Submission No 113

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

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Rural Health Submission

I am a Doctor in Cooma and work in general practice and at Cooma hospital looking after ward patients and in then emergency department.

There are so many inequities for rural patients, below is a list of some of these.

Patients who are brought into Cooma Hospital in the evening often have to be admitted overnight as they have no transport home. The Taxi service doesn't run at night, and they may not have relatives or neighbors who can transport them home. This is not ideal, and results in a lot more Doctor and Nurse time as the admission process is not quick. Medication must to be charted and checked. There is no easy solution to this.

Community access to GPs is limited. Many towns just do not have enough GPs. Bombala which is just over 1 hour from Cooma is struggling badly with GPs retiring and the remaining GPs all near retirement. As we are already busy in Cooma, its hard to justify driving over an hour each way to see patients in Bombala, when we are already fully booked in Cooma. For these situations there should be consideration of a travel subsidy to try and attract nearby Doctors, ie from Cooma, Bega, Pambula in this case.

Again for patients in Cooma and many smaller places, if they have a fracture, the treating doctor at the local hospital will check with the nearest orthopaedic department about treatment and follow up. Usually the suggestion is the patient should travel to the fracture clinic for review in the next week. These consultations are sometimes necessary but often just a 30 second look at an xray and the patient is sent home, loosing a day of work for them and the person driving them.

Most of these could be done by teleconsult, with the local hospital facilitating this . The xray can be done locally and plasters can be done locally. If the teleconsultation identifies any issues then the patients can get transferred. This could be local, but could also be a statewide run system for smaller hospitals able to access a NSW wide tele fracture clinic.

In most small hospitals in NSW patients are discharged home without any medication. Usually this is because there is no pharmacist at the hospital every day. So the doctors write scripts for the patients, which they can then collect. This is probably violating some federal/ state agreement as I understand it, but there is no other solution. In the past this was not too hard to do. But now as more and more medication require special authorizations it is becoming almost impossible to do with the IT systems in the hospital. In Cooma we will often write these prescriptions at our practice with the GP software and then take the prescriptions to the hospital for the patient. The hospital IT systems can't write prescriptions. Handwritten prescriptions for authority medications are time consuming. This gets done as otherwise patients will suffer.

In Cooma we have gradually lost various specialist services. We used to have a visiting plastic surgeon once a month. This stopped years ago and the hospital will not replace them. The hospital says there is no demand, because they are unaware of all the patients now having to travel great distances to see a plastic surgeon for skin cancer surgery. As a result a number of local GPs now do a lot of skin cancer surgery, which is excellent, but some patients who should be seen by a plastic surgeon are not able to see one, and will tell the local doctors either you do this or Ill leave it. This is not ideal.

The reduction in elective surgery also has flow on effects in that as theatre gets less busy, the GP Anesthetists get less busy, and have trouble maintaining their anesthetic skill for emergencies and for obstetrics – ie caesarean sections. The feedback we get in small hospitals from visiting surgeons is they love operating here. They know all the staff, and the patient flow and results are particularly good. There needs to be a push to maintain rural surgery so rural people do not have to travel large distances for services, and the hospitals can stay busy enough to offer safe emergency services. If you want to have theatre staff on call, you have to be able to offer them employment, and keeping small hospital operating theatres busy helps do this.

Rural patients often have unexpected specialist fees. If I want to refer a patient for a hernia repair, or to get their knee replacement, we are lucky to have excellent surgeons in the area who can see them and do this. But they only see patients in private, so to get an operation in the public system they must first be seen in private. The other alternative is to refer them to Canberra hospital over an hour away to be seen there via the public clinics. The local surgeon we have are excellent, but they need to be paid, and the local NSW hospitals don't provide much in the way of public clinics.

There is huge inertia in the hospital system to change and improvement. An example we have identified in Cooma hospital that patients often don't get a glucose test in the emergency department with their blood tests. The reason is that most of the doctors are used to this being done automatically with blood tests they order via the private pathology services outside the hospital. As a result, patients with undiagnosed diabetes are missed, and sometime this is not identified for days. This has been ongoing for the last 2 years. It has been rejected a number of times by the hospital executive and NSW pathology. Usually the reason is that they don't want to do this just for Cooma, but want to make it area wide. Then they cost this and say it will cost hundreds of thousands of dollars a year, and they have no money.

The Australian college of emergency medicine and the Australian pathology both support this approach. See link below. They say all emergency department patients should have glucose testing as part of the UEC test, (Urea , electrolytes and creatinine). In fact the sheet they produce calls the test a UEG – with the G for glucose.

https://acem.org.au/getmedia/57501811-e932-4c74-85be-159f0621917f/RCPA-ACEM-Guideline-v01-(Mar-13)-Final.aspx

When I ash the LHD for the pricing, which seems absurd, I cannot get it. It seems unbelievable to me that its this is actually as expensive as they say, as the private pathology companies just do it as routine testing. I believe Westmead hospital has looked at this and has been able to make this happen in their ED. We can't, and patients continue to have delayed or missed opportunities to diagnose their diabetes.

NSW needs to get statewide systems for Doctor credentialling. At present newly qualified Doctors can come to town with an Anaesthetic qualification called a JCCA. If they are on the training scheme as a GP, then its unclear and variable as to how much supervision they need if any when they are doing anaesthetics.

The IT systems for radiology in our area are outdated. Patients can get a CT in Cooma, but if their specialist wants to see it, they must take a copy of the CT scan on a CD to them. Often the specialist doesn't even have a computer with a CD anymore, and they just order another CTscan. CDs are not suitable technology anymore for what is just an IT problem.

Getting trainee doctors into rural areas is difficult. We are limited by the GP training organizations as to how many trainees we can have every year. This directly flows onto how many Doctors there are who can work in the hospital in rural areas. Although there is a rural generalist push, for GPs who do surgery, obstetrics, anesthetics etc, there is no recognition of the ED work that goes on in rural areas. The training organizations don't really seem to realize the experience trainees get in well supported rural Eds is invaluable and allows them to continue this work in the future if they wish. In the last few years, we have been having to knock back trainees who want to come and work in this area due to limitations put in place by the training organizations.

The workload in rural Eds can be much higher than tertiary centers with much less support. In Cooma we get everything, trauma, cardiac arrests etc. We also look after patients on the ward, have to do the entire patient admission without any help from ward doctors etc and are usually seeing an average of about 1 patient every 40 minutes in ED. When I last enquired about the work rate of Doctor in tertiary centers in ED, it seems seeing 1 patient every 90 minutes in some city hospitals is considered busy. And that is with full surgical, medical, pediatric, ICU etc services available to come and see patients. This variety that we get in rural areas, and having to be able to do it all is one of the attractions for rural medicine to some, but to others just leads to burn out due to the high workload.

Patients in rural hospitals struggle to get transferred to tertiary hospitals. I have had patients with worrying cardiac symptoms in Cooma hospital, and when I speak to the Cardiology registrar in Canberra, the say we will see them tomorrow and do a stress test. Then they realize the patient is in Cooma, not Canberra, and the advice changes to, you can discharge them and get the GP to refer them to a cardiologist for follow up in the next month.

This applies to almost all of the internal medicine specialties. Its extremely hard to get patients a timely transfer from a rural hospital to a tertiary center. This is a common complaint from rural hospitals. The difficulty in transfer to larger hospitals. It should not happen. If the rural hospital doctors feel they can't deal with the patients issues, then the larger hospital must just accept them. This lack of support and backup from large hospitals is a cause of a lot of rural doctor stress.

I hope these are of some use and am happy to discuss any of this.