Community and general practice terms for prevocational junior medical officers: experience and development in South Australia and Western Australia

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ABSTRACT

- Changes in health care systems in Australia have had an unanticipated impact on the traditional scope of education and training opportunities for junior medical officers (JMOs) in public hospitals.
- It has become apparent that the context of JMO training must expand and evolve.
- The value of general practice and community-based term rotations for JMOs is well established in the literature.
- South Australia has successfully implemented JMO training in rural and urban general practice settings, and in areas of workforce need in metropolitan community health centres.
- Western Australia is piloting new models of JMO education and training in outer metropolitan and rural areas, with the intention of expanding its education sites in 2008.
- Community and general practice terms are in keeping with key objectives of the Australian Curriculum Framework for Junior Doctors, showing that a new era of cooperative venture between universities, postgraduate medical councils, regional training providers and health networks, and specialist training colleges is achievable.

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In this article, we describe how community and general practice term rotations have been incorporated into junior medical officer (JMO) training programs in South Australia and Western Australia. We outline the forces that are changing the traditional context of JMO training, and link the development of community and general practice terms with what JMOs want (Box) and the objectives of the Australian Curriculum Framework for Junior Doctors. We include a brief consideration of the planning challenges entailed in the establishment of these term rotations.

The changing context of JMO training

Changes in health care systems in Australia are affecting the environment of JMO education and training. Delivery of health care has become increasingly specialised, with consequences for the traditional style of medical training, which is concentrated in major public teaching hospitals.[4] Public hospital inpatients now represent a limited part of the health care spectrum, resulting in increasing competition for scarce clinical resources by trainees spanning the continuum from universities through the postgraduate years.[5] The range of learning experiences in the teaching hospitals is reduced both by the focus on serious, less common patient presentations, and by decreasing inpatient numbers following the move towards, for example, day-only interventions and "hospital in the home" programs.[4-6] Reduced length of stay has resulted in less continuity-of-care experience. The requirement in modern enterprise bargaining agreements to adopt safe working hours further limits JMOs' access to opportunistic training. It is apparent that the context of JMO training must expand.

Another impetus for change in the JMO training environment is the current increase in numbers of medical students. The time is fast approaching when the teaching hospitals will be inundated with new graduates all needing accredited training placements. In 1996, the Medical Training Review Panel (MTRP) recommended that "all postgraduate medical officer training include at least one rural term, be it in a hospital or general practice setting, and at least one community-based term, again either in general practice or a community health service".[7] The looming wave of new JMOs will drive the creation of new term rotations, with expansion into general practice and community terms fulfilling, to some extent, the MTRP recommendation. The extent of this expansion will ultimately be constrained by the current national shortage of general practitioners, and hence their capacity to supervise and train JMOs in community settings.[8]

The evolution of community-based term rotations in South Australia

In 1997, GPs in the rural community of Cleve, on eastern Eyre Peninsula, developed a proposal to train interns in a rural community environment. Supported by the then Commonwealth Department of Health and Family Services and the then South Australian Department of Human Services, eight interns (postgraduate year 1 [PGY1]) rotated from Adelaide's Flinders Medical Centre to Cleve in 1997 and 1998 to work under the supervision of the local GPs. In 1999, the rotation was transferred to Jamestown in the mid north, where interns undertook 10-week rotations, once again under the supervision of local GPs who provided services to both the hospital and community health centre. This rotation was positively evaluated.[9]

This experience, in conjunction with pioneering postgraduate year 2 (PGY2) placements in Albany, WA, paved the way for the establishment of the Rural and Remote Area Placement Program, introduced in 2000.[10]

In 2002, the Postgraduate Medical Council of South Australia (PMCSA) received funding, through the MTRP, from the Australian Government Department of Health and Ageing, to pilot the introduction of metropolitan community terms for PGY2 and postgraduate year 3 (PGY3) junior doctors at The Second Story youth health service and Nunkuwarrin Yunti Aboriginal health service in Adelaide. By the end of 2004, SA had established a successful track record for limited, non-hospital-based training terms for interns in general practice, and junior doctors in PGY2 and PGY3 in community terms. Thus, SA was well placed and ready when the Prevocational General Practice Placements Program (PGPPP) was launched in January 2005.

The PGPPP was developed by the Australian Government in response to the significant national shortage of GPs.[11] It was hoped that including general practice experience in JMO training programs would encourage more JMOs to pursue careers as GPs. Australia-wide, the PGPPP initiative will eventually provide up to 280 general practice and community placements per year for prevocational doctors (equivalent to 70 full-time doctors). At the same time, studies of general practice terms for interns have shown the educational advantages of including general practice terms for JMOs.[9,12]

South Australia has been at the forefront in taking advantage of this PGPPP opportunity. In 2005, every major intern teaching hospital in Adelaide was able to offer rotations to JMOs in either general practice or community terms. Since January 2005 (based on PMCSA data), the number of general practices involved has increased from eight to 17 (10 rural and seven urban), leading to about 39% of the intern cohort undertaking a general practice term in 2007. In addition, the PMCSA developed PGY2 and PGY3 community terms along clinical themes in areas of workforce need, such as adolescent, Indigenous, and prisoner health, and drug and alcohol services. At any one time, there are six JMOs in PGY2 and PGY3 from across Adelaide in these placements, which provide JMOs not only with learning opportunities, but also the experience of working in under-served areas.

The enthusiastic uptake of general practice and community terms in SA is possibly the result of:

- the successful past history and track record;
- "word of mouth" recommendations by participating JMOs;
- recognition by feeder hospitals that the inclusion of these terms is a recruitment advantage;
- proactive support from the PMCSA, the Medical Board of SA, and the SA general practice education and training programs and their general practice communities; and
- strong support from the SA Department of Health.

The value of the general practice rotation in intern education has been highlighted by studies in the United Kingdom, dating from 1982, and in SA from 2001.[9] In the most recent evaluative study of general practice term rotations, interns in SA reported that the training value includes: exposure to undifferentiated patient presentations; gaining experience in a wide range of common, less serious conditions (not seen in teaching hospitals); and direct access to learning through immediate supervision and feedback.[12] The study showed that there are marked differences between general practice terms and other hospital-based core terms for interns, and that these experiences are complementary, together making a well rounded training program. A recent quote from a participating PGY2 JMO on a community term placement also supports their value:

> Had a wonderful experience with broad and stimulating clinical work, excellent clinical supervisors and mentors, supportive and experienced multi-D [multidisciplinary] staff, and interesting and diverse clients. Exceeded my expectations.

As these terms have become recognised in the SA medical community, the PMCSA has been approached by feeder hospitals and other community-based primary health agencies suggesting more term rotations that could be developed. The development of these additional terms is currently limited more by lack of available JMOs than by funding opportunities. While the number of JMOs is expected to increase over the next decade, the national shortage of GPs means there is limited capacity in the community health system to sustain further expansion of training placements.[8]

What junior medical officers want[1]

- Junior medical officers (JMOs) have repeatedly stated in consecutive national forums that their first priority revolves around education and training in the context of service delivery.
- JMOs support the concept of a national curriculum framework[2] and its stated objectives, which are:[3]
  - application of previously learnt skills in real clinical practice settings;
  - creation of generalist doctors through the development of comprehensive and broad term rotations; and
  - linkage between undergraduate curricula and college training requirements.
- JMOs support the exploration of new term rotation options, such as general practice and community terms, both to broaden training exposure and to accommodate the imminent rapid expansion of the JMO medical workforce and its training placement requirements.
- JMOs are looking to the postgraduate medical councils to ensure these new term rotations are subject to the same robust accreditation standards as current metropolitan hospital-based positions, with appropriate supervision and training and no risk that they will be solely backfilling more senior workforce shortages.
- JMOs want JMO welfare to form part of the accreditation criteria.
- JMOs are aware that access to good education and training needs to be sustainable, and to this end, rural, general practice and community terms need to be adequately supported, both financially and professionally. ◆

New models: the Western Australian initiative

In November 2005, the Organisational Development Division of the Western Australian Department of Health initiated the Community Residencies Project, to shape the future medical workforce of WA. The aim of the project is to develop JMO posts that involve providing community medicine (such as general practice and palliative care) in the outer metropolitan and rural areas of WA.

Pilot sites for 2007 have been developed at the Joondalup Health Centre, Bunbury Regional Hospital, and local general practices. These sites have combined rotations covering the disciplines of general practice, emergency medicine, palliative care and paediatrics. Each site has a series of rotations that suits the needs of the area and incorporates the provision of community medicine, either on a part-time or full-time basis. For example, the post in Bunbury involves part-time general practice and paediatrics as a combined term. This enables a broadened exposure to clinical experience in situations where historically there has not been enough to justify a full-time PGY2 or PGY3 position.

All community residency posts have been accredited by the Postgraduate Medical Council of Western Australia, thus fulfilling the requirements of the Australian Curriculum Framework for Junior Doctors.[3] In this way it is envisaged that the positions will be accepted as standard prevocational training positions for JMOs and meet the prevocational training requirements of all specialist colleges.

During 2007, the pilot sites will be evaluated and new sites will be developed in the outer metropolitan regions of Armadale and Kwinana–Rockingham, and the rural areas of Kalgoorlie, Gerald-

ton, Karratha and Albany for JMO placements in 2008. It is anticipated that 20 full-time-equivalent JMO posts will be ready for 2008 to help meet the needs of the increasing numbers of medical graduates requiring prevocational placements.

Planning and development challenges

Experience from SA and WA indicates that the implementation and sustainability of community and general practice terms requires substantial resourcing in recognition of several factors. Examples are:

- Indemnity cover for JMOs, supervising doctors and feeder hospitals — this has proved problematic for New South Wales.
- Professional and physical capacity of practice — JMOs need their own properly resourced consulting room, and professional capacity must exist for appropriate supervision.
- Housing — comfortable housing needs to be provided for rural placements, and this may include capacity for families.
- Education infrastructure — the advantages and efficiencies of vertical integration need to be recognised. Cooperation and collaboration between universities, specialist colleges, regional health networks and state health departments are crucial.
- Professional and social integration — plans need to be in place to ensure that JMOs are included socially within the community, and that clinic staff and clientele accept the new roles of JMOs on placement in the practices.

Currently, all rotations in SA and WA are accredited by those states' postgraduate medical councils, ensuring that these requirements are met.

Conclusion

With such a range of forces reshaping health care delivery in Australia, the education and training of prevocational doctors need to evolve. Community and general practice term rotations represent a new and much needed way of augmenting traditional hospital-based programs, and are in keeping with the core objectives of the Australian Curriculum Framework for Junior Doctors.[3] Such terms have been successfully implemented in SA, and the pilot of a new program is underway in WA.

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Competing interests

None identified.

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References

1 Edmonds M. JMO national forum report 2006. http://www.pmcsa.org.au/jmos/index.htm (accessed Mar 2007).
2 Gleason AJ, Daly JO, Blackham RE. Prevocational medical training and the Australian Curriculum Framework for Junior Doctors: a junior doctor perspective. *Med J Aust* 2007; 186: 114-116.
3 Confederation of Postgraduate Medical Education Councils. Australian Curriculum Framework for Junior Doctors. November 2006. http://www.cpmec.org.au/curriculum (accessed Mar 2007).
4 Dowton SB, Stokes M-L, Rawstron EJ, et al. Postgraduate medical education: rethinking and integrating a complex landscape. *Med J Aust* 2005; 182: 177-180.
5 Crotty BJ. More students and less patients: the squeeze on medical teaching resources [editorial]. *Med J Aust* 2005; 183: 444-445.
6 Hillman K. The changing role of acute-care hospitals. *Med J Aust* 1999; 170: 325-328.
7 Medical Training Review Panel. First report, August 1997. Canberra: Commonwealth Department of Health and Family Services, 1997. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-workforce-education-metmtrp1.htm (accessed Mar 2007).
8 Thistlethwaite JE. Altruism can no longer support community-based training [letter]. *Med J Aust* 2006; 185: 53-54.
9 Mugford BV, Braund W, Worley PS, Martin A. Rural intern training. *Rural Remote Health* 2001; 1: 86.
10 Nichols A, Worley PS, Toms L, Johnston-Smith PR. Change of place, change of pace, change of status: rural community training for junior doctors, does it influence choices of training and career? *Rural Remote Health* 2004; 4: 259.
11 Australian Government Department of Health and Ageing. Prevocational general practice placements program. http://www.health.gov.au/internet/wcms/publishing.nsf/Content/Prevocational+General+Practice+Placements+Program-1-lp (accessed Mar 2007).
12 Martin AA, Laurence CO, Black LE, Mugford BV. General practice placements for pre-registration junior doctors: adding value to intern education and training. *Med J Aust* 2007; 186: 346-349.

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