The evolution of general practice training in Australia

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ABSTRACT

- Training for general practice in Australia has undergone a 60-year evolutionary process punctuated by revolutionary events.
- The discipline of general practice has also evolved significantly over this period.
- Today's Australian general practice training program strongly resembles its ancestors, with adaptations that better suit its regionalised environment.
- General practice training has been affected frequently by political and professional forces.
- Many of these forces were powered by the government's need for general practice training to deliver immediate workforce solutions, and the profession's struggle to respond.
- Pressure on general practitioners to train increasing numbers of clinical learners is challenging traditional apprenticeship models.
- The Australian general practice training program needs to continue to evolve if it is to remain successful within its volatile environment.

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The 2009 general practice-themed issue of the Journal used a Darwinian motif to explore the development of Australian general practice into a species that seems unsure of its place in the current health environment. That issue's editorial painted Australian general practice as a poorly led discipline that was corporatised and bureaucratised, riven by internal politics, and stricken by heavy-handed government control.[1] With such powerful political, corporate and societal forces all acting to shape the profession at the same time, "intelligent design" seems a more apt metaphor than Darwin's somewhat passive evolutionary model. Certainly, successive federal governments have chosen to play a creationist role rather than benignly allowing general practice to evolve at its own pace.

Nevertheless, there is some merit in looking at the way the discipline of general practice (and, more specifically, general practice training) has responded to the many major changes in its environment over the past 60 years. Most of these changes have been too sudden and non-negotiable to allow leisurely adaptation of existing approaches, much in the way that meteorite strikes enliven otherwise sluggish evolutionary processes in uncompromising fashion. But, in 2011, the heritage of Australian general practice training can still be clearly seen in its current manifestation.

Defining the discipline

A landmark article published in *The Lancet* in 1950 by a visiting Australian physician, Joseph Collings, cast scorn upon the ill-defined discipline of British general practice:

> it is accepted as being something specific, without anyone knowing what it really is. Neither the teacher responsible for instructing future general practitioners, nor the specialist who supposedly works in continuous association with the GP, nor for that matter the GP himself, can give an adequate definition of general practice. Though generally identified with the last century concept of "family doctoring", usually it has long ceased to be this.[2]

Collings went on to recommend that the role and scope of general practice within the newly developed British National Health Service be immediately clarified by GPs themselves.[2] This "meteorite" galvanised the establishment of the British College of General Practitioners in 1952; committees on undergraduate and postgraduate education were established the following year, and guidelines for medical student and postgraduate training were developed over the ensuing decade.[3]

These British developments were keenly observed from the antipodes. Faculties of the British college were formed in each Australian state during the 1950s and, in 1958, coalesced to form the Australian College of General Practitioners. Both colleges gained a Royal Charter in the 1960s. The Australian College's early aims included establishing general practice education for undergraduates and regular continuing postgraduate education, but no mention was made of a specific vocational training program for the developing discipline at that time.[4]

While the Royal Australian College of General Practitioners (RACGP) currently defines general practice as: "the provision of primary continuing comprehensive whole-patient medical care to individuals, families and their communities",[5] its British counterpart expands the World Organization of Family Doctors (Wonca) Europe definition to list 11 characteristics of general practice that include such important elements as coordinating care, providing advocacy, being person-centred, dealing with undifferentiated illnesses, and promoting health.[6] General practice's consultation style is presented as unique, and it is mastery of this vital doctor–patient interaction that distinguishes the discipline. Indeed, becoming competent in the consultation is at the heart of general practice training.

The birth of Australian general practice training

Following a successful approach to the new Labor government in 1973, a small amount of money ($1.1 million) was granted to the RACGP to set up a training program dubbed the Family Medicine Programme (FMP),[7] the forebear of today's Australian General Practice Training (AGPT) program.

The FMP was initially an optional program of educational support for those commencing as GPs. Approved hospital terms were followed by subsidised, supervised terms working in educationally accredited general practices with enhancements such as seminars and feedback on observed practice from visiting educators. For what was always intended to be a training program with vocational end points, the early years of FMP were remarkably unstructured and lacking in measurable outcomes. Although the RACGP already conferred its Fellowship by examination, it was not at that stage the novice's required "ticket of entry" to a general practice career, but rather an opportunity for practising GPs to demonstrate their mastery of the craft.[8] An educational philosophy

that eschewed formal examinations and workforce orientation frequently put the FMP's leadership at odds with government and with the RACGP itself, as evidenced by a slew of reviews both internal and external over its three decades of survival.[7] The RACGP examination for Fellowship eventually became the compulsory end point of training and entry to the profession in 1995, following the introduction of a vocational register in 1989 onto which existing GPs could be "grandfathered" if they had not undertaken the examination.[9] Vocational registration allowed recognised GPs access to higher Medicare rebates in return for continuing their professional development.[10,11]

General practice as a specialty

The last two decades of the 20th century were a time of major change in Australian general practice and its vocational training program, although the cores of each remained largely unaffected. While the RACGP collaborated with the government on the establishment of the vocational register, a new species of general practice organisation appeared in the form of federally funded Divisions of General Practice, which sought to coordinate local general practice services and achieve better health outcomes within defined regions.[12]

Meanwhile — in the general practice training biosphere — the FMP had been revised and refocused following a significant 1982 review commissioned by the then Federal Minister for Health.[13] Its loose 4-year arrangement was tightened and requirements added for a minimum 6 months in subsidised and supervised general practice placements, strengthening the master–apprentice relationship between supervisors and registrars. A formal end point was added in the form of a Certificate of Satisfactory Completion of Training,[7] which provided some exemptions from sections of the Fellowship examination (still an optional undertaking at that time). Further revisions occurred over ensuing years, with the FMP evolving into a 3-year program comprising 1 year of accredited post-internship hospital rotations, 1 year of supervised general practice posts, and 1 year of further approved clinical experience — a structure that is still evident in today's program. An obligation to better target medical workforce development was acknowledged, with the requirement for GP registrars to undertake part of their training in an "area of medical service need", usually rural. By this time, the program was being administered by a network of offices in each capital city with regional offices in North Queensland, the Northern Territory and Australian Capital Territory, Gippsland and rural New South Wales, all coordinated by a national office in Melbourne.

The evolution of vocational training — and the discipline of general practice itself — was again hastened by government intervention during the 1990s. Apart from fixing the RACGP examination as the compulsory end point of training, the *Health Insurance Amendment Act (No. 2) 1996* (Cwlth) mandated a competitive entry process for the RACGP Training Program (as the FMP had been renamed in 1993). From 1995, those wishing to enter general practice training were required to compete through the RACGP's new selection process for a government-set quota of 400 places nationally; only those in training or already qualified as GPs could access Medicare benefits. Apart from these legislative prods, the RACGP's publication of its curriculum for general practice in 1997 was a major step forward in the profession defining its discipline.

The climate within which the RACGP Training Program was operating continued to shift significantly and rapidly during the 1990s. At the same time that governmental fears of an oversupply of GPs in some areas were restricting entry to a general practice career, community concerns were mounting about the supply of GPs to rural areas. While rural populations were growing, the proportion of GPs practising in rural areas was decreasing.[14] International medical graduates with geographically constrained rights of practice became an increasing part of the solution.

In true evolutionary fashion, ongoing survival required rapid change, or ceding of ground to a better suited organism. The RACGP had established a Faculty of Rural Medicine in 1992 (later named the National Rural Faculty) and a Rural Training Stream within FMP in recognition of the need for extra training — especially in procedural skills — for those preparing specifically for rural practice and to provide support to them and their families.[15] However, a schism arose within the profession over the vocational end point for this rurally enhanced program not having "stand-alone" status as a distinctly rural Fellowship. This divergence within the general practice species was marked by the Rural Doctors Association of Australia response to a plebiscite of its members — in 1997 it launched a separate rural medical college, the Australian College of Rural and Remote Medicine (ACRRM), to set standards and provide training for rural medicine.[7,16]

"The way forward"

Ongoing government concerns about the state of education and training for GPs led to another major government review of general practice education in 1997 (the Ministerial Review of General Practice Training).[17] The RACGP Training Program was the major focus of the review, with particular attention given to rural training and vertical integration. The major outcome of the review was a the establishment of a National Council for General Practice Education to "overcome the ongoing problems of fragmentation in the system and lack of collaboration between players", and to oversee and advise the minister on the future direction of general practice.[17] The budget for general practice training was increased and 50 new places were added to the existing 400 on the condition that 150 of those places were based in smaller rural areas. Financial incentives of up to $60 000 over 3 years were offered to registrars to take up those rural places.

While attempts were made by the RACGP Council to reform the management of the Training Program during the last years of the decade (including engaging with rural and university stakeholders on steering committees), the program struggled towards the new century, maintaining its focus on educational quality rather than responding to the abrupt climate shift towards workforce supply.[17] Perceived neglect of rural concerns had become a significant political issue during the late 1990s, and politicians were aware of voter backlash in country electorates.[18] A small group of rural doctors proved effective politically in this volatile environment[19,20] and pressure mounted on the government for a separate training program for rural general practice, beyond the existing small pilot scheme for remote areas which continues today.

In June 2000, the then federal Minister for Health and Aged Care responded with an announcement to a group of rural doctors that:

> The delivery of education and training for GPs will move towards … a regionalised approach over the next 18 months, which will be overseen by [a] new Board of General Practice Education and Training.[21]

This was the most interventionist of the four options proposed by the 1997 review in its report, *The way forward*.[17] The RACGP's

monopoly on training for general practice ended 18 months later when funding became contestable through General Practice Education and Training (GPET). The RACGP Training Program's final "dinosaur killer" had arrived.

The birth of the Australian general practice training program

The first years of the new century were a time of frenetic activity as the regionalised general practice training environment took shape. GPET was established on 5 March 2001 under the *Corporations Act 2001* (Cwlth) and the *Commonwealth Authorities and Companies Act 1997* as a company limited by guarantee, with the federal Minister of Health and Aged Care (representing the Commonwealth) as its sole member. With some independent directors and others nominated to the Minister by general practice stakeholder organisations, GPET's prime role was to establish a regionalised training program — the Australian General Practice Training (AGPT) program.

In response, the RACGP established its subsidiary company, General Practice Education Australia (GPEA), which operated between 2001 and 2004 to complete the training of registrars already enrolled with the College, and to train new entrants in regions where local providers were not yet ready to do so.

Local general practice stakeholders such as universities, Divisions of General Practice, rural workforce agencies and Aboriginal community controlled health organisations formed not-for-profit companies to bid for training contracts from GPET. Their boards also included nominees of the RACGP and ACRRM, Aboriginal representatives, supervisors and current registrars. These training consortia and the regional boundaries they claimed developed to best suit the environments in which they found themselves. The whole state of Western Australia, for example — occupying one-third of Australia's land mass, remained one region, while GPET granted regional training provider (RTP) status to five separate consortia in Victoria, which is only 3% of the nation's area. Victoria does have more than three times the population of WA in less than a 10th of the area, showing vastly different training environments for the same profession.[22]

Nevertheless, the 22 new RTPs were required under the conditions of their contract with GPET (and as enshrined in GPET's constitution) to provide training according to the standards of the profession.[20] This meant that RTPs delivered the new AGPT along very similar lines to the preceding RACGP Training Program and used the College's curriculum to help their registrars prepare for its examination, which remained the sole end point of training. This monopoly was finally broken in 2007 when the Australian Medical Council granted interim accreditation to ACRRM to provide a pathway to the specialty of general practice. Thus, a registrar enrolled with GPET to train for general practice in AGPT with an RTP could now choose to prepare for Fellowship of ACRRM or Fellowship of the RACGP (with an optional extension to gain a Fellowship in Advanced Rural General Practice) or both.

Central to the concept of regionalisation is using local training opportunities to prepare doctors to meet the specific needs of the community within which they are training. While the training program remains generally similar in each of the 17 RTPs that remain from the 22 pioneers (following several mergers), local influences appropriately enhance the details. Darwin would be pleased at the diversity the original species has acquired as it strives to succeed in each environment, while the progenitors of the FMP would still recognise the centrality of the GP supervisor in guiding the registrar's development.

The way further forward

As a regionalised general practice training program, AGPT approaches its 10th anniversary in 2011 as a significantly evolved creature from its origins as the RACGP's FMP in 1973. Whereas medical workforce considerations were clearly secondary to educational concerns for the RACGP, GPET receives much more specific direction as to the Minister's expectations of the AGPT program. The 2009 Ministerial "Statement of Expectations" outlines the government's expectations as:

- implementation of 900 new training places in 2011;
- taking over of the Prevocational GP Placements Program previously managed by the colleges;
- expansion of vocational training in Indigenous health;
- encouraging innovation and integration in training models; and
- increasing the attractiveness of general practice as a career.[23]

The environment within which AGPT is delivered continues to change, so further evolution of the program can be expected. Health care reform remains a major government initiative and, as is the case overseas, primary care in Australia is increasingly seen as needing strengthening and connecting as the centrepiece of an effective, efficient and sustainable health system.[24] True vertical integration of the general practice training pathway — by which the future GP is conveyed seamlessly from medical school to independent general practice by the same training provider — remains an unachieved goal.

The increasing number of clinical learners who need to be placed in general practice is putting pressure on the apprenticeship model that has underpinned medical training for centuries. Preparing the next generation of GPs in an effective, efficient and sustainable manner will require reappraisal of this powerful but expensive model. The introduction of "GP superclinics" and "Medicare locals" (both government-funded initiatives designed to strengthen and expand primary care) will also exert significant influence on the continuously evolving training program.

The Darwinian view of evolution is somewhat brutal: a species that is poorly suited to a changed environment needs to make way for one that is better suited. And that newly dominant species had better keep an eye on the weather if it wishes to retain its place. Extinction is only a moment away for those who live in the moment rather than anticipate the future.

However, it is wrong to say that evolutionary success has much to do with being "better" than one's antecedents. Despite Spencer's sociological interpretation of Darwin's theories of natural selection as "survival of the fittest"[25] — phraseology that Darwin himself eagerly adopted — successful evolution has less to do with strength and merit than the ability to read a changing environment and to effectively change to suit it.

Competing interests

I was a GPET Board member until August 2009. I facilitated a workshop for GPET, the RACGP and ACRRM in December 2009; my fee was shared equally between the three. I was Victorian State Director of the RACGP Training Program from 1998 until 2001. I was the inaugural CEO of GPEA from 2001 to 2002.

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