Vocational Training in Australia

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Summary

Australia has a structured vocational training programme to prepare medical graduates for general practice, with a clearly defined curriculum and a set of expected competencies. It is run over 3 years with an optional fourth year for rural skills. It is the only recognised gateway to independent general practice, and attracts more applicants than it can accommodate. Funding comes from the national government, which sees the programme as integral to the development of primary health care. This is the second of 3 articles looking at general practice in Australia, based on my observations during a 6 month sabbatical in that country, in 1998.

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Discussion

Introduction

The Federal Government of Australia made a commitment to primary health care a number of years ago. This sounds familiar. However, unlike South Africa, a major thrust of this commitment was to ensure that there would be adequate numbers of well-trained general practitioners to meet the needs of the population. For this reason, the Royal Australian College of General Practitioners (RACGP) is given a large budget every year to train doctors for general practice. This is done by means of the (vocational) Training Program*.

The aim of the program is "to produce graduates who have the knowledge, skills, and orientation necessary to undertake competent, unsupervised general practice, meet their community's health care needs, and support the current and future goals of the Australian health care system."[1] What more could be expected from a programme, and what more could a government ask of a training programme it is funding?

The Structure of Training

The RACGP training program is a highly organised, structured, rational process implemented by training directors in each State, co-ordinated by a national trainer director, and answerable to a national training board. Some bigger States have more than one director, most also have rural training directors, and in some areas the RACGP contracts university departments to run its training.

The program runs over 3 years, after which trainees are eligible to sit the exam for the fellowship of the college. Those enrolled on the rural program do an extra year, in order to develop additional skills and can acquire a diploma in Rural Health. Trainees are called registrars, in the same way as trainees in other specialities.

Potential general practitioners start their training anytime a place is secured after completing internship (see below). The structure of the program includes hospital rotations and periods in supervised general practice. Hospital rotations are done within regional training hospitals. The anomaly here is that, although the registrars participate in release days (see below), during this period training is almost entirely within the hands of hospital based specialists, who often have stereotypical attitudes towards primary care and general practice. In other words, there is lack of congruence between the context (and quite possibly the content) of this aspect of the training and the final outcome envisaged by the curriculum

There is a clearly defined curriculum laid out by the College. This is grouped under the five domains of general practice, which they have identified[1], viz.

1. Communication skills and the patient doctor relationship.
2. Applied professional knowledge and skills.
3. Population health and the context of general practice.
4. Professional and ethical roles.
5. Organisational and legal dimensions.

There are minimum essential skills defined under each of these core areas, providing an impressive core set of competencies expected of general practitioners.

Teaching and learning methods for the different domains are suggested, and a comprehensive list of the knowledge and skills expected of all registrars is laid out. This compares with the

outcomes that the Department of Education will now require of all Family Medicine courses in South Africa, and provides good examples for us.

Apart from the general skills and knowledge described, registrars are also expected to become competent in 3 compulsory elements of the curriculum, viz. Aboriginal health, advanced life support, and, from the year 2000, general paediatrics.

In addition to structured rotations in hospital (known as basic terms), lasting 12 to 18 months, and periods in general practice (known as advanced terms), lasting 18 to 24 months, registrars also participate in a number of seminars through the year (known as releases) run by local General Practitioner educators. Their structure and format vary widely across States and regions. The releases are intended to ensure that all domains of the curriculum are covered, as well as providing an important source of ongoing support.

In terms of general practice sites, the RACGP is moving away from the old-boy network of teachers and supervisors, to accrediting general practices as training practices. This means they have to meet certain criteria, be inspected regularly for quality assurance, and to participate in ongoing audit, to ensure trainees are working in appropriate environments and are being supervised by good role models. There is, however, some tension regarding the number of urban versus rural practices that are accredited.

Rural Skills

I will discuss the rural component as part of the final article in this series. Suffice it to say, for now, that the Advanced Rural Skills component focuses on procedural skills for rural practice, and must be done in approved rural training sites or regional hospitals.

A joint committee of general practitioners and specialists evaluates candidates. This component is co-ordinated by a national Director of Rural Training.

Motivation

Why do doctors do vocational training? Apart from a desire to gain further skills and knowledge, potential General Practitioners enrol because there are both carrots and sticks. The carrot is this: vocationally registered doctors (those who complete the program) are paid significantly more per consultation than those who are not registered (see previous article). The sticks, on the other hand, are provider numbers, which are required to access remuneration from the Health Insurance Commission, and which are no longer issued to doctors who are not vocationally registered, except in a few underserved areas. The result is that the program is over-subscribed (by about 30%) and young doctors are often faced with the choice of going to less popular areas or waiting for a year or more to get into the program. This is something we can only dream of at this stage of our profession in South Africa, but it is certainly something to aspire to.

There is at present only one way of being vocationally registered, which is through the RACGP training program, though doctors already in practice (e.g. in underserved areas) may sit the exam after 5 years. However, the Australian College of Rural and Remote Medicine, which feels the rural training offered by the RACGP is inadequate, is challenging this monopoly.

One major area of difficulty I observed is that, where the training program accredits hospitals for basic terms and enrols registrars, the hospitals or hospital departments themselves appoint doctors for rotations in the particular institutions, according to the posts available – leading to much confusion and juggling of people and places. In spite of the successes, generalists and specialists still often land up in conflict, and hospital bureaucracies do not always cope well with the flexible needs of training.

Funding

The entire program is federally funded. It is this funding which limits the total number of places, determines which States the places are in, and guides where applicants come from (there is positive rural discrimination). For this reason too the curriculum focuses on areas of importance in the National Health Policy, so that Aboriginal Health, Women's Health and, more recently, Men's Health are given prominence. The RACGP is thus answerable to the national government, through a training board. In theory at least, this ensures that the training is appropriate and relevant to the needs of consumers; in practice, it means there is a large, entrenched

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bureaucracy at work, which is as slow to change as bureaucracies anywhere. Registrars in general practices are also now salaried employees of the government, instead of being paid a fee for service by the Health Insurance Commission – a recent change that initially evoked a strong negative reaction from doctors in training practices, who had benefited from the extra income brought in by registrars. In order to protect the registrars, the number of patients to be seen per week by them is laid down in the contract.

In spite of the funding issue, many GP's are keen to be involved in the training programme, as supervisors and educators, both because of the contribution they make thereby to the development of the profession, and because of the stimulation and interest it brings to their practices.

Assessment

An annual examination is set nationally and administered in a number of sites. It includes written questions (key features problems), an applied knowledge test (like an OSCE), and a clinical examination, i.e. consultations, increasingly using standardised patients (actors who play the role of patients).

Particular emphasis is placed on Australia's national health priorities, viz. cardiovascular health, cancer control, injury prevention, mental health and non-insulin dependent diabetes mellitus. (What would our priorities be?)

Increasingly, the focus is on the development of a portfolio by registrars as a means of in-training assessment, including a log book in which each registrar is required to record all learning experiences, supervisors' assessments, research reports and publications, audit activities, and a record of additional courses, conferences and seminars attended.

The Fellowship of the RACGP (the end qualification of the programme) is entirely separate from and unconnected to, Masters programmes in family medicine, or in rural health, run by universities around the country.

What can we learn?

Australia, like the UK, offers a structured vocational training programme for general practice, with particular emphasis on national health priorities. This is an excellent example to follow. A 3-year programme such as this, commencing post-internship would fit in well in South Africa. In view of the planned change to a 5-year medical school curriculum, this could be started during the second year of internship, and community service could be included. A big advantage we have is that in South Africa, doctors can acquire the kinds of procedural and technical skills obtainable only through regional hospital rotations in Australia, while still being supervised by skilled generalists, at district hospitals and in district clinics, with back-up by regional specialists. The balance between service demands and time for learning and reflecting is one we will always struggle with in a developing country such as ours, but the positive aspect of this is that there is never any lack in opportunities for learning.

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It is unlikely that there will be major state funding for such vocational training in the short term, so the academic bodies of family medicine will have to take the initiative in this, in co-operation with local district health services. I believe there is no shortage in South Africa of potential training sites, as well as skilled family physicians and other generalists who can act as teachers. These can be slowly mobilised. However, quality assurance, accreditation of practices or clinics, and supervision of training are major issues that would need to be addressed.

The licensing of practices, and the planned registration for independent practice with the Health Professions Council of South Africa, can be used as mechanisms to ensure that vocational training becomes as sought after here as it is in Australia.

The exercise already being undertaken by the Family Medicine Educational Consortium, to agree on outcomes for family physicians training, is an excellent step towards defining the breadth of knowledge and skills needed for family practice in South Africa. It would be a useful exercise to reflect on national health priories and to ensure these are clearly addressed in any curriculum.

The recognition of the importance of rural practice and the skills it requires is also a useful lesson we can learn in structuring any training in South Africa.

**Although Australia usually follows British spelling, the American "program" is used instead of "programme". I have adopted this spelling when referring specifically to the RACGP Training Program.*

References

1. Smith, J (Ed) RACGP Training Program Curriculum (2nd Ed) Melbourne, RACGP, 1999.