A patience of professors

The Foundation Professors of "Community Practice" in Australia, 1974–2003

Max Kamien

ABSTRACT

- The 1973 inquiry into the "Expansion of Medical Education in Australia" resulted in the appointment of nine professors of "Community Practice".
- We (the foundation professors) have been leaders in a reform movement within medical schools and general practice and have had to fight hard for the right and resources to do the job for which we were appointed.
- Our most significant accomplishment has been to broaden the orientation of medical education beyond hospitals and laboratories to the community and those in the community who are underserved.
- Although small in numbers, our discipline fights above its weight and is essential for medical school accreditation by the Australian Medical Council.

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WORLDWIDE, THE FIRST APPOINTEE to a Chair of General Practice was at the University of Edinburgh in 1963. Robert Scott's Chair was funded by a bequest from the estate of the Scottish general practitioner, Sir James Mackenzie, who had achieved renown through his research into the rhythms of the heart.[1] This world-first appointment preceded a rising community concern about the shortage of general practitioners in the Western world and about the importance of training medical students in general practice.[2-4] In North America, the first Professors of Family Medicine were appointed at Penn State University (1967) and the University of Western Ontario (1968).

In Australia, the Whitlam government commissioned an inquiry on the "Expansion of Medical Education in Australia", chaired by Professor Peter Karmel, a Professor of Economics and Foundation Vice-Chancellor of the Flinders University of South Australia. The other six members of the Committee came from a background of obstetrics, medicine, neurology, and hospital administration, and included a Commonwealth statistician and the Queensland Auditor-General. The Karmel Committee reported that exposure to general practice was an essential part of the training of all medical students.[5] The Commonwealth government then allocated, for the first time, specifically dedicated funds for the development of "community practice" within Australian universities.

Despite strong representation from the Royal Australian College of General Practitioners (RACGP), the Karmel Committee was not convinced that general practice should be regarded as an intellectual discipline in its own right. It recommended that general practice be taught as a subject in academic departments of community medicine, with "community practice" as its practical application.[5] This semantic confusion led to the different medical schools placing varying degrees of emphasis on the place of general practice within the wider field of community medicine and public health, which was already well-established in some universities.

Although some information has been published about academic general practice[6-8] and about individual foundation professors of community practice,[9-13] there has been no study of the group as a whole. In this article, I describe our biographical details and some of our personal views.

For editorial comment, see page 8

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Method

All the foundation professors provided detailed answers to the following questions:

- Outline your career and work before taking up your chair.
- What sparked your interest in becoming a senior academic?
- What do you consider to be your most significant accomplishments?
- What do you consider to be your major missed opportunities?
- What were your greatest joys in being a professor?
- What were the greatest difficulties you have faced in your work?
- How did your work affect your personal and family life?
- What are your current views on the state of general practice?
- What advice do you have for your successors?

I supplemented this information with interviews of five of the professors and from feedback on a draft of this article.

Results

All nine foundation professors of "Community Practice" were appointed between 1974 and 1976 and took up their positions within the next 12 months (Box). Four of the nine came from a background of general practice, three from primary medical care in developing countries and two were specialist physicians with experience and interest in public health. Six had held subprofessorial university appointments and one had been a full-time hospital administrator. Their

The foundation professors, qualifications at appointment, original titles, universities and years of service

Charles Bridges-Webb
MD, FRACGP
Community Medicine
Sydney
1975–1994

Neil Edwin Carson
FRACGP, FRACP
Community Medicine
Monash
1975–1993

Max Kamien
MD, FRACP, MRCP, FRACGP, DPM, DCH
General Practice
Western Australia
1977–2003

Jean Norelle Lickiss
MD, MRACP, FRCP, BMedSc, DTM&H
Community Health
Tasmania
1975–1983

Timothy George Murrell
MD, FRACGP, DTM&H, CLJ
Community Medicine
Adelaide
1975–1994

Anthony James Radford
FRCP, MRCP, FRACP, MFCM, SM, DTM&H
Primary Health Care
Flinders
1975–1994

James Geoffrey Ryan
BSc, FRACGP
Community Practice
Queensland
1975–1986

Ian William Webster
MD, FRACP
Community Medicine
New South Wales
1975–2001

Ross Wharton Webster
FRACGP, MRACP
Community Health
Melbourne
1974–1989

primary professional qualifications were FRACGP and FRACP (3), FRACGP (3), FRACP (3), and five held a university doctorate. Three of the new professors had started their careers in general practice in New Guinea, and two had worked closely with Aboriginal communities in New South Wales. Four had been active in the politics, research committee or examination of the RACGP and two had been state presidents and federal councillors of the Australian Medical Association. Their direction and that of their department was largely influenced by their background and whether their university already had an active Department of Public Health.

What sparked your interest in becoming an academic?

> *"In my student days I was taught nothing about general practice, community medicine, ethics or patient behaviour (apart from a little rat psychology). I determined that my career path would be to address these deficiencies".* A Radford

The most frequently cited reason for becoming an academic was "a desire to make a difference". Most of us wished to produce more holistically oriented doctors whose work would encompass a community perspective, in addition to their diagnostic and therapeutic roles. We saw future doctors helping to alleviate the burden of ill health in the community by addressing areas such as poverty and dispossession, which contributed to that ill health.

All of us had an interest in the intellectual underpinnings of medicine and healthcare, enjoyed teaching, and thought that work in a medical faculty would provide us with the opportunity to become involved in a mix of social medicine, clinical practice, and innovations in health policy.

Three of the professors had developed an interest in teaching by having students attached to their general practice. This had led to a strong involvement in educational matters within the RACGP. The advent of chairs of general practice/community medicine provided them with the opportunity to move into academia on a full-time basis. One foundation professor chose academic general practice because it provided the opportunity to pursue his long-term research interests and further his already substantial achievements in general practice epidemiology.

Accomplishments

"To convert an inward-looking faculty from a purely hospital focus to a recognition that students needed to understand the realities of general practice as well as improve poor consultation skills". R Webster

All the foundation professors regarded our most significant accomplishment as having broadened the scope of existing medical curricula. Innovations included the use of video feedback in teaching consultation and communication skills, computer-based learning laboratories, and multidisciplinary and community-based education where students could learn about the effects on health of non-medical factors such as poverty, isolation and ageing. Other achievements included the introduction of a postgraduate Diploma and a Masters in General Practice (now completed by over 500 GPs), and courses on teaching to assist GP preceptors.

Five of the professors published regularly (averaging 2.5 Medline cited papers per year), covering general practice epidemiology, cancer epidemiology and palliative care, the aetiology of disease, the needs of the elderly, rural workforce issues, Aboriginal health and medical education.

Four professors reported significant accomplishments in setting up teaching health centres, hospital-based teaching units and community health services. They were also proud of raising the image of general practice in their university by taking over the organisation of final MB BS examinations, chairing academic councils, influencing Commonwealth or state healthcare policies through involvement with a variety of non-university advisory committees, and having set up a university department and finding the resources to nurture a future generation of academic GPs.

Recognition of these achievements has included awards in the Order of Australia to seven of the nine foundation professors.

Missed opportunities

"I spent too much time teaching and leading at the expense of research into my areas of interest". I Webster

The most commonly reported missed opportunity was learning to find one's way about the medical school and university, especially in search of teaching and research funding. Even those who thought they understood the system were never able to achieve any equality of funding with the more established departments. This lack of funding resulted in understaffing and an inability to provide for much needed faculty development of junior staff.

Other missed opportunities were thought to be:

- failure to develop a research theme, or a greater research presence;
- failure to achieve vertical integration of undergraduate and postgraduate education; and
- failure to set up or to maintain a clinical base in which high-quality general practice could be modelled, demonstrated and used as part of a research base.

The main reasons for these missed opportunities were a failure to obtain support from our state branch of the RACGP, expending too much energy and time fighting for a place in the academic sun, and sitting on too many university, federal, state and professional committees.

Greatest joys

"I always get a buzz when students understand the issues of the human predicament beyond the purely medical, and pride when students volunteer to work in outreach programs with Indigenous communities, the homeless or young drug users". I Webster

The greatest joy was in "helping and watching medical students and junior academic staff grow". This included setting up curricula and learning opportunities which helped students to acquire the important skills of diagnosis, but also broadened their horizons from a narrow focus on disease to a broader understanding of the meaning and expectations that the illness had for patients, their family and the wider society.

The next most common pleasure was the opportunity for scholarship and intellectual stimulation. This occurred mainly through the opportunities afforded by sabbaticals and long service leave. Other satisfactions were the ability to pursue research, the opportunities for publication, and the collegiality afforded by a cohesive department and being part of an international "brotherhood" of GP researchers.

Two of the professors, completely new to university life, gained considerable entrepreneurial satisfaction in learning to access external funding. They believed that their universities regarded this as a greater measure of their success than the conventional pursuits of teaching and research.

Greatest difficulties

"I found the University supportive, but resources for community-based medicine were always a problem". I Webster

All nine foundation professors bemoaned their lack of curriculum time, staff, accommodation, research and teaching money, and their inability to get a fair share of the resources available to the longer-established and "more mainstream" departments and their faculties. Two of the professors were very conscious of a lack of collegiality from members of other departments, describing these established academics as "resource bullies". Professor Eric Saint, then Dean of the Faculty of Medicine at the University of Queensland, made similar remarks in his 1981 review of the new departments, commissioned by the Tertiary Education Commission. He thought the solution lay with the existence of a friendly dean.[14] Most of the professors found their deans helpful and supportive, but three found them disinterested or even hostile to general practice and community medicine.

Four of the professors commented on departmental instability due to personalities "adept at the art of white-anting" (ie, undermining). Also, three hybrid departments had structural difficulties that led to disagreement about aims and resources. One professor described his experience as "cruelly caught between the sociologists on the left and the GPs on the right".

Personal and family life

"My life has been my work but has also given me the opportunity for wide involvement in community organisations and public affairs". I Webster

The foundation professors were asked about the effects of their jobs on personal and family life. Five reported intermittent periods of depression and anxiety, or just plain exhaustion brought on by the chronicity of the previously mentioned conflicts, a lack of academic and support staff and the need to work long hours.

Three of the professors said they took their troubles home, with negative effects on their spouse and children. A further three reported their job as all consuming. But for two, this enhanced their life through intellectual challenge and the opportunity to meet people and be involved in a wide variety of organisations, and thereby influence public health policy.

Three of the five professors who had been in rural practice appreciated the more predictable and regular hours of academia, while two found the calls on their time to be greater. This was largely due to their desire to maintain a commitment to clinical practice, including after-hours calls, and the frequency of meetings held at night and on weekends.

Current views on the state of general practice

Academic general practice

"Academic general practice has come a long way, but we are still fledglings in comparison with long-established medical departments". R Webster

Four of the foundation professors thought academic general practice was doing well and a further three said it had come a long way, but that academic GPs were still "naive fledglings, not yet fully accepted or heard in the halls of academia". We all saw the strength of academic departments as being in the relevance and excellence of our teaching, with a much slower building up of research capacity. Two of the professors thought that an improved research performance, focused on the major causes of morbidity and on the best primary care strategies for combating them, was the key to medical school and university acceptance.

RACGP

"The RACGP needs a PR consultant". T Murrell

Nearly all the foundation professors were disappointed with the RACGP's failure to support, let alone champion, academic general practice. They could see little wisdom in a college reluctant to join forces with universities in adding value to teaching and research endeavour. Other major criticisms were lack of focus on its core tasks of setting standards for education and patient care, and engaging and educating the public on what they should reasonably expect from their GPs and the best way to get it. Nearly all of us had long advocated the recent decentralised restructure of the RACGP.

Divisions of General Practice

"A good voice for general practice if it works in harmony with the AMA, RACGP and academic general practice". G Ryan

Divisions were generally seen as good voices for general practice if they worked collaboratively with the RACGP and universities; if not, they were seen as similar to the old style RACGP (ie, controlled by non-medical administrators) and, although well funded, as yet another player competing with underfunded universities for scarce resources.

Australian College of Remote and Rural Medicine (ACRRM)

"ACRRM is good for emphasising the needs of rural Australia but should not divide general practice". C Bridges-Webb

Three of the foundation professors agreed that rural medicine is different from metropolitan medicine, and that ACRRM was useful for emphasising the needs of rural Australia. They maintained that the test of its success was whether its activities attracted more GPs to the country. Another three were more critical, saying that ACRRM's major achievement had been to divide general practice. None were in favour of having two different qualifications for general practitioners.

Vocational training

"I can see no value in the upheaval of a program which was already evolving". N Carson

Political activity from ACRRM resulted in a series of reviews on the future of vocational training.[15] The reviews' recommendations resulted in the then Minister of Health, Dr Wooldridge, removing the RACGP Training Program's monopoly on vocational training (from 2002) and putting it out to tender by regional consortia. Most foundation professors saw the current process as an expensive "mess". Three could see no value or advantage in the change, but another three saw it as an opportunity to correct the long-missed opportunity of a vertically integrated educational program.

Advice to successors

"Be yourself. Do what you are good at". C Bridges-Webb

The foundation professors stressed that understaffed community-based academics cannot be good at everything and therefore have to focus on two or three areas of activity. These activities were to maintain credibility as a clinician, pay serious attention to university politics, provide good leadership and role modelling, and facilitate a good research and teaching program.

The foundation professors advised their successors to spend at least three sessions a week practising medicine. This was to maintain credibility as a skilled GP and role model for students. It was also to maintain credibility with "the bag-carrying GP". They stressed the need to "do all you can to prevent a gulf between 'working' and academic GPs" and advised new professors to visit their GP teachers as often as possible, and to serve on various committees of their Division and State Faculty of the RACGP.

Most of the foundation professors saw their main role as one of leadership. They advised their successors that establishing a reputation as a good leader and manager was as

important (if not more so) as establishing a reputation in research. They stressed that this leadership should include a role as an advocate for the weak, deprived and medically underserved people in communities, both in Australia and in its near neighbours.

The next most frequent piece of advice concerned the need to pay attention to internal and external university politicking, and to attend all university meetings to avoid the risk of losing the department's funds. Three of the professors advised "developing eyes in the back of one's head, learning to recognise hostile academic 'colleagues' and developing the ability to deal with them".

Conclusion

General and "community" practice was born to struggle within medical schools. It was unlike new medical specialties that were based on new knowledge or new technology. It was person- rather than disease-oriented and was set up to teach and research outside of teaching hospitals. It was a medical education reform movement: a threatening counter-culture to the established basic science and hospital-based clinical departments. It also began at a time of diminishing resources for universities.

There is little doubt that we as foundation professors have been agents of educational change within our medical schools. We have systematically introduced students to community-based medical care, which is where most patients receive most of their care most of the time. We have helped students to focus on the most common disorders, given them strategies to avoid missing serious disease and legitimised a preventive and community perspective to the doctor's role. This includes the role of doctors in helping to tackle the healthcare needs of people who are underserved in our community. We have also been pathfinders in affirmative entry to medical school for those who were previously under-represented, such as rural high school students. Our departments or disciplines are small and, apart from those students who spend up to a year in rural clinical schools, the proportion of our share of curriculum time is in the single digits.[7] But we do have a strong, positive influence in medical schools. A medical school without such a discipline would not achieve accreditation from the Australian Medical Council.[16]

Our prime motive in joining academia was to make a difference to medical education and through that to the amount and quality of the medical care of the Australian population. We had to fight hard for the right to do the job for which we had been appointed. Nevertheless, we also had the opportunity and the privilege to make change happen. Medical schools are better than they were in their focus on consultation skills, equity and in the relevance of their curricula.

The Karmel Committee's doubts about the academic credibility of general practice have been disproven and the meaningless compromise term "community practice" has disappeared. All the medical schools have a general practice entity and the number of full Professors of General Practice has risen from 1 in 1977 to 15 in 2003.

By the end of 2003, all the foundation professors will have retired from their university chairs and, to quote Norelle Lickiss, "we are but threads in the fabric of mankind". This article records something of our struggles, joys and triumphs. It could be a starting point for future professors of community medicine, general practice or primary care to consider before they take up the shuttle to add their thread to the rich tapestry of Australia's medical endeavour.

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Competing interests

None identified.

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