Medical generalism & the future of Family Medicine

Professor Richard Murray
President
‘Rural Generalist Medicine’
an expansive generalist role for Family Physicians needed particularly in rural communities...

• Comprehensive, coordinated ambulatory care for individuals, families and communities
• Hospital in-patient care & emergencies
• Extended specialised skills as required to sustain comprehensive health services
• A systems & population health approach relevant to the community of practice
...and Singapore, the world?
So why medical generalism?

1. Affordability, safety, effectiveness (*pick two*)
2. Beyond credentials/scope to a ‘system of care’
3. Re-thinking quality & safety
4. Disruptive technologies & generalism
5. The social contract & value-for-money
1. Affordability. Are we really short of doctors?...

Doctors, density per 1000 population, Australia and selected countries

Sources: OECD Health Data 2013: Statistics and Indicators. [www.oecd.org](http://www.oecd.org)

No: the real issues are mostly excessive sub-specialisation, geographic maldistribution & inefficient models of care

Doctors: density per 1000 population in Australia across geographic areas, 2011

And how much can we really afford to spend?

‘New, improved and more’ – for everyone

Change in Australian governments’ health expenditure ($bn)
2002-03 to 2012-13

Source: Daley, J., McGannon, C., and Savage J., 2013, Budget pressures on Australian governments. Grattan Institute. (Analysis of AIHW (2012); AIHW (2012) ABS (2013a) Cat. no. 6401.0 Tables 1 and 2; ABS (2013c) Cat. no. 3101.0 Table 59)
2. Systems of Care: beyond individual professional credentials/scope
eg: Kidney failure in remote Australia

- Numbers needing renal replacement doubling in remote Australia every 5 years
- **Access to haemodialysis** a key issue
- Metro service models based on ‘home HD’ (pt & family helper) or major centre ‘satellite HD’
- **Remote models** embed ‘satellite’ in PHC context in remote centre, with training & support for ‘home’ HD
- ‘Home’ often better in local clinic, with salaried healthworker, community nurse or lay helper
- Medical oversight – ‘GP nephrology’: extended skills, ‘delegated practice’ relationship with distant specialist nephrologist
- **Better outcomes**...

Features of a system of care

The Network: referral pathways, training, supervision, ‘phone-a-friend’, education, QA, advocacy for & with communities

The Culture: patient-centred, inter-reliance, cultivation of personal relationships, trust, respect

Family Physician & primary care team
3. Re-thinking quality & safety

- Volumes actually poorly correlated with outcomes
- Team competence appears as important as individual competence
- Whole system planning required, not narrow ‘facility’ focus (“whose risk?”)
- Accessibility, acceptability are integral to quality & safety
- Generalism usually preferred to narrow-scope or ‘organ-based’ care
“Specialism, now a necessity, has fragmented the specialties themselves in a way that makes the outlook hazardous. The workers lose all sense of proportion in a maze of minutiae. Everywhere, men are in small coteries, intensely absorbed in subjects of deep interest, but of very limited scope. ... Applying themselves early to research, young men get into backwaters far from the main stream.”

Sir William Osler
4. Disruptive technologies help re-balance generalism

- Education at a distance
- Information at the bedside
- Breaking down the walls of medical care
Eg: Tele-Derm

Dr Jim Muir
Teledermatologist extraordinaire

ACRRM TeleDerm service & educational resource
Telederm at the front-line...

When your practice includes Afghanistan, Tele-Derm is an essential service

Submitted July 19th 2013

Working out of Al Minhad military air base in Dubai, more than 9,000 kms from Perth, Australian medical registrar Flight Lieutenant Daniel Gwynne's patients are a very long way from consulting specialists.

Yet, Dr Gwynne (pictured, left) has been able to get a dermatologist's opinion on challenging patient skin conditions in a matter of hours using Tele-Derm, a free service managed by the Australian College of Rural and Remote Medicine.

"Tele-Derm has been very useful in helping me diagnose and treat a wide range of skin conditions," Dr Gwynne explains. "Although there's a six-hour time difference between here and the dermatologist I can usually get a response inside 48 hours. It's the ideal second opinion and encourages good safe ways to practice."
Jim’s Q: Intermittent lesions on woman in 60s

Sent: Friday, 15 November 2013 4:43 PM
To: Murray, Richard

Intermittent lesions on woman in 60s

Jim’s questions for you: 15th Nov 2013

These lesions are on the upper limbs of a woman in her sixties.

They have been an intermittent problem for 4 years. They last 3-4 days.

- Describe the lesions and give a differential diagnosis.
- What would you ask about their evolution?
- What is their significance?

To see larger photos, read other case study questions, or to submit your answer to this week’s question...

Click here to submit your answer

Abrupt appearance of lesions on arms

See the answers to last week’s questions
Tele-medicine – the rural way

- Access for communities
- Consultant care in context
- Education & skills transfer
- Efficiency
- Supporting a ‘system of care’

Cost savings from a telemedicine model of care in northern Queensland, Australia

Abstract

Introduction: Telemedicine is a rapidly growing field with the potential to improve access to healthcare services, particularly in remote and rural areas. In this study, we examined the cost savings associated with the implementation of a telemedicine model in northern Queensland, Australia.

Methods: We conducted a retrospective analysis of all telemedicine consultations provided by the Telemedicine Services Unit in the region from January 2010 to December 2012. The costs associated with each consultation were recorded, including travel and accommodation expenses for both the patient and the healthcare provider.

Results: A total of 500 consultations were conducted during the study period. The average cost per consultation was $250, with a range of $100 to $500. The total cost of all consultations was $125,000.

Conclusion: The implementation of a telemedicine model in northern Queensland resulted in significant cost savings. This model has the potential to be scaled up to other rural and remote regions, thereby improving access to healthcare services.
The social contract & professionalism

Society grants:
monopoly over use of a body of knowledge and the privilege of self-regulation

The profession guarantees:
professional competence, integrity and the provision of altruistic service to society

“For the ideal of professionalism to survive, physicians must understand it and its role in the social contract. They must meet the obligations necessary to sustain professionalism and ensure that healthcare systems support, rather than subvert, behaviour that is compatible with professionalism's values” Cruess S, Cruess R

2. In: Smith R. Medical professionalism: in with the old, out with the new. J Royal Soc Med. 2006; 99(2)
Implications of the social contract for Family Medicine

- **Value for money**: working at ‘top-of-licence’
- **Teamwork**: medical expertise in a broader team
- **Leadership**: person-centred, generalist care across the patient journey

You are in this business as a calling, not as a business; as a calling which exacts from you at every turn self-sacrifice, devotion, love and tenderness to your fellow men. Once you get down to a purely business level, your influence is gone and the true light of your life is dimmed. **Sir William Osler**
‘Generalism’ still appeals, to whom?

Exploring the Temperament and Character Traits of Rural and Urban Doctors

Diann Eley, MSc, PhD1; Louise Young, MPsychEd, PhD1; and Thomas R. Pryce, PhD2

ABSTRACT: Context: Australia shares many dilemmas with North America regarding shortages of doctors in rural and remote locations. This preliminary study contributes to the establishment of a psychological profile for rural doctors by comparing temperament and character traits with those of urban doctors. Purpose: The aim is to compare the individual levels and combinations of temperament (e.g., energetic and stable) and character (e.g., good, practical, and warm) traits of rural and urban GPs. Methods: Rural (n = 120) and urban (n = 90) GPs completed a demographic questionnaire and the TCI-R. Results: General practice is most often a mixture of types including “Introversion” and “Conscientious.”

Myers-Briggs Type Indicator (MBTI). However, the variety makes it difficult to characterize a general practice with a unique pattern of personality characteristics.
The real generalists must stand up...!