General Practice Super Clinics — how will they meet their educational objectives?

Alistair W Vickery, Jennifer Dodd and Jon D Emery

ABSTRACT

- The Australian Government will provide $275 million over 4 years to general practice infrastructure across Australia with the rollout of 31 General Practice Super Clinics.
- One of the core objectives of these Super Clinics is to support medical education.
- Several studies have demonstrated that the major barriers to teaching in general practice are time, space and money.
- We argue that General Practice Super Clinics can provide a responsive, flexible work culture; and improved payment and targeted resources to support the need for increased teaching capacity, and to attract and retain workforce for general practice and primary care.

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The Australian Government commitment of $275 million over 4 years for the development of 31 General Practice Super Clinics (GPSCs) around Australia has as one of its core objectives to

> support the future primary care workforce by providing high quality education and training opportunities supported by infrastructure for trainee consulting rooms, teaching rooms and training facilities to make general practice attractive to students, new graduates, GP trainees and registrars and other health professionals.[1]

Almost 100 years ago in the United States, the Flexner Report on teaching and training recommended appropriate infrastructure and funding, adequate teacher training, and rigorous research to inform evidence-based practice. An editorial in the Journal echoed the current relevance of these observations, asserting a need for

> general practice with TLC — Time for teaching, Learnedness in the art and science of teaching, and a Commitment to teaching the next generation of young doctors the art and science of medicine.[2]

General practitioners enjoy teaching; a report from the Australian Institute of Health and Welfare, *General practice activity in Australia 2006–07*, showed that 50% of GPs taught medical students and 33% taught GP registrars.[3] However, with expansion of medical student and GP registrar places across Australia, further capacity for teaching in general practice is required. The major barriers to teaching and training in general practice have been identified as time, space and money.[4]

These challenges can be detrimental to the overall culture of a practice and its attitudes to teaching. General practices in which the practice principals or corporate owners do not encourage teaching are unlikely to have medical students. Building this "culture of teaching" within a practice is vital and may be even further challenged in corporate practices, in which issues of space and money will be perceived as paramount.

Given the Australian Government's emphasis on teaching roles for GPSCs, what is the capacity of GPSCs to respond to Australian training needs? We discuss this on the basis of our own recent research (Box 1) and previous studies on medical education in general practice.

Time

The doubling of Australian medical students, set to begin graduating by 2010, has been well documented.[5] In addition, there is a shortage of GPs in the Australian health workforce.[6,7] Reductions in GP numbers and work capacity due to feminisation and ageing of the GP workforce, desire for flexibility of working hours and other "work–life balance" factors are expected to present challenges until at least 2015.[8]

Part-time GPs find it more challenging than their full-time colleagues to meet the demands of their clinical workload and find time to teach. Changes to working patterns, with both male and female doctors reducing their working hours and fewer GPs becoming practice principals,[9] will limit capacity to take on greater teaching roles.

Education and training in general practice has traditionally been delivered through clinical placements in private practices. A shortage of GPs and a rapid increase in the number of medical students has accentuated the education and training gap for clinical placements and the time available for GPs to commit to teaching. In addition, the demand for general practice health services has increased. With the ageing of the population, increasing health demand and the continuing GP workforce shortage, we can expect that the demands for time and clinical services placed on general practice will increase over the next 10 years.[10,11]

Space

The second barrier is physical space to teach. General practices are private businesses providing services as efficiently as possible to ensure good care and profitability. There is a moderate recompense for infrastructure expenditure in GP registrar funding, but none available for medical student teaching. Best models of teaching in general practice require opportunities for students and trainees to conduct their own consultations under supervision.[12] This means infrastructure costs to the practice to provide additional consulting rooms for students and trainees.

Money

Practices that teach medical students are eligible for a Practice Incentives Program (PIP) payment from the Australian Government of $100 per 3-hour session of teaching, with a maximum of two sessions per day.[13] This financial teaching incentive, despite its name, has been found to be inadequate. It is insufficient to compensate for the income opportunity loss, as fewer patients are treated when teaching.[14]

We have found that the PIP is perceived by GPs as onerous and too bureaucratic. It usually fails to reach the doctor in the practice who provides the teaching, with the practice either

1 Key findings of a survey of Western Australian general practitioners and registrars, 2008

We surveyed 600 GPs and GP registrars (response rate, 54.6%) in WA in 2008.

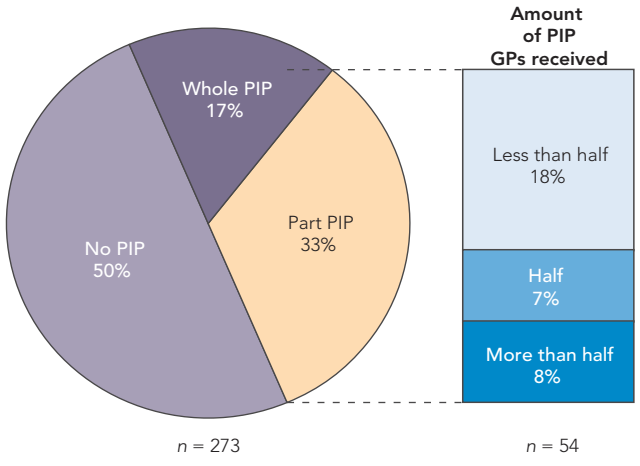
Of these, 61.5% of GPs currently teach medical students and 22.3% teach GP registrars.

The main barriers to teaching were:

- Lack of time (94.6%)
- Lack of appropriate office space (64.1%)
- Inadequate payment (53.8%)
- Work part-time (27.8%)
- Practice does not teach (15.0%) ◆

absorbing the whole PIP payment or passing on less than 50% to the individual teacher (Box 2). Furthermore, GP registrars are currently unable to claim a PIP payment in their own right for teaching. This creates a further disincentive for GP registrars to become involved in teaching.[15]

2 Proportion of general practitioners receiving Practice Incentives Program (PIP) teaching payment, 2008*



* Data are based on a survey of Western Australian general practitioners and registrars, 2008. ◆

Do the General Practice Super Clinics provide solutions?

Time

Currently, there are no alternative funding streams within the GPSC program to support an expanded teaching role and provide protected time to teach. New models for funding teaching are required to free up more GPs to teach. The current fee-for-service model does not encourage or support activity other than clinical practice. GPSCs provide the opportunity to test new approaches to funding general practice education. Teaching capacity in general practice could be increased by the establishment of dedicated teaching practices funded to ensure financial sustainability while still operating clinically under the fee-for-service model. Remuneration of teaching doctors with salaries, supported by additional funding to education providers, such as universities or regional training providers, is another alternative to afford protected time to teach.

Space

GPSCs will provide some additional space for teaching in general practice through explicitly identified building and infrastructure funding for new teaching space, including extra consulting rooms for students and trainees, and seminar rooms. In addition, the funding can be used for information technology that supports teaching, such as videorecording consultations and electronic learning resources.

With only 31 GPSCs, less than 1% of nearly 5000 general practice clinics in Australia, this space may not make a significant difference to teaching capacity across the country. However, there is the potential to encourage cultures of teaching in GPSCs through the adoption of leadership roles and the provision of necessary resources and support. The additional space could be used to explore more innovative approaches to teaching, including vertically and horizontally integrated models. Clinical and educational teams could be developed to create interprofessional learning opportunities for medical students, allied health professionals, registrars and GPs, established through the GPSC model. However, will this new space be sufficient on its own?

Money

Innovation and flexibility of funding that recognises the diversity of general practice business models is needed to increase the capacity for teaching in general practice. The barriers identified in remuneration for teaching suggest that new approaches are required. To increase teaching capacity in general practice, payment should be a true incentive for teaching, so that GPs will be encouraged to teach in a time of workforce shortage and increasing health demand. Specific payments for teaching, targeted to the GPs and GP registrars who teach, must be addressed to encourage more vertically integrated training and to increase the number of GP teachers.

Other enablers

Improved coordination and communication between and within key medical organisations and practices is vital, given that multiple organisations are involved in education in general practice and other health disciplines. This would particularly facilitate vertical and horizontal integration of training. Adequately resourced GPSCs could be instrumental in the coordination and collaboration of these networks.

Additionally, more flexible approaches for teacher training, such as training opportunities on weekends and after hours or through web-based delivery, are required for part-time GPs and others. These alternative models could be trialled in GPSCs to evaluate their wider acceptability and sustainability.

GPSCs will need to offer education and peer support to GPs who do not teach because of rural location or lack of collegial support. Early evidence from rural clinical schools suggests that this can be achieved with investment in teaching infrastructure in rural and remote areas.[16] This, too, would result in more GP teachers and increased retention of younger, older, part-time and female GPs who find the present system too inflexible and costly.

Conclusion

We suggest that GPSCs are well placed to provide the necessary technological resources, office space and flexibility of hours for

teaching. GPSCs will need adequate recurrent funding if they are to play a lead role in the establishment of better teaching practices. A responsive and flexible workplace culture, improved payment, and targeted resources and support are needed to increase teaching capacity, and to attract and retain doctors in general practice. With additional funding and new models of training, GPSCs could be part of the solution to training the new medical workforce in Australia. The GPSCs at present may solve locally the issue of space, but unless they also offer solutions for time and money, their potentially important educational role will be limited.

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References

1 Australian Government Department of Health and Ageing. GP Super Clinics national program guide. Canberra: DoHA, 2008. http://www.health.gov.au/internet/main/publishing.nsf/Content/pacd-gpsu-perclincs-programguide (accessed Jul 2009).
2 Van Der Weyden MB. Expanding primary care-based medical education: a renaissance of general practice [editorial]? *Med J Aust* 2007; 187: 66-67.
3 Britt H, Miller GC, Charles J, et al. General practice activity in Australia 2006–07. Canberra: Australian Institute of Health and Welfare, 2008. (AIHW Cat. No. GEP 21.)
4 Pearce R, Laurence CO, Black LE, Stocks N. The challenges of teaching in a general practice setting. *Med J Aust* 2007; 187: 129-132.
5 Joyce CM, Stoelwinder JU, McNeil JJ, Piterman L. Riding the wave: current and emerging trends in graduates from Australian university medical schools. *Med J Aust* 2007; 186: 309-312.
6 Access Economics. Primary health care for all Australians: an analysis of the widening gap between community need and the availability of GP services. A report to the Australian Medical Association. Canberra: Access Economics, 2002.
7 Australian Institute of Health and Welfare. Medical labour force 2006. Canberra: AIHW, 2008. (AIHW Cat. No. HWL 42.)
8 Harris MG, Gavel PH, Young JR. Factors influencing the choice of specialty of Australian medical graduates. *Med J Aust* 2005; 183: 295-300.
9 Brooks PM, Lapsley HM, Butt DB. Medical workforce issues in Australia: "tomorrow's doctors — too few, too far". *Med J Aust* 2003; 179: 206-208.
10 Australian Government Productivity Commission. Australia's health workforce. Canberra: PC, 2006.
11 Thistlethwaite JE, Leeder SR, Kidd MR, Shaw T. Addressing general practice workforce shortages: policy options. *Med J Aust* 2008; 189: 118-121.
12 DeWitt DE. Incorporating medical students into your practice. *Aust Fam Physician* 2006; 35: 24-26.
13 Medicare Australia. Practice Incentives Program (PIP). http://www.medicareaustralia.gov.au/provider/incentives/pip/index.jsp (accessed Jul 2009).
14 Thistlethwaite JE, Kidd MR, Hudson JN. General practice: a leading provider of medical student education in the 21st century? *Med J Aust* 2007; 187: 124-128.
15 Dick ML, King DB, Mitchell GK, et al. Vertical Integration in Teaching And Learning (VITAL): an approach to medical education in general practice. *Med J Aust* 2007; 187: 133-135.
16 Eley DS, Young L, Wilkinson D, et al. Coping with increasing numbers of medical students in rural clinical schools: options and opportunities. *Med J Aust* 2008; 188: 669-671.

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