

## Fostering generalism in the medical workforce

2012

This document outlines the AMA position on the broad measures that should be in place to promote 'generalist medical practice' as a desirable career option for medical practitioners.

### 1. Definition and scope

- 1.1. This position statement addresses the training aspects of generalism. For the purposes of this position statement, the term 'generalist medical practitioner' refers to general practitioners (GPs), rural generalists and general specialists, such as general surgeons and physicians who retain a broad scope of practice. This definition is based upon the definition provided by Health Workforce Australia .
- 1.2. Quality of care and patient safety must be the highest priority in any effort to reform the health workforce. Improved training models and pathways, better recognition and support for generalist medical practitioners, and appropriate remuneration will lead to improvements in safety and quality of care, and improved patient outcomes.
- 1.3. The AMA calls for:
  - (a) Clearly defined training programs and pathways for generalist medical practitioners;
  - (b) Greater recognition and support for generalist medical practitioners;
  - (c) More comparable remuneration for generalist medical practitioners; and
  - (d) Further work to quantify and predict generalist workforce requirements and distribution as a matter of urgency.

### 2. Introduction

- 2.1. Generalist medical practitioners play a vital role in the health system as clinicians, teachers and researchers in all settings, from tertiary public hospitals to remote practices.
- 2.2. Over the last decade, the medical workforce has become increasingly specialised, driven by changes in knowledge, technology, health service delivery and health care financing.<sup>2</sup> Subsequently, the number of medical graduates choosing a generalist career path has decreased. The desire for specialisation and sub-specialisation combined with busy practices, lack of support and poor remuneration for doctors<sup>2,3,4</sup> has also contributed to the decline in the provision of generalist care in all settings.
- 2.3. Generalist care<sup>5</sup> in collaboration with other medical specialists is the key to successfully managing the health care of an ageing population and increasing numbers of patients with complex multi-system conditions. As with all medical care, the issue of access is crucial regardless of setting.

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<sup>1</sup> Health Workforce Australia. Health Workforce 2025 – Volume 3 – Medical specialties. Adelaide: HWA, 2012.

<sup>2</sup> Landau LI, Gerber JP. Factors influencing generalist intention across medical school years. Concurrent paper of the 11<sup>th</sup> National Rural Health Conference; 2011 Mar 13-16; Perth, Australia.

<sup>3</sup> Australian Institute of Health and Welfare 2012. Medical workforce 2010. National health workforce series no.1. Cat. no. HWL 47. Canberra: AIHW.

<sup>4</sup> Australian College of Rural and Remote Medicine. Barriers to the maintenance of procedural skills in rural and remote medicine. Brisbane: ACRRM, 2002.

<sup>5</sup> Jenkins PF, Thompson, CH, MacDonald AB. What does the future hold for general medicine? *Med J Aust* 2011; 195:49-50.

- 2.4. Improving the distribution of the medical workforce, providing greater support for generalist career pathways and placing a greater emphasis on team based care is central to delivering high quality cost-effective health care to patients regardless of locality, and is especially important for people living in outer metropolitan, regional, rural and remote communities.
- 2.5. It is crucial that generalism is seen as a career path in itself, and is accompanied by a supporting framework and shift in status to establish it as an attractive vocation for all medical practitioners. Further research is required to investigate the factors that influence the decisions of medical graduates to pursue these pathways.
- 2.6. The AMA proposes a number of strategies to support a career in generalism that focus on:
  - (a) developing attractive training models to encourage trainees to undertake a generalist medical practitioner training program; and
  - (b) increasing recognition of, and support for, generalism, including improving the level of remuneration for generalist medical practitioners to encourage generalist medical practise.

### 3. The decline in generalism

- 3.1. Over the last decade there has been an overall decline in the generalist medical practitioner workforce in Australian public and private medical practice. Reports suggest that only 20 per cent of general (non primary care) specialists practice some amount of generalist medicine<sup>2</sup> in Australia compared to 50 per cent in the United Kingdom and 40 per cent in New Zealand.
- 3.2. Poor access to sub-specialist services in rural and remote areas has meant that generalist primary care medical practitioners are increasingly relied upon to provide a significant amount of surgical, anaesthetic and obstetric care in these communities despite a shrinking workforce.<sup>7</sup>
- 3.3. Current evidence suggests that the trend towards centralised, sub-specialised care is not always in the best interest of the patient or cost effective for the health system.<sup>2,8</sup> In all hospitals, generalist medical practitioners are needed to serve an ageing community among whom chronic multisystem diseases are on the rise, and to manage undifferentiated patients with multiple comorbidities.<sup>9</sup>

### 4. Training models that encourage more generalist careers

- 4.1. Parallel to sub-specialist careers, generalist medical practice is a complex amalgamation of clinical and non-clinical knowledge and skills that requires specific training and education directed to developing a broader generalist skill set.<sup>10</sup> Generalist training should provide medical graduates with a varied skill base, the chance to experience a range of practice areas and to identify areas for the development of a special interest if desired.
- 4.2. Exposure to generalist medical practice should occur throughout undergraduate, prevocational and vocational training and should include access to training networks, models and structured training programs in later years to support generalist career paths during vocational training.

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<sup>6</sup> Murray R. Action time for regional postgraduate training. *Medical Observer* 2012; 22 Jun.

<sup>7</sup> Pashen D, Murray R, Chater B, et al. The Expanding Role of the Rural Generalist in Australia – A Systematic Review. Australian College of Rural and Remote Medicine. Brisbane: ACRRM, 2007.

<sup>8</sup> Internal Medicine Society of Australia New Zealand (IMSANZ) and the Royal Australasian College of Physicians. General Medicine in Australia and New Zealand: The way forward. Sydney: IMSANZ, 2000.

<sup>9</sup> Rural Doctors Association of Australia. A National Advanced Rural Training Program Discussion paper. Canberra: RDAA, 2012.

<sup>10</sup> MedEd09. Investing in our Medical Workforce. Summary of the Medical Education Conference; 2009 Oct 30-31; Sydney, Australia.

- 4.3. The development and provision of articulated generalist training pathways, curricula and infrastructure within hospital and community sectors will assist junior doctors to develop the skills to become generalist medical practitioners. Training pathways should provide training in a diversity of skills and a variety of experience allowing the development of a generalist skill set. The expansion of the provision of formal qualifications, through completing specific special interest training pathways for future GPs (such as the Diploma of Obstetrics of Gynaecology or DRANZCOG) should be considered.
- 4.4. Improved linkages between tertiary, regional and rural hospitals, universities and medical colleges are essential. The development of functional and reciprocal links between these institutions and the integration of prevocational and vocational training pathways within these networks must be a priority to ensure trainees undertaking generalist training have adequate access to relevant terms in larger urban hospitals. This link must also continue after training is completed to allow for skill refreshment and updating. These linkages will promote generalism, facilitate the articulation of training pathways by potential trainees, and enhance the capacity of regional and rural centres to provide junior doctors with the sufficient breadth and depth of training.
- 4.5. The development and trialling of specific generalist vocational training programs and pathways should be supported. A number of models are emerging to encourage a career in generalism:
- (a) Dual training: this concept is not new but is emerging as a promising model to deliver the requisite medical workforce needed to meet future health care demands.<sup>11</sup> An example of this model is delivered by the Royal Australasian College of Physicians in which trainees undertake core training in general medicine and further training in an additional speciality, enabling both breadth of practice but also depth in a specific subspecialty. Adoption of similar models in other vocational training programs would facilitate the expansion of a generalist medical workforce.
  - (b) National advanced rural general practice training pathways: this model represents a step toward developing an incentive based career pathway for doctors in advanced generalist medical practice.<sup>11,12</sup> Under this pathway curricula could be embedded as part of the GP training program and linked to the relevant GP qualifications awarded by ACRRM and RACGP.
- 4.6. It is vital that adequate funding is provided to support innovative and emerging generalist training models and improve access to generalist training pathways. In particular, the development of appropriate teaching infrastructure and satisfactory supervisor support needs to be addressed.
- 4.7. Appropriate supervision is essential to maintaining patient and junior doctor safety and to ensure the educational validity of placements. Innovative models of rural and remote supervision and mentoring must be explored and expanded where possible to facilitate generalist training in these settings. Development of appropriate educational infrastructure is a core part of this process.
- 4.8. Correcting rural funding inequities is necessary to support infrastructure for generalist training in these settings, especially where there has been a historical deterioration in resourcing. A clear evidence base should be established before services in these areas are restricted or withdrawn on the basis of safety and quality.<sup>7</sup>

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<sup>11</sup> Royal Australian College of Physicians. Linked dual-trained physician care in rural communities. RACP 2012.

<sup>12</sup> Australian College of Rural and Remote Medicine. Annual Report 2010/2011. Brisbane: ACRRM 2012.

## 5. Increased recognition and support for generalism

- 5.1. Cultural change within the medical profession to recognise and promote the value of a generalist medical practitioner career is central to improving the attractiveness of this career option. In response to this, governments and policy makers must develop strategies and incentives to facilitate generalist medical training. These should take account of:
- (a) Improving support for generalist medical practitioners, particularly in rural and regional areas, to lessen high workloads and burn out rates – negative factors that often discourage trainees from undertaking a generalist career. Strategies include adequate locum cover to manage workloads and facilitate professional development leave, and the provision of an appropriate clinical environment (for example, adequately skilled support staff and operating theatres) to enable a range of procedural work to be performed locally.
  - (b) Providing generalist medical practitioners and trainees with access to continuing professional development (CPD) activities. The appropriate use of technology has the capacity to enhance learning opportunities particularly in regional and rural areas; such initiatives might include access to clinical updates via podcasts and use of videoconferencing facilities.
  - (c) Increasing state and federal government funding for generalist and procedural training positions in both public hospitals and private practice, in line with medical workforce planning recommendations. Generalist and broad based procedural training capacity must be resourced adequately as a matter of urgency. This strategy should address existing patterns of workforce mal-distribution and be commensurate with community need. Increased funding for the infrastructure to support generalist medical practitioners and trainees, strengthening generalist hospital and academic departments,<sup>13,14</sup> and the introduction of evidence based incentives to encourage generalist training and practice in areas of workforce need must be considered.
  - (d) Providing professional indemnity insurance cover and support for generalists that is sufficiently broad in scope to ensure there are no legal or financial impediments to practice.

## 6. Improving remuneration to encourage generalist practice

- 6.1. The AMA notes that medical practitioners are usually better remunerated in sub-specialty disciplines (particularly for procedural work) and for these reasons it is not unusual for generalist medical practitioners to drift out of the generalist area as they build up practice in sub-specialty areas. Remuneration and support for generalist medical practitioners in both public and private practice must be improved to reduce the financial disincentives.
- 6.2. The introduction of sustainable and relevant financial incentives for generalist medical practitioners with broad based advanced skill sets who are prepared to work in outer metropolitan, regional and/or rural areas, will also encourage those doctors who wish to undertake practice in these areas.

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<sup>13</sup> Internal Medicine Society of Australia New Zealand (IMSANZ) and the Royal Australasian College of Physicians. Restoring the balance: An action plan for ensuring the equitable delivery of consultant services in general medicine in Australia and New Zealand 2005-2008. Sydney: IMSANZ, 2005.

<sup>14</sup> Hitchcock K. How the rebirth of general medicine will save lives. *The Monthly* [internet] 2012. 5 Jul.

**See also:**

*AMA Position Statement on Regional/Rural Workforce Initiatives – 2012*

*AMA Position Statement on Prevocational Medical Education and Training – 2011*

*AMA Position Statement on Medical Training in Expanded Settings Including the Private Sector – 2007*

*AMA Position Statement on Early Streaming Into Specialty Training – 2006:*

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