

Australian academic general practice: looking back, looking forward

Gains have been made, but many challenges remain

IN THIS ISSUE OF THE JOURNAL, Kamien, one of the foundation professors of general practice in Australia, adds an important contribution to the history of general practice as a discipline within Australian schools of medicine (page 10).¹ He explores the views of his fellow foundation professors, appointed nearly 30 years ago, and the roles they played in the reform movements in Australian medical education.

By their efforts, the foundation professors laid the groundwork for the continuous advancement of the academic discipline of general practice. Their work included the training of staff (some of whom are the present heads of general practice departments), and the establishment of research programs that continue to contribute to the evidence base, such as the Bettering the Evaluation and Care of Health (BEACH) study at the University of Sydney.² Much of the initial opposition they encountered has dissipated. Academic general practitioners are now generally respected by their medical school peers, and innovative curriculum design in many schools (such as the programs at Newcastle, Monash and James Cook medical schools) has been spearheaded by GPs. They have achieved international reputations in their fields of expertise, and recently Australia has become an exporter to academia in the United Kingdom and Canada.

Other influences have affected these developments. The general practice reforms in the early 1990s, introduced by the then federal health minister, Brian Howe, led to new avenues for research and research training through the General Practice Evaluation Program. This program spearheaded opportunities for individuals to pursue Master and Doctoral degrees, which were not always available within the founding departments of community practice.

Since 1988, the Australian Medical Council (AMC) has insisted on a greater emphasis on general practice in the curriculum, and all medical schools now have chairs of general practice. In addition, they all have supporting infrastructure of teachers and researchers, funded by Commonwealth grants supporting teaching (eg, through the Rural Undergraduate Support and Coordination Programme)³ and research (eg, through the Primary Health Care Research Evaluation and Development Strategy).⁴

Kamien found that some foundation professors shared an ambivalent view of the Royal Australian College of General Practitioners (RACGP) and were “disappointed with the RACGP’s failure to support . . . academic general practice”. This has changed. In 2003, academic general practice is re-establishing its links with the RACGP. The current president of the RACGP is a professor of general practice. The chairperson and several members of the current RACGP council are general practice academics, as are the chairs of the college’s national standing committees, such as the Research Committee and the Education Committee.

If academic general practice has “arrived”, what are the future challenges? Although the discipline has established itself in the medical schools, the problems outlined by Kamien and by others remain.⁵ Academic staff have impossible teaching loads and, consequently, little time for research or research training. Furthermore, the allocation of resources in medical schools tends to disadvantage general practice. In response to AMC requirements, the input of general practice across the whole medical curriculum has increased, but intramural funding has not kept pace with this increase. There are serious concerns about recruitment to the general practice workforce and poor morale among practising GPs.^{6,7} Reasons for these issues include a relative fall in remuneration for general practice compared with other medical disciplines, concerns about litigation in private practice, and the “red tape” demands of government with new programs (such as the Extended Primary Care Medicare items). Local solutions must be found.

For a research culture to continue to expand, we will need to answer the criticism that “there is simply no rigorous evidence for many of the daily clinical decisions in general practice”.⁸ Much of the research to date has been of a health services nature,⁹ and more clinical research, including robust randomised controlled trials located in general practices, needs to be pursued. The researchers themselves will need to be seen as relevant and helpful to the “bag-carrying practitioners”; there is a need to explore new ways to enable and promote research training among practising doctors who want to enhance their academic skills in practice. Those of us who are charged with the undergraduate education of medical students need to provide appropriate role models, who should emphasise professional competency and autonomy that is not undermined by the concerns of government.

The discipline needs to be taught in a supportive environment, avoiding the impression of complexity and uncertainty sometimes gained by students, who are quick to compare it with the certainty of hospital-based teaching. The decentralised focus of medical education should enhance recruitment and retention of GPs. Mechanisms to achieve vertical integration include the sharing of staff and facilities, with joint appointments. Teaching programs and assessments need to be shared, and common processes used across regions to ensure uniformity of standards. The placement of students in practices requires careful management of complex databases and good personal communication with practices. The support of teachers at a distance is a constant challenge — innovative methods, such as videoconferencing and Web-based resources, are being trialled.

Training opportunities for GPs in academic research and teaching are limited and difficult to achieve. The present scholarship arrangements, such as those of the National Health and Medical Research Council (NHMRC), are often inappropriate in terms of support and reimbursement.

Links with postgraduate training consortia and the productive vertical integration of teachers, staff and curricula have the potential to enhance all involved. The same potential exists with departments of rural health and rural clinical schools, as shown in models already established (for example, in northern Queensland).¹⁰ Opportunities need to be developed for collaboration with the RACGP and training consortia for registrars to spend time in academic posts during fellowship training.

The charter of the Divisions of General Practice is quite distinct from the functions of medical schools, and divisional roles in implementing programs of health improvement initiatives and practice support are well defined. However, the potential for collaboration with academic departments remains largely unfulfilled.

General practice as a discipline is now represented on the Committee of Deans of Medical Schools and on the NHMRC assessment panels (although not on the council itself). Academic GPs will need to develop stronger leadership roles to consolidate our gains to date.

The foundation professors had the courage and vision to begin the journey. Those with the responsibility of continuing leadership will need skill and flexibility to sustain the momentum in the changing and challenging environment of general practice.

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