Barriers and enablers for implementing general practice training

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BACKGROUND
The Australian College of Rural and Remote Medicine (ACRRM) curriculum is designed for rural and remote general practice in Australia. We explored the potential for its implementation in the Northern Territory (NT).

METHODS
Forty-two doctors who might teach or study the ACRRM curriculum were interviewed on the predicted barriers to the curriculum, strategies to overcome these barriers and a model for curriculum delivery.

RESULTS
The themes that emerged were: recognition of the ACRRM fellowship, the structure and content of the curriculum, using the curriculum, and delivery of the curriculum. The current curriculum seemed peripheral to the daily activity of general practice registrars and general practice supervisors. Other barriers to registrar learning in the NT were identified.

DISCUSSION
The project outcomes were ways to achieve a better balance of service provision and educational opportunity for general practitioners in training, as well as strategies specific to delivery of the ACRRM curriculum.

The Australian College of Rural and Remote Medicine (ACRRM) curriculum is designed for rural and remote general practice in Australia.[1] It was written by rural and remote general practitioners working with educationalists, and is competency based and modular.

Regional training consortia have provided general practice training in Australia since 2002, encouraging training to reflect the knowledge, skills and values needed for practice in different locations. The end point assessment of training is the Fellowship examination of The Royal Australian College of General Practitioners (RACGP). During training both the RACGP[2] and ACRRM curricula can be used.

The Northern Territory (NT), apart from Darwin, is classified as RRMA 5–7,[3] and so appears ideal for trialling the ACRRM curriculum. We found no published studies on the implementation or evaluation of an entire curriculum for general practice training. General practice training programs around the world combine general practice and hospital experience.[4-6] The optimum balance of these is not known.

The implementation of curricula combines educational ideas with change management, 'pressure for change and support for change'.[7] The aim of this project was to identify the barriers to the implementation of the ACRRM curriculum and to suggest strategies to overcome them. Different models of curriculum implementation were considered.

Methods

We used qualitative research methods[8-10] and interviewed doctors who might study or teach the ACRRM curriculum. Their geographical isolation and dispersion meant that individual interviews were the most practical method. We used purposive sampling from general practice division and employer lists to choose representative doctors by gender, location, employment arrangements and involvement in training.

The interviewers were experienced remote practitioners. Participants were given a summary of the ACRRM curriculum and interviewed using a schedule (derived from the literature) and modified after pilot testing. The interviewee's qualifications, teaching commitments and years of remote experience and the training opportunities, accommodation, clinic space and information technology facilities at their clinical setting were documented. Interviews were recorded, transcribed and checked for accuracy by the doctor interviewed.[11]

This information was analysed thematically, together with the literature, to develop four possible models for implementation of the ACRRM curriculum. Participants then gave feedback on these models.

We proposed, discussed and agreed categories of major and subthemes of interview material. Each interviewer analysed the content of their own interviews and the content of one of the other's interviews to ensure consistency of subtheme allocation. The project manager checked the interviewer's subtheme allocation.

The Alice Springs Institutional Ethics

Committee approved the project.

Results

Forty-two GPs were interviewed – no-one declined to participate. The tape did not record in two interviews. Our sample was representative of each geographical region, gender and type of practice (*Table 1*). Ten current or potential supervisors had been in the NT for less than 1 year.

Table 1. Project participants according to work location and type

Medical practitioner category	Women	Men
Registrars in general practice training program		
Basic term	2	1
Advanced term	2	1
Mentor term	1	2
Part time	1	–
Leave of absence	1	–
Supervisors and potential supervisors		
Private practice – urban	1	1
Private practice – remote town	1	4
Aboriginal medical service	2	3
Salaried – remote location	2	–
District medical officer	–	3
GPs in hospitals	–	3
Remote medical administrator	–	1
Rural other medical practitioners		
Remote community	1	1
Remote town		3
Medical educators	1	1
Hospital medical administrator – urban	1	–
Total	**16**	**24**

Recognition of the FACRRM

The main barrier to acceptance of the ACRRM curriculum was that its Fellowship qualification is not recognised as a tertiary qualification. There was concern that even were the FACRRM to become a route to vocational registration, its qualification holders would risk being trapped in the country, preventing a subsequent move to a city. Most considered the curriculum was appropriate to their clinical practice, some feeling the RACGP curriculum was aimed at city practice.

General practice registrars, general practice supervisors and medical educators had little knowledge of the ACRRM curriculum, and because of uncertainty and structural change in general practice training, were reluctant to change from the RACGP curriculum. Some thought that implementing the ACRRM curriculum would make little difference and considered that the two curricula were complementary.

Structure and content of the ACRRM curriculum

Participants advocated for a distinction between its core and advanced components. For example, surgical and obstetric procedures are needed in a rural setting, but not in a remote setting. Participants were asked about the assessment of competency undertaken by supervisors. Most registrars considered this acceptable providing that it was valid and reliable, while supervisors wanted training in it, and were concerned about potential conflict between the assessor and teacher role. Similarly, recognition of prior learning must be awarded in a valid and reliable way. Registrars emphasised the need for the curriculum to be flexible, enabling part time study and interruptions.

Using the ACRRM curriculum

Health care in the NT is characterised by populations with relatively high morbidity and mortality that creates rich learning opportunities. Workforce shortages[12] make it difficult to maintain a priority for teaching registrars.

General practice supervisors wanted more clarity of their role and more training. Neither registrars nor supervisors found the current curriculum relevant. Only medical educators used it regularly. Although supervisors and medical educators considered it the registrar's responsibility to cover the curriculum, registrars thought it the responsibility of supervisors and medical educators.

Delivering the ACRRM curriculum

Barriers identified to delivery of the ACRRM curriculum were time, family commitments and finance. General practice supervisors said they lose money teaching and wanted changes in funding supervisor time, particularly in high cost remote areas. Travel costs were a problem, with many sites accessible only by charter plane. Thus, greater input from supervisors into NT wide training, although welcomed, might not be realistic. Some potential remote sites lack the necessary accommodation and clinic space for a registrar.

The four proposed models of curriculum

delivery were:

- apply ACRRM curriculum to current RACGP program framework
- independent study model
- distance education model, and
- training led by registrars and supervisors.

Participants preferred the model that applied the ACRRM curriculum to the current RACGP framework.

Access to information technology was seen as improving in remote areas, but still not reliable. Although participants supported the use of CD ROMs and on-line learning, they were seen as supplements to, not replacements of, face-to-face teaching.

Discussion

The study's strength was the high response rate. The use of an interview schedule gave it structure, although this risked limiting the range of answers. Our findings may apply to other rural and remote areas of Australia.

The limited awareness of the ACRRM curriculum and limited use of the RACGP curriculum suggest curricula are peripheral to general practice training. Nevertheless, the ACRRM curriculum seemed appropriate to general practice training in the NT. It could complement or replace the RACGP curriculum. General practice training consortia need to establish who is responsible for ensuring that the curriculum is covered.

Further research is needed to explore how a curriculum is most effectively used in general practice training. Is the 'curriculum that walks through the door' (ie. learning based on current service workload) as effective in training as a formal written curriculum? The threat to learning posed by service commitment is shared in hospital training.[13-15]

Some issues remain unresolved. Different skills are needed for remote as opposed to rural medical practice. Does a FACRRM gained in rural practice qualify a doctor to work in remote practice? It may be inappropriate to teach procedural skills to a future remote GP who will work without a hospital; rather, public health material may be more useful.

The higher costs of delivering the curriculum identified in rural and remote areas means that more resources are needed than in metropolitan areas. It is interesting to speculate on whether such investment would be less or more costly than the current recruitment of overseas trained doctors.

Implications of this study for general practice

What we already know about this topic

- The RACGP Fellowship exam is the end point of GP training.
- Regionalised training can reflect the knowledge, skills and values needed for practice in different locations.
- The ACRRM curriculum is designed for GPs in rural and remote regions.

What this study shows

- The ACRRM curriculum could be delivered in the NT.
- Structural barriers prevent optimal learning by registrars in the NT.

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