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Publication details:

Culture, Health and Sexuality
v. 13
Chapter No. 10
pp. 1151-1164
1369-1058 (ISSN)

Publication Date:

2011

Publisher DOI:

<http://dx.doi.org/10.1080/13691058.2011.607904>

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This is an electronic version of an article published as:

Newman, C.E., Kidd, M.R., de Wit, J.B., Reynolds, R.H., Canavan, P.G., Kippax, S.C. (2011) What moves a family doctor to specialise in HIV? Interviews with Australian policy key informants. *Culture, Health and Sexuality*, 13(10): 1151-1164. <http://dx.doi.org/10.1080/13691058.2011.607904>

Culture, Health and Sexuality is available online at:
<http://www.tandfonline.com/toc/tchs20/current>

What moves a family doctor to specialise in HIV? Interviews with Australian policy key informants

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What moves a family doctor to specialise in HIV? Interviews with Australian policy key informants

The population of people living with HIV in Australia is increasing, requiring an expert primary care workforce to provide HIV clinical care into the future. Yet the numbers of family doctors or ‘general practitioners’ (GPs) training as community-based HIV medication prescribers may be insufficient to replace those retiring, reducing hours or changing roles. We conducted semi-structured interviews between February and April 2010 with 24 ‘key informants’ holding senior roles in organisations that shape HIV care policy to explore their perceptions of contemporary issues facing the HIV general practice workforce in Australia. Informed by interpretive description, our analysis explores how these key informants characterised GPs as being ‘moved’ by the *clinical*, *professional* and *political* dimensions of the role of the HIV general practice doctor. Each of these dimensions was represented as essential to the engagement of GPs in HIV as an area of special interest, although the political dimensions were often described as the most distinctive compared to other areas of general practice medicine. Our analysis explores how each of these dimensions contributes to shaping the contemporary ‘culture of HIV medicine’, and suggests that such an approach could be useful for understanding how health professionals become engaged in other under-served areas of medical work.

Keywords: Australia; culture of HIV medicine; general practice; medical professions; primary care

Word count: 7,422 (excluding title page and abstract)

Introduction

Anecdotally, the many health professionals working in these areas of HIV medicine and with marginalised communities... remain there because of personal commitment and passion. There is evidence that this situation will not continue indefinitely (Savage et al. 2009, 25).

It seems easier to respond to our enthusiasms by trading in facts than by investigating the more naive question of how and why we have been moved (De Botton 2009, 27).

While the population of people living with HIV in Australia is currently small in comparison with other parts of the world, their numbers are gradually increasing. Patient demographics are also changing, with HIV infection appearing increasingly outside of the main affected populations of gay men and the geographical location of HIV positive people becoming more dispersed (Jansson et al. 2010). HIV medical care is provided in a range of settings, including public hospital outpatient units and sexual health centres, but a special feature of the Australian approach is that care is also available from specialist family doctors (called general practitioners) working in private community-based medical practice settings (called general practices) (Pell et al. 2008). This approach has made care more easily accessible to many people with HIV, which is important for both equity reasons and the serious personal and system costs of inadequate HIV care and treatment (Fleishman et al. 2010). General practitioners (GPs) trained in and accredited as 's100 prescribers' [ie. authorised to prescribe HIV medications as regulated by the 'Section 100' Highly Specialised Drugs Program] are able to develop close and trusted long-term relationships with members of the most at risk and often marginalised populations, particularly gay-identified and other homosexually active men (e.g. Russell 2004). The almost three decades that have passed since HIV was first detected have featured dramatic treatment advances, associated with a transformation in the models of HIV primary care in Australia from acute care to chronic disease management,

including emerging health issues related to living longer with HIV (Orth et al. 2008). These treatment changes and the changes in the demographic and geographic profile of the HIV epidemic in Australia are creating new challenges for models of care delivery and some policy 'nervousness' has become evident about whether sufficient numbers of new GPs are taking up HIV prescriber training in order to replace those who are planning to retire, reduce their hours of work or change their roles (Savage et al. 2009; Whittaker and Watson 2005).

Workforce shortages in general practice have received considerable policy and research attention in recent years (e.g. Piko and Phillips 2010; Shadbolt and Bunker 2009; Thistlethwaite et al. 2008), although a number of medical specialties including geriatric medicine and obstetrics and gynaecology also report persistent workforce shortages (Tay et al. 2009; Torrible et al. 2006). While Collyer has noted that 'most analyses of workforce shortages in the health system have focused narrowly on factors directly impacting on the supply and demand of clinical workers' (2007, 250) with particular reference to remuneration, medical education and numbers of training places, it is promising to note that recent health workforce research has argued for taking better account of the changing social and economic dynamics of working lives in general practice, which include increasingly transient career trajectories and changing meanings of work for clinicians of both genders (Piko and Phillips 2010). The emerging literature on GPs with 'special interests' – defined by the Royal Australian College of General Practitioners as the development of 'advanced competence' in particular areas of practice after GP training has been completed (Royal Australian College of General Practitioners 2007) – has a particular contribution to make here, especially in relation to the commonly posited claim that developing specialist skills and knowledge can increase GP job satisfaction and retention (e.g. Boggis and Cornford 2007; Gerada et al. 2002; Spurling and Jackson 2009; Wilkinson et al. 2005).

HIV is an ‘area of special interest’ for many of the GPs who provide HIV care in Australia, yet very little is known about the particular issues facing this component of the health workforce. In the 1980s and early 1990s, international research on the experiences of providing HIV care was mostly focused on the attitudes of health professionals regarding working with people with HIV infection, often describing a lack of knowledge about HIV transmission and a discomfort in working with patients who identified as gay or inject drugs (e.g. Brown-Peterside et al. 1991; Gerbert et al. 1991). The early research with Australian clinicians reported accurate knowledge of HIV transmission but noted that the discussion of sexual health risk practices was difficult for many and some were concerned about personal safety and public reaction (e.g. Kirkman et al. 1999; Mulvey and Temple-Smith 1997; Paine and Briggs 1988). One of the few studies of the Australian HIV workforce conducted since the introduction of effective treatments in the late nineties described a decrease in the emotional intensity of this work and an increase in job satisfaction due to the development of long relationships with patients (Yallop et al. 2002). More recent research in Australia focusing on clinicians’ experiences of providing care to gay men in relation to the prevention and treatment of HIV has found that GPs provide a safe, accepting and non-judgmental environment where gay men can feel comfortable discussing a variety of personal issues, including sexual health (Newman et al. 2010a; Newman et al. 2010b; Russell 2004).

Australia’s Sixth National HIV Strategy (2010-2013) has recognised that ‘both HIV specialised and generalist general practitioners continue to play a wide role in HIV care, with the majority of people living with HIV seeing a Section100 GP for their HIV care’ (Commonwealth of Australia 2010, 33), but also that there are ‘recruitment and retention difficulties for Section100 GP prescribers and clinicians with an interest in HIV’ (2010, 47). In comparable international settings, a ‘looming HIV workforce shortage’ has also been reported in the United States (Adams et al. 2010, 977), and British research has found that

GPs are reluctant to accept the increased role in HIV care that policymakers have begun to ask of them (Defty et al. 2010). However, as already noted, the beliefs that circulate about how and why health professionals become and remain engaged with HIV care are mostly anecdotal, and very little published research is available on the role that complex factors such as ‘personal commitment and passion’ (Savage et al. 2009, 25) might play in the recruitment and retention of GPs with a special interest in HIV. In fact, there is little information available generally on what GPs and other health care workers might find either rewarding or challenging about HIV medicine as an area of professional interest.

The study from which this paper is drawn is designed to address this gap in knowledge by investigating what ‘moves’ a GP to pursue or sustain a special interest in HIV. We have borrowed the concept of being ‘moved’ in one’s career from Alain de Botton’s *The Pleasures and Sorrows of Work*, both for its flexibility in encompassing both internal (eg. personal motivations) and external (eg. training pathways) factors but also its timely challenge to counter the conventional ‘facts’-based framing of work and career by exploring ‘the more naive question of how and why we have been moved’ (2009, 27). Our broader study includes interviews with general practice clinicians and an analysis of how HIV medicine is represented in policy and medical education texts which address GPs. However, this paper reports on the first phase of interviews which targeted a group of key informants who hold senior roles in HIV sector organisations in Australia, including government, advocacy and medical education bodies. We are drawing on Colebatch’s ‘social construction’ approach to critical policy research to frame this group of key informants as participants in the production of policy discourse about HIV care in general practice. This approach is aligned with what Shaw has described as the ‘policy-as-discourse’ framework within policy research, which attends to ‘the linguistic resources by which the socio-political realm is (re)produced... [to help policymakers] look in different ways at the nature of the social

problems they have to address' (2010, 209). In line with this principle, the insights from this analysis are intended to contribute to the literature on how health professionals become and remain engaged with particular areas of special interest, especially those relating to the provision of care in challenging or under-served areas of medical practice in developed nations.

Method

Ethics approvals for the study were received from the National Research and Evaluation Ethics Committee of the Royal Australian College of General Practitioners and the Human Research Ethics Committees of participating universities. Interviews with 24 key informants were conducted between February and April 2010. Potential participants were first nominated by the study's Expert Committee, comprising researchers from general practice, health sociology, social psychology, and Australian history and representatives of Australia's community-based HIV organisations and the general practice profession, including several GPs who currently provide HIV care in different parts of Australia. 36 potential participants were then shortlisted by the lead investigators with the aim of recruiting participants from a diversity of professional and demographic backgrounds. The first author had responsibility for inviting potential participants, conducting the interviews, and managing the process of interview transcription and de-identification. 24 people agreed to take part in either in person (14) or phone (10) interviews. Two declined to take part because they felt they did not have sufficient expertise on this topic and no reply was received from the other ten people. Those who did not take up our invitations did not differ on major demographic characteristics from those who did take part.

Interviews were conducted both in person (14) and by phone (10). Participants were told that the open-ended questions in our semi-structured guide explored contemporary issues

facing the HIV general practice workforce in Australia. Before the start of each interview, written consent was secured from the participants who were interviewed face-to-face, and verbal consent (following a structured protocol) from the participants interviewed by phone. All participants were offered AU\$150 reimbursement. Participants employed by public sector organisations declined the payments. Most interviews took around one hour to complete. Given the participants were recruited because of their professional (policy, advocacy and education) role rather than their personal life histories, the discursive style of almost all interviews was largely issues-based, as opposed to experience-based.

More men (17) than women (7) took part in interviews, which is at least partly indicative of the gender balance in the senior positions of many organisations in Australia, including those relating to health and HIV. Five participants self-disclosed as HIV positive during the course of the interview, although this was not asked of them. A significant number were trained in medicine (10) and allied health (3), with the remainder describing their professional backgrounds as community sector (3), public sector (3) and ‘other’ (5) (e.g. accounting, computing, media). The setting in which they were currently employed or engaged was fairly evenly split across the non-government (10), government (7) and medical education/training (7) sectors. Their scope of interest in relation to HIV was mostly state-level (12) and national (9), and three participants were explicitly concerned about particular affected populations.

Our analytic approach was informed by interpretive description (ID) (Thorne 2008), which provides a constructivist framework for applied qualitative health research. Thorne recommends adopting an inductive, constant-comparative approach to analysing qualitative data which involves hypothesising about how potential patterns in the data might form relationships which can then be built into a coherent whole, while also iteratively ‘interrogating’ individual themes for their internal consistencies and variations. We also made

use of the Braun and Clarke (2006) guidelines for thematic analysis during the various iterations of coding, reviewing and recoding, as well as the qualitative analysis software NVivo 9. However, ID provided the broad analytic framework, particularly in relation to how we chose to conceptualise and communicate our findings. Adapting the work of Sandelowski and Barroso (2003), Thorne argues that a successful interpretive description will extend the analysis beyond a ‘topical survey’ (an exhaustive listing of all associated topics) to either a ‘thematic summary’ (description and interpretation of the most significant groupings and patterns in the data) or a ‘conceptual description’ (revealing latent patterns through identification and interpretation of original and/or imported concepts). ID also explicitly aims to support communication of findings in a form that will be easily ‘grasped, appreciated and remembered’ (Thorne 2008, 169), in order to have the best chance of informing policy or practice.

[Figure 1 near here]

Results

The key themes we identified across the interview data have been visually reproduced in Figure 1 as a ‘conceptual description’. This diagram is intended to illustrate what we are describing as the *clinical*, *professional* and *political* ‘dimensions’ of the role of HIV general practice doctor (as articulated by this group of policy key informants). The results section will explore specific examples from each of these dimensions to reveal both the central claims and debates among policy key informants about what moves a GP to pursue and sustain a special interest in HIV, and also how this might contribute to shaping a ‘culture of HIV medicine’ in general practice settings.

The themes we identified in the policy key informant interviews included several which highlighted what this group saw as most notable about the *clinical* dimensions of the role of HIV general practice doctor. There was consistency in the idea that this role is ‘special’, not only because GPs do not prescribe HIV medications in many other countries, but also because of the particular expertise that this component of the GP workforce has developed in managing HIV infection in the context of complex psychosocial issues and an ageing and demographically diverse population. However, there was some debate about how to accurately characterise HIV clinical work, illustrated in the following two examples of the HIV GP ‘providing routine management of HIV as chronic illness.’

In some respects, it’s far less ‘exciting’ medicine to be involved in. It’s far less ‘passionate’ medicine to be involved in than it was when you were talking about people who were dying or, or having, you know, considerable health challenges ... [Now] It’s prescriptive. It’s this drug or this set of drugs, these set of tests. [KI_01]

I think it’s completely understandable that a young, hotshot, recent graduate going into general practice in the 1990s would ... see HIV as being a ‘now’ issue: it’s very ‘hot button’, it’s exciting, there’s a lot of science going on, there’s real opportunity to engage with a real, immediate public health issue and a really exciting area of medical science. I don’t think that’s the case anymore. I think HIV GPs write scripts the same way that they treat a myriad of other diseases. [KI_13]

These policy key informants believe that HIV care in general practice settings has become *routine* since the advent of effective treatments, with the excitement of responding to a new and changing medical condition being replaced by the familiarity of managing a chronic illness. The implication is that HIV has less to hold a GP as it becomes less distinctive from more ‘ordinary’ areas of general practice medicine.

Others believed that HIV medicine was commonly represented to GPs as a particularly *complex* field of clinical practice, which they believed would either scare away or

entice GPs into this area of work, depending on how much of a clinical challenge they were seeking. The following examples relate to the perceived role of the HIV GP in ‘addressing complex health and psychosocial needs of people with HIV.’

[A]most everywhere you go [HIV is] described as, “It’s becoming more complex.”... [But] I think that’s an expression of the complexity of the service system ... [which is] complicated, it’s difficult and it’s time consuming. But what ends up happening is that [people living with HIV] get called ‘complex clients’ ... [And so some GPs] maybe shy away from it, who wouldn’t if there wasn’t that same sort of frame. [KI_02]

[N]ot always but often enough, [HIV infection is associated with] substance abuse, mental health, questions [of] self identification ... And then, of course, comes [viral] resistance patterns, and all of those things. So it’s complex from multiple points of view. And that’s nice. And people want to be challenged. I mean who wants to sit in a practice and not be challenged? And the young GPs now, they’re looking for that... The complexity, the interesting nature of HIV infection and all the issues that come along with it. [KI_14]

These extracts suggest that policy key informants believe that the ways in which HIV medicine is ‘represented’ (or perhaps even socially constructed) will influence who wants to do that work. In addition, while these key informants all agree that HIV no longer represents a medical ‘emergency’ – at least in the Australian setting – they conceptualise doctors of different ages and eras as being differently affected by the shift in the clinical nature of HIV work, whether that shift be towards more routine or more complex clinical practice. This produces an impression of HIV GPs as generationally distinct, and as differing according to their stage of career. For example, older or more experienced GPs are seen to have benefited from becoming engaged in an era when HIV was a public health emergency, and when HIV care apparently contained more excitement and passion. In contrast, younger GPs are described as requiring different kinds of motivating drivers to become and to stay involved today, with a particular focus on how the clinical work of HIV medicine is represented.

A set of themes describing the perceived *professional* dimensions of the role of HIV GP was also identified in these interviews including collaborating across HIV care teams and disciplines, contributing to HIV shared care arrangements (particularly between non-prescribing GPs and HIV specialists), and actively seeking support to become and to remain engaged in HIV medicine. While the professional priorities of HIV GPs formed a large part of these interviews, there was variability in how key informants characterised the relationship between individual GP career trajectories and workforce governance and policy. This section considers examples from the three following professional dimensions: 1) ‘aims to succeed in business and lead a balanced life;’ 2) ‘seeks support to remain engaged in HIV medicine;’ and 3) ‘has career trajectory regulated by national workforce policy.’

1) The GP workforce is crazy ... I actually call it the ‘normalisation’ of the workforce ...

Because it is GPs now wanting a life: GPs not wanting to work full time [or] be on call seven days a week ... [M]y opinion is, that if you could peel away all the things that affect GPs as GPs ... you’re going to find you’ve got a very small number of issues that are actually about HIV itself ... [Although, outside Sydney and Melbourne], especially... a GP that works in HIV does not want to be known as ‘the HIV doctor’ ... I don’t think [that is due to] discriminatory reasons or anything. Like they’re actually workflow delivery things... [T]heir books are closed. They can’t take more patients ... They want to be able to see their patients with their coughs and colds and flus and kidney stones and ingrown hairs, and all the other things ... [And] by being an HIV service, they lose a whole pile of stuff. [KI_06]

2) [T]o be a competent prescriber ... one needs to really do a fair bit of work to keep up with developments and, you know, the ever changing information about side effects and all of that sort of stuff. So I think that’s an issue for GPs who are either working in the HIV field or considering getting into it, is that it’s a lot of work. And you’d sort of want to have quite a big cohort of patients to make it worth your while, specialising to that degree. [KI_08]

3) [A] generation of [HIV GPs] ... are now coming to the end of their useful life ... [T]he question is how to renew and bring in a next generation of people ... [Because HIV is] not the

biggest thing in the health system ... [L]et's say over the next couple of years we found twenty people in their thirties who are prepared to take this on, we'd be right ... I think it's got something to do with the way in which the two [general practice and sexual health] colleges work ... And it's got something to do with the workforce planning system that has developed ... [But] I'd be interested just in incentives and the money ... can you make a good living out of doing it? [KI_23]

These extracts illustrate how the role of the HIV GP is characterised with reference to the broader professional cultures and economies of medical practice in Australia. In all three examples, the HIV GP is inscribed with the (uncontroversial) right to negotiate a manageable workload, with remuneration noted in the final example as a key factor in attracting new recruits to the area. What is interesting to observe here are the assumptions about how GPs are believed to negotiate between the opportunities and obligations attached to a specialised area of medical practice such as HIV. Having a small number of HIV positive patients that GPs care for is noted in the first two examples as the most significant barrier to engaging with HIV because of their commitment to be available to other patients, their desire for a balanced life, and the (perception, at least, of a) prohibitive amount of training required to stay on top of developments in the field of HIV medicine. None of these examples present a very good case for what HIV medicine might offer to GPs as a rewarding area of special interest, with a much more dominant focus on the many structural and individual reasons why other professional choices for GPs are likely to be more attractive.

Lastly, these policy key informants describe a set of *political* dimensions that represent HIV GPs as a highly politicised group within the Australian health workforce. It was common in these interviews to hear the HIV GP described as someone who plays an advocacy and support role for HIV positive patients and is active in changing discriminatory social attitudes about HIV, despite the increasing 'demotion' of HIV in the perceived hierarchy of the (post-HIV-crisis) priorities of Australian public health funding. These

accounts closely associate the work of HIV medicine with caring for ‘marginalised communities’, as noted in this paper’s introductory quote, and represent HIV as a culturally and politically distinctive area of health need compared to most other areas of general practice medicine.

The political examples we will look at in most detail here are drawn from the two themes that most explicitly articulated a ‘personal politics’ of HIV work: 1) ‘motivated to work in HIV medicine by sexual identity politics;’ 2) ‘resilient to emotional challenges of providing HIV care.’

1a) Well, the GPs who provide HIV care – let’s be very frank – are either gay, gay men, or to a degree women ... [And] I don’t see really why that would change very much. I don’t think it’s going to be the case that there’s going to be a whole cohort of straight GPs who are going to take this over. [KI_23]

1b) And I mean lots of young, gay-boy doctors don’t want to work in HIV. Because either it’s seen as boring and routine medicine or they don’t want to be tarred with ‘everything-has-to-be-HIV-related.’ Which is the way they sort of saw it or they’ve had to, to fight that off. I mean I know that, that is a generalisation but it’s a generalisation based on talking to all of those young, gay, male doctors that I know who are in that group. [KI_01]

2) [A]s I said before with people being very passionate about the area. With that passion comes, you know, does the passion lead [to burnout]? ... I think back to some of the GPs I knew early on who – the ones without HIV – who were sitting on one side of the desk saying, you know, “That could have been me on the other side.” And a very, you know, quite strong identification with their patient. [KI_01]

For some of these key informants, gay identity was deployed as a necessary condition for the role of HIV GP; it was also proposed to have ‘led the passion’ for many of the HIV GPs they have known over the years. For others, the role that gay doctors played in the early HIV response in Australia was believed to have produced an unsustainable merging of personal

and professional identities and – perhaps because of this – to be discouraging some younger gay doctors from becoming involved today. These extracts imply that one of the things that moves a GP to work in HIV is that they are often gay men themselves and they have a desire to care for their own communities, even if this doesn't account for the considerable number of female and heterosexual male doctors providing HIV care around Australia. What is most consistent across even the variations within these themes is the assumption that the politics of HIV work has to have a good and close fit with the personal belief systems of GPs in order to effectively engage and maintain their interest over time.

Discussion

The conceptual description we proposed in Figure 1 illustrates both the breadth of themes we identified in interviews with policy key informants and some of the relationships that we believe contribute to their meanings. By describing these themes and organising them into distinct dimensions, we show how particular ideas are being produced here about what moves a GP to pursue and sustain a special interest in HIV, but also how these are seen to contribute to shaping the 'culture of HIV medicine'. While some of the perceived dimensions of the HIV GP role may be typical of other parts of the general practice workforce, our analysis suggests that it is the particular combination of these clinical, professional and political dimensions that policy key informants believe is most special here, and therefore what is likely to be of most use in growing and supporting the HIV GP workforce. As a summary, our results suggest that policy key informants believe that what moves a GP is: 1) how the *clinical* work of HIV medicine is represented; 2) how the *professional* opportunities and obligations of HIV medicine are balanced; and 3) how the *politics* of HIV work fits with the personal beliefs of individual GPs. In addition, our policy key informants believe that individual GPs are moved by their 'generation' and stage of career, number of HIV positive

patients, and own sexuality. Another factor noted in the data but not featured in our analysis was geographic location, an important issue for all Australian GPs.

There are two main limitations to our approach which are useful to acknowledge. The first is that, in this paper, we are researching the Australian clinical workforce without incorporating their direct accounts. Our aim here was to explore how senior members of organisations which shape HIV care policy think and talk about the role of the HIV GP. As policy theorist Colebatch suggests, the process of developing policy involves ‘interpreting the world in a way that makes it appropriate to address particular situations in particular ways’ (2009, 30). Therefore, while this particular paper is limited to considering the view of policy ‘makers’ and ‘shapers’, exploring these accounts can nonetheless provide valuable insights into how these workforce issues are conceptualised and therefore how they are likely to be addressed. Forthcoming analyses will focus on how Australian HIV GPs themselves describe their work and their reasons for engaging with and maintaining an interest in HIV over time. Another limitation of this paper is that we are focused on a particular clinical role – the Australian GP who prescribes HIV medication – that is not necessarily common in other parts of the world. Nonetheless, while our findings are not directly generalisable to other HIV and health service settings, we do believe that the way policy key informants talk about the role of the HIV GP has relevance to other settings and to other professional roles, particularly those facing workforce shortages and those represented as challenging or under-served areas of medical practice, at least in the developed world.

While the health workforce literature is predominantly focused on the economic and structural factors that influence workforce recruitment and retention (e.g. Collyer 2007), other parts of the interdisciplinary social and behavioural sciences literature can provide useful guidance in interpreting our findings. In particular, the sociology of the medical professions can help us to think through why the representation of HIV medicine might matter to GPs in

making decisions about an area of special interest. For decades, this branch of medical sociology has shown how medical specialties and sub-specialities are socially produced and reproduced both within the medical profession (e.g. Friedson 1970) and in relation to other forms of health and medical practice, such as alternative medicine (e.g. Saks 1994). Research from the UK has argued that professional boundaries both within ('intra-professional') and across ('inter-professional') medical specialities are undergoing change and negotiation through the governmental process of establishing and regulating special interest areas for GPs (e.g. Martin et al. 2009). Those authors have proposed that the increasing specialisation within general practice is more broadly consolidating the dominance of the medical specialist over the 'cultivated all-rounder' (Pickard 2009, 263). Our analysis suggests that similar processes may be underway in Australia, with the role of the GP with a special interest in HIV characterised as particularly 'unique' in contrast with the role of 'ordinary' GPs, which has a similar (if unspoken) implication that specialist medical roles are more 'special' than generalist ones. In this context, the way in which HIV medicine is represented is likely to mean a great deal for GPs who are increasingly expected to develop particular competencies in their medical practice. Their areas of special interest can therefore take on the significance of a major career decision, which may be why so much seems to be riding on how the clinical nature of this area of interest is constructed and communicated.

The psychological research on the role of individuals' values in medical career decisions may also be of use in interpreting our findings, particularly those relating to how GPs negotiate and balance the professional opportunities and obligations attached to the field of HIV medicine. This is still a relatively focused area of research, and usually based on the assumption that a 'commitment to a career specialty depends more on values than on any other factor' (Borges and Hartung 2010, 780). For example, the value of 'benevolence' has been associated with identifying primary care as a specialty aspiration among US medical

students (Schubot et al. 1995), and with higher levels of professional satisfaction among US family physicians (Eliason and Schubot 1995). Other researchers have suggested that having a ‘societal orientation’ as a medical student is related to choosing family medicine/general practice as a career (Wright et al. 2004). This research indicates that medical students who pursue general practice are often motivated by more than money, prestige, or any of the other professional values traditionally associated with a medical career, which suggests that GPs are already more open to taking on ‘challenging’ areas of special interest or work with ‘marginalised communities’ than medical practitioners in other specialties. However, what is less well understood in this literature is which values or value systems might motivate a GP to take on work (and to keep on taking it on) in an area such as HIV, particularly if it represents only a small part of their general practice work. There are important opportunities here for health workforce research regarding how values influence GPs at different points in their careers particularly in terms of the areas of special interest in which they are engaged or open to pursuing, and how these values may change over time along with changing patient needs, health systems, and social contexts.

Collyer has argued that health workforce research needs to take better account of the ‘social factors [that shape] the labour market as a whole, both nationally and internationally’ (2007, 250). Some of the broader social factors that are of relevance in helping us to understand how policy key informants describe the role of the HIV GP include the rollout of effective HIV treatments, the governance of general practice and other areas of medicine, and the ageing of the Australian population. While each of these should inform policy that aims to support and grow the HIV general practice workforce in Australia, the factor that seems most unique to this field of medicine is the changing politics of sexual identity. Our policy key informants both proposed and challenged the idea that HIV GPs are connected to this area of work by virtue of their own sexual identities. While there is little doubt that a deep personal

identification between doctors and patients in this sector in the early years led to both vocational passion and – in some cases, at least – to emotional burnout, the idea that the sexual identity of practicing clinicians needs to ‘match’ with that of their patients seems quite particular to this area of medicine. Most of the (rather limited) literature on gay- and lesbian-identified doctors focuses on their experiences of homophobia (e.g. Burke and White 2001; Chur-Hansen 2004; Risdon et al. 2000), rather than proposing a particular association between sexual identity and chosen areas of medical practice. However, this may well simply reflect the lack of opportunities for research funding on this topic. Sociological and historical research suggests that sexual identity has changed over the past few decades, alongside and in connection with the unfolding of the HIV epidemic, and in response to increasing social and legal acceptance of sexual minorities, particularly in high income countries. This ‘post-gay’ thesis suggests that gay men and lesbians no longer need to organise their sense of self around their sexual orientation (Reynolds 2007; Seidman 2002), which flows through to their choices of friends, social environments, and work. If you accept this argument, then it follows that gay men may be less likely to continue to (typically) take on the role of HIV general practice doctor, and other kinds of motivating factors will take their place. While it remains to be seen what those factors are likely to be and how successful they are in growing the HIV general practice workforce over time, there is little doubt that there will continue to be a need for the personal beliefs of doctors to have a good ‘fit’ with the politics of HIV care.

Conclusion

In response to a gap in the literature on what moves a GP to pursue or sustain a special interest in HIV, we examined how policy key informants describe the role of the HIV general practice doctor. While some of the perceived dimensions of this role may be typical of other parts of the general practice workforce, our key informant interviews suggest that it is the

particular combination of clinical, professional and political dimensions that constitutes what is most special about the role of HIV GP, and how these contribute to shaping the ‘culture of HIV medicine’. Making use of the breadth of insights that are available across the interdisciplinary social and behavioural sciences is useful in thinking through how medical practitioners become and remain engaged in the care of people living with HIV, with broader implications for the engagement of health professionals in challenging or under-served areas of medical work in developed nations.

Acknowledgements: Many thanks to the key informants who agreed to take part in interviews for this project. Thanks also to our Expert Committee members including Ms Levinia Crooks AM, Mr David McGuigan, Dr Mark Bloch, Mr Ian Watts, Dr Ronald McCoy, Ms Linda Forbes, Dr Jeanne Ellard, Associate Professor Marilyn McMurchie OAM, Dr Catherine Pell, Dr William Donohue and Dr David Ellis. This study was funded by a Project Grant (568632) from the Australian Government’s National Health and Medical Research Council. In addition to competitive grant funding schemes, National Centre in HIV Social Research projects are partly or fully funded by the Australian Government Department of Health and Ageing.

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Figure 1. Perceived dimensions of the role of HIV general practice doctor in Australia

