Changes to the landscape of GP training, but some aspects stay the same. Should we expect further delays to medical officer training progression?

Scott Kitchener

Abstract

ADF medical officers must complete military, military health and civilian GP training to progress to the independently deployable status of Medical Level 3. (ML3). Changes to administration of the Australian General Practice Training program (AGPT) is making recruitment more challenging for medical officers. Budget changes have removed the prevocational GP placement program that supported progression to Medical Level 2 (ML2) when medical officers are deployable under supervision. Regional training providers [of the AGPT] still experience difficulty finding GP training placements and integrating GP training with military and military health professional development, and the regional nature of these providers does not serve the national mobility of ADF registrars. AGPT Policies for ADF GP training are outdated. As a result ADF registrar training continues to be delayed compared to that of civilian registrars.

Changes to the AGPT Program and continuing issues in the efficiency of civilian GP training for ADF medical officers will require reconsideration of coordination of this element of training to avoid restricted availability of deployable medical officers.

Introduction

To progress from a newly graduated and registered medical practitioner to an independently functioning military medicine practitioner, Medical Officers (MO) and Medical Commanders need to consider new approaches to acquire civilian medical training. Securing civilian medical postgraduate training places for medical officers is becoming more competitive, associated with national medical workforce growth and changes to the civilian training support program in the Federal Budget 2014. Further delays in medical officer progression to ML3 may result without reconsideration of coordination of civilian GP training for medical officers.

Background

Along with military and military health training, MO must complete further medical training to achieve the standard of Medical Level 3 (ML3 - deployable unsupervised).[1] The majority of MO will be required to complete Primary Care postgraduate medical training to the standard of vocational registration with the Medical Board of Australia, usually by achieving Fellowship in either the Royal Australian College of General Practice (RACGP) or potentially in the Australian College of Rural and Remote Medicine (ACRRM). The latter has not been a commonly used pathway to date.

The current model of training for Medical Officers utilises the Commonwealth funded Australian General Practice Training (AGPT) program to support training requirements towards Fellowship.[2] The AGPT financially supports Regional Training Providers (RTP), which provide logistic and academic support to Registrars including those in the ADF.

Changes to the landscape of civilian training support will potentially compromise the progression of ADF Medical Officers towards ML3. Recruitment of MO to RTP has become more competitive and funding for ADF MO training by RTP has changed and may change further. Some things that have remained the same are the difficulty RTP experience in understanding and supporting ADF MO and the delays in the time taken for ADF MO to complete civilian training in General Practice.

This paper will detail these issues and open discussion on the potential impact.

Recruitment of ADF MO to RTP is becoming more competitive

Competitive selection to the AGPT is required for the limited places available and to satisfy College requirements for entry to training. Selection may occur during any postgraduate year, beginning with

Internship (postgraduate year 1) for commencement on the Program in the following January as an ADF registrar.

The Commonwealth has steadily increased the places available on the AGPT Program. From a modest program attracting 675 applicants for 600 positions in the 2005 entry,[3] the appeal of general practice training has grown. The AGPT attracted 2245 applicants sitting the entry examinations for 1500 positions beginning in 2015.[4,5]

With increasing numbers of applicants, ADF registrars, who were previously additional to the registrar numbers allocated to each RTP, are now included under the cap for each RTP. This increases the need for ADF applicants for AGPT to be competitive for these limited positions, in addition to being competitive to join a College training program.

Changes in funding for ADF MO civilian training

While an increase in registrar places available appears to be a positive for ADF MO, funding for these places has come from ceasing the Prevocational General Practice Placement Program [PGPPP]. This program served the ADF well, providing funded, supervised, civilian general practice exposure during postgraduate year 2 that has expedited progress to ML2. These terms could be recognised as meeting hospital training time (RACGP Hospital terms or ACRRM Core Clinical Training terms) for the purposes of the AGPT. Loss of this program will reduce such opportunities prior to medical officers beginning return of service obligations, so delaying progress to ML2.

Further significant changes in the Federal Budget 2014 reduced [AGPT] funding for State employed registrars in order to make savings to expand the program elsewhere. The focus of this direction is toward supporting more training in private general practice. This is entailed in the reformation of Federalism being undertaken by the Commonwealth Government in defining State sovereignty.[6] Risk exists for compromise to funding for GP training of ADF medical officers. Support for registrars not engaged in private general practice will need to be reviewed and negotiated with the Department of Health as funding for training is reformed.

RTP difficulties in supporting ADF MO

Regional Training Providers have gathered annually at the GPET (GP Education and Training) Convention to discuss [their] issues with ADF Registrar training. The themes remain constant.[7,8,9]

Issues include:

- Transfer of ADF Registrars between RTP, commonly required due to the regionalised nature of RTP and ADF MO required to choose a RTP long before they receive their posting for return of Service that will determine their training location.
- Limited harmonisation of policies between RTP regarding hospital terms, recognition of prior learning and release of ADF Registrars for civilian placements.
- Management policies of billings arising from civilian practice placements.
- Apparently inconsistent and variable availability of MO for civilian placements.
- ADF registrars without a civilian placement, or more commonly left with the placements remaining after civilian registrars have already chosen earlier in the academic year and before military and military health courses have been completed by ADF registrars. This is particularly a problem in RTP, when registrars must find their placement among the list of available training practices rather than actively choosing their position.

Some RTP have been critical of the medical training available to ADF MO, insisting on a further release of ADF registrars to civilian practices for training.[10] Concerns of the quality and adequacy of civilian supervision in the ADF have also been raised as limiting to the training of ADF registrars.[11]

In fairness, difficulties with managing the training of ADF registrars by civilian RTP do arise because of confusion about the requirements for civilian training. The AGPT policy guiding ADF Registrar training was last issued in 2008 as a "transition" policy.[12] It was recently updated as the sponsoring authority, [GPET], was being dissolved in December 2014. The policy will require further review since it is exclusively related to RACGP involvement and silent on ACRRM training, and still refers to the now non-existent PGPPP. This will leave further uncertainty regarding policy.

Nevertheless, AGPT Guideline s3.1.2.5 clarifies that ADF registrars require six months full time equivalent in civilian general practice and this is a requirement for both RACGP and ACRRM training. Both this guideline and the new AGPT policy for ADF registrars recommended GP terms be completed during hospital rotations in postgraduate year 2. Of course, with the demise of the PGPPP also in December 2014, this will be difficult and potentially cause a resurrection of RTP advising ADF Registrars to acquire this placement by resigning their hospital post before completing two years of hospital rotations

and consequently the College-required exposure to hospital rotations.

Beyond this issue, with the increasing number of registrars seeking private practice placements, the opportunities for ADF registrars to secure such placements to meet College requirements will become more difficult. Rather than having to accept placements left over after civilian registrar placements, ADF registrars may be left with no civilian training placement options as training capacity is reached.

Notwithstanding the inherent difficulty in integrating GP training by a civilian organisation with military and military health training by each of the three uniformed Health Services, shifting and uncertain policies make efficient coordination of a training program for a registrar by a RTP almost unachievable.

Training transit time for ADF registrars

The ease of fit of civilian coordinated GP training with military and military health training during the early years of medical officer service in uniform has been previously discussed in this Journal.[13] Analysis of training time of registrars on the AGPT Program in 2011 found there were training delays of ADF compared to civilian registrars.[14] At the time, 51 ADF registrars had completed FRACGP through the AGPT Program, taking an average of 4.42 years including 48 weeks recognition of prior learning [RPL]. This was 0.4 years longer than 2226 civilian registrars who had similarly completed training. At this time, few if any military health and military training courses were recognised for the value they provided in preparing an ADF registrar for practice in the military cultural environment. With the annual intake of ADF registrars, this delay translates into several full time equivalent independently deployable medical officers per year not available to the ADF. Central coordination of ADF registrars, rather than regionalised training provision, and understanding of military health training and experience were recommended.

In 2014, several military health training courses have been recognised for College training. Repeating this analysis in 2014, it is found that registrars now join the AGPT earlier, evidenced by much smaller claims of RPL with time credit [6.08 weeks, SD: 16.76 weeks], than civilian registrars who claimed a mean of 18.10 weeks [SD: 25.51 weeks]. However, mean time from AGPT start to FRACGP for 208 ADF registrars was 4.34 years [SD: 1.28]. In this period 6785 civilian registrars took on average 3.46 years [SD: 1.38] to FRACGP. Accounting for differences in RPL, ADF registrars averaged total time to completion of FRACGP on AGPT of 4.48 years [SD: 1.32] which remains longer than the 3.81 years [SD:1.46] taken by civilian registrars. These are overlapping distributions, but they appear to be diverging. The delay in ADF registrar training remains the same.

Conclusions

ADF medical officers will find it more challenging to secure positions on the AGPT should the current arrangements of recruitment to RTP for access to the AGPT Program continue.

The loss of funded prevocational general practice placements as part of hospital rotations during postgraduate year 2 and difficulties in securing any private practice training placement will cause delays in progression to ML2 and potentially compromising progress to ML3, depending on how RTP manage acquisition of civilian GP training placements.

Uncertainty exists with potential changes to funding of RTP for registrars not engaged in private general practice. These may further reduce the desirability of ADF applicants to RTP, when these Providers continue to find their management difficult.

The civilian-coordinated regionalised approach to support general practice training of the national ADF medical officer workforce hasn't been as efficient as it is for civilian GP registrars. A more standardised approach to ADF registrar training needs to reflect the national and international mobility of Defence registrars and the imperative to integrate and recognise military health training and experiences.

An updated AGPT approach to ADF registrar training is well overdue. This should proceed in partnership with the Health Services responsible for medical officer training. Recognition of the changing landscape of GP training and the more intractable issues now well known to current and past ADF registrars should permit a new training coordination solution to arise. A dedicated national ADF training provider partnership, preferred regional providers with focus on ADF training needs, or an integral training capability for GP training are such solutions. As highlighted in 2011, central coordination and better understanding of military and military health training integration should be re-considered.

Author's affiliations: Medical Director, QRME, Clinical and Academic Lead, Rural Health, Griffith University Research Lead, Agricultural Health & Medicine Research, University of Southern Queensland
Corresponding author: Prof. Scott Kitchener , PO Box 2076, Toowoomba, QueEnsland, AUSTRALIA, 4350
Email: s.kitchener@qrme.org.au

References

1. Defence Health. Medical Levels. Available at: http://www.defence.gov.au/health/mocss/competency.asp Last viewed 15 February 2015.
2. General Practice Education and Training. About the AGPT program. Available at: http://www.gpet.com.au/Junior-doctors/AGPT-program Last viewed 15 February 2015.
3. Applicants for general practice fall. Australian Doctor 13 October 2004. Available at: http://www.australiandoctor.com.au/news/latest-news/applications-for-general-practice-fall Last viewed 15 February 2015.
4. 2245 Junior doctors sit online test for GP training. General Practice Education & Training. Available at: http://medianet.com.au/releases/release-details?id=805760 Last viewed 15 February 2015.
5. Budget Paper No. 2: Budget Measures, Part 2: Expense Measures. Available at: http://www.budget.gov.au/2014-15/content/bp2/html/bp2_expense-14.htm Last viewed 15 February 2015.
6. Reform of the Federation White Paper. Available at: http://federation.dpmc.gov.au Last viewed 15 February 2015.
7. Crampton R. ADF Registrars – are we any further ahead? GPET Convention, Adelaide 2009.
8. Cockayne T, Gemmell-Smith F, Canalese R et al. Mining for gold: finding the mother lode in training of ADF registrars. GPET Convention, Perth 2013.
9. Kitchener S. Workshop: Partnering with Navy, Army and Air Force to improve medical readiness. GPET Convention, Brisbane 2014.
10. Smith P. GP supervision missing in action at ADF, Australian Doctor, 28 March 2013.
11. Rollins, A. New front opens in Defence contract battle, Aust Med 2013; 25.06: 10.
12. Training for Registrars who are full-time members of the Australian Defence Force. AGPT (Transition) Policies, 3.1, 2008. Available at: http://www.gpet.com.au/Junior-doctors/AGPT-program Last viewed 15 February 2015.
13. Kitchener S. General Practice training in the ADF – square peg, round hole? JMVH 2009; 17(4): 13-16.
14. Kitchener S, Rushbrook E, Brennan L, Davis S. Training ADF Medical Officers to civilian GP standards – reflections on military medicine and its links to GP Education and Training. Med J Aust 2011, 194: S79-83