

Defining the specialty of general practice

POSITION STATEMENT



This paper puts the ACRRM position on the specialty of general practice. It includes consideration of the issues relating to terminology as well as to providing a common understanding of what is meant by the term 'general practice' with reference to Australian practice and the literature.

Language is a potent potential source of confusion in this discussion. We will use the term 'general practice' to apply to the professional field of practice and distinguish this from the capitalised 'General Practitioner' (GP) and 'Rural Medical Generalist' (RMG) that will be used to describe professional disciplines working in the general practice domain.

The meaning of 'general practice'

What is general practice? Is it a philosophical approach to medicine? A scope of clinical practice? A private sector model for office-based primary care? Or a first contact and gate-keeping role within a healthcare system? Does general practice extend to hospital medicine, procedural practice and public health as well as primary medical care? And in making policy choices on the boundaries of the specialty, whose interests should have primacy—those of professional groups, policy-makers / funders or the community?

ACRRM adopts a broad interpretation of the specialty of 'general practice'. This approach is consistent with the history of medical generalism. More importantly, it is also consistent with current and projected future community needs for generalist medical practitioners who have the requisite skills to provide comprehensive and continuing care for individuals and communities across the primary and secondary care continuum. ACRRM considers Rural and Remote Medicine to be the fullest expression of the specialty of general practice.

No medical craft group exists in a vacuum. With the proliferation of specialist medical disciplines in the post World War II period, communities, policy-makers and professional groups in most developed countries sought to re-establish a role for the medical generalist within modern healthcare systems. 'General practice' or 'family medicine' has wrestled with defining itself from the time of its emergence as a formal medical discipline in the 1960s and 70s.^{1,2,3,4,5,6} Two broad approaches to the evolving definition can be identified: assertion of a new patient-centred professional ethos in medicine (one that emphasises integrated contextual care of the whole person rather than the disease); and another focusing on the community's need for doctors with the ability to provide comprehensive and continuing care (clinical generalism across the continuum and an ongoing therapeutic relationship).

The desire to establish a distinct professional and academic identity for the General Practitioner (something more than a mere aggregation of bits from other medical disciplines) has seen various fads and phases over the last 30 years as well as differences between- and within-countries. In urban population centres and in academic medicine, the emphasis has tended to be on general practice as a professional ethos—driven in part by the proximity to specialist medicine, tertiary hospitals and competition for status and legitimacy. Thus 'family medicine' (a term formally adopted for the discipline in the US and used in Australia from the 1970s) was used by some as a claim on specialisation in 'the family'.⁷ Engel's 'bio-psycho-social model' as applied to disease causation and health care has been a central theme.⁸ This paradigm has the GP as the expert listener and communicator, an advocate who uses the doctor-patient relationship as a therapeutic tool in managing the holistic needs of the person and their family in a setting that is low risk for serious disease. However, comprehensiveness—along with coordination, continuity and patient focus—has also been a central tenet of general practice. Unpalatable as it has been for some, most communities still need the 'jack of all trades'—master of none or no. The World Organisation of Family Doctors (WONCA) developed an international consensus description the universal characteristics of the General Practitioner in its 1991 statement. The definition emphasises the General Practitioners' personal and primary responsibility for initial, continuing and coordinated care, the generalist clinical competencies to provide "the greater part" of health care and a strong patient, family and community orientation.

WONCA definition of general practice and family medicine, 1991⁹

The General Practitioner or Family Physician is the physician who is primarily responsible for providing comprehensive care to every individual seeking medical care and arranging for other health personnel to provide services when necessary.

The General Practitioner / Family Physician functions as a generalist who accepts everyone seeking care, whereas other health providers limit access to their services on the basis of age, sex or diagnosis. The general practitioner / family physician cares for the individual in the context of the family, and the family in the context of the community, irrespective of race, religion, culture or social class. He is clinically competent to provide the greater part of their care after taking into account their cultural, socio-economic and psychological background. In addition he takes personal responsibility for providing comprehensive and continuing care for his patients.

The General Practitioner / Family Physician exercises his / her professional role by providing care, either directly or through the services of others according to their health needs and resources available within the community he / she serves.

Clinical generalism and general practice

It is in the dimensions of clinical comprehensiveness and continuity, that there has been the most within- and between-country variation. In Western Europe and the United Kingdom, with socialised health care systems (particularly hospitals) and strong specialist cultures, the trend has been towards a diminished scope of clinical practice and continuity of care for General Practitioners, particular in relation to after-hours, maternity services and in-hospital care. In countries where private insurance has underpinned General Practitioner access to hospitals and / or with large medically under-served rural areas (the United States, Australia, Canada and South Africa for instance) an older tradition of an extended scope of generalist clinical practice spanning primary and secondary care has been preserved to a greater extent.¹⁰

Family medicine groups in the United States have recently undertaken a major national review of the discipline for the 'Future of Family Practice' statement. Among other things, the United States has affirmed an expectation of direct participation by Family Practitioners in hospital and maternity care as core elements of professional service in the 'new model of Family Medicine'

"Although the office setting will continue to be an important site for care, it is important to emphasize that to integrate patient care effectively, future family physicians will need to be prepared to provide services in a variety of settings, including hospitals and long-term care facilities; in short, they will provide care wherever the family physician's services are needed by patients."¹¹

Community hospitals in the United States have had a strong base of Family Physicians as staff and a service commitment to their communities.¹² The American Academy of Family Physicians reports that 52% of its members provide emergency department services, 82% have hospital privileges and 23% undertake obstetric deliveries (with most of those performing vacuum extraction).¹³

In contrast with the United States, the recently developed European definition of family medicine / general practice (with a three page definition, 11 central characteristics, 6 core competencies and 7 pages of explanatory notes) makes brief mention of hospital based care but only to contrast it with the role of the General Practitioner.¹⁴ Twenty years previously, the Leeuwenhorst statement on 'The General Practitioner in Europe' included an expectation that the general practitioner would attend patients in the "...consulting room...their homes and sometimes in a clinic or hospital."

Apparently arbitrary changes in General Practitioner roles have therefore emerged as a consequence of pressure from specialist colleagues, hospital credentialing and health financing reforms, movements in insurance premiums and a range of other drivers—without reference to what basket of services might in the best interests of the community. This exposes the problems inherent in defining general practice circularly as 'what a GP does' (or worse still, 'only what a private GP does!'). And definitions based on values and practice orientation provide little bedrock upon which to anchor professional standards and curriculum content, let alone clinical privileging and credentialing decisions. While patient-centeredness, communication, brokerage and a capacity to sensibly manage undifferentiated health problems are core features of the discipline, it seems increasingly churlish to claim these capabilities exclusively for the General Practitioner.

Many General Practitioners in Australia and elsewhere have relinquished procedural, obstetric, hospital, public health and medically complex care for a scope of office-based community practice characterised by management of minor ailments, counselling, preventive activities, shared-care for chronic conditions, advocacy and referral-orientated medicine. At the same time, continuity is being eroded by trends to part-time work and reduced participation in after-hours care. Perverse incentives arising from fee-for service arrangements in a globally insured population have driven the phenomenon of 5 minute medicine and the rise of the 24-hour clinic to cream the simple (profitable) cases. The rise of the uni-dimensional clinic and 'GP with special interests' further threatens the medical generalist tradition.¹⁵ And complex care has further shifted to private specialists as a consequence of government support for private health insurance.



All this sits poorly with demographic and epidemiological trends in most Western health systems—as they face the challenges of ageing population, the rise of chronic disease and a medical workforce supply crisis. Ironically, specialist practitioners in surgery, internal medicine and paediatrics have been moving away from generalism in their respective fields;^{16,17} and the nursing profession (and others such as the Physician Assistant in the United States) have been extending their scope of practice into areas traditionally considered the domain of the doctor.¹⁸ Were medical workforce trends rational, General Practitioners should be filling the gap in generalist medical expertise rather than retracting scope of practice. There is a good case that given demographic trends, cities will be needing the rural medical generalist model before too long.¹⁹

So what of general practice in rural and remote areas and the Rural Medical Generalist? The divergence in scope of practice and required skill-set between rural and urban generalist practice has been widening for the reasons outlined above.^{20,21} The complexity of services provided by medical practitioner's increases with increasing rurality or remoteness. In Australia, the more rural the doctor, the more likely they are to manage myocardial infarctions to a higher level, administer cytotoxic drugs, perform forensic examinations, stabilise injured patients pending retrieval and coordinate discharge planning.²² This observation is consistent with data from Canada, a country with similar population and geographic challenges.^{23,24} This extended scope for rural generalist medical practice has had important implications for vocational training and maintenance of professional standards.

General practice and training in Rural and Remote Medicine

ACRRM considers Rural and Remote Medicine to be the discipline that represents the fullest expression of the specialty of general practice.

While the question of training requirements for rural general practice was initially a contested issue in Australia, there is now consensus between the Royal Australian College of General Practitioners (RACGP), the Australian Government and ACRRM that standard General Practitioner training does not adequately prepare a doctor for independent rural general practice. The converse is not however true. Doctors trained in Rural and Remote Medicine are capable of functioning in office-based community practice in larger population centres alongside their urban-trained counterparts. The discipline of Rural and Remote Medicine therefore encompasses the broad definition of general practice, of which office-based primary care is a subset.

ACRRM considers the 1991 World Organisation of Family Doctors (WONCA) summary statement above to be an appropriate reference definition for the specialty of general practice. The Rural Medical Generalist possesses the competencies to provide personal, primary, comprehensive and continuing care for individuals, families and communities in the rural and remote as well as urban context. The RMG can function with a high degree of professional independence in a range of Australian healthcare settings including office-based community practice, rural hospital and emergency settings, Aboriginal community-controlled health services, the Royal Flying Doctor Service and in geographically isolated practice such as remote Indigenous communities, mining camps and on scientific expeditions.

The scope of general practice that is provided by the RMG includes: management of undifferentiated acute and chronic health problems across the lifespan in an unreferred patient population; providing continuing care for individuals with chronic conditions; undertaking preventive activities such as screening, immunisation and health education; responding to emergencies including stabilisation and definitive management as appropriate; providing hospital-based secondary care where required; delivering obstetric care; and undertaking a range of population health interventions at the practice and community level.

These attributes are reflected in the ACRRM curriculum model of principles that underpin all aspects of the curriculum, implementation and assessment processes; the domains of rural and remote medical practice that create an organising framework for the curriculum and assessment blueprint; the 72 learning outcomes that are organised under each domain; and the curriculum statements detailing the depth and breadth of the content covered.

Find out more

If you have any queries relating to this Position Statement, please contact us by:

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ACRRM acknowledges Australian Aboriginal People and Torres Strait Islander People as the first inhabitants of the nation. We respect the Traditional Owners of lands across Australia in which our members and staff work and live, and pay respect to their Elders past present and future.



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