
# The decision to enter general practice

**Chris Pearce,** *MBBS, FRACGP, FACRRM, MFM, is Senior Lecturer in Rural General Practice, the University of Melbourne, and was a medical educator and regional coordinator in the former Royal Australian College of General Practitioners Training Program, Victoria.*
**Kelsey Hegarty,** *MBBS, FRACGP, PhD, is Senior Lecturer, Department General Practice, the University of Melbourne, Victoria.*

The numbers applying to enter the Australian General Practice Training Program have been declining over the past few years, leading to unfilled places in some of the new general practice training consortia. While the reason for this has largely been ascribed to the uncertainty in training issues, the reasons are more complex than that, and can be grouped into intrinsic (flexibility of training, flexibility of career, remuneration) and extrinsic (role models, changing demographics) reasons. It is unlikely that a single solution will reverse this decline.

The federal government has announced a welcome increase in the numbers of general practitioners to be trained in this country, an increase from 450 to 600 annually. However, last year there were vacancies in regional general practice training programs. One would have to ask how will the increase in training places have the desired effect if we cannot currently attract graduates to general practice training to capacity? And why despite all the efforts of government to provide incentives for geographic based initiatives, is rural general practice not more popular? Even without a scholarship, an intention to enter rural general practice can trigger all types of support, from HECS debt waiver to $60 000 worth of financial assistance for general practice training.

So let us start with an analysis of what is known about those applying for general practice training and why this figure is falling (*Figure 1*).[1] This information is important if we are to address workforce issues. While it is tempting to blame the current uncertainty in training, the situation is much more complicated. For a start, it is important to realise that the decline is part of a worldwide trend in falling interest in general practice in the developed world, with sequential drops recorded in Canada in 2000[2] and 2001,[3] while unmatched places exist in both the USA[4] and United Kingdom[5] systems.

In his early work on career management for the UK National Health Service, Francis identified the many and varied factors that influence junior hospital doctors to chose a lifelong vocation:

- material rewards (seeking wealth and a high standard of living)
- power and influence (seeking to be in control of people)
- search for meaning (seeking to do things which are believed to be valuable for their own sake)
- expertise (seeking a high level of accomplishment in a particular field)
- creativity (seeking to innovate and be identified with original output)
- affiliation (seeking nourishing relationships with others at work)
- autonomy (seeking to be independent and to make key decisions for oneself)
- security (seeking a dependable future), and
- status (seeking to be recognised, admired and respected within the community).[6]

It is appropriate to look at what is happening overseas to see if there are any parallels that can be drawn to our current system. Canada has seen a decline in medical students selecting general practice from 40% to 28%.[7] In Canada, similar to Australia, the urban programs are subscribed to adequately, while rural programs have up to 60% vacancies.[3] As put succinctly by one potential Canadian applicant:

> 'On the one hand, being a family doctor who provided total care seems exciting. On the other hand, I am scared that in doing so I will be trapped forever in some isolated community, cut off from the world of research and buried in under a mountain of office expenses and paperwork'.[8]

Other factors identified in Canada as a barrier to entry have been the perception of general practice as a discipline with low esteem and low earning capacity.[2] With rising medical student debt in Canada, this last issue will be further compounded. Student debt will be a concern in Australia, with government reforms in higher education likely to increase the amount of debt carried by Australian medical students on graduation. Debt in New Zealand may even be

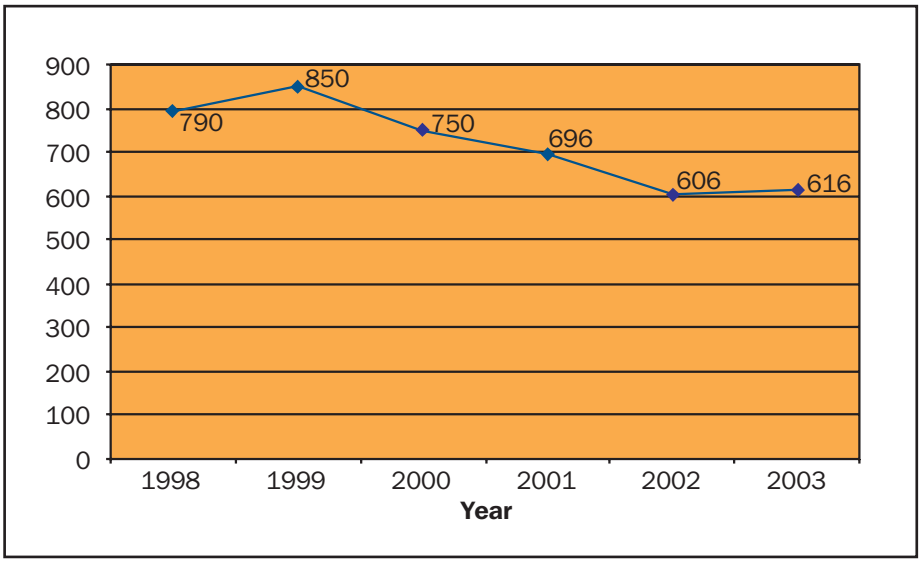


**Figure 1. Numbers applying for general practice training**

**Table 1. Decline in general practice training**

| Intrinsic | Extrinsic |
|---|---|
| Flexible training options | Medical school debt |
| Flexible career options | Changing demographics |
| Clinical content | Role models |
| Remuneration levels | |

driving its graduates overseas in search of higher remuneration,[9] and in the USA, debt levels of a mean of USD72 000 were driving residents into more remunerative specialties and forcing them to look at 'moonlighting' to support themselves.[10] Rising costs also influence the intake of students into medical schools, with those from rural areas and low incomes less likely to be represented.[11]

In North America, entry into vocational training occurs at graduation while in the UK, similar to Australia, there is usually 2–3 years of general hospital work before selecting a training program. What seems clear is that one of the key features in influencing a career choice is exposure to general practice and GPs as role models, in either system. One study has clearly shown an improvement in attitudes to GPs during a medical course, with more students indicating a preference for general practice in those who had exposure.[12] United Kingdom hospital doctors and general practice registrars have clearly identified exposure (or lack of it during hospital jobs) as a determinant in their choice.[13] Indeed, for UK hospital doctors, there is still the perception of 'ending up a GP' when other avenues are exhausted.[14]

Flexibility and lifestyle issues rate highly as an influence on career choice for surgeons and anaesthetists.[15,16] Although these issues may rank as high as clinical content, there is a perception that general practice provides a better lifestyle, but lower clinical content compared to other specialties.[17]

Which brings us to the Australian situation, where there is no doubt that general practice is changing and tension exists between the older generation and the expectations of the new.[18,19] To begin to understand the factors at work, we must first realise the revolution that has happened in medical school training over the past 15 years. Medical schools now offer a mix of undergraduate and postgraduate courses, the effects of which are to raise the age of students at graduation, many of whom already have two or even three degrees. Curricula have changed too, with emphasis on problem based learning and community based activities.[20] Most schools have increased exposure to primary care, which is a positive step.

Australian medical schools are also graduating many more women than in the past, and have now reached parity with the population at large. The proportion of women enrolled in medical schools has risen from 43.4% in 1989 to 57.7% in 1999. This will have significant impact on our medical workforce as a whole, as women work different hours to men and have different lifestyle expectations.[21] Women are more likely to choose general practice, anaesthesia, radiology, psychiatry and emergency medicine. There is also evidence that GPs from culturally and linguistically diverse backgrounds are more likely to choose different specialties.[22] General practice will not be as popular with doctors from non-English speaking backgrounds who are increasingly represented in our medical schools.

However, medical school changes are not the only contributor to alterations in the numbers of doctors choosing general practice as a career. The pool of applicants for general practice training come largely from doctors in junior hospital posts (usually 2–4 years after graduation). Workforce shortages in these posts result in a significant proportion of these posts being filled with overseas trained doctors. In Victoria, there are 330 intern posts and 450 second year hospital posts, leaving 120 to be made up from other sources, largely overseas trained doctors. These doctors are more likely to be found in rural and outer urban hospitals, traditionally seen as better hospitals for general practice experience. This group has no experience of Australian primary care other than what they experience in hospital posts. If research in other environments has identified positive exposure to general practice as important,[13,14] the question becomes just what is the exposure for these doctors?

There is the turmoil in general practice training itself. When the government opened up training to competition, it broke down 25 years of stability in training

provider (The Royal Australian College of General Practitioners [RACGP]) and ushered in a new era. From there being one provider of training there are now over 20, with variations in areas such as selection, standards and portability across the country. In dealing with the tensions between the Australian College of Rural and Remote Medicine (ACRRM) and the RACGP over training issues, the profession has accepted a decrease in professional autonomy and independence.[23] It would be tempting to blame much of the drop in applicants on this turmoil alone, but at least one study has demonstrated that external turmoil may have little effect on hospital doctors' choices.[14] By contrast, Canada's investigation into the decline has identified fear, uncertainty and doubt (FUD) as a possible contributing factor.[24] Many of the changes to training, such as enforced rural and outer urban placements, may work to reduce the perception of flexibility and lifestyle, tilting the balance in favour of specialties such as emergency medicine, anaesthetics or radiology, all of which offer similar flexibility and lifestyle options.

## Conclusion

So what lessons can be drawn from this? Briefly we summarise the factors at play by looking at those intrinsic to the profession and those extrinsic (*Table 1*). These factors emphasise the multifactorial approach that will need to be taken to reverse the decreasing numbers of doctors entering general practice. Thornett et al[25] suggest that diversifying career options for junior doctors within general practice might attract more. One of the difficulties is the lack of good, current Australian data as to which of the factors discussed above have the greatest influence on career choice. Solutions such as the establishment of pre-vocational general practice posts during hospital years (similar to the ACRRM's Rural and Remote Area Placement program) and increasing exposure to role models in early career years could be influential. However, there needs to be an examination of the career structure of general practice, both at training and post-training level. What is really missing is an in-depth study examining these issues in detail from an Australian perspective. There is no current published evidence of what barriers and facilitators to entry to general practice exist for the current cohort of Australian doctors.

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AFP


**Correspondence**

Email: cpearce@unimelb.edu.au



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