



Postgraduate Medical Council
of Western Australia

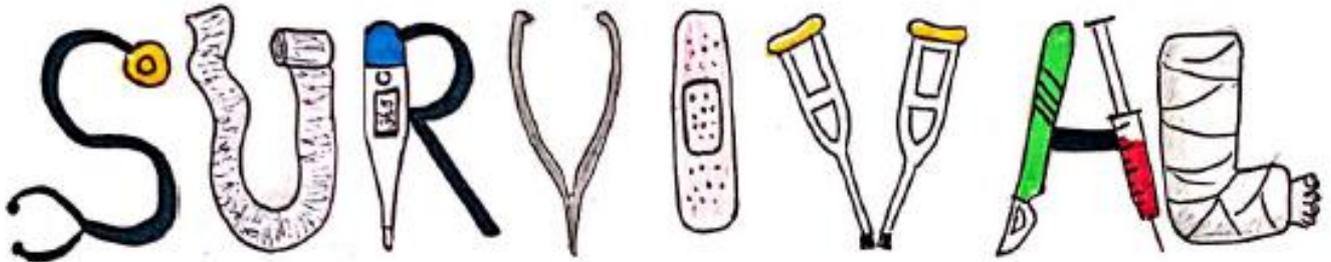
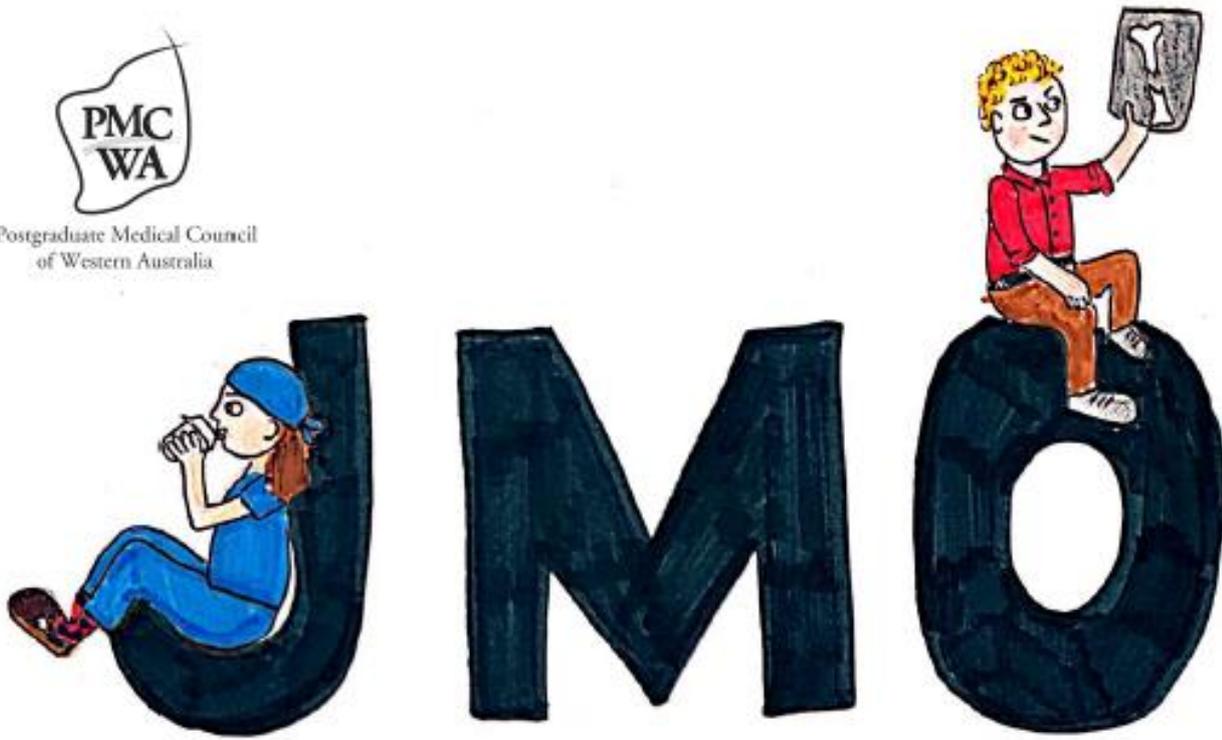


Image credit: Dr Elizabeth Carr

Written by Junior Doctors for Junior Doctors



Postgraduate Medical Council
of Western Australia

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This document is available online at:

www.pmcwa.org.au

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1 | INTRODUCTION

1.1 | WELCOME

Congratulations on surviving and successfully completing medical school! Thank you for taking the time to read this guide. We hope it will help you understand who the Postgraduate Medical Council of Western Australia (PMCWA) is, why they are around and what they do for you. They are always keen for new junior doctors to become involved, so feel free to contact them via the PMCWA website (<https://www.pmcwa.org.au/committee/wa-jmo-forum/>) or by emailing them directly at PMCWA.JMOF@health.wa.gov.au.

1.2 | WHO WE ARE

The Junior Medical Officer (JMO) Forum exists to enable improved communication between JMOs and the PMCWA. Membership is determined by representation from the tertiary hospitals' junior doctors, Junior Doctor Societies and elected positions of Co-Chairs who oversee the running of the JMO Forum and its activities. Medical student representatives from the University of Notre Dame (UND) Fremantle, the University of WA and Curtin Medical School also participate in the Forum. Education, accreditation, doctors' welfare and AMA DIT liaison representatives are elected at the first meeting of the year. The JMO Forum aims to enable effective JMO representation on relevant PMCWA Committees and other bodies to facilitate two-way communication. All junior doctors are welcome to join the JMO Forum. For more information see section 3.10 – JMO Forum (page 11).

1.3 | PURPOSE OF THIS GUIDE

This document can be used as a reference point throughout your junior doctor years. It includes a range of information and contacts and can be used as a guide for where to go for help or advice. It also contains details on the various junior doctor committees beyond the PMCWA JMO Forum. This document gives you an idea of the standards and expectations that come with working as a junior doctor in WA.

2 | DEFINITIONS

2.1 | WHAT IS PREVOCATIONAL TRAINING?

Prevocational training is the beginning of postgraduate medical education in which doctors develop competencies after completion of their basic medical qualification.

The first year after graduating from medical school is a compulsory supervised training year known as internship or postgraduate year 1 (PGY1). The following year/s (PGY2, PGY3 etc.) are spent working as a Resident Medical Officer (RMO). The PGY1 and PGY2+ years that a doctor undertakes prior to entering a vocational training programme provides the grounding for future vocational training. PMCWA oversees training, accreditation and educational opportunities for junior medical staff in these early postgraduate years.

2.2 | DPMEs, DCTs, MERs AND MEOs

Each hospital has a Department of Postgraduate Medical Education or Postgraduate Medical Education Unit that coordinates education, supports training and offers career advice for doctors. Every hospital that employs interns must have the following officials:

Director of Postgraduate Medical Education (DPME)

- The DPME is a consultant who has general responsibility for overseeing hospital-wide postgraduate medical education activities, including orientation of doctors. This person is only available at sites directly employing interns.
- S/he has specific responsibility for overseeing the training of prevocational doctors in accordance with the PMCWA Accreditation Standards, as well as the Australian Medical Council and Medical Board of Australia Standards.

Director of Clinical Training (DCT)

- The DCT is a person to approach in times of stress or difficult situations as they will be able to provide you with support and advice.
- S/he is usually a consultant at the hospital whose role includes assisting with the prevocational training program, providing feedback and advice to junior doctors and liaising with term supervisors regarding JMO issues.

Medical Education Registrar (MER)

- The MER is a good first point of contact for junior doctors in need of help.
- S/he is a registrar employed by the hospital whose role includes teaching, development of educational materials/programs, supporting and advocating for junior doctors and supporting the work of the Postgraduate Medical Education Unit.

Medical Education Officer (MEO)

- The MEO specifically assists with the prevocational education and training experience.
- You will come to know your MEO very well in your intern year as s/he will be present at the intern teaching sessions and will keep you up to date with news relevant to interns.

Contact your Postgraduate Medical Education Unit to identify the DPME, DCT, MER and MEO at your hospital.

2.3 | INDIVIDUAL HOSPITAL ACTIVITIES

Fiona Stanley Fremantle Hospitals Group

Fiona Stanley Hospital (FSH) is WA's largest tertiary hospital and primarily serves the south metropolitan area. It has 783 beds and approximately 100,000 Emergency Department (ED) presentations per annum. FSH provides the service of most tertiary specialities. It is located 20 minutes south of the central business district (CBD).

Rockingham General Hospital and Fremantle Hospital also operate under the South Metropolitan Health Service and interns will have the opportunity to rotate through these peripheral sites. In addition to this, FSH gives interns opportunities to work in Albany and Broome and RMOs to St John of God (SJOG) Murdoch. The activity at Fremantle has changed since FSH opened but the heart remains, with JMOs rating the rotations at Fremantle highly!

The Stanley Medical Officers' Society (SMOS) is an advocacy, social and support group that represents the interests of all JMOs and consultants employed by FSH. It organises key social events including the end of term parties, annual gala ball, and ensures the medical staff common room is stocked with caffeine & provisions throughout the week. This is an important society to be a part of as a new doctor!

Royal Perth Bentley Group

Royal Perth Hospital (RPH) is WA's longest serving hospital. It has 450 beds and is situated in the CBD. RPH offers an extensive range of services including the state trauma centre.

Armadale Health Service and Bentley Health Service operate under the Royal Perth Group and as a JMO you have the opportunity to work at these sites. In addition to this, RPH gives JMOs opportunities to work at Midland, Bunbury, Kalgoorlie and Port Hedland.

Socially, RPH has an enthusiastic RMO society with a very busy social calendar: from Milligan's Bar on a Friday evening to numerous cocktail parties and the annual ball.

Sir Charles Gairdner Osborne Park Health Care Group

Sir Charles Gairdner Hospital (SCGH) provides over 600 beds and is only 4km from the CBD. It is home to a comprehensive cancer centre and is also the state's principal site for neurosurgery and liver transplantation.

The RMO society keeps a busy social schedule with Friday night drinks, cake and patisseries for morning tea twice weekly in the common room and an annual ball.

St John of God Midland

St John of God Midland Public & Private Hospitals (SJGMPPH) opened in November 2015 and is comprised of 367 beds, 307 of which are public beds servicing patients in the east metropolitan and Wheatbelt regions.

SJGMPPH provides a comprehensive range of services including emergency medicine, critical care, day chemotherapy, psychiatry, paediatrics, aged and stroke care, obstetrics & gynaecology and surgery. Previously seconding interns from RPH, 2020 is the first year interns will be directly employed by SJGMPPH.

Interns have the options to choose a rotation stream with a term at SJOG Subiaco Hospital ICU, and subsequent RMO rotations may include terms at SJOG Murdoch and Mt Lawley Hospitals.

SJGMPPH has an emerging JMO Society and will provide you with a unique experience in a smaller cohort with high quality training, supervision and research opportunities working under some of the State's leading specialists.

WA Country Health Service

The WA Country Health Service (WACHS) is the largest country health service in Australia, covering 2.5 million km². WACHS has full year internship positions at Albany Health Service and Bunbury Regional Hospital. There are also opportunities to experience rural medicine through rotations from the Perth metro hospitals to WACHS sites.

Albany

Albany Health Campus is the regional referral centre for the Great Southern region, servicing the needs of a population of approximately 55,000 people. The state-of-the-art, integrated hospital facility opened in May 2013, and offers a wide scope of services including emergency medicine/high dependency unit, general medicine (including palliative care), general surgery, orthopaedics, obstetrics & gynaecology, paediatrics and mental health, amongst others. The campus is also the location for the regional cancer centre, and there is an on-site renal dialysis unit.

When you join the team at Albany Health Campus, you'll become part of a close-knit community of health professionals, all offering excellent support to you as a junior doctor. Managing patient outcomes in a rural setting will add value to your learning experience, and you will have a unique opportunity to follow your patient's journey in a way you might not experience in a metro hospital setting.

Bunbury

Bunbury Hospital is the regional hospital for the South West region, comprising a 135-bed public facility located alongside a similar size private hospital. The campus delivers health care to more than 80,000 of the region's local residents, as well as seasonal visitors, and acts as the regional referral centre for the district. The emergency department provides good exposure to a young and diverse case-mix, reflective of a major teaching hospital, within a regional setting.

You will work with a team of supervising consultants and registrars who are committed to the training and education of junior doctors, offering you an excellent educational experience at Bunbury Hospital.

Joondalup Health Campus

Joondalup Health Campus (JHC) is the major hospital for Perth's northern corridor. It is divided into two sections; a private and public hospital and is Australia's largest public private partnership hospital with over 500 beds. JHC is part of Ramsay Health Care and thus if you elect to work there your salary is dictated by Ramsay Healthcare Awards rate.

As an intern you may be seconded to work at JHC via SCGH. The hospital RMO society is tightly integrated with the hospital executive and other hospital services, allowing for strong representation on junior doctor issues such as welfare, education and training.

King Edward Memorial Hospital for Women

King Edward Memorial Hospital for Women (KEMH) is WA's only public tertiary maternity and gynaecological hospital. JMOs can work at KEMH from PGY2 onwards - although preference is given to PGY3+ and JMOs can apply for either 6 or 12-month contracts. Secondments include Joondalup Health Campus and Osborne Park Hospital. Senior residents are given opportunities to work in Kalgoorlie, Bunbury, Fiona Stanley and Midland. Skills developed at KEMH are desirable for multiple career paths such as vocational training or diplomas of obstetrics and gynaecology, emergency medicine, paediatrics and general practice.

In addition to specialist and general obstetrics and gynaecology, residents are given the opportunity to do rotations in psychological medicine at the Hospitals/Mother Baby Unit, neonates and emergency.

Subiaco train station is a five-minute walk from the hospital. The RMO society keeps the doctors' common room well stocked with good coffee, as well as organising end of term events, regular drinks and the annual KEMH ball.

KEMH provides a comprehensive education experience for Residents which includes daily half hour tutorials and two to three hours of education, available on site and via VC every Friday afternoon. There are also wellbeing support initiatives such as the mentoring program, supportive seniors, debriefing programs and monthly facilitated wellbeing sessions.

Perth Children's Hospital

Perth Children's Hospital (PCH) is the dedicated children's hospital in WA. The hospital is located opposite SCGH in Nedlands and has 298 beds. JMOs can work at PCH from PGY2 onwards, with both 6 and 12-month contracts provided. Those wishing to join the Paediatric Training Program should seek a 12-month contract. Part-time contracts are available for JMOs on a case-by-case basis. JMOs can be seconded to metropolitan and rural paediatric units including SJOG Midland, KEMH (neonates) and Kalgoorlie Regional Hospital.

Many junior doctors choose to complete the Sydney Child Health Program (previously the Diploma of Child Health (DCH)) while working at PCH, particularly if they are looking to do Paediatric or General Practice training. This is an external (online) course offered through the University of Sydney and Sydney Children's Hospitals Network.

3 | PREVOCATIONAL TRAINING

3.1 | POSTGRADUATE MEDICAL COUNCIL OF WA

PMCWA was established in 2003 to provide leadership for early postgraduate medical education and training in WA.

3.2 | AIMS OF PMCWA

- Development of guidelines and protocols for the education and training of prevocational doctors and other medical practitioners not in vocational training programs.
- Setting standards for prevocational training positions within health services.
- Accrediting and monitoring medical training positions for prevocational doctors (PGY1 and PGY2+).
- Monitoring and advising on the supply and demand for the prevocational workforce in WA.
- Supporting clinicians and other professionals involved in the education and training of prevocational and other non-vocational doctors.
- Identifying and advising on matters that impact the health and welfare of prevocational and other non-vocational doctors.

3.3 | COMMITTEE AND STRUCTURE

PMCWA members are representatives of the stakeholder organisations involved in the support, education, training, supervision and administration of prevocational doctors and other non-vocational medical officers.

The Council reports to the Minister for Health via the Director General of the Department of Health. There are representatives from the JMO Forum on the PMCWA Council and PMCWA committees (Accreditation and Standards, and Education).

3.4 | ACCREDITATION

The aim of prevocational training is to further the professional and personal development of medical graduates in their early postgraduate years. Through the process of accreditation, the PMCWA helps to assess that sites are providing training to an acceptable standard.

Every rotation that you work in as an intern is reviewed at defined intervals by the PMCWA accreditation team. The aim of an accreditation site visit is to ensure that health services employing prevocational doctors offer sufficient experience, education, training, supervision, assessment, evaluation, support (including resources) and a safe working environment to enable prevocational doctors to meet the objectives of their training.

The accreditation process involves hospitals and other training organisations that employ prevocational doctors being formally evaluated by a survey team using clearly defined and established standards. Survey outcomes often include recommendations for improvements and recognition of excellence. If you are interviewed during a survey, your honest feedback will be sought and valued.

Are you interested in becoming an accreditation surveyor? It's a good way to see what terms are available at other hospitals and how they are run, as well as being the voice for junior doctors in ongoing accreditation for new terms. Email PMCWA.Accreditation@health.wa.gov.au to register your interest. You will start as a trainee surveyor, and work alongside a support and lead surveyor.

3.5 | WORKFORCE

PMCWA and the WA Department of Health recognise that workforce planning is fundamental to the delivery of good health care. PMCWA is represented on a number of important workforce planning committees within the Department of Health that monitor the supply, demand and needs of prevocational doctors in WA. A member of the JMO Forum sits on many of these workforce committees.

3.6 | EDUCATION

The Education Committee is responsible for the identification, evaluation and monitoring of education and training programs for prevocational medical officers and other non-vocational doctors. The Education Committee reports to the Council on strategies and outcomes.

The JMO Education Committee representatives attend both the JMO Forum meetings and the quarterly Education Committee meetings. The role of the representatives is to:

- advocate for JMOs on all educational issues.
- provide feedback on the activities of the Education Committee to JMO Forum members.
- undertake or assist with education projects with the support of the JMO Forum and Education Committee.

3.7 | AUSTRALIAN CURRICULUM FRAMEWORK FOR JUNIOR DOCTORS

The Australian Curriculum Framework for Junior Doctors outlines the knowledge, skills and behaviours required of prevocational doctors (PGY1 and PGY2+) in order to work safely in Australian hospitals and other healthcare settings. It provides a bridge between university curricula and the curricula that underpin college training programs. It is an educational template outlining the learning outcomes required of prevocational doctors, to be achieved through their clinical rotations, education programs and individual learning, in order to promote safe, quality health care.

A copy of the Curriculum Framework is provided in the orientation materials each year (it is also available as a smartphone app e-book – search ‘ACF LP’).

For more information, please refer to the website for the Australian Curriculum Framework for Junior Doctors: <http://curriculum.cpmec.org.au/>.

3.8 | EDUCATION AND TRAINING OPPORTUNITIES FOR INTERNS

- Teaching (once or twice a week) is compulsory and is protected time from your pager. Divert your pager to your resident/registrar for this hour. It is a good break from the ward and the topics are useful.
- Be proactive – there are a wide range of skills you can learn in your intern year such as chest drains, ascitic taps, nerve blocks, lumbar puncture, suturing, and central lines to name a few.

3.9 | EDUCATION AND TRAINING TIPS FOR RMOs

- Resident teaching is available at all accredited sites and is compulsory at most. Support this as it is an excellent opportunity to engage in a wide range of topics that may be outside your area of interest.
- Think about attending courses (ALS2, EMST, CCrISP, ASSET, CLEAR etc.) which may be relevant to your area of interest. They provide a good opportunity to acquire skills in a non-clinical setting and may assist you with training program applications.
- The JMO Forum Education Representatives have put together a Professional Development Leave (PDL) Guide available on the PMCWA JMO Forum website. The PDL guide contains an overview of courses, conferences, research degrees, and options for junior doctors organised by speciality. If you have any suggestions to add to the PDL guide, please email PMCWA.JMOF@health.wa.gov.au
- If you have any education suggestions, contact your DCT and MEO.

3.10 | JMO FORUM

The WA JMO Forum is an initiative to promote better communication between JMOs and PMCWA. It is used to inform JMOs of initiatives/strategies that impact them and to gather information to better inform the PMCWA's JMO activities.

The terms of reference for the Forum include:

- To focus on the participation and involvement of JMOs in the decision making and planning functions of PMCWA and its committees.
- To provide advice to PMCWA and its committees on issues of relevance to JMOs.
- To report to PMCWA committees on relevant issues and where appropriate, forward issues to Council through the committee reports.
- To assist in the development and evaluation of resources developed by PMCWA and its committees.
- To educate and inform key stakeholders of the goals of PMCWA.
- To provide representation on PMCWA committees to support their work in achieving the goals of Council.
- To support members of Council, Executive and Secretariat attending the JMO Forum as a resource on specific issues, when appropriate.

The JMO Forum meets at least once a term. Any JMO may attend and everyone is welcome. Keep an eye out for emails and the PMCWA Facebook page (www.facebook.com/PMCWA) which will advertise the forthcoming meetings.

3.11 | HOW TO GET INVOLVED

Representatives from PMCWA will give a talk during the intern orientation sessions at your hospital. At this time there will be an opportunity to provide your name and email address so that PMCWA can contact you about upcoming meetings and events. Alternatively you can email PMCWA@health.wa.gov.au with your details and the relevant information will be forwarded to you. PMCWA has a Facebook page (www.facebook.com/PMCWA), 'like' the page to keep up to date with all the latest information. The first JMO Forum meeting is generally held in February/March each year and subsequent meetings occur approximately every two months.

3.12 | LINKS WITH AMA DIT, RMO SOCIETIES

The Australian Medical Association (AMA) WA Doctors in Training (DIT) Committee is closely allied with the JMO Forum. The JMO Forum focuses on the educational, supervisory and training aspects of prevocational training. The AMA DIT looks primarily at the industrial aspects of being a junior doctor. This can include issues with lockers, security or on-site hospital facilities as they arise. The AMA DIT also concentrates on the *WA Health System Medical Practitioners AMA Industrial Agreement 2016* and how this is being applied to the work conducted by junior doctors. The AMA helps to ensure fair payment to doctors for the work we perform, while ensuring safeguards in terms of hours and workload in relation to patient safety.

Previous issues that have been addressed by the PMCWA JMO Forum include: inadequate numbers of doctors rostered on for after-hours cover; pager-free protected teaching time; access to library resources; and appropriate rotations for junior doctors. As you might imagine, issues often overlap between AMA DIT, PMCWA JMO Forum and the hospital-based RMO societies.

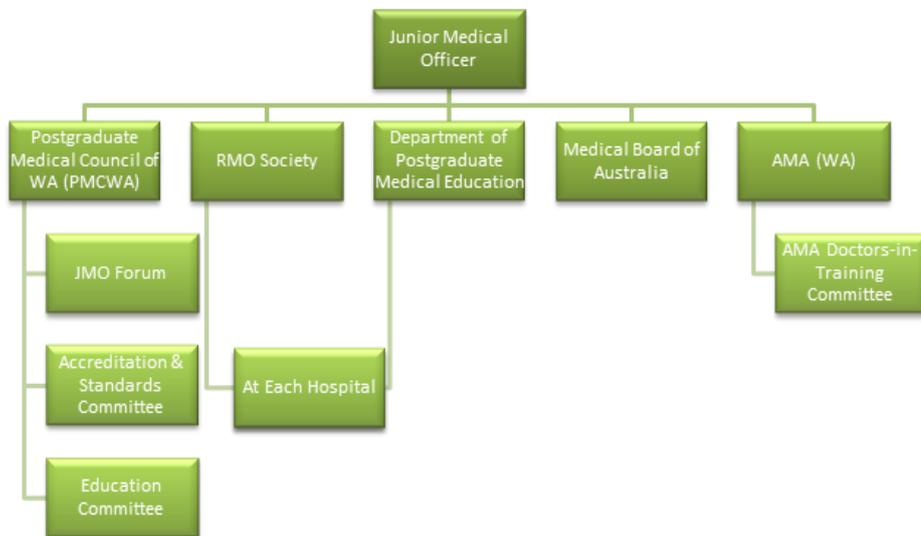
Each of the tertiary hospitals in Perth have their own RMO society with an annually-appointed president and other committee members depending on the hospital. There has been considerable support amongst groups on issues that affect a group of junior doctors including parking, lack of JMOs at certain hospitals and JMOs having to work long unsafe and unsociable hours. The alliance of all these groups, including the medical student bodies (WAMSS, MSAND and Curtin), creates a very powerful voice for the new generations of doctors in our hospitals.

4 | JMO RIGHTS

WHAT TO DO IF YOU HAVE A PROBLEM

4.1 | SUPPORT NETWORKS

A mud map of the groups working for you in WA:



4.2 | POSTGRADUATE MEDICAL COUNCIL OF WA

If you are experiencing issues with access to education, support or supervision, you are able to contact the PMCWA either via email or through the JMO Forum (see section 3.10 for further information). We have several avenues where we can investigate and improve these conditions, including initiating an accreditation survey to ensure the standards are being adhered to.

4.3 | RMO SOCIETIES

For a small fortnightly fee that comes out of your pay, the RMO societies do a lot of work on a junior doctor's behalf. This includes:

- Liaising with hospital administration staff regarding issues such as leave and rostering. Talk to your RMO Society representative if you are having problems at your site – they may be able to assist.
- Providing social supports and Friday afternoon fun – (e.g. Milligan's at RPH,

General Sherman/Blue Room at FSH/Fremantle; and Doctors' Common Room at SCGH).

- Coffee machine, papers, morning tea.

4.4 | AMA (WA) DIT COMMITTEE

The AMA (WA) DIT Committee holds a monthly meeting open to all doctors in training in WA who are AMA members and committed to advocating for the professional, wellbeing and industrial aspects of working as a junior doctor in WA. The committee meets at 18:30 on the second Monday of every month at the AMA (WA) headquarters in Nedlands.

Who can join?

Membership is open to all junior doctors - from intern to senior registrar - who are AMA members. The Committee includes a broad range of sub-specialty and prevocational trainees from across all hospitals and community-based practices.

What issues are discussed?

The Committee examines, discusses and responds to issues affecting the education, training, wellbeing, industrial and professional aspects of being a junior doctor. Key discussion areas of concern are annual leave and parental leave entitlements, safe working hours, part-time and flexible working arrangements, understanding payslips/underpayments, and supporting a healthy work-life balance.

Key achievements for the DIT committee are the annual Hospital Health Check, recent doctors' wellbeing symposiums and advocating for the accreditation of service registrar positions in WA.

Representation to organisations

The AMA DIT Committee also provides representation to a number of internal and external committees. DIT members represent the interests of all junior doctors to educational groups (PMCWA Education Committee, the Joint Consultative Committee for Medical Student Training, JMO Forum, UWA, UND and Curtin Curriculum Committees) and allied PMCWA committees (Executive and Accreditation and Standards), as well as subspecialty interest bodies and national councils (AMA Federal Council of Doctors in Training, National Training Survey Steering Committee, etc). A group of General Practice registrars provide contacts and support to WA General Practice Education and Training (WAGPET) and Community Residency Program Committees.

The circle of representation is completed by external nominees to the DIT Committee. This includes members of the RMO Societies as well as medical

students from universities. Each of these makes the DIT Committee a vital conduit of information from various groups in all areas, from medical politics to the social scene and upcoming ball dates.

Workshops and courses

A number of workshops are available to AMA members, initiated by the DIT Committee. These include:

- Getting Started in Clinical Research – for those interested in getting an edge for their CV by small papers - or for those embarking upon a full Masters or PhD program - potential avenues for funding and mentorship are discussed.
- Intern/RMO Application information evenings.
- Leadership and Management Training.
- Medico Legal Seminars.
- Youth Friendly Doctor RACGP and ACRRM accredited workshops.
- GP Registrar Employment Essentials Professional Development Seminars.
- Doctors in Training Symposium.
- Information Nights on Junior Doctors' Welfare.
- Getting Started in Private Practice – for the DIT nearing the end of their training in any sub-specialty, the 'business of medicine' is rarely discussed but crucially important for survival in the world of private medicine.
- Presentation skills seminar – junior doctors do more presentations than any other professional in their field. Tips on oral presentations, slides and handouts, format and how to make your message clear are covered in this two-day seminar.

For those junior doctors looking at GP as their career pathway, the AMA (WA) has created two new categories of membership specifically for GP Registrars. AMA (WA) recognises that this stage of life reflects many personal and professional demands and, in acknowledgement of this has implemented these new categories to help support GP Registrars with the challenges they face.

So for all new members in 2020 – welcome to the profession and we hope to see your face around the table!

4.5 | MEDICAL BOARD OF AUSTRALIA

In 2010 all states and territories joined the Medical Board of Australia, which is a division of the Australian Health Practitioner Regulation Agency (AHPRA). The Medical Board of Australia has an office in all capital cities, including Perth.

The Board is an independent statutory authority. Its role is to:

- Register medical practitioners and medical students.
- Develop standards, codes and guidelines for the medical profession.
- Investigate notifications and complaints.
- Where necessary, conduct panel hearings and refer serious matters to tribunal hearings.
- Assess International Medical Graduates who wish to practise in Australia.
- Approve accreditation standards and accredited courses of study.

The Board consists of eight medical practitioners, one legal practitioner and three community representatives.

4.6 | MANDATORY EXPERIENCE

As an intern, you hold provisional registration with the Medical Board. Upon successful completion of your internship, you will be eligible for general registration.

All hospitals employing interns provide rosters that include the mandatory core terms. The Medical Board of Australia requires interns to perform satisfactorily under supervision in the following terms:

- *A term of at least 8 weeks that provides experience in emergency medical care*
- *A term of at least 10 weeks that provides experience in medicine*
- *A term of at least 10 weeks that provides experience in surgery*
- *A range of other approved terms to make up 12 months (Minimum of 47 weeks full time equivalent service. A maximum of two weeks approved PDL can contribute to the 47 weeks. PDL cannot contribute to core medicine, core surgery or core emergency medicine time).*

Please keep these requirements in mind if you swap rotations or take leave during one of the mandatory terms.

For further information regarding the Medical Board of Australia please visit their website www.medicalboard.gov.au or contact PMCWA for assistance.

4.7 | PARENTAL, EXTENDED LEAVE, PART-TIME AND JOB SHARING ARRANGEMENTS

The following arrangements may be accommodated via discussion with your employer. Giving adequate notice (10 weeks) to the hospital (usually medical admin/DPME) prior to taking leave is important in having leave approved.

Parental leave

As per legislative requirements and the *AMA Industrial Agreement 2016*, employees are entitled to 52 weeks parental leave in relation to the birth or adoption of their child. Up to 14 weeks (full pay) or 28 weeks (half pay) of this may be paid, if the employee is the primary care giver.

Extended leave

This leave is organised in consultation with the employer. This may not be possible during your intern year, due to internship requirements of supervised training, but is more easily arranged from PGY2.

Part-time

According to the *AMA Industrial Agreement 2016*, a full-time practitioner's request to work on a part-time basis shall not be unreasonably refused. Hours worked will be negotiated with the employer. Some hospitals offer part-time contracts and a variety of options for part-time rotations. Discuss with medical administration at your hospital for further details.

Job sharing

Most hospitals will allow for job sharing, particularly when part-time work is requested. This needs to be discussed with your hospital.

4.8 | SUPERVISION REQUIREMENTS

WA teaching hospitals believe strongly in supervision for the junior doctor. As an intern, there should always be someone senior on site to refer to if there are difficult or specialist decisions to be made. RMOs and registrars also have supervision, however depending on the level of experience or specialty this may not be on site supervision. The PMCWA Accreditation and Standards Committee evaluates each intern/RMO position to ensure supervision is adequate.

If you find that you are not receiving the support that you require, speak to your consultant or Head of Department. If this does not improve the support you are receiving, or you feel that you cannot discuss this with the department, contact your Department of Postgraduate Medical Education. This can be further addressed to PMCWA via the JMO Forum (PMCWA.JMOF@health.wa.gov.au) and if necessary the accreditation of the rotation will be reviewed and concerns investigated.

In a situation where you have a patient who is unwell on the ward and are not sure what to do, contacting your registrar is often the first thing to do. Escalate to the consultant if you are unable to contact your registrar. If your patient is acutely unwell or meets Medical Emergency Team (MET) criteria, activate a MET call immediately as they can help you stabilise the patient. Your registrar should also be contacted at this time.

4.9 | TERM ROTATIONS

Interns and residents generally undertake five rotations of approximately 10-11 weeks duration throughout each year, although some sites (e.g. PCH, KEMH), have four rotations of a longer duration, or six rotations of a shorter duration, respectively.

JMOs are able to preference their term selection from a list sent out by the hospitals following the job application process. First year residents (i.e. PGY2) will generally have to do a leave relief and/or emergency term. There are a small number of terms that are available through a separate process; a term in Clinical Service Improvement that is run through the Institute for Health Leadership at the Department of Health (PGY2+), the Peri-Operative/anaesthetics RMO position (PGY3+) at SCGH, FSH and RPH, and a Critical Care year (PGY2+) (involving anaesthetics, ICU, CCU, ED and leave relief) run through JHC. Speak to the hospital's medical administration staff or PMCWA for details on how to apply for these terms.

For RMOs, there is the opportunity to apply to participate in the Community Residency Program (CRP).

FSH, RPH and SCGH employed RMOs are seconded to undertake CRP placements in either a metropolitan location with Silver Chain or with the WA Country Health Service in a variety of rural locations such as Kununurra, Derby, Port Hedland, Karratha, Geraldton, Esperance, Kalgoorlie or Narrogin.

If found successful, RMOs may be offered the opportunity to complete a clinical term in either a rural or metro CRP placement. Participants remain contracted and salaried to their Primary Employing Health Service (PEHS) but are released to Silver Chain or WACHS on secondment for a term-long placement.

4.10 | CLINICAL STANDARDS, TRAINING AND ASSESSMENT

As a JMO, you are required to meet certain clinical standards and training/educational objectives.

Your clinical standards will be assessed during and at the end of each term by a senior member of your team (usually a consultant). During these assessments your senior is given the opportunity to highlight areas that need improvement and areas in which you did well. These are aligned with the Australian Curriculum Framework (<http://www.cpmec.org.au/Page/acfjd>) and global intern outcomes (www.amc.org.au).

All hospitals provide teaching/training on a regular basis to all JMOs. These are usually weekly sessions addressing problems that commonly arise on the wards. For those who have entered a registrar training program, most specialties have regular teaching sessions.

Some hospitals also provide skills workshops/sessions in which you will learn skills that you may not learn on the wards. Other hospitals will require you to spend time in theatre, with anaesthetics, in the intensive care unit or in other settings to learn new skills and procedures.

4.11 | PAY ISSUES AND PAYSLEIPS

Online payslips became accessible via LatticeWeb from 2019 for WA Health staff. You can visit latticeweb.health.wa.gov.au on the hospital intranet to view, print or email your payslips. Alternatively, you can complete a F5 form to set up automatic emailing of your payslip to your preferred email address.

SJOG employees will be issued with a guide to your payslip and penalties at Orientation.

HOW TO CHECK YOUR PAYSLEIP 101

Please visit [the Health Support Services \(HSS\) Doctors & Medical Administration Intranet page](#) for current payroll information.

Before you attempt to understand your payslip there are a few things you should do first:

1. At the start of each term contact HSS to confirm what your template hours will be. Remember that the template roster for some terms includes after-hours work such as evenings and weekends.
2. Record any work done outside the template hours in a diary/calendar.

- Remember to submit overtime forms promptly after completing a shift - weekly or fortnightly is best. If the department says they will submit overtime forms make sure it gets done. If in doubt, submit them yourself. The worst that could happen is HSS receives two sets of forms. At least that way you stand a better chance of getting paid!
- In alignment with the current industrial agreement, overtime does not need to be prospectively approved.

When you receive your payslip each fortnight take the time to look through it. By following these steps you should have a rough idea of whether you were paid correctly. Please note this information is a rough guide only, as every payslip is different. If in doubt, contact HSS.

- Calculate the total number of hours you should have been paid for over the fortnight. Do this by adding your template hours (e.g. 85hrs) to all the extra hours you have documented in your diary/calendar/phone.
- Calculate total hours you have been paid as indicated on the payslip. Do this by adding up the 'full' hours you were paid for (i.e. add up all the hours where you were paid your hourly rate or above. Ignore anything where you were paid a percentage of your hourly rate e.g. 75%).
- If the numbers in point 1 and 2 are the same you're doing well! You can now proceed to ensure you were paid the appropriate penalties.
- Calculate your entitlement as per the table below.

Penalty rates:

Base hours	1 x base rate
Public holidays	2.5 x base rate
Weekdays	
6pm-0000	1.2 x base rate
0000-8am	1.25 x base rate
Weekends	
Saturday	1.5 x base rate
Sunday-8am Monday	1.75 x base rate
Overtime	
Hrs>80/fortnight	1.5 x base rate
Hrs>120/fortnight	2 x base rate

E.g. (if base rate = \$40)

- Monday – **2hrs** = 2 x 40
- Tuesday (public holiday) – **4hrs** = 4 x 2.5 x 40
- Sunday – **2hrs** = 2 x 1.75 x 40
 - Total = 80 + 400 + 140 = \$620

Remember it takes time and practice to be able to decipher your payslip. So do not worry if you are extremely confused at this point!

Other penalties and payments you may wish to check for include on-call allowances, call back payments, meal payments and any breach penalties. Information on these and other entitlements such as accrual of additional annual leave can be found in the *AMA Industrial Agreement 2016*.

If you think you may have been paid incorrectly, contact HSS and ask them to take you through the hours worked each day during the pay period. You can then check this against your own records.

5 | WHAT'S MY ROLE?

WORKING IN THE WA HOSPITAL SYSTEM

5.1 | SCOPE OF WORK

As a junior doctor, you are part doctor, part administrator and often the primary point of contact for patients and their families. On a usual JMO job, you are required to:

- Write in the notes;
- Complete ward jobs: cannulas, bloods outside of phlebotomy rounds, medication charts, investigation request forms, referrals to other specialties, discharge summaries;
- Clerk patients (on terms such as ED and the acute assessment units).
- Continue to develop your knowledge and skills.

Remember that these are your patients. If you take the time to get to know them and the details of their care as opposed to simply being the team's 'paper pusher', you will learn a great deal more.

5.2 | TIPS FOR JMOs

Your junior doctor years are an exciting time during which you will be presented with many challenges and learning opportunities. Remember that many have gone before you, so if you feel overwhelmed there is always someone to talk to.

Be organised

- Get a good handover from the previous interns – this is invaluable!
- On day one talk to your team, clarify their expectations of you throughout the term.
- On ward rounds take the time to clearly write down all the jobs you need to do, clarify things as you go.
- Keep a bunch of radiology forms, consult forms, med charts and inpatient notes in a clip board so that you do not need to be running back and forwards unnecessarily. You can also do the forms as you go while the stickers are on hand.
- Pre-empt discharges. When someone is close to discharge make sure their summary is started and their discharge medications are done. This ensures that you are not being chased the following day at ward rounds to get the paperwork done as the patient is walking out the door.

Prioritise jobs

- At the end of ward rounds prioritise the jobs to be done. If possible sit down with your registrar to quickly run through what needs to be done and which tasks are more urgent.
- Get consults done early as registrars prefer to be called in the morning (not ten minutes before they are due to finish).
- Radiology is also another job to organise early as several processes may need to be organised before the patient goes for their scan.

Don't dump on your colleagues

- Ward cover should be an emergency service, not picking up the pieces from disorganised interns. Make sure you have:
 - prescribed warfarin daily;
 - re-written medication charts on Friday;
 - checked / ordered blood and x-ray results daily;
 - addressed patients who were hyper or hypoglycaemic overnight;
 - written a plan for fluid replacement if necessary.

Writing in notes

- Minimum information includes names of those on the round (from most to least senior), date, time, your name and signature and pager number.
- A good way to start your entry is to quickly revisit who the patient is and why they are in hospital i.e. '78 year old female with CAP, day 2 IV ABx'.
- Write legibly (this may become a legal issue).
- Ensure there is an entry for each patient every day, even if only brief.
- If you are ordering a test, try and make it obvious why it is being ordered and document the result when you have it.
- If the patient's problems and care is complicated, write a problem list at the front of the notes to highlight the hurdles to discharge.
- Make your plan very clear. This is what is referred to by nursing and allied health staff to guide treatment for that day – it makes their job easier and facilitates timely discharge if the plan is clearly stated.

Communication

- Ensure the written plan is verbalised to the appropriate nursing staff. They'll make notes on their handover sheet based on your advice and this will facilitate thorough care of the patient.
 - Advise the shift coordinator regarding impending discharges.
 - If you are asked by the ward staff to review a patient, do it! It doesn't look good to have 'Doctor refused to review patient' in the notes. Respect their opinion, many will be far more experienced than you. Furthermore, write in the notes afterward so that there is evidence that you were there and what you did, allowing the next person reviewing them to be up to speed.
-

Consulting colleagues

- Ensure you have a clear understanding of what your team or consultant is wanting from another specialty – e.g. what is the clinical question; do they want phone advice, a review of the patient, or the other specialty to potentially take over that patient's care
- Make sure you follow up your written consult with a phone call. Make sure you have all relevant notes, blood results and radiology available before you call so that you do not get caught out when they fire questions at you. Make sure your referral refers to a specific clinical question to be addressed.
- The same goes for radiology requests and it often pays to speak to radiology directly. If contrast is required know the patient's creatinine.
- If you run into difficulty referring a patient, ask your RMO or registrar for assistance.

Managing ward cover

- Carry a pen torch and a copy of 'On Call'.
- Prioritise jobs! Ward cover is invariably a very busy shift ranging from acutely unwell patients to rewriting medication charts.
- Handover unwell patients (and MET calls attended) to the night cover JMO.

Seek help early

- Do not be afraid to ask for help. You are a doctor under supervision so do not feel like you have to make all the decisions.
 - Stand up for yourself. Do not do anything that you are not comfortable doing, such as running a code or doing a consent form for a procedure that you know nothing about.
-

5.3 | TRAPS FOR YOUNG PLAYERS

Lab results

- If you order a test, it is your responsibility to follow it up.
Some tests like pathology and microbiology take time to come back so make sure you set yourself a reminder to check (you could put the patient's sticker in a little notebook or put it in your phone).
- Interpret in the context it was ordered. Treat the patient, not the lab test i.e. +ve MSU results in the context of an asymptomatic patient.
- Remember that all investigations cost money and excessive 'routine' investigations add up for both the Department of Health and the patient (think of all those needles!).

Fluid management

- It is harder than you think and can be potentially dangerous, as a general rule do not prescribe fluids without going to see the patient.
- Think about body weight, oral intake (or lack thereof), losses through drains, and electrolytes.
- Ensure you know how to assess fluid balance; there are some useful apps that can assist here.

Medication charts

- Do not rewrite blindly – check all medications / doses / routes until satisfied. Check allergies.
 - If unsure of the dose, check with eMIMs, AMH, a colleague or a pharmacist (pharmacists are always happy to be consulted).
 - Remember, some drugs need monitoring e.g. warfarin, digoxin, vancomycin and gentamicin.
 - Consider if dose reduction is needed in renal impairment.
 - If patients have completed their course of medication, cease it (e.g. antibiotics and steroids). It's also good practice to write the reason why the medication was ceased as it can be very confusing for subsequent doctors to work out what's going on if things are simply crossed out.
-

Drug levels

- Do not blindly chart warfarin, refer to INR and consider whether the drug should be withheld in the context of the patient's admission.
- Write the correct info on the request form i.e. when checking drug levels write the specific time the test was taken. If unsure of the timing, check with the lab.
- Remember to consider drugs that are cleared by the kidneys in the setting of renal failure.

Radiology on ward cover

- Know your review spots in a CXR, e.g. the small pneumothorax or subdiaphragmatic free gas.
- Do not clear an NG tube placement until completely satisfied (a clinical review may be warranted).
- If in doubt, seek help or ask your friendly radiologist.

BSLs on ward cover

- You will be called to prescribe insulin for high BSLs, do not just prescribe four units of insulin blindly, consider timing, presentation and reasons for poor control.
 - Review the patient and the insulin chart, look for identifiable causes for hyper- or hypoglycaemia.
 - Insulin is renally cleared so be wary in renal impairment. Prescription should then be reviewed by the day team.
-

5.4 | WORKLOAD

This will be entirely variable depending on the job. Expect base hours between 40 and 50 hours/week, including a Saturday morning ward round on many rotations. In addition, there is often a separate roster for after-hours ward cover (this tends to be the case on 'quieter rotations') and on-call roster on terms such as ED. You are paid for your lunch breaks (no doubt implying that it is common to not be able to take one but at least always make yourself stop for 15 minutes to eat).

During many terms, you will be rostered to work 'ward cover' shifts on weeknights and/or weekends. On average, these occur once every one to two weeks. This involves responding to issues after the patient's day team has left. Shifts vary in intensity, you could find yourself sitting in the common room most of the night, or you could be paged all night, occupied with ill patients. How busy you are often depends on whether or not the day intern/resident finished all their jobs! (These shifts can usually be swapped amongst other interns/residents).

Remember, help is always available, even if at times there appears to be none. There is always a medical and surgical registrar in the tertiary hospitals and you can always call ED. If all else fails and you're worried you can call a MET, there is no quicker way to get help!

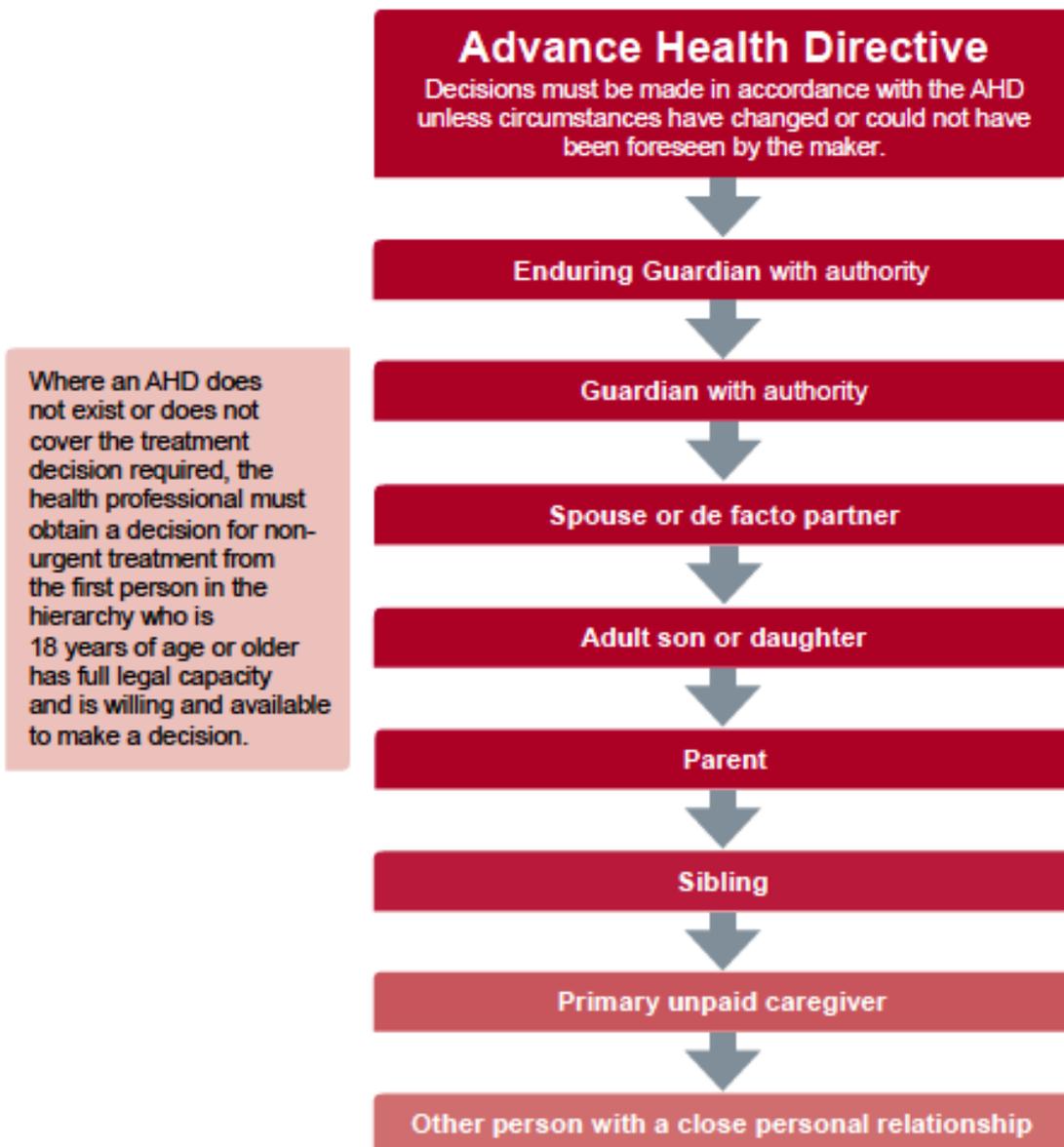
5.5 | OBTAINING INFORMED CONSENT

Obtaining informed consent, and whether one is appropriately trained to do so, is an issue that commonly affects JMOs. The WA Department of Health has a WA Health Consent to Treatment Policy (2016) (http://www.health.wa.gov.au/circularsnew/circular.cfm?Circ_ID=13293)

Some salient points as related to JMOs are synthesised below:

1. Consent is always taken in the context of patient safety.
2. Prior to obtaining informed consent, the prevocational doctor should be satisfied that s/he is aware of the material risk. S/he should also be able to understand that material which can be reasonably withheld in the patient's interest.
3. The prevocational doctor should know the patient well enough to appreciate the specific risks to that patient. A patient may have special needs or circumstances that may in some cases require special or additional information.
4. The prevocational doctor should have sufficient knowledge of the procedure to explain it to the patient.
5. For each placement, there should be an opportunity for an agreement between the term supervisor and prevocational doctor about those procedures for which they are comfortable obtaining consent, those that they would not and those which may vary depending on the individual patient and the prevocational doctor's experience.
6. Hospital process must not allow unfair retribution to a prevocational doctor from a supervisor for reasonably refusing to take consent.
7. Consent is sometimes taken at the last minute when more senior staff are not readily available. There should be a policy to generally obtain consent during pre-admission clinics or equivalent. Where appropriate it may be reasonable to not allow a case to be booked unless consent has been obtained.
8. Where appropriate, consent may not be delegated and must only be taken by a senior resident, registrar or consultant.
9. In the event that a patient who is 18 years or older is not able to give consent and an applicable AHD does not exist, the hierarchy of decision makers for treatment (see Fig.1) must be used to identify a substitute decision maker known (see full policy for further details).

Figure 1: Hierarchy of decision-makers for treatment⁴



If you do not feel that you are adequately prepared to obtain consent from a patient for any given procedure, it is important that you express this to your supervisor/s (registrars/consultants). If you, at any time, feel inappropriately pressured to carry out consents for procedures you should contact either your term supervisor, DCT or DPME.

WA Health has access to a database of over 350 Procedure Specific Information Sheets (PSIS), written in jargon-free language. These can be used to give information to patients during the consent process. Translations into 'Easy Read English' and 19 other languages are available for some of the most popular documents. You will need to use a specific hospital site login to access these.

Queensland Health also has helpful patient information sheets and consent guidelines for common procedures. Available from:
https://www.health.qld.gov.au/consent/html/for_clinicians

5.6 | HANDOVER

Handover is 'the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis.'

Handover is one of the most important skills that you need to acquire as a JMO and is not often taught in medical school. It is important to understand that poor handover ultimately affects patient safety.

The handover tool used in WA is the iSoBAR tool. Handover may include something as simple as asking a colleague to check a blood result or more complex tasks such as handing over patients at term changeover and the more formal handover processes that occur in wards such as the intensive care unit. At the end of your normal day shift you should handover sick patients / those that require review to the evening doctor. If you follow the iSoBAR process you will not miss any vital information.



5.7 | DISCHARGE SUMMARIES

Discharge summaries are a key form of handover, in this case to the patient's GP. Discharge summaries may also be used to communicate with other hospitals or be referred to when a patient is re-admitted to hospital in future. Furthermore, they are used in hospital funding. It is difficult when first starting out to know how much information to include in the discharge summary. At the very least the following should be included:

- Diagnosis (check with your registrar if you are not sure);
- Medication list (clearly specify any medication changes, if possible state the indications);
- Follow up/plan (e.g. how long on those antibiotics?);
- Outpatient appointments (if relevant); and
- Specific (and polite!) instructions to the GP and patient.

A useful approach is to type a short summary of the presenting complaint and management thereof in the box entitled 'Management/Progress' (e.g. 'This 68 year old lady presented to SCGH ED with two hours of central crushing chest pain, which radiated to her jaw. On examination, she was sweaty and pale. Stable vital signs. ECG revealed an acute anterior myocardial infarction...' etc.).

Those who have been in hospital for a long period are obviously more complex and their discharge summary should be started prior to their discharge. A useful approach is to represent key points in dot point form. E.g. This 81 year old man was admitted to RPH following a fall where he fractured his left neck of femur. Summary of admission:

- Fracture neck of femur;
- Subsequent osteomyelitis; and
- Rehabilitation.

Clinical documentation is translated into a Diagnosis Related Group (DRG) by the Clinical Coder.

Good quality clinical documentation in the medical notes will allow for a smooth transcription of a discharge summary. Accurate documentation and being specific with diagnoses and management plans leads to accurate hospital funding. However, there are also certain diagnoses (Hospital Acquired Complications – 'HACs') which can lead to a financial penalty (some are **highlighted in red**) being applied. It may be helpful to present your discharge summaries at a weekly meeting or get a senior to review.

It is important to be as specific as possible in your documentation and to note if a condition was already present before admission or was acquired during their admission.

- **Anaemia:** What is it secondary to (e.g. blood loss or iron deficiency)?
- **Electrolyte disorders:** Is it hypo/hyper and was it treated or monitored – corrected (IV or PO replacement)?
- **UTI:** was it actually a UTI or pyelonephritis?
- **Respiratory failure Type 1 or 2:** (Acute OR chronic OR Acute on Chronic)
- **Peripheral oedema:** What was the underlying cause? LVF or fluid overload and what treatment was given (IV/PO diuretics).
- **Diabetes Mellitus:** List ALL co-morbidities, think of macrovascular diseases (e.g. coronary artery disease, peripheral vascular disease) and microvascular (e.g. retinopathy, peripheral neuropathy, nephropathy)
- **Increased INR:** Secondary to anticoagulants or other coagulopathy?
- **Turbid fluid in abdominal cavity (written on OP report):** secondary to e.g. peritonitis?
- **Confusion: Be specific** is it delirium? Is it due to an underlying dementia or is it delirium superimposed on dementia? Is it transient post-op confusion?
- **Post-op conditions** e.g. atelectasis, ileus
- **Urinary retention:** Is it acute or chronic? Is the catheter blocked (try to flush or re-site)? Acute retention requires emergency treatment + catheter insertion. Consider mechanical causes (obstruction) vs functional (neuropathy, drugs, regional anaesthesia). Basic approach: Physical Ex, bladder scan (pre & post void), urine MCS, UEC, renal tract USS +/- urology input. Check local hospital policies and guidelines.
- **Ulcers:** pressure (what stage was it?), diabetic, venous, arterial
- **Malnutrition:** Check with a dietician if this diagnosis is accurate.

5.8 | PROFESSIONAL STANDARDS

1. Language

Patients expect a high level of professionalism from doctors. It is good to start a relationship using Mr/Ms – this may change depending on the age of the patient and the rapport you have built. You must always introduce yourself and have your name badge visible. Try to use appropriate language when speaking with your patients, remember that a hospital is a confusing and daunting place – so no swearing, jargon or overly casual remarks!

2. Manners

Be polite to all members of staff, you can't do your job solo.

3. Pagers

When sending a page include as a minimum your name, patient name, a contact number and brief summary. It is also helpful if you include urgent or non-urgent in the text of your message. You are required to be contactable during your rostered hours and must answer your pager promptly. However, if you are in the middle of a cannula just get it done and then answer (it's not practical to answer the pager every 30 seconds so you need to prioritise – as with everything else you do).

4. Punctuality

It is important that you aim to be punctual. Furthermore, it is often expected that junior medical staff will have printed patient lists for the team and have reviewed results of the previous day's blood tests etc. before the morning ward round, so it is often useful to arrive at work 10 minutes early.

5. Prioritise patient safety

If you find you are left to deal with a situation that is beyond your level of ability, ask for help from a senior colleague. It is important to know your boundaries (you can't know everything and you shouldn't feel that your question is silly). If you do not agree with a decision from another doctor do not be afraid to question it and escalate if you have concerns about patient safety.

5.9 | PRIVACY AND CONFIDENTIALITY

To keep patient details strictly confidential you should always be aware of who may be able to see your notes, where you leave them, where you throw them away, what you say and who may be listening. This can be tricky, especially when your team takes the lift during a round and continues to discuss the patients while members of the general public share the lift. Remember, the general public occasionally take the stairs too. When talking to a patient in their room, make sure the curtains are always shut, reduce your voice level and be aware of elderly and hearing impaired – speak so they can also see you. Every ward has a confidential paper bin. Throw your lists away there once you have finished with them.

If you take a phone call regarding a patient, ask politely who is calling and their relationship to the patient. If there are guests in a patient's room, ask the patient if they are happy for you to continue talking about their medical conditions. With patients who are unable to communicate, there can be multiple family members involved. Try to convey all information through one family member (usually the next of kin) so that it is clear to all the staff which person can be given confidential information.

Sending pictures of patients via your mobile phone to anyone (even if they are a consulting or treating clinician for your patient) is currently against Department of Health policy and could get you in a lot of trouble (and potentially cost your job). Whilst the use of smart phones and photography continues to be debated in relation to privacy laws and Department of Health policy, make sure you know the policy. Contact your hospital's medical imaging department for clinical care video or photography. This service is underutilised and can be a valuable tool for assessing wounds, lesions and other pathology.

Information and professional development sessions are run by PMCWA, AMA and other organisations. Sign up for training in privacy and confidentiality.

5.10 | DRESS CODE

Dress code is essentially smart office attire such as the 'clinical clothes' you wore at medical school. Closed-in shoes are expected as part of occupational health and safety. There are some rotations and some hospitals that allow junior medical staff to wear scrubs to work but this depends on which area you are working in. It goes without saying that dress should not be inappropriately revealing and should avoid flashy logos, slogans or anything else that patients might take offense to. Neckties are now out of fashion due to the inherent infection control risk, however, some consultants may insist on it. If in doubt, follow the adage of 'when in Rome, do as the Romans do' or simply ask.

5.11 | EQUIPMENT FOR THE WARD

- At least three pens...your registrar will borrow them... forever.
- Clipboards are useful to hold your patient list.
- Extra things in your clipboard such as blank inpatient notes, med charts, radiology forms, consent forms etc.
- Stethoscope (you'll need this on medical AND surgical terms, surgeons never carry them).
- Pager/DECT phone... especially useful when switched on.
- ID badge to prove that you are no longer another medical student.
- *On Call* by Brown, Cadogan and Celenza. A book written by WA doctors for ward cover.
- Log-ins and passwords for online resources.
- If you are going to be present in theatre please write your name and role on your theatre cap and on the theatre whiteboard. Fixomull tape can be written on, cut and applied to your cap.

5.12 | MEDICAL STUDENT PLACEMENTS

Remember, this was you not so long ago! Try to remember your experiences and try to improve this experience for the students attached to you.

5.13 | SURVIVING AFTER-HOURS

After-hours work and night shifts can be the most daunting for junior doctors. However, it is important to remember that you are never alone. The MERs at each of the sites have provided a few tips to help you face after-hours work with confidence.

PCH

Calling switch: 91 from within the hospital, 6456 2222 from outside the hospital

Contacting IT support: via switchboard is the easiest option

When I can't get in touch with my team, who can I call with an urgent Medical question?

The STARS Admitting Registrar is on call for admissions all hours and ward consults during business hours. The STARS Ward Registrar takes ward consults after hours. The PCC or HDU Registrar is available at all times for consults. All can be contacted via Vocera.

Who can I call with a difficult cannula after hours?

Escalate to the STARS Ward Registrar, then PCC Registrar via Vocera.

Who can I call with difficulties interpreting imaging after hours?

STARS Ward Registrar in the first instance. An on call Radiologist is also available via the switchboard after 1900 on weekdays.

Are there any teams that default their after hours care to another team?

Medical teams are all covered by the STARS Ward Registrar after hours. Each subspecialty has an on call fellow/consultant after hours, available through the switchboard.

Haematology/Oncology is covered by the Oncology RMO until 10pm each day, when they handover to the STARS Ward Registrar. A fellow/consultant available for consult via phone at all times.

General Surgery cover Vascular.

Plastics/ENT/Orthopaedics have their own on call registrar.

Burns covered by a rotating roster of surgical registrars. This will be on the roster.

Child protection unit and social work department do not have cover after 10pm. Urgent issues should be directed to the STARS Admitting Registrar.

SCGH

Calling switch: 91 from within the hospital, 6457 3333 from outside the hospital

Contacting IT support: Via switchboard

When I can't get in touch with my team, who can I call with an urgent Medical question?

There is always an after-hours onsite medical registrar or HDU registrar.

Who can I call with a difficult cannula after hours?

Try your registrar first and then the Duty Anaesthetist

Who can I call with difficulties interpreting imaging after hours?

The after hours radiology registrar or medical registrar via switchboard

Are there any teams that default their after hours care to another team?

Check the daily roster on the SCGOPHG health point page and the Doctors Den portal.

Vascular is sometimes covered by General Surgery Registrar – check the daily roster to find out.

Haematology and Medical oncology cover each other after hours.

Gastroenterology and Hepatology cover each other on weekdays and weekends.

KEMH

Calling switch: 91 from within the hospital, 6458 2222 from outside the hospital

Contacting IT support: Via switchboard

When I can't get in touch with my team, who can I call with an urgent Medical question, a troublesome cannula or difficulties interpreting imaging?

The maternal fetal assessment unit (MFAU) and wards 3 – 5 are obstetric. The Emergency Centre (EC) and ward 6 are gynaecology (including pregnancies under 20 weeks).

Ward patient 0800-1700 mon-fri – page the corresponding team resident or registrar

After hours:

For **obstetric patients** there is the labour ward reg (pager 3203) or SR (pager 3299) or consultant via switch. The senior registrar after 2130 is contactable via switch on their mobile phone.

For **gynae patients** there is the EC gynae reg until 2200 (pager 3418). After 22:00 contact the labour ward reg, senior reg (mobile) or consultant (mobile). If the obstetric registrars are unavailable, as they often are due to the acuity of labour ward patients, escalate to the on-call gynaecology consultant.

For **gynae onc patients** contact the fellow or consultant on call via switchboard.

For anaesthetics contact via pager 3225 or call 0420302571

OPH

Calling switch: 99 from within the hospital, 9346 8000 from outside the hospital

Contacting IT support: Dial 13 44 77

When I can't get in touch with my team, who can I call with an urgent Medical question?

1. The Consultant on-call; 2. The Consultant in charge of the patient; 3. The Head of Service; 4. The Medical Co-Director

Who can I call with a difficult cannula after hours?

1. The Obstetric RMO/Registrar on-call;
2. The Consultant Anaesthetist on-call;
3. The Consultant in charge of the patient

Who can I call with difficulties interpreting imaging after hours?

Dial the SCGH Switchboard on 6457 3333 and ask for the Radiology Registrar on-call

Are there any teams that default their after hours care to another team?

General Medicine is covered by the RAC Registrar from 1630hrs. The RAC Registrar will attend Code emergencies on the Surgical Ward, but nursing staff will call the Consultant in charge of the patient for any clinical issues.

RPH

Calling switch: 91 from within the hospital,

Contacting IT support: Via switchboard

When I can't get in touch with my team, who can I call with an urgent Medical question?

There is an AMU consultant on call and if not the SAFE team would be able to assist.

Who can I call with a difficult cannula after hours?

Duty Anaesthetist

Who can I call with difficulties interpreting imaging after hours?

The after hours Radiology Registrar

Are there any teams that default their after hours care to another team?

SAFE team for medical specialties

FHHS

Calling switch: 91 from within the hospital, 9431 3333 from outside the hospital

Contacting IT support: HIN Helpdesk 1300 170 089

When I can't get in touch with my team, who can I call with an urgent Medical question?

1. Medical Registrar;
2. Duty Anaesthetist on-call.

Who can I call with a difficult cannula after hours?

In-Hours: Anaesthetic Registrar - please ensure local anaesthetic and an USS machine are available for the registrar on arrival.

After hours: Medical Registrar

Who can I call with difficulties interpreting imaging after hours?

Radiology registrar at Fiona Stanley Hospital

Are there any teams that default their after hours care to another team?

All medical and surgical teams handover to the relevant HOOT RMO/intern covering their ward at 4pm.

FSH

Calling switch: 22222 from within the hospital, 61522222 from outside the hospital

Contacting IT support: via the help desk

When I can't get in touch with my team, who can I call with an urgent Medical question? Hospital Out of Hours (HOOT) Med Registrar - 28889, AMU consultant on site until 9pm(ish)

What is the escalation pathway for a difficult cannula after hours?

Have two attempts, including looking at the feet veins.

Ask other interns/RMOs (e.g. HOOT)

HOOT Med Registrar e.g. - 28889

(In hours PICC Service, even if only for cannulation)

Anaesthetics Registrar - 28802

Duty Anaesthetist - 28888 (in that order unless clinically urgent)

Who can I call with difficulties interpreting imaging after hours?

Radiology Registrar – 27684, HOOT Med Registrar - 28889, General Surgery Registrar – 27731

Are there any teams that default their after hours care to another team?

The HOOT Team covers all inpatients in the evenings outside of

O&G/AMU/CCU/General Surgery/Ortho. Overnight, HOOT also covers Gen Surgery and Ortho ward issues (with registrar support onsite).

PEEL

Calling switch: 9 from within the hospital, 9531 8000 from outside the hospital

Contacting IT support: IT Service Desk - number is displayed on every networked computer

When I can't get in touch with my team, who can I call with an urgent Medical question? ED Team Leader

Who can I call with a difficult cannula after hours? ED Team Leader

Who can I call with difficulties interpreting imaging after hours? On call radiologist

Are there any teams that default their after hours care to another team?

All patients are under the governance of ED after 2200 hours. On call specialists remain contactable for Paeds, Obstetrics, General Surgery

ROCKINGHAM

Calling switch: 9 from within the hospital, 95994000 from outside the hospital

Contacting IT support: Via switch

When I can't get in touch with my team, who can I call with an urgent Medical question? Escalate to Registrar /consultant on call

Who can I call with a difficult cannula after hours?

Line manager - registrar on call, after hours DNM, Anaesthetist.

Who can I call with difficulties interpreting imaging after hours?

On call radiologist at FSH

Are there any teams that default their after hours care to another team?

Orthopaedics & Geriatrics are covered by ward cover RMOs, escalation is to the on-call consultant, Gen Med Registrar and ICU team. There is 24/7 General Surgery cover.

ARMADALE

Calling switch: 9 from within the hospital, 9391 2000 from outside the hospital

Contacting IT support: 7:30-5:00pm – 1300170089 after hours on call - 0437698914 (for urgent enquiries only)

When I can't get in touch with my team, who can I call with an urgent Medical question?

ICU Outreach available 24hrs extension 2920. Registrar Page 176. Go to ICU in person or call a MET if concerned. MAU 2 Registrar Page 329/285

Who can I call with a difficult cannula after hours?

Duty Anaesthetist Page 077 or ICU Outreach extension 2920

Who can I call with difficulties interpreting imaging after hours?

ICU Outreach extension 2920. MAU 2 Registrar Page 329

Are there any teams that default their after hours care to another team?

Gen Med JMO's provide after hours cover for the whole hospital from 1600 (Reference: Paging List which is sent to all JMO's prior to orientation and a copy is on the AHS Hub).

-MAU 1 (carries pager 292) covers MAU beds 17-32, Team 1 patients on Canning, Rehab and Dialysis. They also carry the MET pagers (pager 292).

-MAU 2 (carries pager 327) covers MAU beds 1-16, Team 2 patients on Canning, Colyer (surgical ward), Obs & Gynae, Paeds and the Mental Health Unit.

MIDLAND

Calling switch: *99 from within the hospital (on desk or wireless phones), 94624000 from outside the hospital/mobile phones

Contacting IT support: *68 from within the hospital, or 1300 00 6800 from outside. Email: service.desk@sjog.org.au or 'IS After-Hours Troubleshooting Guide' available on intranet

Who can I call with difficulties interpreting imaging after hours?

PRC have an on-call Radiologist in Perth until 2100hrs. Contact the on-call Radiographer to speak to the Radiologist. Between 2100 and 0700hrs there is an on-call reporting service that the Radiographer can put you through to. Most consultants have access to radiology at home so they may be able to assist as well.

When I can't get in touch with my team, who can I call with an urgent Medical question?

There are at least 2 medical registrars in the hospital at all time, as well as an ICU registrar. The ICU registrars can be called via switch 24/7. If you remain concerned, the on-call medical consultant is always available to assist. There are also on-call consultants for all specialty inpatient teams. Where you are concerned about the medical status of the patient please activate the red emergency button at the head of the bed and call a code blue via switch (dial 55).

Who can I call with a difficult cannula after hours? Check with the medical registrar/ICU registrar or contact the on-call anaesthetic registrar for urgent support.

What if I am sick afterhours? Please notify your consultant as soon as possible. An early notification definitely helps with covering the shift. Please also email your Department Secretary as soon as practicable.

HOLLYWOOD

Calling switch: 91 from within the hospital, 9346 6000 from outside the hospital

Contacting IT support: Through the After-hours Clinical Nurse Manager

When I can't get in touch with my team, who can I call with an urgent Medical question?

There is always a senior medical officer available in the after hours period (evenings, weekends and nights). If for some reason they are not available, the specialists are all available through the switchboard. If they are not available on mobile, Switch can attempt to call their home number for the JMO. If there is still no response, the After hours Clinical Nurse Manager can check to see if they have a second contact person and try the same for them. If there is no response, there is an on call General Physician 24/7. If they are not available, JMOs can call the ICU consultant on call.

Who can I call with a difficult cannula after hours?

Try other RMOs or the doctor in charge (DIC) for the evening

Who can I call with difficulties interpreting imaging after hours?

Out of hours x-rays will not be reported. The senior doctor (DIC or SMO) will be available to help for these. There is also an out-of-hours radiographer and radiologist who can be contacted via switch after consultation with the treating specialist.

JHC

Joondalup has recently changed to a new after-hours system (Joondalup After hours Clinical task System, JACS). Nursing staff log an after-hours task on the JACS web logger application, JACS then sends the task to the After-Hours Doctor on duty with an active JACS mobile device. Doctors and Nursing staff can monitor workflow through the JACS program as it happens, and this allows the hospital to monitor the overall after-hours workflow.

Calling switch: 9 from within the hospital, 9400 9400 from outside the hospital

Contacting IT support: 1800 243 903

When I can't get in touch with my team, who can I call with an urgent Medical question?

The afterhours medical registrar (5237), or the consultant of the treating team via switchboard. There is also an on-call surgical registrar (9249) and orthopaedic registrar (9370) you can contact if it's a surgical/orthopaedic patient.

Who can I call with a difficult cannula after hours?

You can contact the Afterhours Clinical Nurses (Private – 9791, Public - 5047), another after-hours doctor, the Med Reg (5237) or Anaesthetic junior reg (5224).

Who can I call with difficulties interpreting imaging after hours?

Out of hours x-rays will not be reported. Urgent afterhours CTs are usually reported externally and updated on PRC when available. The med reg on 5237 (or surg/ortho reg if appropriate) would be available to help you to interpret difficult imaging if you are concerned.

WACHS

WACHS has developed hospital-specific 'Survival Guides' to help Interns navigate the challenging first few weeks of work. The guide includes useful contact numbers, pointers on requesting investigations and tips for ward cover shifts.

Albany

Calling switch: call 9 from inside the hospital or 9892 2222 from outside

Contacting IT support: via switch

When I can't get in touch with my team, who can I call with an urgent Medical question? The Medical Registrar or Physician consultant. SMPs are usually pretty happy to help as well.

Who can I call with a difficult cannula after hours? ED or on call anaesthetist if they are around

Who can I call with difficulties interpreting imaging after hours? Everlight imaging (through switch) report images for Albany after hours, or call FSH Radiologist on call

Are there any teams that default their after hours care to another team? All medical teams (SMP1/SMP2/Physician/Pioneer) are managed by the medical ward cover JMO then the on-call consultant after hours. Gen Surg and Ortho share an on-call roster and look after each other's patients after hours and on weekends. On the weekends the Physician/Geriatrics/Palliative/Onc/Haem teams share a roster too.

Bunbury

Calling switch: 9 from inside the hospital; 9722 1000 from outside.

Contacting IT support: stickers on every computer and/or monitor have the numbers to call. These vary depending on the issue and time of day.

When I can't get in touch with my team, who can I call with an urgent medical question? The on-call medical registrar, someone holds this phone 24/7 and the number is 1327.

Who can I call with a difficult cannula after hours? Medical registrar, 1327.

Who can I call with difficulties interpreting imaging after hours? Radiology is provided in Bunbury by Global Diagnostics, who have an on call radiologist at all times. The number is available on the daily on call sheet, copies are kept with switch and ED.

Are there any teams that default their after hours care to another team? No, all teams have an on-call registrar or consultant. As Bunbury does not have every specialty, refer to the daily on call sheet as some services are referred to Perth.

6 | HEALTH AND WELLBEING

LOOK AFTER YOURSELF FIRST

See PMCWA “Health and Wellbeing Guide”

Participate in hospital wellbeing initiatives – if not for yourself, to support others.

Eat, drink and go to the toilet.

- Eat regularly and choose healthy options.
- Have regular drinks of water (not just coffee). Keep a water bottle close.
- When it is difficult to take a break at work, keep some food at hand to reenergise yourself. Good options are nuts, dried fruit, bananas, plain rice crackers and muesli.

Rest

- Plan your holidays early, it gives you something to look forward to.
- Take a few minutes to stop; focus on your breathing and do some mindfulness exercises.

If you are sick, stay at home

- Doctors get sick too and are entitled to time off. When at work you are expected to be at your best, so make sure that you feel 100% when you are there.
- If you are sick, follow the departmental guideline which usually involves contacting your registrar/consultant and clinical services/medical administration to let them know.
- You are not required to provide a reason for sick leave, however you are required to provide a medical note if you take more than 2 consecutive days off.

Keep active

- Join a gym or a group/sports team that suits your interest.

Health care

- Check out the list of healthcare practitioners on the Doctors’ Health Advisory Service of WA’s website that have self-identified as having an interest in treating healthcare professionals.

- Get a regular GP to obtain care and medical treatment, including prescriptions and referrals. It is a common mistake to 'doctor shop' but get to know a single GP and get to know them well.

Seek help early (see section 7).

Kindly adapted, with permission, from PMCT's 'An apple a day keeps the doctor away: a health and wellbeing guide for Junior Medical Officers'.

TRANSITIONING TO NIGHT SHIFT

All doctors in training have to face the challenge of night shifts, and there's good evidence that working at night can impair doctors' work performance and their health.

The following strategies can improve your ability to successfully and safely manage your next set of night shifts:

Day of first night shift

- Sleep until you wake naturally (don't set an alarm).
- Avoid a morning coffee.
- Have a 90-minute nap between 2.00pm and 6.00pm.
- Have a coffee after your nap.

During night shift

- Maintain exposure to bright light.
- If possible, take a nap of 10-20 minutes during the early part of the shift.

When to eat

- Eat your main meal immediately before the night shift.
- During the night shift, eat lightly to remain comfortable (ideally high-protein, low-carbohydrate food).

Last few hours and on your way home

- Avoid caffeine and nicotine.
- Try to avoid exposure to bright light (e.g. wear sunglasses even on a cloudy day).
- Consider public transport rather than driving.
- Not sure you are safe to drive? Contact the hospital nurse manager via switch to request a taxi voucher.

Days between night shifts

- Try to get to sleep as early as possible.
- Avoid bright lights or screens.
- Sleep in a dark, quiet and cool room.
- Create a routine for bed (e.g. bath or reading).
- Maximise your sleep time and remember that any sleep is better than none, even fragmented or shortened sleep episodes.
- See your GP if you think you need medication. Do not self-prescribe.

Resetting after night shift

- Attempt a nap (90 or 180 minutes) immediately following the shift.
- Go outside after waking.
- Aim to go to bed as near as your usual time as possible.

Adapted from MDA National's First Defence publication: Surviving Night Duty by Dr Sara Bird, Executive Manager, Professional Services.

Related reading: McKenna H & Wilkes M. Optimising sleep for night shifts. BMJ 2018; 360 :j5637.

7 |

WHERE DO I GO FOR HELP?

RESOURCES AND SUPPORT SYSTEMS

It is well known that your intern and resident years are an intense, challenging and frequently stressful time that will test you both clinically and personally. If you or a colleague are finding things overwhelming or are experiencing any difficulties in your personal or professional life, help and support is available. The key message is to talk to someone about it and remember that you are not alone. A good junior doctor is one who knows how and when to ask for help; help is always available.

7.1 | HOSPITAL SUPPORT

Your JMO years can be a challenging time and will test your clinical confidence and knowledge many times over! Other interns can also be a great source of support and learning. Call on your residents for help, they were you not so long ago. Registrars and consultants are always around and are generally approachable and happy to help with any issues. Your MER or MEO can often arrange a bit of extra support or teaching for you. The Medical Education department are the people to talk to if you have problems with your rotation, personal issues or any other problem affecting your work.

Wellbeing and support programs are being created in each of the major teaching hospitals in order to support JMOs during difficult times.

North Metropolitan Health Service

SCGH- A new wellbeing program has been developed by the Postgraduate Medical Education (PGME) unit which includes monthly clinical debriefing "POW WOW" sessions, mindfulness training and a pathway for those seeking support. In addition, departmental welfare advocates exist for those requiring 1:1 assistance and all these details can be found on Moodle. Those requiring assistance or support should contact PGME in the first instance.

KEMH- A monthly debriefing and wellbeing program is run by PGME and the Department of Psychological Medicine. The MER, PGME, pastoral care or the Department of Psychological Medicine can be contacted for those seeking

further support. RMOs are also encouraged to link in with the mentoring program.

PCH- The 'Paeds in a Pod' mentorship program is offered to all JMOs at the start of each year. The first point of contact for those seeking help should be the Chief Registrar, MER, Director of PGME, or DCT, all of whom are located within PGME.

South Metropolitan Health Service

FSH- A doctors' welfare committee has been established in order to develop a new welfare program at FSH. The MERs are a suitable first point of contact for JMOs requiring support. FSH also has a mentoring program available for interns. A monthly 'What's up Doc?' session for clinical debriefing also takes place at FSH which clinical staff are encouraged to attend.

East Metropolitan Health Service

RPH- A Wellbeing Officer has been employed by RPH to assist all JMOs who are requiring individual support. Each term a fortnightly wellbeing session is run for Interns at RPH; interns must sign-up to participate. These programs have been established via Pastoral Care at RPH.

WA Country Health Service

Both Bunbury Regional Hospital and Albany Health Service have local Medical Education Units tasked with assisting junior doctors requiring support. The Central Medical Education Unit, including the Director of Medical Education, are also available as a point of contact should you feel you need external assistance. WACHS has a number of formal support services, details of which are available on the intranet (WACHS > Clinical > Medical Education Unit > Junior Doctor Support).

7.2 | PERSONAL HEALTH AND WELLBEING

If you or a colleague is finding things overwhelming and/or you are unwell, the key message is talk to someone about it.

The second important point is, despite how you feel you are never alone. You may feel as though you're the only one struggling but this is never the case, reaching out will help you to cope and will preserve patient safety.

There are some great points of contact and resources around to help, see table below for specific contact details.

Service	Details
Doctors' Health Advisory Service	<p>An independent, confidential, 24-hour service staffed by experienced doctors. Calls can be anonymous and made by the person themselves, a family member, colleague or friend.</p> <p>(08) 9321 3098 (available 24/7) www.adhn.org.au/contact/western-australia</p>
GP	<p>The AMA WA Doctors in Training Welfare Committee and Doctors Health Advisory Service WA (DHASWA) provides information on self-care and a list of GPs who have a special interest in doctors as patients. Currently, the list includes General Practitioners and Psychiatrists, with a plan to expand to other specialists including psychologists.</p> <p>The 'Doctors for Doctors' list is available online on the DHASWA website: http://www.dhaswa.com.au/drs-for-drs/</p> <p>When ringing, simply identify yourself as a Doctor to the receptionist, in order to be given priority for an appointment.</p>
Employee Assistance Program (for public sector employees)	<p>A free, professional and completely confidential counselling service is provided, either over the telephone or in person, and is available 24 hours a day. Your employer does not find out who accesses this service.</p> <p>Converge International Website: www.convergeinternational.com.au Tel: 1300 687 327</p> <p>LifeWorks (formerly Optum) Website: https://lifeworks.com.au/eap/ Tel: 1300 361 008</p> <p>WACHS (Regions) Contact details for Employee Assistance Program providers vary by region and are available on the WACHS Intranet Page.</p>
Department of Postgraduate Medical Education	<p>The Director of Postgraduate Medical Education and Medical Education Officer at your hospital are always available to discuss any personal or work-related concerns.</p>

See the PMCWA JMO Health and Wellbeing reference for WA JMOs for further information – available on the PMCWA website (<https://www.pmcwa.org.au/publications/>)

7.3 | INDUSTRIAL

If you are having issues with your pay, working hours, rosters etc., there are a few places you can call on for help. As always, a first port of call may be your immediate senior staff member. Depending on the situation, this may not always be the ideal person to ask for help. The next person to chat to would be your MER or MEO. Industrial issues sometimes go beyond all these resources and in these cases the place to seek help is directly from the AMA. The way to get help from them is easy – all you need to do is be a member and then you can contact them.

7.4 | MEDICO-LEGAL

Issues of a medico-legal nature as a JMO can be quite stressful. In general, it is always better to seek advice earlier rather than later, even if you never end up needing the help. Your immediate senior staff members are helpful in these situations for debriefing and support.

Your MEO can help direct you to appropriate staff within the hospital (such as the staff in Legal) for your situation. Finally, always make sure you have an up to date membership of a Medical Defence Organisation and give them a call straight away. A lot of MDOs offer free or reduced yearly rates for junior doctors in their initial years of practice.

8 | QUICK REFERENCE GUIDE

8.1 | COMMON ACRONYMS

Acronym	Definition
AHPRA	Australian Health Practitioners Regulation Agency
AMA	Australian Medical Association
CBD	Central Business District
DCH	Diploma of Child Health
DCR	Doctors' Common Room
DCT	Director of Clinical Training
DIT	Doctor in Training
DPME	Director of Postgraduate Medical Education
ED	Emergency Department
FHHS	Fremantle Hospital and Health Service
FSH	Fiona Stanley Hospital
HSS	Health Support Services
JHC	Joondalup Health Campus
JMO	Junior Medical Officer
KEMH	King Edward Memorial Hospital
MEO	Medical Education Officer
MER	Medical Education Registrar
MET	Medical Emergency Team
PCH	Perth Children's Hospital
PDL	Professional Development Leave
PEHS	Primary Employing Health Service
PGME	Postgraduate Medical Education
PGY	Postgraduate Year
PMCWA	Postgraduate Medical Council of Western Australia
RGH	Rockingham General Hospital
RMO	Resident Medical Officer
RPH	Royal Perth Hospital
SCGH	Sir Charles Gairdner Hospital
SMOS	Stanley Medical Officers' Society
UND	University of Notre Dame
UWA	University of Western Australia
WA	Western Australia
WACHS	WA Country Health Service
WAGPET	Western Australian General Practice Education and Training

8.2 | CONTACT NUMBERS

Organisation	Contact Details	
PMCWA	9222 2125	www.pmcwa.org.au
AHPRA	1300 419 495	www.medicalboard.gov.au
AMA	9273 3000	www.amawa.com.au
DHASWA	6389 4500	www.dhaswa.com.au
FHHS	9431 3333	www.fhhs.health.wa.gov.au
FSH	6152 2222	www.fionastanley.health.wa.gov.au
JHC	9400 9494	www.joondaluphealthcampus.com.au
KEMH	6458 2222	www.kemh.health.wa.gov.au
PCH	6456 2222	www.pch.health.wa.gov.au
RGH	9599 4000	www.rkpg.health.wa.gov.au
RPH	9224 2244	www.rph.health.wa.gov.au
SCGH	6457 3333	www.scgh.health.wa.gov.au
SJOG Midland	9462 4000	www.sjog.org.au

ORIENTATION WEEK: 6TH-10TH JANUARY 2020



13th January – 29th March (11 weeks)

KEMH: 13th January - 8th March (8 weeks)

PCH & SJOG: 13th January - 5th April (12 weeks)



30th March – 7th June (10 weeks)

KEMH: 9th March - 10th May (9 weeks)

PCH & SJOG: 6th April - 12th July (14 weeks)



8th June – 16th August (10 weeks)

KEMH: 11th May - 12th July (9 weeks)

PCH & SJOG: 13th July - 11th October (13 weeks)



17th August – 25th October (10 weeks)

KEMH: 13th July - 13th September (9 weeks)

PCH & SJOG: 12th October - 10th January 2021
(13 weeks)



26th October – 10th January 2021 (11 weeks)

KEMH: 14th September - 15th November (9 weeks)



KEMH: 16th November - 10th January 2021 (8 weeks)

2020

INTERN AND RMO TERM DATES