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Tom Brett

University of Notre Dame Australia, tom.brett@nd.edu.au

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**Tom Brett**

MA, MD, MRCGP, MICGP, FRACGP, is Associate Professor and Director, Notre Dame PHC RED, The University of Notre Dame Australia, Western Australia. tbrett@nd.edu.au

New medical graduates

Can general practice help with training?

Medical student numbers in Australia have increased significantly in recent years. A resulting increase in medical graduates is inevitable and desirable. Western Australian medical graduates will double by 2012 and treble shortly afterward. Insufficient training positions in hospitals will likely require additional training opportunities to be provided by general practices. This article reviews innovative general practice training schemes for new medical graduates in Australia and overseas. It examines whether Australian general practice can play a role in training the rising numbers of new doctors.

■ **General practice is not generally regarded as an integral part of early postgraduate training for new medical graduates. Apart from community based training schemes¹⁻³ involving enthusiastic general practitioners, training positions for new doctors have generally been hospital based. As a result, general practice has missed an opportunity to show its potential as a training facility and to aid recruitment to its own workforce.⁴**

The changing nature of medicine, with shorter hospital stays and greater reliance on new technologies, means fewer opportunities for clinical exposure to real patients in hospital settings.⁵ Combined with increasing numbers of students entering Australian medical schools, the situation demands that different approaches be assessed and utilised.^{6,7} The experience of using general practice in undergraduate and postgraduate training has largely been positive.

Western Australia has seen a significant increase in medical student numbers. The 2005 opening of the graduate entry medical school at the University of Notre Dame plus increased numbers (including a new graduate entry program) at the University of Western Australia have seen medical student numbers jump from 764 in 2000 to 1001 in 2005. The expected intake for 2008 is 340.

The anticipated surge in new medical graduates will have an impact throughout Australia.⁸ The total number of Australian medical graduates will jump 81% from 1608 in 2005 to 2916 in 2012.⁹ Medical graduates in WA are projected to increase by 109%, from a total of 113 in 2005 to 237 in 2012.⁹

Despite this expansion, Australian general practice struggles to fill its training positions.^{10,11} In 2004, Charles et al¹² identified an Australian GP workforce undergoing considerable change. Increasing numbers of women GPs, an aging male GP population, a general contraction of hours worked and a continuing decline in rural doctor numbers were identified as key factors in the workforce shift.

These changing demographics mirror other western democracies in which a greater emphasis on work-life balance in 'the new general practice' has progressively replaced the traditional 'vocational' approach.¹³ This shift in professional discourse among new GPs

– both male and female – and the concomitant search for ‘nice work’ has been postulated as worsening the inverse care law (whereby those who need care most are least likely to receive it).^{13,14} Reduced work hours and increased subspecialisation mean more GPs are required.^{9,13}

The increased number of new medical graduates demands suitable postgraduate training positions.⁹ Overseas, general practice exposure in postgraduate year (PGY) 1 and 2 has been shown to be both feasible and meaningful for the new doctor pursuing a career in either primary care or hospital medicine.^{1,3}

The Australian experience

South Australia was the first Australian state to trial community general practice rotations.² The Cleve and Jamestown intern (PGY1) schemes under the supervision of local GP trainers were favourably evaluated. These initiatives were later expanded to incorporate community terms for PGY2 and PGY3 doctors in the Adelaide area and foreshadowed the Australian Government’s Prevocational General Practice Placements Program (PGPPP) which began in 2005.

In 2006, a community residency program that included 3 months supervised general practice was developed by the Government of Western Australia Department of Health in association with Western Australian General Practice Education and Training (WAGPET).² Insufficient applications for the WAGPET program caused the planned 20 positions to be reduced. Three of the four rotations were taken up in 2007.²

The United Kingdom experience

Intern (PGY1) positions began in the United Kingdom in 1951, with PGY1 doctors expected to gain supernumerary experience within a supervised hospital setting; instead they soon became ‘an extra pair of hands’ with little formal training. The *Medical Act* 1978 introduced the possibility of PGY1 training in general practice. Guidelines were further clarified in 1997 by the General Medical Council’s (GMC) document ‘The new doctor’.¹⁵

Postgraduate year 1 rotations were established in Southampton¹⁶ in 1979 and at St Mary’s^{17,18} in 1981. The latter involved 4 month medicine, surgery and general practice rotations and still operates today. It has been the subject of a number of positive evaluations.^{17,18}

In 2003, Illing et al¹ undertook a review of the evidence from 19 different schemes in England and Scotland. They reported on the generally positive experiences from 180 PGY1 doctors, 45 GP trainers and 105 hospital specialists. Significantly, none of the schemes was found to be expanding.¹ Major impediments to their development included the additional workload on GP trainers and inadequate remuneration.

Postgraduate year 1 doctors were positive in their evaluations and recommendations to colleagues.¹⁹ The GMC’s aims were met, and matched traditional hospital training;²⁰ the experience of a wider range of learning was a bonus. Communication skills and hospital doctors’ subsequent communication with GPs were improved. Diagnostic uncertainty at the general practice consultation – lacking peer support,

nursing care and easy access to diagnostic tests or senior medical opinion – was seen as a powerful learning experience that changed attitudes toward GP hospital referrals.^{1,3}

Most hospital specialists (93%) were in favour of the schemes, although some regarded 8 month hospital rotations as insufficient.²¹ Overall, supervision and tutorial support were more available in general practice.^{21,22} The additional time spent in supervising PGY1 doctors compared with GP trainees was universally noted.^{1–3}

The UK adopted a 2 year compulsory program for all new doctors in 2005. Foundation year 1 (PGY1) and foundation year 2 (PGY2) act as bridges between undergraduate and specialist or general practice training. General practice is seen as an integral part of this development.

The Danish experience

The Danish experience with general practice exposure began in 1991 when it became compulsory for all new medical graduates to train in general practice.²³ Tutor evaluation felt that while new graduates had limited experience and required extra supervision, there was value in their work capacity, which yielded neutral or improved economies to the practice.²⁴

Another evaluation²⁵ stated that trainees should have their own room plus daily teaching about individual patients, as well as weekly conferences about particular subjects related to the practice.

Donegal scheme

The first Irish intern (PGY1) general practice rotation scheme commenced in Donegal³ in 2004 and involved two established general practices. The rotations comprised 6 months surgery, 3 months geriatric medicine and 3 months general practice, and were oversubscribed in the first year.

A 2006 evaluation³ was positive, with general practice exposure seen to complement hospital experience, especially in areas of patient communication and decision making. The experience gave interns a greater understanding of why GPs refer patients to hospital and a better appreciation of the importance of good discharge planning. The increased demands of PGY1 on the GP supervisor were also noted, especially when general practice placement occurred at the start of rotations. Adequate funding to support such schemes was seen as vital to their future success.

Can WA help meet the challenge?

The ability of WA general practice to accommodate increasing demands for training new doctors is unknown. Can an overstretched GP workforce summon the energy to develop additional enthusiastic trainers to meet future demands?

The additional supervisory burden involved in training new doctors (PGY1 and PGY2) is significant.^{1–3,7} General practice lacks the resources, infrastructure and collegiality that teaching hospitals provide. Payments for disruption to practice routine, provision of consulting space for the intern, loss of income for the GP providing the training, and the cost of keeping the trainer’s own skills up to date

are rarely acknowledged. Declining GP numbers mean fewer trainers, and goodwill cannot last forever.

Edwards et al⁴ noted that because many doctors make career choices at the end of PGY1, general practice placements offer significant opportunities to boost recruitment. Some recruitment impediments should be reassessed.

Compulsory rural placements affect general practice registrar applicants, especially women applicants.¹⁰ Larger metropolitan practices have little incentive to become accredited training practices if they cannot access trainees. This might change if the increased supply of doctors guaranteed the availability of suitable applicants for training posts – but other career choices beckon.

Allowing specialist trainees to undertake 3–6 month rotations into general practice would encourage mutual recognition between specialties and help them complement each other.³ The benefits are well recognised,^{1,3,15} and provider number legislation could be altered without great difficulty. Increasing bureaucracy is burdensome for general practice^{9,12,13} and is unlikely to encourage involvement in teaching.

With infrastructure and financial support, practices could become centres for teaching, research and self evaluation. Doctors in training could have their own consulting room and develop a sense of belonging. Trainers would be awarded academic titles commensurate with their role. General practice registrars could help teach their junior colleagues and medical students.⁷

A one-off payment by government to fund extra consulting rooms in accredited training practices could be a useful start. Practice trainers and supervisors – as well as external clinical teachers – need to be adequately remunerated for their work. Such payments could attract many part time and semiretired GPs who might enjoy this type of visiting and teaching.

Conclusion

For the past 50 years the postgraduate training of PGY1 and PGY2 doctors has largely been hospital based. Innovative schemes involving general practice rotations run by enthusiastic GPs and supportive specialists are emerging but are not yet part of the norm.

The experience with PGY1 and PGY2 placements in general practice has been very positive, with future specialists benefiting even more than GPs.^{1–3} Early exposure to general practice creates an opportunity for new doctors to experience primary care as a potential future career option.

A highlight of general practice rotations has been that doctors experience the referral of patients from primary care into the hospital system, and the return of patients to their own communities. This reinforces the importance of good discharge planning whereby the GP understands exactly where the patient is headed once they leave hospital.

Whatever future models are used to encourage GP involvement in the training and development of our future doctors, it is unrealistic to expect such developments to prosper without adequate allowances of time and funding. General practitioners who provide training in

their practices should receive the academic as well as the financial recognition their efforts deserve. The surging numbers of new medical graduates in WA over the next few years offer general practice both a challenge and an opportunity.

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