

Training for general practice: How Australia's programs compare to other countries



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Background

General practice in Australia and internationally has undergone a dramatic transformation over the past half century in terms of recognition, academic status, organisation and funding. Training pathways have also evolved in response to this changing environment.

Objectives

This paper compares some of the features of Australian and international general practice training using the educational standards developed by the World Organization of Family Doctors' (WONCA) Working Party on Education as a framework.

Discussion

General practice training in Australia, particularly rural training, is strong by international standards, but more lessons can still be learnt from other settings. Local contextual factors mean there are substantial differences in training across jurisdictions, but there are a number of similarities. There is increasing attention being paid to the many roles of a general practitioner, and the importance of a formalised, structured and well-resourced training program. More needs to be done internationally to ensure high-level primary care is available to all people, particularly the underserved.

General practice and general practitioners (GPs) have well-established roles in most healthcare systems across the world. Regarded as 'the foundation of the most successful healthcare systems', it is likely that, despite considerable contextual variations, all family doctors share the common objectives of continuity and comprehensiveness.^{1,2}

Postgraduate general practice training has changed substantially over the past 50 years. In addition to developing as a distinct academic discipline, growing recognition as a specialty, increased undergraduate curricular time and establishment of national colleges and academies, training has become more formalised and structured.

The Royal Australian College of General Practitioners (RACGP) established the Family Medicine Programme in 1973 as an optional educational program with no mandatory exit examination. The 1990s saw the introduction of a competitive selection process limited to 400 places, mandatory assessment by the RACGP Fellowship³ and increased focus on rural training. The Australian College of Rural and Remote Medicine (ACRRM), established in 1997, acknowledged 'the importance of rural and remote medicine as a broad but discreet form of general practice' and 'the need for well-designed vocational training and continuing medical education for rural doctors'.⁴

Local context is key in determining appropriate models of training for general practice. Key features of selected general practice training systems, which consider features of the training model (entry point, duration, existence of a defined curriculum and formal assessment, and regionalisation) and governance (funding source, independent assessment and university affiliation), have been described.⁵ Much depends on the role of general practice in the healthcare system, and the better defined and regulated training models are found in nations where general practice is central to the organisation of healthcare.

The use of terminology varies substantially. For example, in the US, family medicine is one of several 'primary care' specialties. In other countries, particularly in the developing world, general practice is relatively weak and doctors work as part of broader primary care teams, not always with specific specialty training.⁵

In countries with extreme workforce shortages, the doctor–patient ratio makes personal continuity with individual patients nearly impossible, so continuity of care relies on protocols established by the primary care team.¹ Such variations in practice will clearly have implications for the training model and the capacity to train.

Standards for postgraduate education

The World Federation for Medical Education (WFME) has developed global standards in postgraduate medical education, defining nine categories (Box 1). These standards, developed to be applicable globally, provide a robust framework for the educational standards, specific for family medicine, developed by the World Organization of Family Doctors' (WONCA) Working Party on Education (WWPE).⁶ This paper uses these standards to describe some features of postgraduate general practice training in Australia and internationally.

Mission and outcomes

Training organisations need to define their mission and outcomes in conjunction with key stakeholders.

Australian general practice trainees can train to the standards of either or both the professional colleges – ACRRM and RACGP. Both colleges have a strong focus on educational standards with curriculum statements and expected competencies that reflect community needs and are accredited by the Australian Medical Council (AMC).⁷

There are similar international frameworks; for example, the Royal College of Physicians and Surgeons of Canada has developed the CanMEDS Physician Competency Framework, which describes seven roles required for optimal healthcare outcomes:

- medical expert (central role)
- communicator
- collaborator
- leader
- health advocate
- scholar
- professional.

These international frameworks describe broader roles than just clinical practice, with implications for modern curricula, resources and assessment.⁸

There has been recent interest in the social accountability and responsibility of educational institutions – the obligation to orientate education, research and service activities towards priority health concerns of the community they have a mandate

Box 1: WWPE's standards for postgraduate medical education

- Mission and outcomes
- Training process
- Assessment of trainees
- Trainees
- Staffing
- Training settings and educational resources
- Evaluation of training process
- Governance and administration
- Continuous renewal

to serve. These priorities are jointly defined by government, health service organisations and the public (especially the underserved), and should determine how educational providers frame their mission and intended outcomes.⁹

Training process

Australian general practice training has well-developed processes, with an emphasis on in-practice teaching, which allows registrars to gain experience in a variety of settings relevant to their subsequent careers. Training is conducted in an apprenticeship-style model, with trainees contributing to the workforce by seeing patients under graded supervision. This is in contrast to North American residency programs, where residents are more intensely supervised in academic family medicine practices.

The duration of general practice training in Australia – minimum three years post-internship or four years for rural training with advanced procedural skills – is similar to most countries. Training in Canada consists of two (more intensive) years; Singapore has a three-level pathway, starting with a one-year Diploma in Family Medicine;⁵ and New Zealand has introduced a six-year Fellowship in Rural Hospital Medicine training.¹⁰ Recent Canadian reports argue that training should increase from two to three years.¹¹

ACRRM and the RACGP Rural faculty have developed specific rural training pathways that are well regarded internationally. While similar models now exist in North America, New Zealand and parts of Europe, in many jurisdictions there is no formal rural training pathway, curriculum or assessment. Much more needs to be done to meet rural workforce needs globally.

Australia's medical workforce distribution remains a concern, suggesting that the decentralisation of medical education has not sufficiently addressed a social accountability mandate. The growth in training numbers has not yet produced a sustainable rural general practice workforce, and retention rates are sub-optimal. Recent rural medical education initiatives may make a difference, although outcomes are available from only a few programs.^{12,13} Queensland's Rural Generalist Pathway, established in 2006, is one example of a socially accountable program preparing graduates for practice in a specific context.¹⁴

Assessment of trainees

Most jurisdictions have well-defined approaches to high-stakes assessment, drawing on considerable international interest and expertise in the assessment of clinical competence.

The RACGP's exams are well recognised internationally, and conjoint examinations are delivered in Hong Kong and Malaysia. ACRRM's assessment represents the world's first postgraduate examination in rural and remote medicine. These Australian assessments separate training from the examination process, which is usually regarded as best practice.⁵

Internationally, a further challenge is assessing and remediating other 'non-cognitive' domains – for example, the CanMED's roles such as leader, health advocate and professional.⁸

Trainees

There is considerable international variation in the admission point to general practice training, from postgraduate year (PGY) 1 in North America to PGY2 or later in Australia and PGY4 in Malaysia.⁵ Most jurisdictions have developed formal application and admission processes. However, perhaps more could be done to ensure individual programs select candidates who are most likely to meet the health needs of the region, particularly underserved populations, thereby meeting their social accountability mission.

Trainee numbers have grown in nearly all jurisdictions – for example, from 450 to 1500 in Australia from 2003 to 2015.¹⁵ Numbers have increased in other nations where enhancement of primary care is seen as an important strategy for health system reform. Kidd notes that 'China has embarked on a massive drive to train and recruit up to 400,000 GPs in the next seven years in order to reform the country's healthcare system to meet the current and future needs of the population'.¹⁶

Models of trainees' remuneration vary internationally. Employment of trainees by private practices is common in Australia, resulting in variations in income and workload, with General Practice Registrars Australia (GPRA) negotiating the National Minimum Terms and Conditions.¹⁷ In the UK, funding is held and salaries are paid by training providers, producing a stable income during training, regardless of workload.¹⁸

Staffing

Approaches to staffing vary substantially across jurisdictions. Well-funded programs in countries with advanced economies usually employ staff to manage and deliver the training program, with rigorous approaches to appointing and supporting in-practice supervisors.⁵ The approach in Australia to supporting supervisors via practice visits, workshops and online activities, supported by options of additional university courses leading to educational qualifications, is typical of such jurisdictions. By contrast, limited support in low-resource settings means there may be little time or opportunity to provide supervision and, often, trainees are more oriented to service than education.

Training settings and educational resources

Training locations need to offer sufficient facilities, case-mix and exposure to a broad range of experiences as locally appropriate. These factors vary substantially across jurisdictions, including both ambulatory and inpatient settings. Many training programs allow training in other regions and countries.

A high level of educational expertise is available in Australia, but not always in lower-resources settings. Innovations such as the Argentinian online education program, Profam, may offer new directions (Box 2).^{1,19}

Evaluation of training process

While rigorous program-level evaluation is usually associated with more developed countries, feedback from trainers and trainees, and use of trainee performance data can be undertaken in any setting.

In Australia, despite considerable monitoring of training settings and involvement of stakeholders through accreditation processes, more attention needs to be paid to the outcomes of the program – the impact on local workforce and the ability to address the needs of the underserved – rather than on the program's processes. Kitchener notes that training providers in Australia are not required to report their rural workforce outcomes, and advocates for measures such as the rural retention rate, which is the proportion of registrars in rural practice one or more years after completing training.²⁰

Governance and administration

The various models of governance have marked differences in:

- funding sources (usually government or self)
- involvement of universities
- influence of peak organisations and regulatory authorities.

Many jurisdictions have adopted regionalised models, enabling local flexibility in training pathways and experiences, but with a common end point to ensure maintenance of standards.

The debates and changes in governance structures may not necessarily be helpful to the mission of addressing quality

Box 2: PROFAM – A continuing education program that aims to deepen training in primary healthcare

Focus is simple, practical and clinical, directed at the most common tasks of health personnel.

PROFAM offers three options for delivery:

- distance (6000 students from Argentina, Brazil and other Spanish-speaking countries over 15 years)
- classroom (more than 4000 participants since 1992)
- blended learning (over 2000 students since 2007).

Jointly organised by the Department of Family and Community Medicine of the Italian Hospital of Buenos Aires, the Department of Education and Research (DDI) and the Graduate Institute School of Medicine Hospital Italiano de Buenos Aires (HIBA) program.

and workforce issues. There are risks of 'expensive over-governance', where 'competitiveness can also override cooperation', potentially harming general practice training.²¹

Continuous renewal

Renewal of the structure, function and quality of the training program should be based on data, and on prospective studies and analyses. While such systems are reasonably well developed in jurisdictions such as Australia, changes in governance and funding arrangements mean that it is hard to sustain long-term change. Such approaches are less common in lower resource settings.

Conclusion

While general practice training has many international variations relating to resourcing, local healthcare systems and the status of general practice, it is growing and strengthening worldwide. Australia's training program, particularly in rural medicine, is well regarded, reflecting the profession's relative strength. Globally, more needs to be done to ensure high-level primary care is available to all people, particularly the underserved.

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