Medical Deans

AUSTRALIA AND NEW ZEALAND

The Doctors our Communities Need:

Building, Sustaining and Supporting the General Practice Workforce in Australia and New Zealand

September 2023

Medical Deans
AUSTRALIA AND NEW ZEALAND

The Doctors our Communities Need: Building, Sustaining and Supporting the General Practice Workforce in Australia and New Zealand

Position Paper

September 2023

Table of Contents

Executive Summary

Primary care is the bedrock of healthcare in Australia and New Zealand, and a well-trained, well-resourced and right-sized General Practice workforce is essential to the provision of quality primary care. However, shortages in the General Practitioner (GP) workforce in Australia and New Zealand are well documented, and evidence indicates the problem is growing in both countries with a substantial number of GPs indicating they plan to retire in the near future[1], declining numbers of doctors choosing that career path, and a growing and ageing population increasing demand for primary care services. GP consultations in New Zealand increased by nearly 12% between 2008 and 2016, higher than the population growth of 10.2% during the same period of time[2]. In Australia, the number of General Practice Medicare services provided in 2021-22 were almost 20% greater than the number of services provided in 2018-19[3].

In New Zealand, the proportion of graduates with an interest in General Practice and Rural and Remote medicine as a future specialty was 22.2% in 2016 but dropped to 16.2% in 2020[4]. Australian medical graduates' preference for a career as a GP has fluctuated a little over the last thirteen years with just under 19% of the 2022 graduating cohort indicating a preference for a future career as a GP or Rural Generalist[5], increasing from the 11% selecting GP in 2010 and 2011 (and noting there was an additional 2-3% selecting Rural & Remote Medicine in these years).

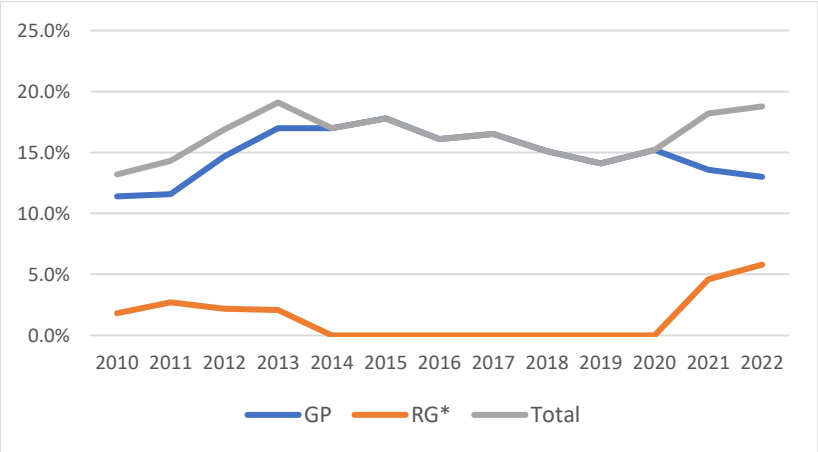

Figure 1. Proportion of medical Australian graduates preferencing General Practice or Rural Generalism*

Note: * Between 2010 and 2013 a response option of 'Rural & Remote Medicine' was available. In 2014 this was removed, and in 2021 the option 'Rural Generalist' added, reflecting the new GP sub-specialty.

[1] The Royal Australian College of General Practitioners' 2022 Health of the Nation survey reported that 25% of respondents stated an intention to retire within 5 years, up from 18% the previous year. See RACGP, *Health of the Nation 2022*, (2022) https://www.racgp.org.au/getmedia/80c8bdc9-8886-4055-8a8d-ea793b088e5a/Health-of-the-Nation.pdf.aspx

[2] Martin Jenkins (2020) *Health Workforce Funding Review – Current State Report* https://www.health.govt.nz/system/files/documents/pages/health_workforce_funding_review_-_current_state_final_25_nov.pdf

[3] RACGP (2022) 'General Practice Patient Numbers Leap by More than a Million' https://www1.racgp.org.au/newsgp/professional/general-practice-patient-numbers-leap-by-more-than#:~:text=More%20than%20a%20million%20more,subsidised%20GP%20in%202021%E2%80%9322. Analysis of AIHW (2022) Medicare-Subsidised GP, Allied Health and Specialist Health Care Across Local Areas: 2021-22 and AIHW (2021) Medicare-Subsidised GP, Allied Health and Specialist Health Care Across Local Areas: 2019-20 to 2020-21

[4] The New Zealand MSOD Steering Group (2021), *National Report on Students Graduating Medical School in New Zealand 2016-2020,* https://www.otago.ac.nz/oms/otago831361.pdf

[5] Medical Deans, (2023) *MSOD National Data Report 2023,* https://medicaldeans.org.au/medical-schools-outcomes-database-reports/

At the same time, the number of General Practice training places being filled in Australia is declining. Whilst the number of GP Registrar training places has remained constant at 1,500 per year, this was last filled in 2017 and the number of both eligible applicants applying and training positions being filled has dropped year on year[6]. Recognising the need to boost their GP numbers, New Zealand has recently increased by 50% the number of GP training places available[7].

To meet the healthcare needs of our communities, it is clear that we need to grow the GP workforce in our two countries. This is best done by both supporting more medical graduates and early career doctors to choose GP specialty training in Australia and New Zealand, and by supporting GPs in sustaining their careers.

This paper outlines the views of our member medical schools on the necessary reforms to build the skilled, sufficient and sustained GP workforce Australia and New Zealand needs. Our comments are built around five key areas that underpin our recommendations:

- **Student recruitment**: a greater emphasis by medical schools on recruiting and admitting applicants with the traits that evidence indicates are predictive of future GP career choice;
- **Learning for and about GP**: general practice, and generalism more broadly, is a visible and central aspect to the training of all medical students and early-career doctors;
- **Learning in GP**: medical students and early career doctors undertake a greater proportion of their clinical learning in primary care (and other community-based) settings, with teaching and training embedded into the core business and clinical models of care and supported and strengthened vertical integration of GP teaching and training;
- **Supporting graduates to progress to practice**: PGY1 and PGY2 doctors gain substantial experience in General Practice and primary care, for which they have been properly prepared;
- **The GP Profession**: General Practice is an attractive vocation, with the necessary understanding by all doctors of GPs' role, collegial respect for all specialties across the medical profession, parity in early career salary and entitlements, and supported career progression post fellowship.

The training continuum cannot exist isolated from the broader context of primary care and General Practice in Australia and New Zealand. Innovative change is also required to:

- **The primary care environment**: GPs able to build portfolio careers through experience in teaching, research, and medical leadership;
- **Research and build the evidence base:** better funding and support for research to build and expand the evidence base for factors that influence GP-career choices.

The critical situation in General Practice and primary care is an opportunity for us to create the teaching, training and research system in the primary care sector able to develop the doctors our communities need. This paper outlines a vision, and the means of achieving this vision, for a medical education and training continuum which better supports students to positively experience General Practice. It will enable graduates and junior doctors have meaningful, continued connection to General

[6] These figures are in reference to Australian General Practice Training positions, and include registrars pursuing fellowship with both RACGP and ACRRM. See e.g., S Calafiore (2023) *Exclusive: 252 GP Registrar Places Left Vacant as Applications Collapse* https://www.ausdoc.com.au/news/exclusive-252-gp-registrar-places-vacant-as-applications-collapse/

[7] See e.g., *Plan for Big Boost in GP Training Numbers* (Ministerial Press Release) 4 October 2022

Practice through their prevocational years. It will also support the General Practice workforce to create these learning experiences and build more attractive pathways into a GP career.

Whilst there are usually heightened pressures for General Practice and the primary care workforce in remote, rural and regional settings, the recommendations in this paper apply no matter the geographic setting. However it does need to be recognised that the scope of practice of Rural Generalists[8] in Australia and Rural Hospital Doctors in New Zealand straddles primary, secondary and tertiary care, and as such these doctors have unique skillsets, responsibilities and training pathways. The additional needs and challenges for this workforce must be considered, but are not covered here.

Medical Deans' paper released September 2021, *Training Tomorrow's Doctors: all pulling in the right direction*[9], laid out our vision for a medical education and training continuum that leads to an adaptable and supported workforce with the required capabilities, and in the right numbers, right places, and right specialties to serve the needs of our communities. This document continues on from that work and outlines a series of action-oriented recommendations aimed at achieving demonstrable outcomes for the General Practice workforce.

Further work by Medical Deans is planned to provide our perspective and recommendations to address other key areas of medical workforce need, including: remote, rural and regional; First Nations doctors; mental health; and clinician educators and clinician researchers.

[8] We note the impending recognition of Rural Generalism as a specialist field of General Practice.
[9] Medical Deans Australia and New Zealand Discussion Paper, 2021 https://medicaldeans.org.au/md/2021/09/Training-Tomorrows-Doctors-all-pulling-in-the-right-direction-September-2021.pdf

Medical Deans' Vision for General Practice and Primary Care

The Primary Care Environment and Context in Australia and New Zealand

An environment in which GPs work to their full scope of practice as part of a multidisciplinary primary care team, are appropriately remunerated for their expertise and are given every opportunity to participate in teaching and training, research, and leadership

Student Recruitment

An emphasis on recruiting students who demonstrate characteristics that are associated with subsequent GP career choice

Learning For and About General Practice

General practice perspectives embedded as core components of curricula in every year of the program, and GPs feature prominently as educators, leaders and role models

Learning In General Practice

Infrastructure funding, fair reimbursement for time spent teaching, and simplified administrative processes to enable teaching and training to be embedded into the general practice clinical and business models

Supporting Graduates to Progress to Practice

Substantial and meaningful exposure to and experience in general practice for final phase students and PGY1–4 trainees as they progress their leaning and plan their careers

The GP Profession

General Practice recognised by funders, the community, the medical profession, graduates and students as a diverse, rewarding, rigorous and valued medical vocation

Building Research and the Evidence Base

Research into the factors that influence the choice to pursue and sustain a career in general practice to build the evidence base and inform policy

Summary of Recommendations

			Relevant stakeholders
Student Recruitment	1	Universities align student recruitment and admission to incorporate best evidence for primary care workforce outcomes	Medical schools
	2	Government to substantially boost the number of medical school places, targeted to medical schools who demonstrate evidence-based strategies to increase the number of graduates with a propensity to pursue GP careers	Governments
Learning for and about General Practice	3	Medical schools and postgraduate training providers to ensure: - General practice and GPs are sufficiently and appropriately reflected in curricula, pedagogy and assessment - Generalism is more strongly embedded into curricula, pedagogy and assessment	Medical schools and postgraduate training providers
	4	Medical schools, postgraduate education providers and health services to adopt a policy of zero tolerance for derogatory language being used across or between disciplines	Medical schools, colleges, health services, peak bodies
	5	Medical schools and health services to increase flexible study options (for example, part-time), to facilitate a more inclusive and diverse medical workforce	Medical schools and regulators
	6	Medical schools to ensure GPs are in prominent roles in all medical programs, including leadership positions and promotion to professorial level	Medical schools
Learning in General Practice	7	Government to provide support to universities to enable medical schools to provide appropriate support to students in GP placements, recognising the absence of the hospital administrative and support structures in GP settings	Governments, medical schools, colleges, GPSA
	8	Government to review remuneration for GP teaching and training activities to ensure: - Payments adequately compensate for the time invested, and annually adjusted for inflation - Payment model that supports teaching by a broader range of professionals within the primary care team	Governments
	9	Government to make available infrastructure funding, such as for parallel consulting rooms which are solely for teaching and training purposes	Governments
	10	Medical schools, GP colleges and registrar and supervisor peak bodies to work together to ensure vertical integration in general practice teaching and training is supported by all stakeholders and strengthened so that medical students have opportunities to learn from near-peer mentors	Medical schools, colleges, GPSA, GPRA and other peak bodies
	11	Colleges review training for GP supervisors at all stages of the training continuum, to reduce duplication in this and to better support vertical integration across the training pipeline	Colleges and GPSA
Supporting Graduates to Progress to Practice	12	Medical schools to review preparation for internship terms and activities to ensure students with an interest in progressing to general practice training locations post-graduation are prepared for this	Medical schools
	13	AiMs and similar pre-intern roles to be reviewed to see how these programs can contribute to student learning in the GP curriculum in a measurable way	Medical schools and colleges
	14	Training providers to ensure all PGY1 and PGY2 doctors gain substantial quality experience in general practice	Training providers, colleges and GPSA
	15	Hospitals, postgraduate medical councils, GP supervisors and GP peak bodies to develop strategies to ensure PGY1-PGY4 doctors retain frequent and meaningful connections with general practice in their early years of medical practice	Training providers, colleges, GPSA, GPRA, and other peak bodies

The GP Profession	16	Colleges, regulators and health services to explore ways of increasing flexibility in GP training pathways	Colleges, regulators, employers, GPRA, other peak bodies
	17	Governments to review funding and remuneration in general practice to ensure salaries and benefits are commensurate with hospital-based doctors: - The Medicare schedule to be reviewed to ensure GPs are appropriately compensated - GP registrar salaries and employment conditions to be at parity with hospital-based registrar salaries - Opportunities to participate in research (including presentations at conferences), teaching, and professional leadership are made more available to GPs and do not result in loss of revenue due to time away from seeing patients	Governments, employers, colleges and GPRA
	18	All stakeholders to take meaningful steps to address the hidden curricula and ensure collegial respect exists, and is demonstrated by leaders to students, junior doctors and registrars	All stakeholders
	19	Colleges and regulators support GP career progression post fellowship through further recognition of GPs with special interest and similar roles	Colleges, employers and peak bodies
Building the Research & Evidence Base	20	Funding is made available by government to support further research on the determinants of medical graduates choosing general practice as a vocation in which to practice and train, including the development of funded and coordinated clinician-researcher training pathways	Governments, supported by stakeholders involved in research
	21	Universities and colleges to support research projects and partnerships which explore these questions, paying particular attention to regions and communities which are underserved by a GP workforce (for example, rural, outer metropolitan, disadvantaged communities)	Colleges, medical schools and other stakeholders involved in research
The Primary Care Environment & Context	22	Government, research funding bodies and universities recognise and support general practice as an environment for research inclusive of clinical, public health, health systems research and research focused on medical education, of largely untapped potential, and work with partners to boost and further support research in general practice including the development of a funded GP clinician researcher pathway	Government, universities and other stakeholders involved in research
	23	GP colleges to enable and promote portfolio careers for GPs, allowing a combination of clinical practice, teaching, research, and management and administration, are strongly supported by all parties, and these careers are showcased to students and junior doctors as normal rather than exceptional	Colleges, employers, medical schools and peak bodies

Student Recruitment

An emphasis on recruiting students who demonstrate characteristics that are associated with subsequent GP career choice

Medical schools are the conduit to a career in medicine and, as such, need to be cognisant of and responsive to the needs of the communities they serve. To support their role in developing our future doctors, medical schools need to ensure their student recruitment and selection gives sufficient consideration and weight ***to align with evidence-based indicators of future GP career choice.***

There is an emerging body of evidence that graduates with backgrounds that are traditionally underrepresented in medical programs (such as lower socio-economic circumstances, first in family to attend university, migrant) are more likely to stay local to their medical school and pursue careers in specialties such as General Practice[10]. A history of community service and older students have also been posited as possible discriminators aligned with future GP vocational choice[11].

There are also indications that the level of educational debt students accumulate may make primary care careers a less attractive option, especially for those coming from middle income family backgrounds[12]. Increasing the participation in medical school of students from traditionally underrepresented backgrounds, many of whom may lack financial resources to fund studies when compared to more traditional medical student cohorts, may necessitate consideration of policies to reduce or minimise their education debts to make medical school, and future practice as a GP, a realistic option for these students.

Student admissions criteria and frameworks need to expand from a prime focus on selecting the top academic performers from within a pool of high-achieving applicants to also include pro-active ***recruitment*** of applicants who demonstrate traits (whether this be in terms of background, aptitude, etc.) linked to future practice as a GP. We should also consider the role GPs play in student recruitment processes[13].

The substantial shortages in the GP workforce must be addressed. In line with the vision of the Australian government's National Medical Workforce Strategy[14] to "improve the domestic self-sufficiency of the medical workforce", government needs to ***invest in a substantial increase to the number of medical school places***, targeted to medical schools with admissions procedures (and program structures) that apply best evidence for producing general practice workforce outcomes.

As is discussed further in this document, this boost to graduate numbers must be aligned with a concomitant growth in the training capacity within primary care (and other community-based health settings), to ensure students and early career doctors can experience a greater proportion of their learning in primary care settings. This will require structural reform to postgraduate training to

[10] See e.g., J. Dowell, M. Norbury, K. Steven and B. Guthrie (2015) *Widening Access to Medicine May Improve General Practitioner Recruitment in Deprived and Rural Communities: Survey of GP Origins and Current Place of Work*, BMC Medical Education 15:165

[11] J Thistlethwaite, S Leeder, M Kidd and T Shaw (2008) *Addressing General Practice Workforce Shortages: Policy Options*, Medical Journal of Australia, 189:2

[12] See e.g., J Phillips, D Weismantel, K Gold and T Schwenk (2010) *Medical Student Debt and Primary Care Specialty Intentions*, Family Medicine 42:9

[13] The UK has also made and enacted recommendations regarding the role of GPs in student recruitment processes; see e.g., UK Medical Schools Council & Health Education England, *By Choice – Not By Chance: Supporting Medical Students Towards Future GP Careers*, November 2016 ("*By Choice – Not By Chance")*, https://www.medschools.ac.uk/media/2881/by-choice-not-by-chance.pdf Recommendation 4

[14] Australian Government National Medical Workforce Strategy, Vision pg 15; National Medical Workforce Strategy 2021–2031 (health.gov.au)

address the dominance of hospital settings and bring greater balance so that our future doctors are learning in, about, with, and for the community-based care we need them to practise. An advantage of building this primary care training capacity in conjunction with the boost to medical graduate numbers is that it will help ameliorate any disruption to service delivery in tertiary hospitals which rely heavily on their junior doctor workforce and therefore struggle to release them to train and work in the non-hospital sectors.

Medical Deans recommends

- ✓ Universities align student recruitment and admission to incorporate best evidence for primary care workforce outcomes
- ✓ Government substantially boost the number of medical school places, targeted to medical schools who demonstrate evidence-based strategies to increase the number of graduates with a propensity to pursue GP careers

Learning for and about General Practice

General practice perspectives included as a core component of curricula in every year of the program, and GPs feature influentially as educators and role models

We need to move way from a medical education and training model that is so heavily dominated by the hospital sector and the care provided in that environment, to one that recognises, values and drives learning in community-based healthcare settings – which is where the majority of healthcare is provided and where technology is rapidly accelerating access. Our current training model is substantially impeding our ability to prepare our future doctors for their role.

Medical schools have a key role to play. Curricula – of medical schools and postgraduate years – need to have ***sufficient focus and content on medical care and health issues managed by general practice and in non-acute settings***. Arguably, this means there needs to be an increase in the space given to General Practice and non-acute care in medical school and postgraduate curricula. The dominance of hospitals within our education and training model has led to an over-emphasis on non-GP clinical cases and situations, despite the burden of illness and majority of services required being for preventive, primary, and long-term care – all of which are best delivered in a community-based or home setting. Failing to address this means that our future doctors are not being prepared to meet patient needs.

All doctors, no matter what specialty they pursue, must have the necessary understanding of the role of GPs in patient care – vital to good patient outcomes. More appropriate learning of this specialty will enable students and early career doctors to more fully experience and understand the intellectual rigour, stimulating challenges, range of opportunities, and professional and personal rewards of a career in general practice and encourage more to consider this training pathway.

It needs to be highlighted that there are many reports that current teaching about general practice does not accurately reflect its role or indeed the clinical situation. Education providers and educators need to ensure that their curricula, pedagogy and assessments are not inadvertently presenting general practice using deficit language or misleading cases. For example:

- Do case studies describing a patient presenting to a hospital portray the patient as not receiving the care or assessment they should have received from their GP?
- Is sufficient importance given to ensuring learning about effective patient discharge communication, or are these characterised as ‘loose ends’ or paperwork?
- Do learning and assessment resources showcase the benefits to patient care of effective communication and collaboration between GPs and hospital-based specialists?

These instances not only impact students’ and junior doctors’ learning and future behaviours relating to team-based care and patient management (and therefore patient outcomes), they foster misunderstanding, disregard, and disrespect between specialties, and create a context whereby General Practice is not viewed as highly as it should be.

Questions that could help educators consider this include:

- *Curricula:* do medical curricula give appropriate priority to demonstrating the rigor, variety and importance of General Practice, and primary and community care?
- *Pedagogy:* is the medical curriculum taught in a way that demonstrates and role models General Practice as a specialty equal to other specialties?
- *Assessment:* is General Practice presented in assessment in a manner consistent with other specialties, and reflective of the full breadth of General Practice?

The need for greater generalist capacity across all specialties is widely accepted[15], and the importance of a generalist focus on primary medical education is recognised internationally[16] as well as in Australia[17]. A generalist curriculum is not the same as a General Practice curriculum, however, a medical program that gives substantial space to generalism will be more likely to positively showcase General Practice. The most effective and meaningful way to implement this is by ensuring that ***generalism***[18] ***is embedded in all aspects of the medical program***. The most effective and meaningful way to implement this is by increasing the prominence of generalism in schools' medical programs and prevocational training.

A zero-tolerance approach to derogatory language across or between specialties needs to be explicitly adopted in all medical school and postgraduate programs and learning environments. The *hidden curriculum* is a well-known and influential phenomenon, and often feeds and fosters negative portrayals of GPs[19], resulting in a detrimental impact on students' career choice (as well as impacting on patient care and outcomes, as noted earlier). Attention needs to be given to ensure all inter-specialty interactions within medical learning environments demonstrate the collegiate respect and professional courtesy expected of students and doctors. Inter-specialty respect should also be expected in all patient-facing settings, as derogatory language across or between specialties can negatively impact on patient care.

Flexibility within medical programs is needed to enable all students, including those from traditionally underrepresented communities, have every reasonable opportunity to complete their program. MSOD data linked to the 2020 Ahpra registration data indicates that just over 10% of GPs had dependent children during medical school, compared to 5.5% of other doctors; likewise, 6.3% had caring responsibilities for other dependents, comparted to 3.7% of other doctors[20]. This, together with the evidence suggesting that medical students from traditionally underrepresented communities are more likely to pursue GP careers, indicates that added flexibility within medical programs has the potential to see an increase in students with an aptitude for and interest in a GP vocation undertaking medical programs. Such flexibility could include:

- *Part-time study paths*: students with carer responsibilities should not be excluded from medical education
- *Increased flexibility around deferrals*: recognising that a multitude of reasons exist which may necessitate time out from study

[15] See e.g., Australian Government Department of Health, *National Medical Workforce Strategy 2021-2031*, (2021) *("National Medical Workforce Strategy")* https://www.health.gov.au/sites/default/files/documents/2022/03/national-medical-workforce-strategy-2021-2031.pdf. Priority 4 of the Strategy is *"Build the generalist capability of the medical workforce"*

[16] See e.g., *By Choice – Not By Chance*, Recommendation 5

[17] See e.g., *National Medical Workforce Strategy*, Action 16

[18] Generalism is a *"professional philosophy of practice, distinguished by a commitment to holistic, integrated, person-centred care, the broadest scope of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community health needs.*" Postgraduate Medical Education Governance Council (Canada) (2018) *Report on Generalism in Postgraduate Medical Education* https://pgme-cgc.afmc.ca/sites/default/files/news/Generalism%20Working%20Group%20Position%20Paper%20FINAL.pdf

[19] See e.g., *By Choice Not By Chance* – recommendation 11

[20] Data accessed from Medical Deans' data dashboard which links MSOD responses with Ahpra registration data: https://app.powerbi.com/view?r=eyJrIjoiMzEyNjRmYjAtOGFlMS00MWQzLWI0Y2UtYmVlMTgyOTM4NDQ3IiwidCI6IjljY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9&pageName=ReportSection5e5459dc898591506e79

- *Recognition of prior learning*: for example, nurses or allied health professionals wishing to transition to medical careers should be recognised as bringing meaningful knowledge, skills and experience to a medical program.

Underpinning this is the need to ***expand the GP academic workforce***. This includes the appointment of GPs to senior leadership and professorial positions. Students need exposure to positive GP role models throughout their medical programs. GPs are specialists in generalism and so should be centrally involved in reviewing the role of generalism in medical programs, and need to be the drivers of changes to the role of GP in medical programs. Greater support for GPs to complete PhDs and other research projects needs to be put in place, and universities need to ensure their promotion criteria do not disadvantage GPs balancing clinical and academic work.

Medical Deans recommends

- ✓ Medical schools and postgraduate training providers to ensure:
  - General practice and GPs are sufficiently and appropriately reflected in curricula, pedagogy and assessment
  - Generalism is more strongly embedded into curricula, pedagogy and assessment
- ✓ Medical schools, postgraduate education providers and health services to adopt a policy of zero tolerance for derogatory language being used across or between disciplines
- ✓ Medical schools and health services to increase flexible study options (for example, part-time), to facilitate a more inclusive and diverse medical workforce
- ✓ Medical schools to ensure GPs are in prominent roles in all medical schools, including leadership positions and promotion to professorial level

Learning in General Practice

Infrastructure funding, fair reimbursement for time spent teaching, and simplified administrative processes to enable teaching and training to be embedded into the general practice clinical and business models

Learning for and about General Practice can only be effective when it includes practical and positive work integrated learning opportunities **in** General Practice and primary care settings. However, the training capacity in primary care is currently severely constrained by space, time and the funding model. Reform is needed to both ensure that teaching and training is embedded into GP clinical and business models, and to recalibrate the teaching and training 'system' to include more learning in settings beyond hospital walls.

Primary care funding reform must include teaching and training – it cannot be an add-on. There must be a more appropriate match of the investment in teaching, training and research in primary care with that made in tertiary hospitals.

Students need to be provided with high-quality, hands-on, and well supported learning experiences in primary care settings. There needs to be sufficient space for students to work at a level appropriate to their stage of training, sufficient clinical activity to provide them with well-rounded learning experiences, and high-quality supervision to facilitate their learning. It is imperative that any growth in demand for teaching capacity in primary care takes account of the need to ensure that students' learning experiences have all the requisite components. This requires funding for teaching spaces in clinical settings, policies which support multidisciplinary learning in primary care, review of teaching payments, and streamlining of supervisor training.

The process for becoming a well-trained supervisor should be as straightforward as possible. GP supervisor training across the continuum should be reviewed to reduce duplication of requirements of colleges and universities where it exists.

GP practices often do not have the administrative infrastructure and support inherent to tertiary hospitals. This can be a barrier to practices accepting medical students, given the added administrative workload of supporting these placements and the inability to benefit from economies of scale. Universities and medical schools should therefore be supported to provide ***additional support to students in GP placements*** to address this. This support needs to be nuanced to the needs of individual practices, taking account of their business, financial and structural models, as well as the clinical model and scope of practice of the clinic and clinicians. A self-employed Rural Generalist supervising one medical student, for example, will require different support to a GP in a large metropolitan teaching practice. In some practices, there may be scope and desire to be funded to provide these services in house; however, in many smaller practices, this is unlikely to be desirable or practical. For this reason, and based on the relationships medical schools have with their placement practices, medical schools are well placed to oversee these functions, if they are supported to do so.

Students and doctors in training should be able to learn from high quality interprofessional experiences in primary care settings. For example, participation in a nurse-led vaccination clinic, or time spent with a pharmacist who works with the GP on the management of patients with co-morbidities, provide students and doctors in training with valuable learning experiences, as well as the opportunity to gain further, practical knowledge about multidisciplinary teamwork in healthcare. Students and doctors in training learning from other healthcare professionals occurs routinely in hospital settings, and there is no reason why this is not the case in General Practice. In New Zealand

there is no such restriction[21]. Whilst many medical schools and general practices in Australia do include these cross-professional learning experiences, as they are not funded they are occurring despite policy rather than encouraged and enabled by policy. This current model also severely undermines the interprofessional learning medical students are taught, and a clear example of where policies need to be better aligned.

In Australia, the Practice Incentives Program (PIP) (Education) Payments have remained at the same rate since 2015, and no longer reflect the costs of running a general practice. Funding to support General Practice placements in New Zealand have similarly remained static. ***Remuneration for GPs supervising medical student placements in both Australia and New Zealand need to be increased,*** to appropriately reimburse GPs for income lost by seeing fewer patients whilst teaching, with a commitment made to indexation of payments. We note the Australian government's imminent review of General Practice Incentives Programs. It is crucial that training is a central part of these reviews and that the review considers changes which will see a material increase in the payments practices and individual supervisors receive to compensate for teaching activities. Further, in Australia these payments need to include learning experiences with other healthcare professionals team working with the supervising GP. Payment structures also need to be reviewed to ensure they reflect the diversity of business, financial and structural models which are the reality of contemporary general practice. Some models appear based on the assumption that supervision and learning activities occur solely in GP-owned and operated clinics. This assumption may inadvertently fail to provide remuneration to the supervisor.

Parallel consulting, which allows students to gain valuable clinical skills (such as taking patient histories) from working semi-independently, provides excellent training irrespective of which area of medicine they build their career in, and are the most rewarding experiences of GP placement. It is a valuable learning method for students in GP placements[22]. Parallel consulting is predicated on the availability of a consulting room to house a student. For many practices, this is not possible. As such, ***infrastructure funding is required to allow teaching practices to make available additional consulting rooms solely for teaching purposes***. This would ideally involve funding renovations, but where this is not possible, funding to replace income lost from a designated teaching space should be considered. This funding should be linked to KPIs or similar measures to ensure that the space remains for teaching use.

Students need to work alongside near-peers – junior doctors and GP registrars – who can be meaningful mentors and role models for medical students and can assist students to plan a career which includes GP. ***Increased vertical integration across the medical training continuum*** is needed. Vertical integration offers significant benefit to students in that they can learn from and with those on the next step of their career development path, and exposes junior doctors and registrars to teaching from the early days of their General Practice career. This in turn supports the view that teaching is part of the clinical model of General Practice. An ***increase in students completing longitudinal placements or integrated clerkships*** would further improve student outcomes, not just in terms of academic outcomes but also the development of clinical confidence and identity[23].

[21] For example, the Year 4 General Practice and Primary Care placement in the University of Auckland program explicitly includes experiences working with nurses, and makes available where appropriate opportunities to work with other primary health professionals.

[22] See e.g., L Walters (2014), *Parallel Consulting in Rural Medical Education*, WONCA Rural Medical Education Guidebook, https://ruralwonca.org/wp-content/uploads/4.3.4-Walters-Parallel-Consulting.pdf

[23] L Walters et al (2012), *Outcomes of Longitudinal Integrated Clinical Placements for Students, Clinicians and Society*, Medical Education. 46.

Medical Deans recommends

- ✓ Government to provide support to universities to enable medical schools to provide appropriate support to students in GP placements, recognising the absence of the hospital administrative and support structures in GP settings
- ✓ Government to review remuneration for GP teaching and training activities to ensure:
  - Payments adequately compensate for the time invested, and annually adjusted for inflation
  - Payment model that supports teaching by a broader range of professionals within the primary care team
- ✓ Government to make available infrastructure funding for parallel consulting rooms which are solely for teaching and training purposes
- ✓ Medical schools, GP colleges and registrar and supervisor peak bodies to work together to ensure vertical integration in general practice teaching and training is supported by all stakeholders and strengthened so that medical students have opportunities to learn from near-peer mentors
- ✓ Colleges review training for GP supervisors at all stages of the training continuum, to reduce duplication in this and to better support vertical integration across the training pipeline

Supporting Graduates to Progress to Practice

Programs and initiatives to allow final phase students and PGY1-4 trainees to receive substantial and meaningful exposure to and experience in general practice as they plan their careers

Positive and substantial exposure to general practice in medical school is important; however, meaningful exposure to and sustained connection with general practice in prevocational years is vital to influencing graduates' future GP career choice.

11.1% of the Australian 2010 graduating cohort said they wanted to be a GP (see Figure 2). In New Zealand, 19.8% of the 2012 cohort indicated a preference for becoming a GP, with a further 2.6% saying they wanted to practice in Rural Hospital Medicine, for a total of 22.4% of the cohort preferencing a general practice career (see Figure 3).

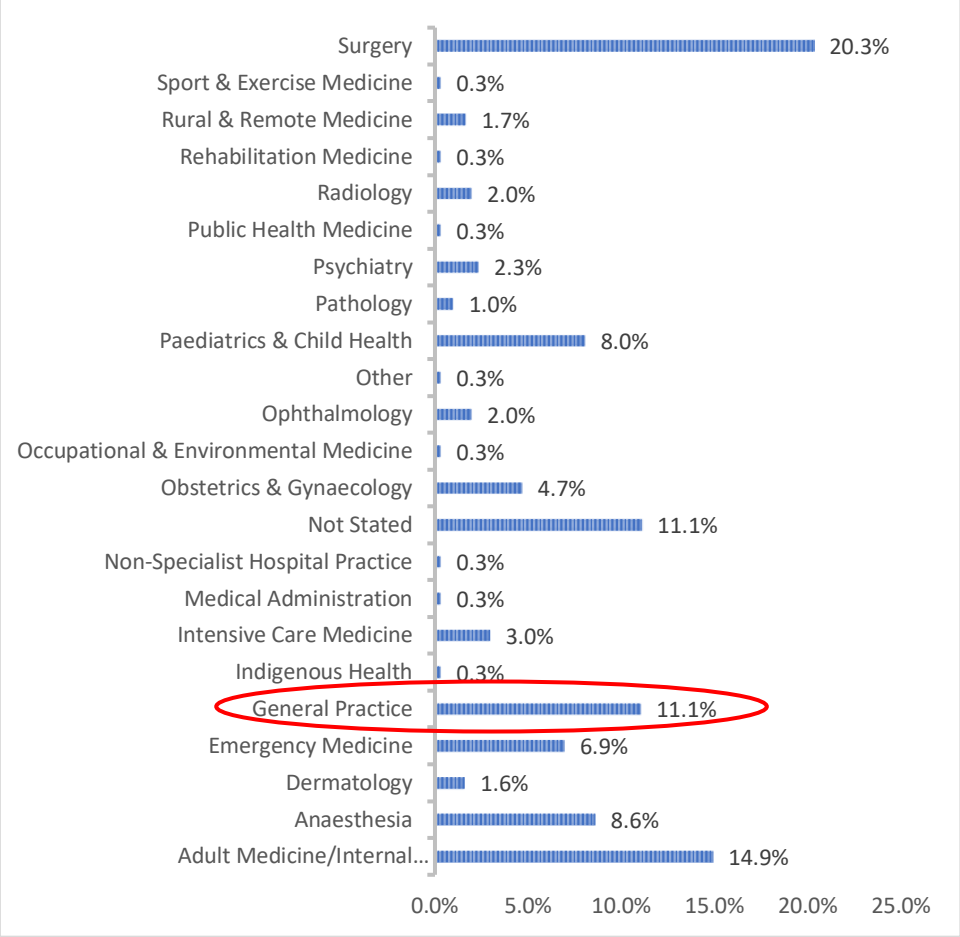

Figure 2: Australian graduates' preferred medical specialty, 2010 MSOD cohort[24]

[24] Data and graph obtained from Medical Deans' data dashboard which links MSOD responses with Ahpra registration data: https://app.powerbi.com/view?r=eyJrIjoiMzEyNjRmYjAtOGFlMS00MWQzLWI0Y2UtYmVlMTgyOTM4NDQ3IiwidCI6IjljY2Y4YjAxLWJhZTQtNDQ2ZC1hZWNhLTdkYTljMDFlZDBmOSJ9&pageName=ReportSection5e5459dc898591506e79

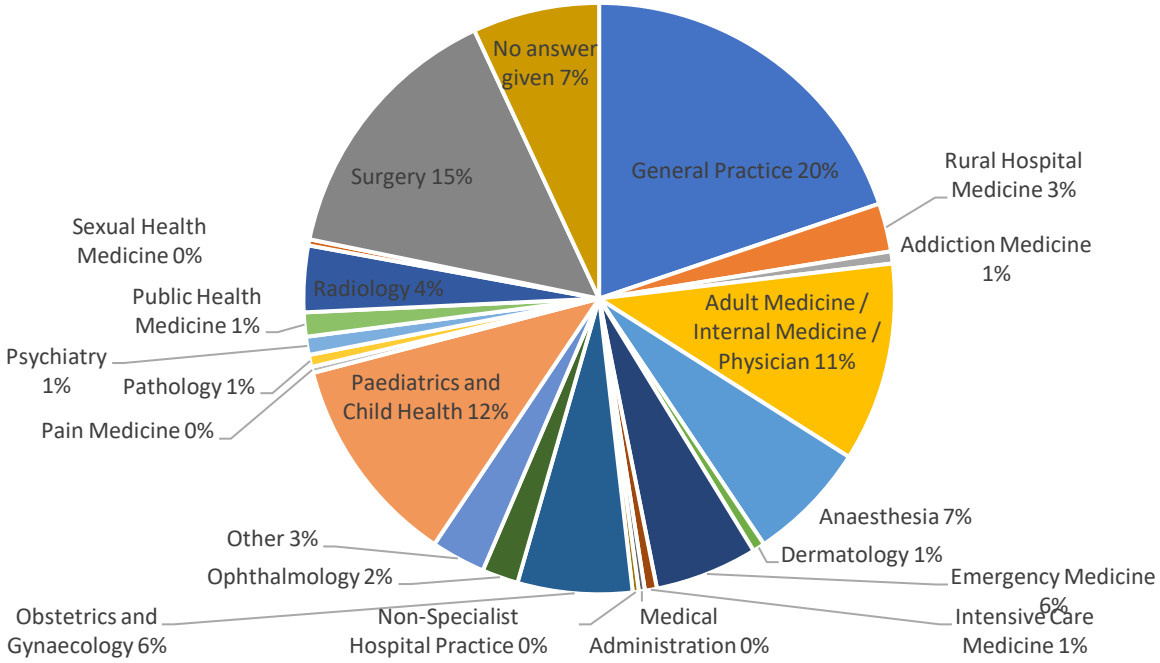

Figure 3: New Zealand graduates' preferred medical speciality, 2012 MSOD cohort[25]

The Medical Schools Outcome Database (MSOD) data has been linked to the Australian Health Practitioners Regulatory Agency (AHPRA) medical registration data, allowing us to see how Australian medical graduates' preferences have played out over time. Similar linkages have been undertaken in New Zealand, enabling similar analyses.

Figure 4 (below) shows the Australian 2010 graduating cohort and where they were working in 2022. We see that 77% of 2010 final year students who indicated a preference for future practice as a GP were working as GPs. A further 13% have no specialty as yet, showing that only 10% have pursued a different specialty.

[25] Data obtained from the New Zealand MSOD project: https://www.otago.ac.nz/oms/education/mbchb/about/accountability/external/msod-project/?utm_source=dynamic&utm_medium=redirection&utm_campaign=nzmsod&utm_term=&utm_content

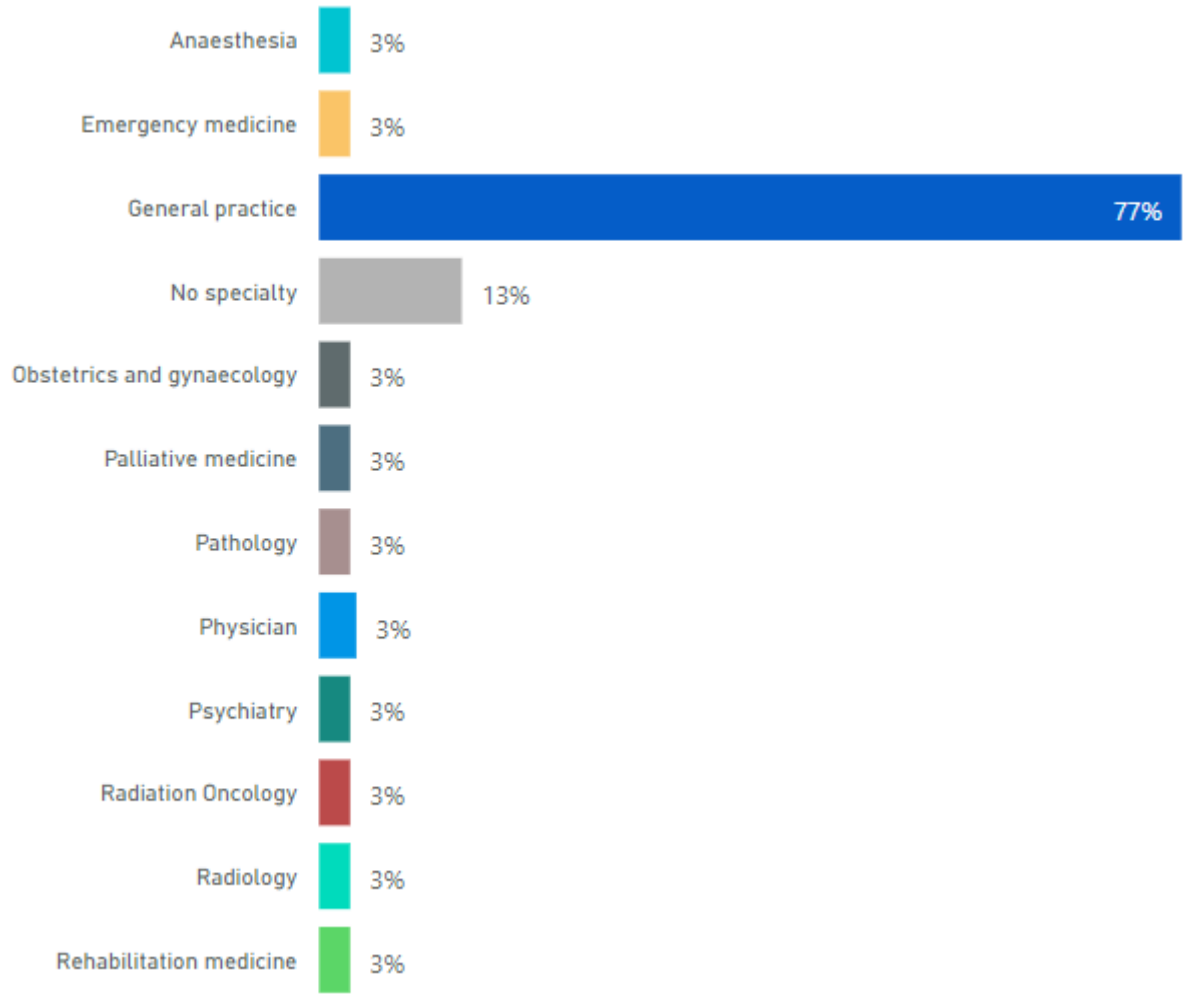

Figure 4: Registered medical specialty in 2020 of the 2010 MSOD cohort who preferenced a GP career[26]

New Zealand data tells a similar story. Figure 5 (below) shows the New Zealand 2012 cohort and where they were working in 2022. We see that 56.6% of 2012 graduates who indicated a preference for future practice in General Practice or Rural Hospital Medicine were working in these specialties in 2022, with 37.7% not yet having a specialty, meaning that only 5.7% had pursued a different speciality.

[26] *Data obtained from Medical Deans Data Dashboard.*

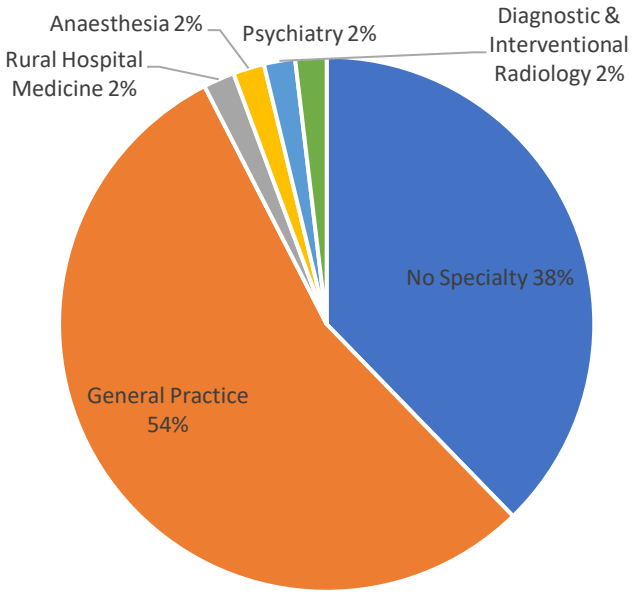

Figure 5: Registered medical specialty in 2022 of the 2012 New Zealand MSOD cohort who preferenced a GP career[27]

The New Zealand Ministry of Health estimates that 28.3% of doctors practicing in New Zealand in 2022 were GPs.[28] Similarly, the AHPRA medical register shows that 27% of doctors registered to practice in Australia in 2022 were working as GPs (see figure 6 below).

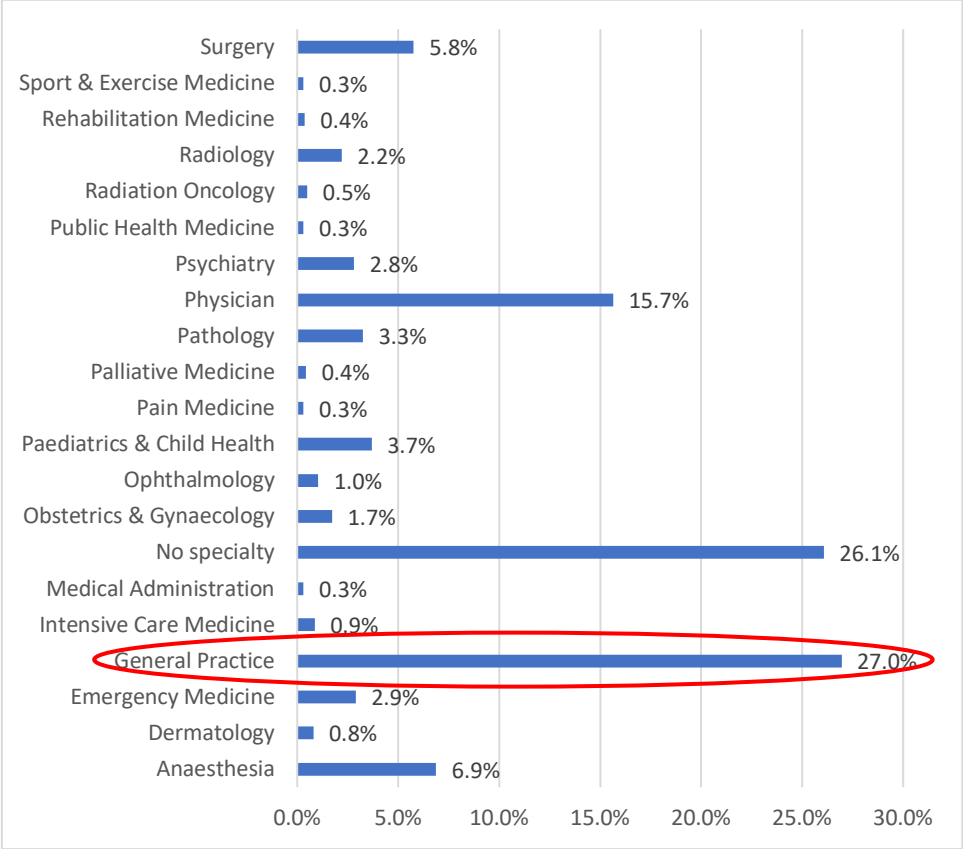

Figure 6: Australian medical workforce by specialty in 2022

[27] *Data obtained from the New Zealand MSOD Project*
[28] Data obtained from New Zealand Ministry of Health by the New Zealand MSOD project team

Looking at the data from those who responded to the MSOD survey when they graduated, we can see that almost two thirds of these Australian GPs did not preference general practice at that time.

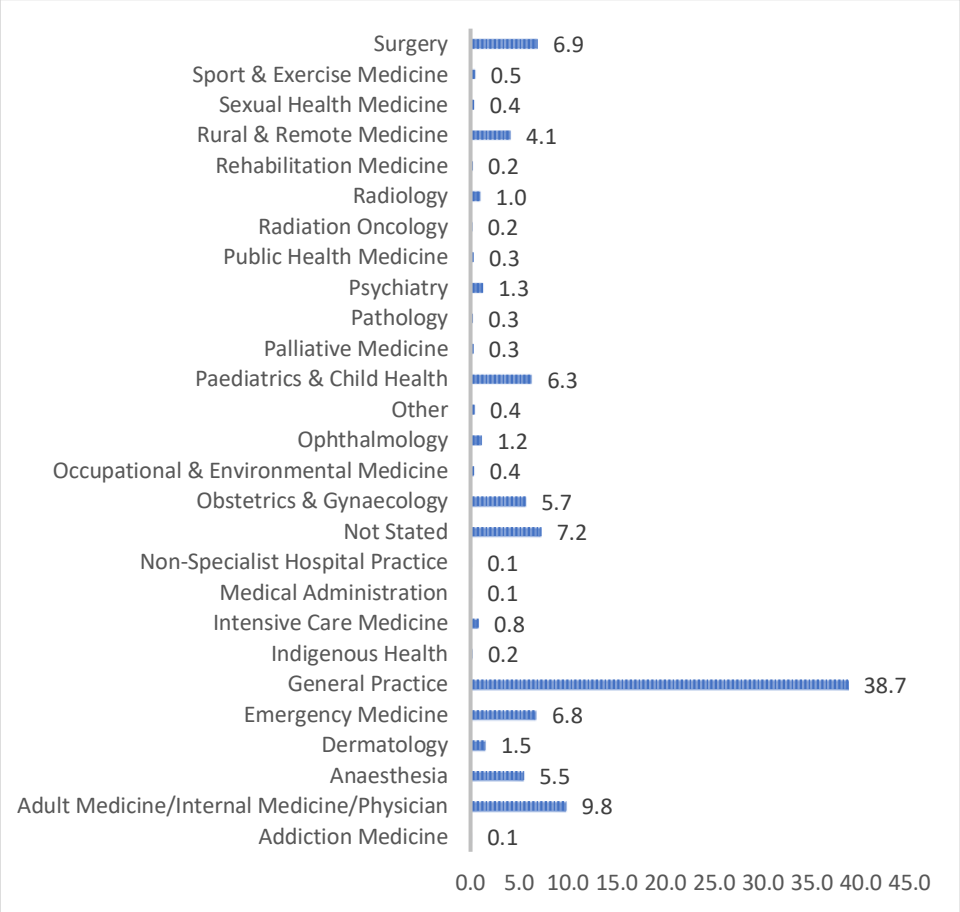

Figure 7: Future career preferences of the Australian GP workforce in 2022 at time of graduation

Linked data from New Zealand shows that 51.7% of GPs (including doctors working in rural hospital medicine) identified this as their preference at graduation, meaning that almost half of GPs in New Zealand did not preference this specialty at graduation.

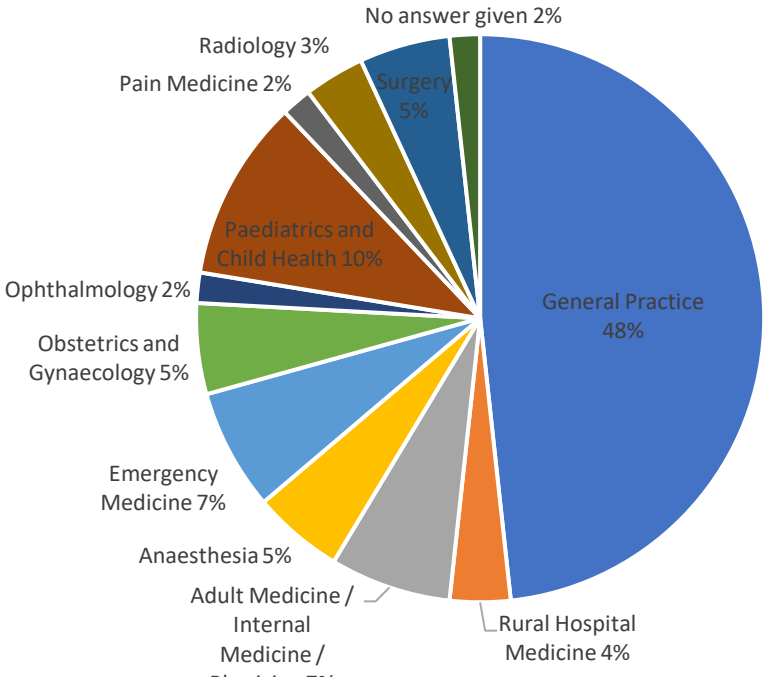

Figure 8: Future career preferences of the New Zealand GP workforce in 2022 at time of graduation

This data shows that medical school is an important influence on the future career choices of graduates. It shows that very often, those interested in pursuing general practice when they complete medical school do actually pursue that path.

It also tells us however that the postgraduate years are a highly influential period in terms of future career choices. This confirms that ***substantial experience in GP and community care settings during PGY1 and PGY2*** is vital, as is supporting PGY3 and PGY4 doctors to stay connected with general practice.

As such, we need to build capacity in the system for prevocational doctors to undertake more of their training in General Practice settings. A program co-designed by government, Colleges, medical schools, and doctors in training[29] which places junior doctors in General Practice is required in order to achieve this. Lessons about what was effective about the former Australian Prevocational General Practice Placement Program[30] would also be valuable.

The recently revised John Flynn Prevocational Doctor Program in Australia[31] is a very positive step, however is only focused on GP placements in rural areas. Extending this to urban and metropolitan areas should be considered.

New Zealand's prevocational training programme[32] now requires PGY1 and PGY2 doctors to complete a community-based clinical attachment to support postgraduate doctors' learning "*with the delivery of health care outside the hospital setting, including an understanding of the interface between*

[29] This could be modelled on the *Community Residency Program* which the AMA has proposed: *Community Residency Program for Junior Medical Officers (2015)*: https://ama.com.au/sites/default/files/documents/AMA_Community_Residency_Program_for_Junior_Medical_Officers.pdf

[30] See e.g., J Thistlethwaite, S Leeder, M Kidd and T Shaw (2008) *Addressing General Practice Workforce Shortages: Policy Options*, Medical Journal of Australia, 189:2

[31] https://www.health.gov.au/our-work/john-flynn-prevocational-doctor-program

[32] https://www.mcnz.org.nz/registration/maintain-or-renew-registration/pgy1pgy2-and-nzrex-training-requirements/

primary and secondary care and the wider health care network"[33]. Regulators in Australia have likewise taken steps in this direction through the shift in focus from mandatory rotations and terms to a stronger emphasis on the training program and its outcomes as a whole, in the National Framework for Prevocational Medical Training[34], and has placed increased emphasis on making community terms more available for prevocational doctors, including the prospect of mandatory community terms for all PGY1 and PGY2 doctors in the future. This is an encouraging move which will see prevocational trainees gain experience in a range of settings and with a diverse mix of patients, and will foster a stronger preference for future practice in General Practice.

Systems-level change is required to ensure that the increased scope and quantum of prevocational training in community-based settings are properly supported. Training needs to be embedded into the clinical and business model of General Practice to ensure that the infrastructure and capacity is there to meet future demand. It is essential that prevocational training in General Practice does not come at the expense of medical students' learning experiences in General Practice.

It is vital that ***all junior doctors retain meaningful connections with General Practice and primary care through their prevocational training***. The absence of visible and positive GP role models in postgraduate years has been identified as a barrier for junior doctors to choose GP training programs[35]. You cannot be what you cannot see. As such, junior doctors need continuing connection to GPs and General Practice and primary care. The specific form this takes will vary based on training location and the interests of the trainee, but should include a mix of formal learning, hands on training, and informal mentorship from and opportunities to connect with GP role models.

If the postgraduate training space is to feature prevocational placements in GP and primary care settings more prominently, medical schools will need to make a corresponding increase in the portion of their transition to practice terms which focus on GP and primary care. As such, medical schools should ***review their final terms specifically, with a view to increasing the exposure of students to GP and primary care***. Involving students with an interest in General Practice as a career, as well as GP Registrars, in this review would be advantageous to ensuring that preparatory activities reflect what students and doctors in training need.

Some jurisdictions are considering paid positions within the health services for final phase students which are primarily for the purpose of adding to the clinical workforce, for example, Assistants in Medicine (AiM) in NSW. These roles in many respects function similarly to pre-internship terms and to the very well-established Trainee Intern role in New Zealand. ***Further exploration as to the viability of AiMs in General Practice and primary care settings*** should take place. Likewise, as part of the exploration of what AiMs in GP settings would look like, ***the potential, measurable contributions to student learning of the medical curriculum through this experience should be examined.***

Colleges and regulators should explore ways to embed greater flexibility for registrars undertaking training: this could include part-time options (to allow time for caring responsibilities, to allow time for completion of a PhD, etc.) and greater support for trainees to defer. GP training has traditionally

[33] Medical Council of New Zealand (2019) *Definition of a Community-Based Attachment*: https://www.mcnz.org.nz/assets/Publications/Definitions/0335a05c07/Definition-of-a-community-based-attachment.pdf

[34] AMC (2022), National Standards and requirements for Prevocational (PGY1 ansd PGSY2 Training Programs and Terms, https://www.amc.org.au/framework/

[35] See e.g., Malatest International for New Zealand Ministry of Health (2022) *Review of the General Practice Education Programme Training Funding* https://www.tewhatuora.govt.nz/publications/gpep-training-funding-review/

been seen as a choice which offers flexibility[36], and it is important that training providers and regulators continue to innovate in how they can meet the needs of training cohorts. Data shows that graduates seek careers which allow them to participate in research and teaching, and work in a range of locations[37]. GP training should allow registrars to access these opportunities whilst in training. Not only will this increase the attractiveness of GP training for some junior doctors, it will also contribute to building the GP clinician educator and clinician researcher workforces, which also need to grow to support the recommendations made in this paper.

Medical Deans recommends

- ✓ Medical schools to review preparation for internship terms and activities to ensure students with an interest in progressing to general practice training locations post-graduation are prepared for this.
- ✓ AiMs and similar pre-intern roles to be reviewed to see how these programs can contribute to student learning in the GP curriculum in a measurable way.
- ✓ Training providers to ensure all PGY1 and PGY2 doctors gain substantial quality experience in general practice.
- ✓ Hospitals, postgraduate medical councils, GP supervisors and GP peak bodies to develop strategies to ensure PGY1-PGY4 doctors retain frequent and meaningful connections with general practice in their early years of medical practice

[36] N Shadbolt and J Bunker (2009) *Choosing General Practice: A Review of Career Choice Determinants*, Australian Family Physician, 38:1

[37] See the MSOD reports for Australia and New Zealand for further information about the interest in teaching, research and working outside capital cities in each jurisdiction.

The General Practice Profession

General Practice recognised by funders, the community, the medical profession, graduates, and students as a diverse, rewarding, rigorous and valued medical vocation

General Practice is a diverse, rewarding and intellectually rigorous medical vocation, and needs to be recognised as such by prospective GPs if the workforce is to grow. It needs to be an attractive career proposition for graduates and a sustainable career for GPs. It therefore needs to be appropriately valued and supported by funders and the whole medical profession. In addition, innovation and change is required by all healthcare and health education stakeholders to positively and accurately represent the benefits of a career in General Practice.

The most obvious area where reform is needed is in funding and remuneration. ***GPs need to be fairly remunerated by government health funding policy and programs.*** Further work should be done by government and health services to ensure GPs' income is commensurate with other specialists, including registrars, early career GPs, and GP leaders. As part of this review, new and team-based models of care should be encouraged and supported, and multiple mechanisms used concurrently to balance the limitation of any one approach.

Flexibility in employment approaches should be encouraged to enable different personal needs and preferences to be options, for example supporting salaried GPs within general practice and GPs employed directly by health services.

A move to a blended payment model must also be considered, allowing for different payment mechanisms to support greater balance between throughput, targets, and outcomes. Blended payment models that incorporate elements of capitation, fee-for-service, target based funding, bundled payments for episodes of care, and performance-based payments and evidence have been shown to better support the different objectives and healthcare priorities of populations and individuals, and encourage a stronger focus on quality and patient outcomes[38]. Payment mechanisms need to account for the broad range of employment and business models found in General Practice. Payment models and mechanisms which work best in GP-owned practices will not necessarily meet the needs of not-for-profit community-controlled clinics, or clinics operated by large health services companies. Policies and processes need to meet the needs of clinics and GPs across all models.

Funding reform must include changes and increased investment in teaching, training and research in General Practice and primary care settings. It is vital that we realise the substantial and much needed benefits of the primary care environment being a well-utilised, valued, and high-quality teaching, training and research system.

GP registrar salaries and employment conditions need to be commensurate with hospital-based registrar salaries and conditions. The income gap between hospital-based registrars and GP registrars, as well as the fact that most GP registrars depart state health services in order to commence their training, and so do not carry over their annual leave, sick leave and long service leave entitlements, means that this is very often not the case.

It has been noted in New Zealand that *'aligning employment terms and conditions for GP registrars with registrars in other vocational programs would remove the main barrier to entering GP education*

[38] OECD Better Policies for Better Lives: Focus on "Better ways to pay for health care", June 2016 https://www.oecd.org/els/health-systems/Better-ways-to-pay-for-health-care-FOCUS.pdf

programs[39]*.'* This was adopted by the New Zealand government in October 2022 and first year GP registrars will now be paid the same as their hospital counterparts[40].

Single-employer models (for example, the Murrumbidgee Rural Generalist Training Pathway and the Tasmanian Single-Employer Trial) are one such approach to this problem, and should continue and expand. However, this model should not be the only model that is developed – it will not be the solution for all GP registrars. Governments must continue to explore additional solutions aimed at ensuring parity in pay and employment conditions for GP registrars.

As the current funding mechanisms for General Practice are dependent on fee for service payments, an important consequence is that this severely limits GPs' capacity to embrace wider aspects of many other salaried medical careers – i.e., teaching, research, and profession leadership – without compromising their income. GP registrar and Fellow remuneration must incorporate funding mechanisms that allow ***GPs at all stages of their training and career to participate in the full gamut of valued professional activities without resulting in lost or reduced income***.

A culture which does not tolerate disrespect of any healthcare profession, and in which leaders proactively demonstrate professional respect to colleagues of different professions is needed. There are too many instances of doctors, other health professionals, media, government, Colleges, universities and other stakeholders talking general practice down and this has an impact of the way students and early career doctors see and feel about the vocation. Professional respect is essential to ensuring that GP is appealing to future doctors and that the high levels of intellectual challenge, professional status, and diverse career options are clear and recognised.

All doctors want opportunities to achieve career accomplishment beyond fellowship. This is commonplace in other medical disciplines, where leadership roles, research and subspecialisation allow Fellows to continue to grow their career. For GPs, there is little beyond practice ownership, which is attractive for some but not all. Colleges and regulators should do more to ensure that ***GPs who have completed additional qualifications in line with areas of special interest have these recognised formally*** to allow their career and training path to continue beyond fellowship.

[39] Malatest International for New Zealand Ministry of Health (2022) Review of the General Practice Education Programme Training Funding https://www.tewhatuora.govt.nz/publications/gpep-training-funding-review/
[40] Plan for Big Boost in GP Training Numbers (Ministerial Press Release) 4 October 2022

Medical Deans recommends

- ✓ Colleges, regulators and health services to explore ways of increasing flexibility in GP training pathways
- ✓ Governments to review funding and remuneration in general practice to ensure salaries and benefits are commensurate with hospital-based doctors:
    - The Medicare schedule to be reviewed to ensure GPs are appropriately compensated
    - GP registrar salaries and employment conditions to be at parity with hospital-based registrar salaries
    - Opportunities to participate in research (including presentations at conferences), teaching, and professional leadership are made more available to GPs and do not result in loss of revenue due to time away from seeing patients
- ✓ All stakeholders to take meaningful steps to address the hidden curricula and ensure collegial respect exists, and is demonstrated by leaders to students, junior doctors and registrars
- ✓ Colleges and regulators support GP career progression post fellowship through further recognition of GPs with special interest and similar roles

Building Research and the Evidence Base

Research into the determinants of medical graduates choosing to train and practice in general practice is prioritised and supported to build the evidence base and inform policy

More needs to be known in the Australian and New Zealand contexts about how, when and why medical students and junior doctors decide on their career, and the factors influencing these choices. Initiatives need to be critically assessed and evaluated to ensure stated aims are met most effectively. There needs to be ***funding made available to support a comprehensive program of research activity to further build and expand the evidence base for GP career choice*** in Australia and New Zealand. This ***research program in turn needs to be fully supported by all stakeholders***, so that the research and evidence base is developed, and continues to grow, so that new and emerging solutions and strategies can be supported and implemented.

Medical Deans recommends

- ✓ Funding is made available by government to support further research on the determinants of medical graduates choosing general practice as a vocation in which to practice and train, including the development of funded and coordinated clinician-researcher training pathways
- ✓ Universities and colleges to support research projects and partnerships which explore these questions, paying particular attention to regions and communities which are underserved by a GP workforce (for example, rural, outer metropolitan, disadvantaged communities)

The Primary Care Environment and Context

An environment in which GPs work to their full scope of practice as part of a primary care team, are appropriately remunerated for their expertise and are given every opportunity to participate in research, teaching, training and leadership of the medical profession

The context and environment in which GPs work needs to be better positioned to support the careers emerging junior doctors want.

Between 59% and 65% of domestic Australian respondents to the MSOD survey across the period 2017 to 2021 have indicated that they want research to play a part in their future career[41]. Between 2016 and 2020, more than 50% of New Zealand medical graduates have likewise identified a desire for research to feature in their career, with only 16% indicating they have no interest in research as part of their medical career[42]. More should be done to allow these graduates to ***work as GPs and pursue their interest in research***. This will be beneficial to growing the General Practice workforce. It will also benefit the primary care and broader healthcare environment through the production of a greater range of research outputs exploring issues in a more diverse range of settings.

[41] Medical Deans (2022) *MSOD National Data Report 2022* https://medicaldeans.org.au/md/2023/05/MSOD-National-Data-Report-2022.pdf

[42] The New Zealand MSOD Steering Group (2021), National Report on Students Graduating Medical School in New Zealand 2016-2020 https://www.otago.ac.nz/oms/otago831361.pdf

The introduction of a coordinated and supported clinician researcher career pathway, running from medical school through to post-fellowship training in research, should be supported. Such a pathway should include prominent roles for GPs, to allow GPs with an interest in research to take advantage of this pathway as appropriate, and to recognise the largely untapped research potential within primary care.

Similarly, interest in teaching is high. Consistently more than 86% of domestic Australian respondents indicate that they want teaching to be part of their career[43]. Between 75% and 79% of New Zealand graduates indicate a desire for teaching to play a role in their medical career, with approximately a further 20% undecided about the possibility of teaching as part of their medical career[44].

What is needed therefore is a ***system which better supports GPs to work "Portfolio Careers" which incorporate clinical work, clinical governance, research, teaching and professional leadership responsibilities*** in a manner that is personally rewarding but also financially viable and secure. There is a perception that this isn't an option for GPs who need to spend their time with patients or lose income. ***Students and junior doctors need to see portfolio careers as the norm, not an exception***.

Medical Deans recommends

- ✓ Government, research funding bodies and universities recognise and support general practice as an environment for research inclusive of clinical, public health, health systems research and research focused on medical education, of largely untapped potential, and work with partners to boost and further support research in general practice including the development of a funded GP clinician researcher pathway
- ✓ GP colleges to enable and promote portfolio careers for GPs, allowing a combination of clinical practice, teaching, research, and management and administration, are strongly supported by all parties, and these careers are showcased to students and junior doctors as normal rather than exceptional

[43] Medical Deans (2022) MSOD National Data Report 2022 https://medicaldeans.org.au/md/2022/08/MSOD-National-Data-Report-2022-1.pdf

[44] The New Zealand MSOD Steering Group (2021), National Report on Students Graduating Medical School in New Zealand 2016-2020 https://www.otago.ac.nz/oms/otago831361.pdf

Conclusion

Medical schools are pivotal in building medical graduate interest in careers in General Practice. However, given that two thirds of GPs chose a General Practice specialty after graduation, it is clear that changes in medical school alone will not bring about the outcomes our communities need.

A postgraduate training system which exposes postgraduate doctors to far broader range of healthcare settings, including General Practice, and community and primary care, will keep General Practice as a viable option for these doctors as they plan their vocation. This will also produce doctors across all specialties with a better, more realistic understanding of General Practice and primary care, which will only yield benefits.

Medical students need to be properly prepared for practice through clinical experiences in General Practice and primary care in which they have the space, supervision and clinical work to obtain meaningful learning opportunities. This needs to be complemented by learning for and about General Practice across the entirety of their medical curriculum, from academic GPs who are role models to students of the types of careers they can have in General Practice.

Proactive recruitment of students with aptitude for and interest in careers as GPs, and an expansion of the factors which influence admission to medical school to include these factors, will further and meaningfully build the cohort of prospective GPs.

All these initiatives are based on the requirement that General Practice be, and be seen to be, a diverse, rigorous and rewarding career. As such, reviews of GP remuneration for clinical and teaching and training work is urgently needed for both Registrars and Fellows. Opportunities for GPs to participate actively in research without losing income, and for more research to be undertaken in primary care settings, will increase the attractiveness of General Practice as a career choice for graduates and early career doctors. So will further opportunities for GPs to participate in teaching, medical, clinical and academic leadership, and recognition of special interests and areas of higher training.

The time for meaningful action to build the GP workforce is now. This action needs to be grounded in the teaching and training of future doctors, and must be holistic in its scope to effect meaningful change. There is no panacea to this issue: for the needed outcomes to be achieved, changes are required at all levels. Bold innovation across the pipeline is needed, and now is the time to make change.

Acknowledgements

This document was developed by a working group under the auspices of Medical Deans Australia and New Zealand. We acknowledge and thank the group members for their contribution and commitment to this matter and to developing this document.

Working Group members

- Professor Kirsty Douglas, Australian National University (Chair)
- Professor Penny Abbott, Western Sydney University
- Associate Professor Katrina Anderson, Australian National University
- Professor Andrew Bonney, University of Wollongong
- Associate Professor David Garne, University of Wollongong
- Associate Professor Lucy Gilkes, University of Notre Dame Australia
- Associate Professor Michelle Guppy, University of New England
- Associate Professor Rowena Ivers, University of Wollongong
- Associate Professor Melissa Kang, University of Sydney
- Dr Elaine Leung, Flinders University
- Associate Professor Nahal Mavaddat, University of Western Australia
- Professor Danielle Mazza, Monash University
- Dr Nerida Paterson, University of Newcastle
- Dr Chance Pistoll, University of Melbourne
- Professor Richard Reed, Flinders University
- Associate Professor Joel Rhee, University of New South Wales
- Professor Gary Rogers, Deakin University
- Associate Professor Jane Smith, Bond University
- Dr Rebecca Starkie, University of Melbourne
- Professor Nigel Stocks, University of Adelaide
- Professor Stephen Trumble, University of Melbourne
- Professor Katharine Wallis, University of Queensland
- Professor Sanjyot Vagholkar, Macquarie University
- Associate Professor Kylie Vuong, Griffith University
- James Boggs, Policy Officer, Medical Deans Australia and New Zealand
- Helen Craig, CEO, Medical Deans Australia and New Zealand

We would also like to express our thanks to all those who provided feedback on the draft versions of this paper.

Suggested citation:

Medical Deans Australia and New Zealand (2023) *Position Paper: The Doctors our Communities Need: Building, Sustaining and Supporting the General Practice Workforce in Australia and New Zealand*. Sydney, Australia

Medical Deans
AUSTRALIA AND NEW ZEALAND

www.medicaldeans.org.au
consult@medicaldeans.org.au