Submission No 371

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

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Submission - Inquiry into health outcomes and access to health and hospital services in rural , regional and remote New South Wales.

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The Rural Generalist Medical Practitioner: A solution for Rural Health woes

This submission is based on the experience of health service delivery in the Dubbo / Warren / Narromine region from the perspective of a Rural Generalist doctor who has lived and worked in this region for 30 years. It is hoped that it will assist the inquiry in understanding the health outcomes and access to health and hospital services in a small area of north western NSW.

The author has viewed the Terms of Reference for the Inquiry.

The observations, conclusions and statements are made specifically from a medical perspective but they have relevance to overall clinical outcomes for patients . The author recognises the importance of nursing and allied health service provision to the clinical outcome for patients and the need for team work to optimise care outcomes.

The author acknowledges the considerable efforts of the three tiers of government to improve sub optimal health outcomes in rural Australia and requests that even more collaboration occur to enhance the focus and efficacy of those efforts –

In particular all tiers should recognise the value of the Rural Generalist Health Practitioner role as a key and irreplaceable component of the solution for many of the problems which this inquiry seeks to address.

Background of the author:

The author commenced rural medical training in Dubbo Base Hospital in Obstetrics in 1990.

The Rural Registrar position held by the author was one of the early rural training initiatives implemented by Rural Doctors Network (then known as the Rural Doctors Resource Network). In 1990 there was concern about recruiting rural medical practitioners !

A Diploma in Obstetrics was completed in 1991 and then followed a series of rural general practice locums in the Dubbo region. The author then travelled to England where Anaesthetics training was completed between 1991 to 1992. After a period of further General Practice training in Bathurst in 1993 a move was undertaken to the town of Warren assuming ownership of a private medical practice and filling a General Practice VMO (Visiting Medical Officer) vacancy at the Warren Hospital. Practice in the town of Warren continued from 1993 to 2014 both in private rooms and the Warren Hospital. In 2015 the author relocated to the larger town of Narromine and joined a long-established group medical practice. The author continued to provide service to the Narromine Hospital until

2019 when resignation of the hospital appointment was required due to personal and family health reasons.

The author continues to provide general Practice services to the Narromine Shire Family Health Centre.

The Rural Generalist Medical Practitioner role:

Until recently the author's medical career had been as a Rural Generalist Medical Practitioner (defined by the Rural Health Commissioner's definition as a doctor providing medical services in the community general practice, hospital inpatient setting and emergency / afterhours setting) in small towns.

This rural generalist role is very demanding but immensely rewarding professionally and personally.

In larger regional centres (e.g., Mudgee Forbes Parkes Cowra) there is often an opportunity for a Rural Generalist Medical Practitioner to work in a team / group practice where an individual practitioner may pursue a specialty interest in their hospital practice (e.g., Surgery, anaesthetics, obstetrics) knowing their colleagues will provide support in other disciplines.

In a small town (< 5000 people) it often means there is no other medical practitioner for support. The practitioner must be comfortable in all specialty areas of medical practice.

The training and experience gained in a larger regional centre may not prepare a rural generalist doctor well for practice in a small town.

It is well recognised that small towns (<5000 people) are generally "under " or "undoctored ", more so than the larger regional centres.

The utilisation of locum or "fly in fly out" (FIFO) medical services to fill Rural Generalist positions in small towns has occurred for more than 20 years. This has proven a poor substitute service for a resident Rural Generalist medical practitioner. Patient feedback is generally negative and chronic and complex health problems are poorly managed if they are managed at all.

There is an opportunity for improvement in the training of Rural Generalist Medical Practitioners appropriate for towns of less than 5000 residents by the NSW Health Rural Generalist Training Programme to more adequately serve the medical needs of the north western NSW region .

Undergraduate Medical Training – Preparing for the Rural Generalist role:

There has long been a recognition of the need for more rural generalist doctors in NSW. There has been much research conducted by university medical schools on undergraduate

medical education and the factors that lead to recruitment and retention of rural generalist medical practitioners.

The author understands from the research that the best way to ensure increased numbers of rural generalist doctors is to provide long periods of undergraduate training (extended clinical clerkships) in rural general practice.

Very few Australian medical schools offer extended undergraduate clinical clerkships in rural general practice. Where they do (e.g., James Cook University medical school) there are increased numbers of Rural Generalist doctors being trained and deployed.

There is an opportunity for improvement in the training of medical undergraduates by the university medical schools in the north western NSW region to serve the medical workforce needs of the region in which they are situated.

Virtual Care.

NSW Health is currently utilising a system of health care delivered by video conferencing in many small western NSW towns. This is called "V Care "("Virtual care ") . The author understands it is part of a broader NSW Health electronic health strategy which includes, but is not limited to, enhanced electronic medical records, clinical role substitution, data analysis and the use of artificial intelligence methodology to assist in service deployment, evaluation and redesign.

Virtual care has been utilised in the US for some years (see averaecare.org). It is not a new idea. In the US it is used alongside face-to-face services to enhance medical service delivery. The author has worked as a rural generalist medical practitioner for NSW Health alongside virtual care and this has resulted in enhancement of clinical outcomes for patients.

The author is not aware of any evaluation of virtual care which indicates that it provides equivalent or superior health outcomes for patients when used in isolation.

Regrettably in north western NSW virtual care is frequently the default medical service delivery methodology and therefore it is used in isolation.

The author has observed, when this service is used in isolation, that there is a high chance of good clinical outcome if the clinical needs of the patient are easily identified and the management requirements are clear. (e.g., acute heart attack)

When the clinical needs of the patient are undifferentiated (e.g., fatigue) there is a heightened risk of adverse outcomes for the patient. The second example would be best managed by a resident Rural Generalist doctor but as already reported there may be a locum doctor or a FIFO doctor or no doctor at all.

There is a role for virtual care to enhance medical service delivery in north western NSW but it is not at this point in time sufficiently mature or evaluated to substitute for face to face medical service provision. Virtual care is effective when used alongside the Rural Generalist Medical practitioner.

Conclusion :

Although the author no longer works as a Rural Generalist Medical Practitioner he receives informal unsolicited negative patient feedback on a daily basis in his general practice work in Narromine.

The negative feedback mostly relates to difficulty accessing face to face medical services and the utilisation of virtual care services in the Narromine and Warren hospitals. The author understands some of the feedback has been forwarded to government representatives , Local Health District community representative bodies and health care complaints authorities .

In recognition of the heretofore unprecedented community disquiet this submission is made with a hope that the committee will advocate for the Rural Generalist Medical Practitioner role as a key and irreplaceable component of the solution to the rural health care challenge.