Remodelling general practice training

Tension and innovation

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Background and objective
The transfer of general practice training in Australia to the two general practice colleges is an opportunity for change in the model of training. The dialectical theory of institutional change suggests that change occurs where organisational structures of training are in tension with the needs of those delivering training, and effective change arises from innovation within these tension points. These tensions have also been faced by general practice training organisations internationally, where solutions have also been crafted. By exploring training tensions and responses to these, the aim of this study was to inform the remodelling of general practice training in Australia.

Method
Senior educators and stakeholder representatives in Australia and internationally were interviewed to identify tensions in training delivery and innovative responses to these. An interpretative qualitative analysis was undertaken.

Results
Eight key tensions and associated innovative responses were identified.

Discussion
Drawing from the findings, this article provides recommendations for remodelling general practice training in Australia.

AN OPPORTUNITY currently exists to review and revise general practice vocational training in Australia. Many of its structures have been in place for decades. However, the landscape of general practice training has changed considerably.[1] In 2020, responsibility for oversight of Australian General Practice Training (AGPT) is to be transferred from the Commonwealth Department of Health (DoH) to The Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM).[2] Therefore, it is timely to examine ways in which general practice training might be revised to retain program relevance and to enhance outcomes.

The dialectical theory of institutional change provides a useful framework for identifying where change needs to occur.[3] This theory highlights that, over time, institutional structures tend to become misaligned with the needs of those doing the work of that institution. These misalignments result in tensions that propel those undertaking the work of the institution to develop workarounds that can be a further source of tension if there is a discordance between the workarounds and the institutional structures. A functional organisation will modify its structures to address these tensions by 'progressive reconstruction'. The alternative is leaving tensions to build to a point of crisis and institutional disintegration.

For AGPT to change by progressive reconstruction rather than by crisis, it is necessary to understand the tensions at the interface of its institutional structures and on-the-ground program delivery. Where there is tension, it is important to identify solutions that work in practice. There are two obvious places to identify such solutions. The first is at the 'coal face', where those doing the work of general practice training are creating solutions to deal with the tensions. The second is from similar institutions elsewhere in the world that are also faced with these tensions.

Insightful expert opinions on how AGPT might be remodelled have been published (Table 1).[1,4–9] There is, however, an absence of research investigating the perspectives of those delivering the program more broadly.

Therefore, with the aim of informing reconstruction of AGPT during the current period of change, the researchers explored the experiences of tension by those delivering the program, the solutions they are creating in response to these tensions and the solutions developed by international general practice training programs in similar environments.

Three questions were asked:

- What are the tensions experienced by those delivering the AGPT program?
- What solutions are those delivering the program enacting in response to these tensions?
- What are international solutions to these tensions?

Methods

The study was conducted using interpretive qualitative methods[10,11] and the dialectical theory of institutional change as its theoretical frame.[3] This theory holds that institutional change happens through the action of institutional inhabitants in response to tensions arising from incompatibility between institutional structures and the needs of the inhabitants to undertake their work. These actions are deliberate and may be individual or collective.

Sampling and data collection

Senior educators were purposively sampled in Australia and from five other countries. The choice of the five countries was based on the similarity of their model of general practice training to the Australian approach and on the countries' innovation and leadership in general practice training. Participants were invited to be interviewed either in person or via video/audio link. Prior consent was obtained. All interviews were recorded and transcribed. Interviews were informed by an interview guide based on our questions, carried out by one of the authors (SW) or a trained research associate, and lasted up to one hour. Prior to undertaking the interviews, publicly available documents were viewed pertaining to the interviewee's organisation to inform the interview and the subsequent analysis.

Participants

Australian-based interviewees were 10 senior educators from the nine Australian general practice regional training organisations (RTOs) and seven leader representatives from five Australian organisations within general practice vocational training: ACRRM, RACGP, General Practice Registrars Australia, General Practice Supervisors Australia and Leaders in Indigenous Medical Education. International interviewees were 11 leaders in general practice vocational training from Canada, Ireland, the Netherlands, New Zealand and the UK.

Reference group

A reference group was established and included representatives from two RTOs, the two general practice colleges and the DoH. This reference group provided advice on the research approach and on interpretation of the data.

Analysis

Analysis was undertaken iteratively, with analysis and data collection occurring concurrently.[12] The data were coded inductively and deductively using NVivo 12.[13] A priori codes were derived from our questions and theoretical perspective. From this, an analytical framework of key themes was created and reapplied to the data.

Consistent with the principle of reflexivity in qualitative research,[14] the researchers drew on their own experiences to understand the data. All the researchers are involved in general practice training including, between them, supervision, supervisor support, program development, health policy and academia. Three of the researchers are based in Australia and one in Canada. A significant driver for this research was the researchers' experiences of the tensions in general practice vocational training.

Analytic rigour was facilitated through testing and refining interpretations by constantly reviewing the data, ensuring multiple researchers analysed the same data and discussed the findings, and discussing findings with the reference group. Findings were tested for authenticity by workshopping these with six separate groups of general practice supervisors and medical educators.

Ethics approval was gained from Monash University Human Research Ethics Committee project 10033.

Table 1. Published expert opinion on issues facing general practice training in Australia

Issue	Expert recommendation
Meeting social accountability imperatives	Targeted recruitment and selection[4,5] Building integrated rural pathways[5] Better metrics for training outcomes[4]
Building cultural safety awareness	Organisational commitment to cultural safety[6] Building cultural education and mentorship capacity[6]
Containing the cost of training	Vertical integration[1] Cooperative rather than a competitive tender approach to training delivery[4,5]
Raising the standard of supervision	Increased support for supervisors[7] Supervisor peer support groups[7] In-practice supervisor professional development[7]
Improving preparation for community-based placements	Integration of hospital and community-based training[5,8,9] Base knowledge requirement and assessment for selection[8] More intensive orientation[8]

Results

Eight key tensions were identified.

1. Centralisation leading to disengagement
2. Difficulty engaging supervisors and registrars with cultural competency training
3. The cost of relational-based education
4. Variable quality in supervision
5. Out-of-practice assessment as a distraction from learning for practice
6. Different needs in the international medical graduate (IMG) cohort
7. Workforce imperatives compromising educational needs
8. Lack of preparedness for community-based training

The following sections first detail each tension, then describe what was being done to address the tension in Australia and internationally.

1. Centralisation leading to disengagement

In Australia, with a steady reduction in RTOs, there has been movement towards centralised educational delivery. The rationale for this included cost savings, quality assurance and development of specialised educational expertise. However, centralisation has compromised the engagement of practices and supervisors with training programs.

> *Our practices, registrars, supervisors were finding it difficult to know which, sort of, team or part of [the RTO] ... could answer their specific inquiry ... our supervisors got left out in the cold ...* (Australian RTO)

In response to this, initiatives have been taken by some RTOs to sub-regionalise their educational delivery to better build local relationships.

> *... [O]ur structure is to try and be as regionalised as possible within that big region. Trying to be as small and personable as possible.* (Australian RTO)

Canada, UK and Ireland had well-developed models of distributed delivery of education where there was a high level of autonomy in the sub-regions and a voice in overall program governance.

2. Difficulty engaging supervisors and registrars with cultural competency training

A remit of AGPT is to contribute to 'closing the gap' in Aboriginal and Torres Strait Islander health outcomes[15] by building cultural competency in registrars. Participants identified a tension in achieving this because of a lack of receptiveness by registrars and supervisors and siloed delivery of the Aboriginal and Torres Strait Islander health curriculum.

> *... [T]he supervisors, if they don't really believe that it's important and aren't supervising and questioning the registrars [about] what they're doing, then we're not closing the loop. And we're certainly not closing the gap.* (Australian stakeholder)

A response to this has been to build a commitment to cultural competency within the RTO from the top down.

> *... [H]aving your CEO and your board driving it was a huge benefit.* (Australian stakeholder)

In New Zealand, cultural educators were an integral part of the training program. Their role included teaching a Māori framework for healer engagement with patients.

3. The cost of relational-based education

Australia and comparative international countries invest heavily in supporting face-to-face education for registrars with their supervisors, visiting educators and peers. The key value of relational-based education was identified as supporting professional identity formation.[16]

> *... [T]he small group, I think, is the best place to teach professionalism. But to do that, you have to have interaction.* (Australian RTO)

Relational-based learning was, however, perceived to be costly in time and resources.

> *If we're going to fund educators, if we're going to pull registrars out of practices at a time, then I want to get biggest bang for buck ... travel costs are huge ... travel time is huge ... it's not just a cost to the registrar. It's a cost to the practice, it's a cost to the community.* (Australian RTO)

With fiscal tightening, there has been pressure to limit these activities and replace them with online education through which the value of relational learning can be lost.

> *If you take it online ... I don't think we have the full bandwidth of human communication ... which is what really medicine comes down to ... relationships with people.* (UK interviewee)

Both Australian and international training providers recognised that face-to-face education should be leveraged for its relational assets and used for networking and benchmarking. Information delivery could be moved to other modalities of education such as online modules and resources.

4. Variable quality in supervision

Participants described tensions relating to variable quality of registrar supervision. They identified three influencing factors. These were: the recent need to recruit large numbers of supervisors because of increased numbers of registrars, the workforce imperatives that motivate hosting a registrar, and the low priority that supervision often had for supervisors.

> *The recent challenge for RTOs has been to ... recruit enough practices and supervisors ... I think it has led to a dilution of some of the standards of supervision and in-practice training.* (Australian stakeholder)

> *... [T]he issue with needing to meet workforce needs as part of our contract is that you have to put registrars in places potentially where they're not going to get adequate supervision or appropriate education.* (Australian RTO)

> *We appreciate that it's a bit of a third or fourth tier of [the supervisor's] priorities ... [they're] all very busy.* (Australian RTO)

Initiatives taken to address this included tagging a proportion of practice payments to specifically compensate the supervisor for the imposition of supervision and encouraging supervisor local networking for peer benchmarking.

Internationally, decoupling of the registrar salary from their work output enables educational imperatives to be prioritised.

> *... [S]o whether you have a registrar or if you don't have a registrar should be almost work load neutral because the registrar will obviously see some patients when they're there but the trainer will see less patients than they normally see because they're doing lots of teaching.* (Irish interviewee)

Ireland, Canada, UK and the Netherlands had much greater professional development requirements for supervisors. In these countries, supervisor professional development is approximately 50 hours annually in comparison to six hours annually in Australia.

5. Out-of-practice assessment as a distraction from learning for practice

RACGP fellowship assessments are end-of-training, out-of-practice examinations. ACRRM assessments are a mix of in-practice and out-of-practice assessments taken during training and a viva-style examination at the end of training. Educators identified a tension where learning for end-of-training out-of-practice exams became a distraction from learning for practice.

> *Assessment drives learning and if you don't pass your exams, you don't become a [general practitioner], therefore I think there's a mindset amongst our trainees of … making sure they pass the exam.* (UK interviewee)

> *We're training for general practice. We're not training to pass exams.* (Australian RTO)

Internationally there has been a trend to move out-of-practice assessments earlier in training to assess foundational knowledge and skills for training and to use in-practice assessment for determining readiness for independent registration. New Zealand registrars undertook an out-of-practice exam after one year of training and a comprehensive full-day in-practice assessment at the end of training.

6. Different needs in the international medical graduate cohort

For the past 20 years, Australia has endeavoured to address the issue of workforce need in underserviced areas by recruiting and indenturing IMGs to work in these areas. These IMGs have become a significant component of the rural general practice trainee cohorts. This was identified as a tension as IMGs were expected to progress through a training program designed for domestic graduates at the same rate despite their varied background skills and experience.

> *… [A] lot of them have come, as you know, from a system that is so different and then they're put in relatively isolated areas, the odds are pretty much stacked against them.* (Australian RTO)

In Australia, the main response to this was to provide additional support when it became apparent that the IMG registrar was struggling.

In Canada, IMGs were required to undertake additional training, practice-based experience and assessment before being granted entry into vocational training.

7. Workforce imperatives compromising educational needs

> *… [T]he problem is that this [training] still is their major health workforce lever in the country.* (Australian RTO)

> *… [F]ee for service reliance and that's the big negative for medical education in this country.* (Australian RTO)

Participants identified a tension between workforce and educational imperatives. RTOs were required to place registrars in areas of workforce need. Further, the trainee's salary was derived from their work.

Action taken by Australian participants to protect educational imperatives included the provision of additional resources and funding where the shortage of clinical services was critical, such as remote and Aboriginal and Torres Strait Islander health services, and putting in place tight contractual arrangements relating to educational requirements.

In all five international models examined, general practice registrars were funded externally to the workplace in a supernumerary capacity for at least part of their training.[4]

8. Lack of preparedness for community-based training

> *… [T]he challenges of knowing the billing system, understanding which drugs to prescribe, knowing how to fit in with the [general practice] environment … rather than a large hospital … can be very difficult.* (Australian RTO)

The transition from hospital to community-based training was identified as a risk for both registrar and patient safety. Because registrar clinical services were required for funding their wages and to manage patient demand, there was a demand for registrars to attend patients from the start. Despite most having had no prior experience working as a general practitioner (GP), registrars were expected to be able to work under Level 3 supervision,[17] which required them to know when to call for advice.

Australian participants addressed this tension with pre-placement group educational sessions and specific skilling workshops. In some sites, initial direct supervision was being provided despite the absence of specific funding.

International programs addressed this issue by overlapping hospital and community-based training and providing for an initial period of observation and direct oversight of all consultations.[8]

Discussion

This research has identified key tensions experienced by senior people responsible for delivering AGPT. These identified tensions both overlap with and extend beyond the issues already flagged in published opinion. The dialectical theory of institutional change suggests that these tensions represent a discordance between the institution of AGPT and the experiences of those who work within it.[3] For AGPT to progressively reconstruct itself, it needs to address these tensions. Avoiding doing so will likely eventually lead to an institutional crisis. With stewardship of AGPT being transferred to the RACGP and ACRRM, it is timely to address these tensions. Some tensions can be addressed at the level of the RTO; others need addressing by the colleges; and others need addressing by government funders and authorities beyond AGPT. For the tensions that can be addressed at the RTO level, the dialectical theory recommends that these be approached by building on the responses already developed by those who work within general practice training. For those tensions that require action by the colleges

or authorities outside AGPT, we believe that international initiatives provide guidance. Using these principles, we make recommendations for addressing each tension. These are detailed in Table 2. Where these align with recently published perspectives, the reference is provided.

For changes that depend on governing bodies external to AGPT, the dialectical theory poses that necessary change can be precipitated through coordinated collective action by those within the institution. Collective action with a shared framework has the capacity for political pressure. Those within general practice training will need to exert such collective pressure if general practice placements during the hospital years and supernumerary funding for registrar wages are to be instituted. With both of these strategies there is already momentum towards change and there are tested frameworks for action. For models of general practice placements during hospital years, there is the decommissioned prevocational general practice placement program[18] and the remaining small-scale rural intern general practice placements.[19] The RACGP has recently supported prevocational placements for addressing the declining interest in general practice.[20] The National Rural Generalist Pathway initiative[21] proposes both early community-based placements and length-of-training contracts with a single employer. If there is a broad commitment to these changes by those invested in general practice training, the shifting political landscape will create opportunities to progress them.

Limitations

This research was broad in its scope and therefore limited in its depth. The reporting of our findings is necessarily an overview. The confines of this article do not grant the capacity to provide detail of the complexities underlying each tension. There are more perspectives on general practice training than the ones we accessed. It is notable that interviews were only conducted with single representatives of general practice registrars and general practice supervisors. These important stakeholders may describe other significant tensions and innovative responses. The analytic approach was interpretative and reflexive. While the interpretations were tested with a reference group and with meetings with supervisors and medical educators, the veracity of the interpretations depends on the resonance they have with those involved in general practice training.

Conclusion

This research identified areas of tension within AGPT and the responses created by those involved. It also identified international initiatives relevant to these tensions. These findings led to the generation of recommended actions and political focus by RTOs and colleges for remodelling general practice training to ensure that GPs are trained to serve the needs of the Australian community.

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Table 2. Recommended actions for addressing identified tensions within general practice vocational training

Tension	Recommendations drawn from actions
Actions within the remit of the regional training organisations	
Centralisation leading to disengagement	Sub-regionalise educational delivery
Difficulty engaging supervisors and registrars with cultural safety training	Commit the entire organisation to cultural safety training with strong input from cultural educators and mentors[6,22]
Costly relational-based education	Emphasise peer benchmarking and role modelling for face-to-face activities Support factual knowledge acquisition with online educational platforms
Variable quality in supervision	Implement specific supervisor payments to provide recompense for the impact of supervision Increase personal development support for supervisors, particularly opportunities for local networking
Actions within the remit of the general practice colleges	
Variable quality in supervision	Increase professional development requirements for supervisors[7]
Out-of-practice assessment as a distraction to learning for practice	Use out-of-practice assessments for selection for suitability for training and in-practice assessments for certification for fellowship
Different needs in the IMG cohort	Institute pre-training general practice immersive experience and assessment for IMGs
Actions for governing bodies external to AGPT	
Workforce imperatives compromising educational needs	Fund registrar wages separate to fees generated by work output[4]
Lack of preparedness for community-based general practice training	Provide and require general practice placements during prevocational hospital-based training[8,9]

AGPT, Australian General Practice Training; IMG, international medical graduate

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Competing interests: All authors are employed by organisations that have a vested interest in general practice training. JB and CK are employed by Eastern Victoria GP Training and DS is employed by The University of British Columbia. SW is employed by Australian National University and is a Senior Medical Adviser, Health Workforce Division, Department of Health, Canberra. This research has informed her work but is a separate endeavour. The views expressed in this report are those of the researchers and are independent of Department of Health policy.

Funding: CK and JB report receiving a wage from Eastern Victoria GP Training (EVGPT) during the conduct of the study. DS reports personal fees (by contact) from EVGPT, during the conduct of the study. SW was contracted to EVGPT for half a day a week for a year to work on this project.

Provenance and peer review: Not commissioned, externally peer reviewed.

Acknowledgements

We wish to express our gratitude to Eastern Victoria GP Training and Murray City Country Coast (MCCC) GP Training for their generous support and funding of this research. We are also grateful for the time and insight provided by the reference group members of this project. We would like to thank our Australian and international research participants who generously shared with us their knowledge, experience and enthusiasm regarding general practice and GP training. We also wish to thank: Ms Jenny Lamb and Dr Merryn Smith for their contributions to administering the project, data collection and early conceptualisation; Professor Marlene Drysdale for advice on the Aboriginal and Torres Strait Islander component of this research; and Professor Debra Nestel and Dr Tim Clement for comment on the final draft.

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