

The Notre Dame Mentoring Model

Teaching obstetrics and gynaecology in a new medical school



Assoc Prof Rodney Petersen
University of Notre Dame Australia



Prof Julie Quinlivan
University of Notre Dame Australia

Funding has always played an important role in determining how the medical curriculum is taught. Historically, universities were allocated funds for students and this was devolved into departments who were reimbursed according to the numbers of students undertaking discrete units within that department and converted into an effective full-time student load.

This drove medical curriculums to be a series of silos of learning patched together under the umbrella of a medical degree.

Thus, since the 1950s, the majority of teaching in obstetrics and gynaecology, as with other disciplines, has been heavily departmentally based, with student's undertaking departmental based rotations.

However, in the past 20 years, three major changes have occurred. The first is the introduction of problem based learning (PBL), with its focus on problems rather than disciplines. In the traditional model, a patient presenting in the O and

G term with lower abdominal pain could be presumed to be an ectopic or ovarian cyst (depending upon pregnancy status) merely because the term was obstetrics and gynaecology. In contrast, in the PBL model a patient presenting with lower abdominal pain could well have a medical, surgical, psychological or O and G cause of pain. PBL teaching, as traditionally envisaged, does not sit well adjacent to a departmental model.

The second major change is that courses, rather than units, are now funded. This means that curriculum are now increasingly centralised in medical education units, so much so that the Australian Medical Council now require such units for accreditation. This centralised approach, in combination with traditional PBL, conflicts with the basic premise of departmental models of teaching.

The final major change is that tertiary referral hospitals, the traditional domain of medical student teaching, are increasingly forced to concentrate on acute casemix. In contrast, secondary referral hospitals and more importantly, the private sector, now provide a broader and more representative casemix of the common and the important in medicine. Tertiary referral centres are left to deal with the esoteric and the extreme.

In recognition of these changes, the Notre Dame School of Medicine Sydney has developed a clinical years model that clearly incorporates private medicine and secondary referral hospitals in a centralised curriculum structure. The role of discrete departments in the course would now appear to be redundant. The clinical years focus should now be devolved to individual practitioners with curriculum oversight, quality assurance and support being provided by a centralised medical education unit. This is almost a return to the traditional Oxford-Cambridge model of university teaching with the focus on the student and their clinical mentor. The important difference is the addition of the centralised medical education unit providing standardised curriculum of learning objectives and resources to maintain quality assurance and standardisation of the course.

The Notre Dame School of Medicine Sydney Mentoring Model

In the mentoring model, a student is attached to an individual clinician for a period of five weeks. In this time the clinician becomes the clinical mentor of the student. A team of eight clinical mentors work across the year with a team of eight medical students. Thus, each mentor has one medical student attached to their ward/practice at any one time for five weeks, eight times consecutively for the year, for a total of 40 weeks.

During a student attachment, a medical student would spend four to five sessions with the mentor and undertake one learning activity in each session. For example, the medical student may be allocated to one day a week in the labor ward where the clinical mentor delivers the majority of their patients and the student would, with patient consent, assist with the labour and delivery care under the supervision of the obstetrician. The learning activity in this situation might be for the student to clerk the patient on admission, or to assist in the observations in labour, or to provide assistance with the delivery. The student may also attend a session in the consulting rooms each week and/or a session in the operating theatre as an assistant. The learning activities in these scenarios are numerous but could include being asked to take a history; undertake an examination of one patient; or having sat in with the clinician whilst they undertook a history and examination, be asked to step outside and develop a management plan that they later present to the clinician and discuss against the actual plan. The learning activities utilise 'teaching on the run' principles and all clinical mentors would be provided

with ongoing staff development consistent with their role as a paid university employee.

Furthermore, the team of eight clinical mentors is supported by a full-time academic hospital coordinator. Clinical mentors are paid university employees and are remunerated at 0.1EFT of a senior lecturer salary. The hospital coordinator undertakes the majority of hospital-based teaching of the curriculum (weekly short case tutorials, clinical debriefing tutorials and journal club meetings).

Independent of the clinical attachments, all medical students work through a centralised medical curriculum in the form of weekly short cases with defined weekly learning objectives centred about a theme. Students attend weekly core lectures, tutorials and computer assisted laboratories at a back-to-base day at the medical school headquarters each week. The back-to-base day relates to the weekly theme and provides standardisation of the medical curriculum independent of the hospital based teaching and clinical mentor's practice case-mix.

The model commences at Notre Dame Sydney Medical School in 2010 when the first student cohort of 112 students commence their clinical years. It is envisaged that the school will increase intake to a maximum of 120 students in the future.

The aim of the mentoring model is to utilise case based presentations and to extend teaching into private environments. The benefit to the student is the opportunity for one on one exposure to a specialist teacher who can also demonstrate how time is managed, how practices are managed and how specialists interact with nursing and allied health disciplines and refer to other disciplines. The advantages for the clinician include recognition of their teaching (with a paid academic appointment) and the provision of evidence based resources and staff development to assist with continuing medical education. Hopefully, the enthusiasm of the medical students will also encourage private practitioners to stay abreast of current issues. In a variation of Plato, 'Students can be the best teachers for they keep us honest to ourselves and our disciplines!'

Frequently asked questions

Doesn't the University of Notre Dame already have a medical school in Fremantle, Western Australia?

Yes. The University of Notre Dame, Fremantle commenced its first intake of 80 students in 2005. It also is a four-year graduate entry medical course but is quite separate to the School of Medicine, Sydney. Both schools have the first two years as pre-clinical PBL based learning however, in the clinical years Fremantle has continued with the traditional clinical model in both public and private hospitals. Both schools have a strong emphasis on personal and professional development, with clinical debriefing sessions occurring weekly throughout the four years of the course.

The two schools have undergone separate Australian Medical Council accreditation and as such, are seen as two separate entities.

Will there be enough private specialists to provide mentorship for these students?

There has been a lot of recent media attention about the under-utilisation of private hospitals and staff not attached to public teaching hospitals. We are implementing a fresh approach to the problem of clinical placements using this model. This model will be implemented only in the first clinical year (third year) where, we

believe, mentorship and professional development are crucial to the student's career. Final year will follow the traditional block rotation approach.

Private medical practitioners have been very supportive of this model and at our affiliated hospitals we currently have enough practitioners interested in supporting the model. Final selection and appointment of clinical mentors will take place in 2009.

What hospitals have a Memorandum of Understanding with the University?

In the clinical years (years 3 and 4) students will be placed into one of three clinical schools (Sydney, Melbourne and Rural).

In the Sydney metropolitan clinical school the affiliated hospitals are St Vincent's Public hospital, St Vincent's Private hospital, Mater Private hospital, Auburn Public hospital, Hawkesbury Public hospital and Calvary Public hospital. In the Melbourne metropolitan clinical school, the affiliated hospitals are St Vincent's Public Hospital, St Vincent's and Mercy Private hospitals, Mercy Werribee Public Hospital, Cabrini Private Hospital, Western Health Public hospitals and Healthcare Private hospitals. The Rural clinical school has the following affiliated hospitals: SJOG Ballarat, SJOG Bendigo, Mercy Albury, Calvary Wagga Wagga and Lithgow Base Hospital.

The average number of medical students on the labor ward per birth in the O and G term will be approximately one student per 900 births comparing favourably to other universities, where the ratio of students per births in O and G terms is approximately one student per 300 births.

Does being a sub-specialist preclude you from being a mentor?

No, subspecialists and specialists can both be clinical mentors. Clinical placements for medical students have always been unique with no two students receiving the same clinical exposure. The standardised Notre Dame curriculum is centrally scheduled and delivered by university staff at specific hospital tutorials and at the back-to-base day. This means that the actual clinical attachment focuses upon a short set of ten learning objectives of generic skills such as: can the student take a history; can they document a history; can they present a history to a consultant; and can they examine a system or present a management plan. These skills are generic and can be taught by both generalists and subspecialists. However, if a specialist only does gynaecology, then it is possible for them to work collaboratively with a second specialist with an obstetric practice and 'share' a medical student.

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**For more information contact Dr Petra Porter on +61 3 5976 5266
email pporter@pacific.net.au**