who contributed to the development of these resolutions throughout the year and at the 2011 AJMOF. Particular mention should be made of the support provided by the Immediate Past Chair of AJMOC, Dr Caitlin O'Mahony and CPMEC General Manager, Dr Jag Singh.

2011 Australasian Junior Medical Officers' Committee

21 November 2011

2011 AJMOC Members:

Dr Josh Savea, Chair – Medical Council of New Zealand Education Committee

Dr Alexis Taylor Julian; Dr Munib Kiani – West Australia JMO Forum

Dr Linny Kimly Phuong; Dr Verna Aykanat – Victorian JMO Forum

Dr Andrew Hutchinson; Dr Emily Hales – Queensland JMO Forum

Dr Lucy Cho – New South Wales JMO Forum

Dr Sophie Plagakis; Dr Ainsley McCaskill – South Australia JMO Forum

Dr Alex Hofer; Dr Shervin Tosif – Northern Territory JMO Forum

Dr Phoebe Stewart – Tasmania JMO Forum