Education for General Practice in the 1980's

by Dr MW Heffernan

Part two in which Dr Heffernan, an Australian GP discusses the current emphasis being placed on vocational training for General Practice in Australia.

Negative aspects of the development

Our experience with the factors listed below would suggest to us that they need to be considered where a vocational programme is being planned, and avoided where possible.

As in the case of positive factors I will list them serially, in order to facilitate examination of them.

At the outset of the programme we accepted a civil service approach to our terms and conditions of employment, and our budgetting processes. This has produced unwarranted problems due to our relative inflexibility in the area of staffing and budgetting, at times making it difficult to reward staff appropriately (thereby maintaining staff morale), and on many occasions making it very difficult to appropriate suitable funds to particular educational objectives.

Our funding is based on the Australian financial year which commences on July 1 and ends on June 30 in the following year. This is not congruent with the academic year which follows the calendar, and this gives us recurring funding problems. For example, hospital residents are basically employed by the calendar year, and there are circumstances where they are rotating out of hospitals into FMP situations in the latter half of the year, which for FMP is in the next financial year. Our commitment to this rotation has to be made in the financial year preceding this rotation, and thus in these circumstances we are gambling that funding for the next year will be forthcoming.

As outlined above our funding is on an annual basis, and we would recommend that any vocational training programme would probably best be funded on the basis of two or three year periods.

We underestimated the number of staff we would require to run the programme. Unlike North America we did not fix any ratio of medical staff to students (this ratio is 1/4 within North America), and as our programme has expanded, we have become successively more stressed as employees.

Even where we take into account the contribution made by every doctor associated with the programme, to the programme, we still only have one full time equivalent member of staff for each 16 trainees.

In the initial phases we failed to recognise the need to establish an evaluation/research component within the programme. By the time this need became clear we were no longer in a staffing situation whereby we could afford to divert medical staff to this task.

The programme subsidises the trainee's salary whilst he is in a general practice attachment, and also pays the teacher for his teaching time. We underestimated the amount of funds that should be available for both these objectives. Further we did not establish any routine method for the updating of these sudsidies.

In retrospect we would probably recommend that a trainee's salary be met in toto by the training organisation whilst he is in his general practice attachment. We would also believe that any general practitioner teacher who has a trainee in his practice, should probably receive a weekly salary of something like $A100.00 per week.

Should the trainee's salary not be totally subsidised, then this teaching allowance would need to be increased. Further, both subsidies need to be updated regularly by some agreed mechanism.

We were slow to accept, though we understood them, the realities of decision making within the civil service and political circles. I suspect that these decision making processes have significant variations between countries, so I will not go into our learnings within this paper.

However any organisation depending on government funding, would be well advised to make a study of the decision making processes operating within their funding authority and the political circles within their country.

Associated with this latter point we did not emphasise to a sufficient degree, a continuing public relations programme, aimed jointly at creating awareness of our programme and establishing commitment to its continuance.

Though this next matter may not be of importance at this point in history, I believe it is still worthy of mention.

It is that we failed to establish with our medical colleagues, health bureaucrats and politicians, that vocational training for general practice is *absolutely necessary* in the context of current under-graduate education.

This tenet should be agreed at the earliest stages of negotiations where one is establishing a vocational training programme, and should be incor-

porated into the platform of that programme.

In a similar vein we did not ensure that our funding authority understood in depth, the educational principles that were being used to establish our programme.

We were slow to develop a conceptual model for vocational training, and this has made it difficult to develop criteria which can be used to guide evaluation and review. This task remains incomplete, though we are making gains, together with the rest of general practice, in this area.[8, 9].

A significant oversight is the fact that we failed to make available the funds to install one-way mirrors and/or television recording/replay facilities in many of our general practices. We believe that the process of direct observation adds a powerful dimension to teaching, [19, 20, 21] and we would see the provision of some or all of these facilities in many of our training practices as being essential.

As a rule of thumb the author would suggest that all the trainees should spend at least one general practice attachment (10-13 weeks) working in a practice where such direct observation forms a major part of the teaching methods used in that practice.

Where one is wishing trainees to rotate between general practice and hospital jobs a sufficiently well developed liaison with hospital administrators is of paramount importance. This remains true whether or not the GP attachment is to a special general practice located within the hospital concerned, or to a remote general practice located within the community. Early attention should be give to developing the mechanism for arranging such rotations.

Because of the emphasis on the general practitioner's surgery as a training environment, many of the medical staff involved with the running of FMP have difficulty in obtaining sufficient ongoing clinical experience.

Our College requires such staff to give at least one day a week to clinical work, and we would support this requirement. However if a programme is organised along lines similar to that of FMP, serious consideration must be given as to how such staff will obtain ongoing clinical experience within a general practice setting. An answer may be to establish some particular practices within which staff could deliver the primary care.

At the time of establishment of FMP (1973) computer technology was too expensive to be considered for implementation within the programme. This is no longer the circumstance, and we would recommend that any programme old or new, should consider the incorporation of micro or mini-computers into its management structure.

At the outset we failed to establish adequate levels of funding in order to allow members of staff to visit overseas colleagues and in order to facilitate the visits of overseas colleagues to our country.

From our experience we know that such visits lead to important gains in knowledge, and we would thus strongly recommend the adequate provision of such funds.

Conclusion

Global trends indicate that there will be an increasing emphasis on primary care within all communities at least until the year 2000. This justifies continuing the emphasis currently being placed on vocational training for general practice.

Indeed, trainees currently being trained in such training programmes now, will determine the quality and cost of primary care delivered in their respective countries up until the year 2030.

Many factors affect the successful development and running of a vocational training programme and these have been reviewed. Important amongst these is the *general practice training trinity* outlined by the author.

Family Medicine Programme is considered to be a success by the Australian Government, and is currently recruiting for vocational training, between 80 and 90% of all those graduates entering general practice within Australia.

FMP trainees are performing at least as well as older and non-vocationally trained examinees in the RACGP's fellowship examination and we have reason to believe on the basis of early studies, that we will be able to provide further evidence that vocational training is effective.

As an organisation we view the vigorous National Trainee Organisation as an important marker of success, producing as it has done very insightful and important statements on a range of issues, such as that on the nature of evaluation that is appropriate to vocational training.[22]

Finally in an economic climate where health budgets in our country have been contained and often effectively reduced, we continue to be funded, and have the current circumstance where our funding authority is recommending substantial increases in the area of teaching and trainee salary subsidies.

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