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Submission By Gary K. Hulse

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To

Education & Health Standing Committee;

Inquiry into the Adequacy and Appropriateness of Prevention and Treatment Services for Alcohol and Illicit Drug Problems in Western Australia.

Undergraduate Medical Education in Alcohol & Other Drugs

Alcohol and drug use in Australia is associated with significant morbidity and mortality, and as such, the area of alcohol and drugs is of direct relevance to most areas of medical education and training. Despite this broad inter-disciplinary appeal, alcohol and drug training and education have in the recent past been distinguished by its lack of coordination within Australian Medical Schools. Apparently its inter-disciplinary applicability has meant that no single department within a Medical School had assumed a clear mandate or responsibility for developing or coordinating education and training in the alcohol and drug area.

To rectify this situation, in 1988 the Ministerial Council on Drug Strategy recommended funding for three years to each Australian Medical School for the appointment of an undergraduate co-ordinator of education and training on alcohol and other drugs[1]. The broad aim of coordinator appointments within each medical school was to improve alcohol and other drug education for medical students through coordination of teaching and training activities. This involved both vertical and horizontal curriculum integration, and coordination of university and teaching hospital and other clerkship activities.

An evaluation of the Australian programme, undertaken when the average duration of coordinators' appointments was only 15 months, documented impressive curriculum gains.[2] Overall findings indicated the programme achieved a 158% increase in drug and alcohol teaching hours and a 383% increase in the number of electives. The mean number of total teaching hours after the coordinators' appointment was also significantly higher than comparable U.S. figures. More recent data document in intern skills following the introduction of medical school coordinators.[3]

Changing emphasis associated with 'State funding'

Following cessation of Commonwealth funding (97) the UWA medical school accessed state partial funding for aa alcohol and other drug position. This reliance on 'State' funding however shifted the emphasis of this position from coordinating education and training activities across medical schools departments to the direct provision of education and training. The net result was that the initial gains of interdepartmental collaboration in a coordinated and negotiated curriculum to train doctors has been slowly eroded.

This loss of emphasis on inter-departmental coordination is occurring in a more complex environment regarding Medical Schools and alcohol and other drug education and training. For example, the UWA Medical School has established a number of Rural Clinical Schools where it could be argued that there is an increased need to focus training on the management of alcohol and other drug problems and the reduction of associated morbidity, mortality, and health and human burden. Additionally, the emergence of new drug types, changing patterns of use as well as new pharmacotherapies has increased the demands facing medical education and increases the need for inter-departmental collaboration (e.g. liaison between the Departments of Clinical Pharmacology, Public Health, Psychiatry, General Practice and Medicine).

Significant input is required to revitalise and expand the coordination of alcohol and drug curriculum in the WA medical school both centrally and to rural clinical schools.

Recommendation: That the state government provide funding to appoint two senior academics within the UWA Medical School to Coordinate education and training activities across the different schools and 6 years of the MBBS program, and within the UWA Rural Schools.

Undergraduate Medical Training in Alcohol & Other Drugs

In addition to the above education concerns, fundamental deficits in training in alcohol and other drugs exist in WA which is not encountered by other Australian States/Territories. Central to this is that while every other State/Territory has at least one (up to three in some states such as NSW) dedicated alcohol and drug clinical unit within their hospital systems, WA has no such facility.

This means that:

1. Any specialist clinical alcohol and other drug undergraduate medical training is provided by services not directly associated with or under the control of the medical training program. Prior to 2007 two sessions (7 hrs) of training was provided by the WA Alcohol and Drug Authority to each year 4 or 5 medical students. This compares with weeks of clinical training provided in other State/Territory Medical Schools. In 2008 however, correspondence from the WA ADA indicated that they were no longer willing to provide this service and this has been scaled back to 3 hrs per week. Further, where this contact previously involved direct clinical exposure, this now takes the form of discussions often with non medical staff without patient contact. Student currently report this as very unsatisfactory. Additionally, student feedback indicate that ADA medical personal set a poor standard as mentors and often raise concern with how these health "professional" talk disrespectfully about their patients.

   In my experience the ADA has never seen undergraduate medical education and training as part of their mandate, has taken on any medical undergraduate training role begrudgingly, and in the majority of instances has sub optimally trained and equipped staff to carry out this medical education and training role.

In contrast other non-government services such as fresh start recover program has show a keen willingness to take and mentor small groups of year 5 medical students for extended two week intensive placements with no request for remuneration.

2. No interns or trainee specialists (i.e. psychiatrists, physicians) are exposed to clinical alcohol and drug treatment as a significant component of their training. This is clearly a short coming in Psychiatry with Alcohol and Other Drugs being part of this medical specialisation. The end result is that while other states have graduating psychiatrists with specialist training in alcohol and drugs, with many becoming prominent alcohol and drug specialists, no such output is observed in WA.

Recommendation: That the WA Alcohol and Drug Authority be integrated into the general hospital systems as a matter of urgency. This would allow both education and training at the undergraduate and postgraduate medical training level. Further entry of interns and registrars from other medical rotations within the hospital system where there are established and transparent standards of care will dramatically change the culture of the WA Alcohol and Drug Authority staff providing a more respectful, responsive, and accountable service to persons effected by alcohol and other drug problems.

Footnote

1. *Walsh, R.A., Hopkins, P.J., Foy, A. & Sanson-Fisher, R.W. (1992). Medical Education on alcohol and hgealth in Australia. Proceedings of the Royal College of Physicians, Edinburgh, 22: 40-44.*
2. *Roche, A. (1989). The development of effective strategies in drug and alcohol medical education: a review. NSW Medical Education Project, Sydney.*
3. *Gaughin et al (in press).*
4. *NCETA (1994) CADEMS – Core drug and alcohol curriculum project*