Is general practice vocational training at risk?

Medicopolitical objectives must be distinguished from the training of high quality GPs

THE HIGH STANDARD OF REGISTRAR TRAINING for Australian general practice has long been recognised,[1-6] and our training model has been replicated overseas. The training program of the Royal Australian College of General Practitioners (RACGP) provided vocational training for GP registrars in Australia for nearly 30 years.

In January 2002, the Commonwealth Government established a new provider model for the delivery of GP registrar training. These changes were in response to government perceptions that aspects of the former training arrangements were not fulfilling some of the needs of the Australian population, especially in meeting workforce requirements in rural areas. General Practice Education and Training Ltd (GPET) was established as a Commonwealth-funded company to manage a new contestable regional model of vocational training.

Twenty-two new regional training providers now carry out the actual delivery of vocational training programs. Funding for training is allocated on behalf of the Commonwealth by GPET to these providers under contract. The regional providers have representation from the appropriate colleges (RACGP and, in rural regions, Australian College of Rural and Remote Medicine), local Divisions of General Practice, local university departments of general practice and rural health, registrars, general practitioner trainers, and in some cases, local consumer representation.

While the methods of delivery have changed, the new training arrangements still follow the curriculum for general practice training set by the RACGP, are based on the standards of education delivery set and monitored by the RACGP, and lead to a single training end point — the Fellowship of the RACGP.

The diversity in the new training arrangements provides the opportunity to reinvigorate GP vocational training. However, there are also risks associated with these new arrangements. These relate to (i) their funding, (ii) the need for widespread professional support for them to succeed, and (iii) concerns among potential registrars about the future viability of a career in general practice. The workforce shortages which have led to these new arrangements for general practice training also pose risks for the independence of the vocational training provided for other medical specialties.

Funding of the new training arrangements: This is currently being provided through short-term contracts. Quality education delivery requires funding stability. Without this stability, the education programs are at risk. These new arrangements need a fair go. The Commonwealth has made a decision to establish a more expensive system of training which requires independent governance and administration in 22 regions across the country. The Commonwealth now has a responsibility to continue to provide adequate funding, and long-term policy commitments and support for the new regional training providers and the profession, to ensure that educational standards are not only maintained but continue to be developed.

Professional unity: The profession also has a responsibility to unite behind the new training arrangements. Without such cooperation, there is a risk that factional differences could hamper the delivery of high quality training and the Commonwealth's new model of alternative governance will not be able to deliver valid outcomes. GPET cannot meet its workforce outputs unless the training programs it purchases meet RACGP standards. The RACGP cannot approve training programs unless they are of an appropriate standard.[7] GPET and its key stakeholders need to develop a collaborative model, which guarantees equity of training standards and opportunities for registrars no matter where they train in Australia. The model also needs to guarantee unified work between GPET and each regional training provider with the relevant professional colleges. And the model needs to meet the community need for access to well trained general practitioners and well supervised registrars.

The current image of general practice and its training requirements among potential registrars: This probably poses the major risk to the new training arrangements. There is a strong need to maintain and enhance general practice as an attractive career choice for medical students and recent medical graduates. This change in the training program structure has taken place at a time when general practice is facing many challenges, including workforce shortages, uncertainty surrounding medical indemnity, and a failure of Medicare rebates to match the rising costs of providing a high quality general practice service. General practice training is also seen as less flexible and less able to accommodate the personal and professional needs of many potential registrars compared with training for some other specialties.

It is clear that the Commonwealth will no longer separate GP training from other challenges facing general practice, especially workforce shortages. All stakeholders must ensure that medicopolitical objectives are clearly distinguished from the work of preparing high quality GPs for the Australian community. There also needs to be public recognition of the importance of a strong, stable system of general practice, and of a well-trained GP workforce to the health of the nation. We need long-term sustainable solutions to the serious challenges facing general practice to ensure that all people in Australia have equitable and affordable access to high quality primary care in the future.

General practice is experiencing the conflicting demands of the government's requirements for medical workforce against the profession's need for continuing high standards of vocational training. This conflict could also lead to enforced changes in training for other medical specialties. It remains to be seen how other colleges respond to the risks posed by similar challenges in the development of their own 21st century registrar training programs.

When facing risks there is some cold comfort in knowing that you are not alone.

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1. General practice education — the way forward. Report of the Ministerial Review of General Practice Training. Commonwealth of Australia, 1998. Available at: www.health.gov.au/hsdd/gp/pdf/minreprt.pdf (accessed Jun 2003).
2. Fabb WE and the Royal Australian College of General Practitioners Family Medicine Programme. Focus on learning in family practice. Melbourne: Royal Australian College of General Practitioners, 1976.
3. Heffernan TM. The first national wide evaluation of the Family Medicine Programme: the methodology being used, its rationale and preliminary results. Melbourne: Royal Australian College of General Practitioners Family Medicine Programme, 1978.
4. Hurley TH, Cummins CJ. The Family Medicine Programme — a report of a review. Melbourne: Royal Australian College of General Practitioners Committee of Review of the Family Medicine Program, 1982.
5. Abrahamson S. Report of the Review of the Family Medicine Programme. Melbourne: Royal Australian College of General Practitioners, 1987.
6. Holsgrove G, Jolly B, Jones A, Southgate L. Alternative approaches to vocational training for General Practice: final report of the London hospitals consultancy team. Canberra: Department of Human Services and Health, 1996.
7. Report of the Australian Medical Council Accreditation Team to the Council of The Royal Australian College of General Practitioners. Melbourne: RACGP, 9th May 2003. ❏

Correction

Re: "Asthma symptoms associated with depression and lower quality of life: a population survey?", the Research article by Robert D Goldney, Richard Ruffin, Laura J Fisher and David H Wilson in the 5 May issue of the Journal (*Med J Aust* 2003; 178: 437-441), in which variables in Box 1 were incorrectly labelled. "Male sex" should have been "Female sex", and "Overseas born" should have been "Australian born". The corrected table is shown.

1: Predictors of asthma determined by logistic regression

Variable	Odds ratio (95% CI)	*P*
Female sex	1.55 (1.22–1.99)	0.003
Depression	1.40 (1.04–1.88)	0.026
Australian born	1.60 (1.18–2.18)	0.003

time capsule

The doctor's name plate

The Federal Committee of the British Medical Association in Australia has recently dealt with the question of the abuse of the name plate which medical practitioners usually display outside their professional chambers or residences. The proposal was made that the Committee should express the opinion that it was undesirable for a medical practitioner to display a name plate on which the specialty practised was announced. The Committee, after careful review of the history of name plates in Australian cities and of the practice that has grown up during the course of many years, came to the conclusion that there was no objection to the announcement on the plate of a specialty, provided that the practitioner confined his activities exclusively to that specialty...

Medical practitioners find it convenient to indicate the place where they may be consulted by affixing a name plate outside their premises. The object is not to attract practice, not to invite a chance patient to enter, but to guide the patient wishing to consult a particular practitioner to the proper address. In an emergency a doctor's name plate is used by the messenger for the purpose of obtaining medical aid as speedily as possible. Under ordinary circumstances the indication should not have the object of arresting the attention of a wandering patient seeking medical aid. On the other hand, there would be no real objection to the reception by a medical practitioner of a patient who elected to consult a stranger merely because the name plate was encountered. Many valuable practices have been built up by young practitioners putting up a plate and waiting. Someone is sure to come sooner or later, although the early callers not infrequently are those who avoid the doctors of longer standing because of unpaid accounts. The plate, however, should be of modest dimensions and it is usually held that there is no need for any indication other than the practitioner's name... In some towns and cities in Great Britain even the affix "Dr." is by common consent replaced by a plain "Mr.," even when the practitioner is a graduate in medicine and practises as a physician. More often practitioners either affix "Dr." to their names, or employ other words to indicate that they are medical practitioners. A few years ago the Royal Colleges of Physicians and Surgeons in England granted their diplomates the right to use the courtesy title "Doctor," provided that they did not convey the impression that they possessed a degree of any university...

... The majority of medical practitioners will, no doubt, adopt a dignified attitude in regard to their name plates and avoid the display of anything which might be regarded as unusual.

Med J Aust **1922; 1: 302-303 [editorial]**