

Training Australian Defence Force Medical Officers to civilian general practice training standards — reflections on military medicine and its links to general practice education and training

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Military medicine has been an area of change over the 10 years of the Australian General Practice Training (AGPT) program. Recent conflicts in Timor Leste and Afghanistan and disaster responses in Pakistan and Indonesia have focused attention and recognition on the importance of primary health care in the work of the Australian Defence Force (ADF).

The goal of the AGPT program is to produce competent, confident practitioners able to practise in a variety of settings, including rural and remote areas. Similarly, the ADF trains doctors to become competent, confident, independently deployable Medical Officers who have completed all military and military health training requirements and the civilian standards of primary health care specialisation. Primary health care training uses the AGPT program delivered by federally funded regional training providers (RTPs).

The AGPT guidelines accommodate variations to the program for ADF registrars.¹ However, despite a training-rich environment and employer policies encouraging training of this selected group of doctors, many ADF registrars still encounter difficulties progressing through the AGPT compared with civilian registrars.

This article examines the links of military medicine to civilian general practice education and training, drawing attention to the variations and difficulties in, and successful approaches for, training ADF Medical Officers, to distil some suggestions for improvement.

Progression to an independently deployable military Medical Officer

Although final decisions on Medical Officer career management lie with single services (the Royal Australian Navy, the Australian Army and Royal Australian Air Force), the ADF Medical Officer Career and Salary Structure (MOCSS) provides a common framework and salary structure. Reviewed in April and May 2010, the MOCSS now includes four competency levels, referred to as Medical Levels (ML1–4), from registered medical officer without military or civilian specialist qualifications to fully trained specialist. MOCSS applies to Medical Officers receiving their Commission after 31 July 2003.²

For doctors entering ADF service after sponsorship through their medical degree, the third postgraduate year is usually the first year of full-time uniformed service. Introductory military officer and military medical training occurs during this year. It is also the year that the most intensive practice-based teaching would normally occur in the (civilian) general practice training programs. At the same time, the new Medical Officers must make the transition from hospital-based civilian practice to military primary care practice, and adapt to military life.

To reach ML1, a Medical Officer must have completed a medical degree, hospital internship and residency years and have unconditional registration in Australia. Proximal supervision is provided during ML1. To progress beyond ML1, a minimum of 3 months of supervised clinical training in a civilian general practice placement

ABSTRACT

- This article examines military medicine and its links to civilian general practice education and training, drawing attention to the variations and difficulties in, and successful approaches for, training Australian Defence Force (ADF) Medical Officers.
- Military medicine has been an area of change over the 10 years of the Australian General Practice Training (AGPT) program.
- Crisis situations like those in Timor Leste and Afghanistan have focused attention and recognition on the importance of primary health care in the work of the ADF.
- To train doctors in military medicine, there are several different models at different locations around Australia, as well as large variations in military course and experience recognition and approvals between AGPT regional training providers.
- At times, the lack of standardisation in training delays the progress of ADF registrars moving through the AGPT program and becoming independently deployable Medical Officers.

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is required. To progress to ML2 (deployable with supervision), Medical Officers must also complete initial officer training specific to their service, in which they are introduced to the distinct cultures of the Navy, Army or Air Force. This is a valuable introduction to networks of colleagues, administrative processes and, for many doctors, the first exposure to leadership and management. Survival training, ship's damage control, field craft, firefighting and weapons training are not only essential skills of the military, but also provide insights into the environmental and occupational health of the working environment.

Medical Officers are also expected to enter a postgraduate training program. Although specialty training in primary health care is encouraged, some Medical Officers elect to pursue training in other specialties such as public health, medical administration or occupational medicine.

To become a deployable Medical Officer (ML3), further military and military health training and completion of a specialist training program in either the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine is required. Both colleges have standards, operating policies and requirements of registrars,^{3,4} and each college program is supported by a curriculum.^{5,6}

Although these programs may be undertaken independently by Medical Officers, the AGPT program makes positions available for ADF registrars. The AGPT has guidelines defining the requirements of the registrar training program, which make specific accommodation for ADF registrars.¹

Medical Officers who successfully progress to other recognised specialty qualifications are classified as ML4.

Military medical training has some tri-service and some service-specific training requirements. All services expect completion and maintenance of the Emergency Management of Severe Trauma (EMST) course. Aeromedical evacuation (AME) is a feature of military medicine — all Navy and Army Medical Officers receive training in rotary-wing AME. Air Force Medical Officers are trained in both rotary- and fixed-wing AME. Navy Medical Officers are trained in underwater and decompression medicine. Army Medical Officers complete the Regimental Medical Officers Introductory Course and the Logistic Officers Basic Course, both of which build knowledge of operational field health support. Air Force Medical Officers are required to complete aviation medicine training and an Operational Health Support Course. These courses draw on the expertise and experience that ADF health services have demonstrated regularly in the past two decades of peacemaking, peace-keeping, disaster relief and warlike operations. They are not only rich and unique training experiences, but are necessary to prepare ADF Medical Officers for military practice.

Current training models in Australian Defence Force health facilities

To accommodate military and military health training and civilian medical training requirements during their first year of uniformed service, doctors are posted to one of a limited number of military health facilities. These facilities generally provide both military and clinical supervision to facilitate transition from civilian hospital practice to military practice.

Navy Medical Officers typically are posted to a Sydney or Perth facility supporting Navy members to progress through ML1. Once at ML2, Navy Medical Officers will post to the Fleet, usually for a 2-year posting, during which they will serve about 7 months a year at sea.

Army ML1 Medical Officers are generally posted to the 1st or 2nd Health Support Battalions in Sydney and Brisbane, respectively, or to Lavarack or Robertson Barracks Medical Centres in Townsville and Darwin, respectively. All these facilities are accredited as composite posts to deliver the AGPT program with releases to suitably accredited civilian general practices. These military facilities include “satellite” clinics of Regimental Aid Posts, which are like general practices supporting individual battalions on the base. After reaching ML2, Medical Officers are likely to be posted to a field unit, such as an infantry battalion, and may undertake specific preparation for deployment with this unit. Alternatively, they may be deployed to a health support battalion.

Air Force ML1 Medical Officers are usually posted initially to larger medical facilities near Brisbane, Sydney, Newcastle or Adelaide for 2 years before being posted to smaller facilities. These postings are also accredited for AGPT training in a composite arrangement with suitable civilian practice. Typically progressing to ML2 after the first year of uniformed service, Air Force Medical Officers are considered deployable in support of flying operations and may be deployed on operations, exercises or AME missions for up to 8 months in the next 2 years, which can affect AGPT training requirements. Posting to remote flying bases, for example Royal Australian Air Force Tindal, Northern Territory, presents difficulties in maintaining suitable civilian and ADF clinical supervisors.

Difficulties and variations

ADF Medical Officers experience some unique challenges during their AGPT experience as a result of their work environment and circumstances, including:

- consistency and continuity issues around learning plans, clinical experience and placement approvals;
- variable supervised primary care experience;
- lack of supervisors and supervision; and
- limited specific RTP workshop opportunities.

Consistency and continuity issues

Registrars typically join the AGPT in their first or second postgraduate year. They are required to nominate and be selected by an RTP by June of that year. Later in their second postgraduate year, Medical Officers will receive a military posting for their first uniformed year of service. They will be posted again 2 or 3 years later. Consequently, ADF registrars need to change RTPs even before they begin the AGPT program and, commonly, at least once during the program. The AGPT guidelines accommodate these postings.¹ However, with 17 RTPs in Australia, ADF registrars have experienced lack of continuity in learning plans and inconsistent recognition of military courses, exercises, deployments or placements from RTPs.

Learning plans are constructed for all AGPT registrars in collaboration with their supervisors and medical educators to meet individual learning needs. Supervisors working in ADF health facilities are often able to reconcile civilian and military primary care learning needs, but few RTPs have medical educators who are able to provide balanced civilian and military guidance based on experience and competency in both environments. Although ADF health training of Medical Officers provides exceptional clinical training opportunities, these are often unfamiliar to RTP medical educators who have not practised in the military. Without being familiar with the vocational end point or the military clinical environment, it is difficult for civilian medical educators to guide ADF registrars or their learning needs. Consequently, ADF registrars report receiving military health training not approved for inclusion in their training and inconsistency between RTPs regarding training approvals.

Approval of deployments and exercises for training has varied for ADF registrars. Prospective accreditation for training of these experiences is sometimes difficult to obtain through the RTP and college, with a limited time for the approval process even though deployments and exercises are defined by operational orders that detail the nature of required health support and the supervisory arrangement for Medical Officers. Medical educators at RTPs and college censors without military experience have limited opportunity to develop an understanding of ADF clinical experiences and placements, particularly in relation to deployments and exercises, so are often not equipped to assess the placement.

Managing variable supervised primary care experience

To progress to ML2, Medical Officers must complete 6 months of supervised primary care in an appropriate civilian setting, preferably including 3 months of supervised general practice in an accredited practice. Some ADF registrars arrive at their first uniformed posting with this experience from the Prevocational General Practice Placements Program (PGPPP).⁷ The PGPPP is funded by the Australian Government Department of Health and

1 Australian Defence Force (ADF) registrars in the Australian General Practice Placements program

| Training year | ADF registrars | | Civilian registrars | |
|---------------|-----------------------------|-------------|---------------------|-------------|
| | Total (% of all registrars) | Withdrawals | Total | Withdrawals |
| 2002 | 14 (1.81%) | 0 | 760 | 6 (0.79%) |
| 2003 | 27 (2.25%) | 0 | 1172 | 24 (2.05%) |
| 2004 | 35 (2.15%) | 0 | 1596 | 44 (2.76%) |
| 2005 | 54 (2.87%) | 1 (2%) | 1826 | 63 (3.45%) |
| 2006 | 61 (3.03%) | 2 (3%) | 1955 | 65 (3.32%) |
| 2007 | 85 (3.97%) | 1 (1%) | 2054 | 64 (3.12%) |
| 2008 | 88 (3.93%) | 7 (8%) | 2150 | 71 (3.30%) |
| 2009 | 80 (3.40%) | 2 (3%) | 2273 | 70 (3.08%) |
| 2010 | 83 (3.24%) | 0 | 2480 | 9 (0.36%) |

Ageing, and is a regionally coordinated program to provide general practice experience to new doctors in supervised accredited training practices. There is no coordinated use of the PGPPP to meet the ADF registrar requirements, so military health facilities must arrange 3-month releases during the return-of-service period. Some ADF registrars have been advised by RTP medical educators to resign from their teaching hospitals to complete a general practice requirement. Unfortunately, this detracts from their hospital term training requirements, which must then be made up later.

Lack of supervisors and supervision

Accredited ADF health facilities release Medical Officers for sessional civilian practice (composite posts), particularly for early terms of the AGPT program, to provide a well rounded primary care exposure. Arrangements vary regarding provision of supervision and teaching responsibilities during these terms, although they are generally provided by the ADF health facility. In the accredited facilities mentioned earlier, supervisors are generally civilian contract health practitioners. However, because few contracts specify a general practice supervision requirement, there is the risk that previously accredited ADF health facilities may not always be able to meet the AGPT supervision requirements for training. In these circumstances, Medical Officers cannot count this time and experience towards their AGPT requirements, ultimately lengthening training time and the time taken to achieve deployable status (ML2 or 3).

Limited specific regional training provider workshop opportunities

Workshop-based training provided by RTPs is usually tailored to registrars' needs and varies between RTPs in content and delivery pattern. This adds to the difficulties of ADF Medical Officers who articulate workshop programs from two RTPs when transferring to a new posting and a new RTP.

Workshop content is guided by college curricula to complement typical civilian practice-based learning. ADF registrars' experiences are often not typical of civilian practice-based learning, which creates specific and different needs for additional workshop teaching. However, no specific ADF registrar workshops are routinely provided to complement their other learning and experiences.

Effect on the progress of Australian Defence Force registrars

The difficulties, variations and challenges above have been identified from anecdotes provided by ADF registrars. However, do these issues translate into demonstrable delays for ADF registrars in passage through their general practice training?

General Practice Education and Training (GPET), which administers the AGPT program for the Australian Government Department of Health and Ageing, has provided data regarding ADF registrars compared with other registrars in the program.

ADF registrars are a small proportion of the AGPT cohort (Box 1). The number of ADF registrars increased steadily from 14 in 2002 before stabilising at over 80 for the past 4 years, possibly reflecting the implementation in 2003 of MOCSS. The proportion of ADF registrars as a percentage of the total registrar cohort peaked in 2007, followed by a small but noticeable decline and falling enrolment. In 2009, ADF registrars did not fill the recruitment quota available into AGPT of 25 places.

The ADF withdrawal rate has been less than or equal to the civilian rate in all years except 2008, which coincided with the peak in Medical Officer support deployed to operations in Iraq and Afghanistan.

The sample size of ADF registrars successfully completing the AGPT program is small (Box 1). Nevertheless, analysis of the 2010 ADF registrar data (Box 2) indicates that it does take longer for ADF registrars to achieve Fellowship. The mean difference in duration is statistically significant ($P < 0.05$).

Discussion

Military medicine training in Australia requires completion of a complex array of military, military health and civilian primary health care training programs that are conducted concurrently.

The essential challenges for ADF Medical Officers entering Medical Officer training are:

- meeting the training requirements of two unfamiliar systems with variable support from their ADF and civilian advisors who often struggle to understand their counterpart systems;
- reconciling the RTP system with Australian and overseas Defence postings;
- coming to terms with practising in an ADF primary and preventive health care environment rather than a civilian hospital-based system; and
- acclimatising to military life.

2 General Practice Education and Training statistics comparing registrars completing the Australian General Practice Training program, Remembrance Day 11 November 2010

| | ADF registrars | Non-ADF registrars |
|--|----------------|--------------------|
| Total no. | 61 | 2561 |
| Mean time in years between start and Fellowship dates (SD) | 3.5 (1.2) | 3.1 (1.2) |
| Mean weeks of prior learning recognised (SD) | 48 (18.9) | 47 (15.7) |

ADF = Australian Defence Force. ♦

The data available support the anecdotal evidence from ADF registrars that they are experiencing delays through their training.

Our examination of the ADF registrars' training structure and the available data suggests that there is scope for further improvement in the structural efficiency of military medical training across and between the major stakeholders — Defence Health, GPET and the AGPT program, RTPs and the colleges — that would lead to a smoother vocational path for Medical Officers.

Defence Health

While ADF health services have made efforts to accommodate the Medical Officer training programs, improvements in supervision and coordination are still possible and desirable. The role of contract health practitioners, who commonly provide primary clinical supervision in military health facilities in Australia, should be recognised in their contracts. Although informal arrangements with contractors exist, inclusion of the requirement in all contracts would improve certainty of recognised training for ADF Medical Officers.

The contribution of civilian practices supporting composite placements with military health facilities must also be recognised. Accommodating transient, sessional registrars from the ADF is not an efficient business model, but the efforts of civilian practices clearly do support the ADF through professional development of Medical Officers. This important contribution is noteworthy.

Examination of options for simplifying and streamlining the ADF-RTP liaison process would be potentially effective in producing independently deployable Medical Officers sooner. Resources for liaison between the ADF and the 17 RTPs are both limited and thinly spread, limiting communication and coordination. There is a single ADF Postgraduate General Practice Training Manager, who has numerous other roles, available in Canberra to advise the 17 RTPs nationally. This function requires more staff members and coordination. The current need for RTPs to liaise directly with the appropriate ADF health facility is also inefficient. One option which would simplify the process is to reduce the number of RTPs managing Medical Officers and accrediting placements.

General Practice Education and Training and the Australian General Practice Training program

The AGPT Guidelines make allowances for ADF Medical Officers in the program. Collectively, these allowances approximate a military pathway through training. Annual RTP allocations of registrars are made according to rural or general pathways available in the AGPT program. Perhaps a similar approach should be considered to allocate ADF registrars to a military pathway that involves RTPs with suitable medical educator expertise.

Opportunities for vertical integration are emerging with the provision of both the AGPT program and PGPPP through GPET. Meeting the basic requirement for 3 months of civilian general practice training with the PGPPP terms should be mandatory for ADF registrars, to expedite passage to ML2 and meet AGPT guidelines for ADF registrars.¹

Colleges

There is scope for specific college curricula for military medicine, as there are for other primary care fields of practice. Military advisors to college censors could be made available, as they are in other specialist colleges, to consistently advise on training pro-

grams, including placements and courses. Military advisors could also lead the development of special skills or advanced training programs with dedicated curricula using the rich training opportunities for ADF registrars.

Prospective approval of placements on deployments and exercises by medical educators suitably familiar with these should be possible with the generic health planning available for these operations. Noting that deployed roles for ML2 Medical Officers are not that variable and supervision is always specified in operational orders, the approval model could function in the same way as accreditation of other placements in the program by accreditation committees.

Regional training providers

The role of RTPs in supporting ADF registrars has some opportunities for improvement. Consistency of training approval may be partially addressed at college level. However, recognition of military health training could be vested in medical educators familiar with the training at RTP and college levels. Decisions, advice and mentoring must be consistent and based on an understanding of both AGPT and military training requirements. There is a role for medical educators with specific military and general practice experience and competence. An educator with such expertise could also construct workshop-based training more tailored for ADF registrars, learning needs to complement their military practice-based experience.

Conclusion

Military medicine training is intimately connected with primary health care vocational training. ADF registrars are a select group of doctors in a supportive training environment, but take longer to complete the AGPT program.

There are opportunities for improving the efficiency of ADF Medical Officer training through coordination, understanding and recognition of the complex training program required of doctors to become independently deployable Medical Officers.

Competing interests

None identified.

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