The role of medical generalism in the New Zealand health system into the future

Carol Atmore

ABSTRACT

New Zealand hospitals are facing medical workforce shortages and an ageing population with increasing multimorbidity. To be sustainable in the future, the future medical workforce will need expertise in dealing with the complexity of people living with multiple physical and mental health issues. This will require a greater focus on generalism within the speciality colleges, and generalist doctors within the hospital settings, as well as their traditional home of community settings. Doctors’ career choices will need to be matched to changing community need.

The Transalpine Health Services generalist, specialist and sub-specialist workforce model developed by the West Coast and Canterbury health systems points the way to future sustainable provision of a quality patient hospital experience as close to home as possible, for people who live in provincial New Zealand, through a regional network approach.

System-wide changes are suggested to support a more balanced future medical workforce. These include greater valuing of careers in generalism, aligning of incentives to promote medical careers based in generalism, developing regional networks that cross existing District Health Board boundaries to provide patient care, and application of system outcome metrics that measure quality of care and patient outcomes in an integrated health system.

The current challenges

New Zealand hospitals are facing medical workforce shortages and a changing patient demographic. The Association of Medical Specialists continues to project workforce shortages for hospital consultants. The Ministry of Health is predicting an ageing population with an increase in people with multiple long-term health conditions in the future. It is timely to consider whether the current mix of doctors’ skills and expertise in New Zealand is fit for purpose, as we look towards the future.

In New Zealand, as in many other developed countries, the last 60 years has seen increasing sub-specialism within medicine. The Royal Australasian College of Physicians now has 24 recognised sub-specialty ‘-ologies’, and the Royal College of Surgeons lists nine surgical subspecialties. Anaesthesia has separated into Anaesthetics and Intensive Care Medicine colleges. Emergency Medicine has developed as its own college. Younger hospital consultants are less comfortable working across a broad scope than the consultants of a generation ago. The proportion of doctors working as general practitioners has also reduced and it is uncommon for them to work within the hospital setting when compared to the past. More doctors train as subspecialists over generalists, and live in main urban centres, in preference to provincial and rural centres.

This drive towards subspecialisation over recent decades has come from both within and without the profession. Within the profession, defining areas of specialised expertise has allowed the development of deeper expertise in a narrower area of knowledge with new technology, which has an appeal in its own right. It also has
allowed doctors to create areas of service which they can stake a legitimate claim on as their territory, both in the public and private hospital settings. Increasing prestige is associated with subspecialisation, and often increased remuneration. Consumer pressure and regulatory body changes, in response to the concerns about competency, has led to narrowing of scopes of practice in an effort to increase standards of care provided to patients.

In provincial New Zealand, the unintended consequence of increased subspecialisation has been the loss of flexibility in the range of services able to be provided at the local hospital. There has been a trade-off between the additional quality gained by subspecialisation and the quality foregone due to this lack of flexibility in smaller hospitals. There are also increased costs involved with the increasing fragmentation that specialisation brings. Grey Base Hospital, on the South Island’s West Coast, is the smallest provincial base hospital in New Zealand. It has been the ‘canary in the coal mine’ of these negative effects of increased medical subspecialisation. It has had long-standing difficulties recruiting and retaining doctors to provide the health services required to meet the local communities’ needs. This has led to a high dependence on locum services to provide 24/7 rosters for each specialty area within the hospital setting. With this high locum use comes the risk of compromise on quality of care provided, as teams and teamwork are weakened.

It is worth noting that not every country has followed this subspecialisation path to the degree that New Zealand has. Whilst the general physician and general surgeon have become rarer and generalist doctors inhabit primary care almost exclusively in England, areas of rural Scotland are endeavouring to maintain or develop the generalist doctor in their hospitals. In rural Australia and rural Canada, comprehensive primary care encompasses hospital, emergency and population health care, with expanded scopes of services in anaesthesics, obstetrics and surgery. Indeed, Australian rural general practitioner colleagues can work in expanded scopes in anaesthesics, obstetrics and surgery with appropriate training, under the Australasian specialty colleges that govern standards and quality on both sides of the Tasman. In the US, generalism in the hospital setting has emerged in what is termed ‘hospitalists’. These doctors, either general physicians or specifically-trained hospitalists, provide generalist care in the hospital setting, and work with subspecialists as the patients’ needs dictate.

The number of people with multiple long-term health conditions in New Zealand is increasing, as it is around the world. As the population ages, obesity rates rise, and social inequalities continue, the number of people living with multimorbidity, including dementia, is projected to rise further. There is an increasing call internationally for a change in how health care is delivered to meet the challenge of ageing populations and multimorbidity. To continue with a preponderance of doctors with subspecialised skills for disease or organ-specific care will see patients with multiple complex health issues getting increasingly segmented and fragmented care. This will likely be expensive, exceed the workforce’s capacity and reduce the overall quality of the care people receive. Subspecialisation for the few could be seen to come at the expense of holistic care for the many.

Medical generalism now and for the future

For health systems to be sustainable in the future, more whole person care will be required. The future medical workforce will need expertise in dealing with the complexity of people living with multiple physical and mental health issues. They will need to be skilled at working in teams with nurses, allied health professionals and patients and their whānau, and coordinating patient care across different settings. This will require a greater focus on generalism within the speciality colleges, as signalled recently by the Royal College of Physicians, and generalist doctors within the hospital settings, as well as their traditional home of community settings. These generalists and general specialists will work collaboratively with sub-specialists as part of the person’s health care team.
So what is medical generalism? A Commission on Generalism in the UK noted that where specialism was about depth, generalism was about breadth. It identified medical generalism as an approach to the delivery of health care that deals with undifferentiated illness and works across inter-professional boundaries, recognising the interdependency of professionals’ skills. Generalism has been described as patient- and family-centred care; and as expertise in whole-person medicine. Generalism is not settings bound, and exists in both the hospital and community. A doctor can practice generalism within their specialty, such as a general physician or general surgeon, or as a generalist with a broad set of skills and expertise who provides care across specialty boundaries.

The generalist doctor in New Zealand is usually found in general practice. They provide whole-person care, using investigation and treatment judiciously, grounded on the evidence base, working in collaborative partnerships with patients, nurses, allied health professionals and their specialist colleagues. A generalist can recognise the limitations of their skills and experience and knows when and where to enlist the most appropriate help, support and advice from colleagues. They are able to tolerate uncertainty and manage tension and ambiguity, understanding how the person fits within their community. They have a broad skill and knowledge base that allows them to synthesize the treatment plan for the whole person, from the various organ and system dysfunctions and social concerns and context of the patient. Traditionally in New Zealand, our generalist doctors work as general practitioners practising in the community, and in local small rural hospitals run by generalists.

What is the right path for New Zealand’s medical workforce to follow that will meet the challenge of changing health needs? Given the changing demographic of our patients and their need for holistic care to deal with their multimorbidity, more generalism in the specialties is needed. As well, a role is emerging for generalist doctors to work with specialists in our provincial hospitals to provide high-quality and sustainable patient care. Julian Tudor Hart’s Inverse Care Law of 40 years ago still applies today, that: “The availability of good medical care tends to vary inversely with the need for it in the population served. This inverse care law operates more completely where medical care is most exposed to market forces, and less so where such exposure is reduced.”

For future health services to be sustainable, doctors’ career choices need to match changing community need. There is no ‘market mechanism’ working within the public health system to ensure this changing need will lead to changes in relative supply of generalists over specialists. Deliberate design is required.

In response to these challenges, embodied in the need to provide sustainable care at Grey Hospital, the West Coast and Canterbury health systems have been planning and implementing a regional generalist, specialist and sub-specialist workforce model to support the provision of Transalpine Health Services. The creation of the rural hospital medicine vocational scope has provided an opportunity for developing generalist doctors within the small provincial hospital setting.

The West Coast paediatric and orthopaedic services are provided by a generalist-specialist workforce, of rural hospital medicine doctors, locally-based specialists, and visiting specialists and subspecialists based in Canterbury. The specialists and rural hospital medicine generalist doctors work together to provide inpatient care, with the rural hospital medicine doctors being the senior West Coast-based doctor for these services out-of-hours and on some days of the working week. In these times, they are supported by specialist services in Canterbury through telephone and telemedicine contact, with a shared laboratory, radiology and hospital summary IT platform. Patients whose care can’t be safely provided on the West Coast are transferred to Canterbury by air or road. Handover and patient review between the specialists and the rural hospital medicine doctors provide ongoing team building and education. It is planned to test a version of this model for general medicine inpatient services. It has potential applicability in other areas, such as mental health.
The success of this new model of service provision depends on high trust relationships with skilled clinicians (doctors, nurses, allied health professionals) on the ground on both sides of the Alps, who see themselves as part of the transalpine team. Easy and timely communication with the right clinical people when required is important. Jointly developing patient pathways which all clinicians follow allows care to be provided consistently and transfers of care to happen without delay. Appropriate use of technology, and joint appointments, with shared responsibility, also have enabled this model to work. Focusing on developing trust, and listening to feedback from people on the ground, have been key to improving services when difficulties have arisen.

The vocational scope of rural hospital medicine is new, and it sits within the Royal New Zealand College of General Practitioners. The number of Fellows is currently small in New Zealand, and emphasis is being placed on training rural hospital medicine registrars, as well as general practice registrars within the West Coast and Canterbury health systems, to match the demand for this new breed of generalist doctors. Fellows can be jointly trained in both rural hospital medicine and general practice and registrars are encouraged to pursue dual training. This provides the opportunity for generalist doctors to increasingly span across the community and hospital settings.

The *Transalpine Health Services* model points the way to a future sustainable way of providing a quality patient experience as close to home as possible, for people who live in provincial New Zealand. It is worth noting that within major urban tertiary hospitals, the need for generalist doctors to manage the complexity of multimorbidity in patients exists alongside the highly specialised services provided.

**Actions needed for a sustainable future medical workforce**

So what is required to develop a more balanced medical workforce that is fit for future purpose? There must be the political will for change, both at the national ‘high politics’ end, but also within the health community. A change in the medical culture is required from one that values subspecialisation above generalism, to one that spreads prestige across the spectrum. We all have a part to play to bring about this change.

Our medical schools and teaching faculties have a significant role to play in promoting generalists as doctors who are highly valued for their broad knowledge and skills over a large spectrum of health issues. Positive exposure to generalist doctors, both in hospital and community settings, in undergraduate and early postgraduate years increase the uptake of generalist careers. Our medical schools have a real opportunity to influence the future career decisions of the next generation of doctors and need to continue increasing the undergraduate exposure they provide to generalism.

Incentives need to be aligned to promote medical careers based in generalism for junior doctors. Academic opportunities, and opportunities for procedural work, have been shown to be equally important as expected future earnings in driving career choice for junior doctors. Increasing the academic base where research in generalism happens would increase its attractiveness as a career. Increasing the opportunities for general practitioners and rural hospital medicine doctors to be involved in procedural work should be considered. Health Workforce New Zealand should direct more funding towards generalist registrar training, both within specialty colleges and within the generalist college. The increase in uptake of general practice registrar training this year shows the value of Health Workforce New Zealand providing junior doctors with information about where future senior medical jobs will lie. It should also consider how to support senior doctors who wish to expand or refresh their skill set to work in a more generalist way.

The specialist medical colleges could more actively promote generalist training within their specialty, as the Royal College of Physicians are doing in the UK. They also could explore endorsing extended scopes of practice for generalist doctors in New Zealand with appropriate training, as the Australian branches of their colleges do.
When the Medical Council of New Zealand considers scopes of practice, they should consider patient access to timely services as an element of quality of care.

District Health Boards need to continue developing regional networks that cross existing DHB boundaries, through their regional service planning and implementation work. The recently created Alliance structures between District Health Boards and Primary Health Organisations offer great potential for developing clinically-led, system-wide governance for integrated care.223

Effective local and regional health systems need to be designed by the doctors, nurses and allied health professionals working in them, with input from patients who use them, and with local management support and enablement. Generalists and specialists working collaboratively will provide shared clinical governance of the health system they create. The Commission on Generalism report noted

“For the patient, it should not have to be generalist or specialist care: we can combine the strengths of each.... That is not to say that generalism should supplant specialistism; rather there needs to be a much more effective spectrum of medical care embracing a generalist perspective and specialist practice.”7

Lastly, system wide outcome measures need to align to measure quality of care and patient outcomes appropriate to the community being served. There should be an increasing focus on metrics that monitor the health system’s ability to keep people with complex multimorbidity and social disadvantage living well in the community, out of hospital and out of aged residential care. The new Integrated Performance and Incentive Framework that the Ministry of Health is leading the design of, with significant sector input, is seeking to do this.23 Its development should be supported and progress watched keenly.

We need a new workforce model to provide sustainable health services in the future. This challenge is not unique to New Zealand. System-wide changes are needed to support a more balanced future medical workforce. The developing Transalpine Health Services model for the smallest provincial hospital in the country points the way to how future sustainable services could be provided in other areas, with generalists, specialists and subspecialists working together. We have the opportunity to become a world leader in promoting generalism, training generalists and redesigning our health system for the changing needs of our population. We must rise to the challenge.

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Author information:
Carol Atmore, General Practitioner
Corresponding author:
Carol Atmore, General Practitioner
drcarolatmore@gmail.com
URL:

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