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

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Partially Confidential

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RDA NSW/RDAA

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Dr Ruth Stewart, Rural Health Commissioner

ACRRM

I write with some observations, examples, and opinions concerning the inadequate health workforce in Rural NSW, much of which would also be pertinent to the rest of Australia.

In November 2020 I was asked to do a locum for Lake Cargelligo hospital for 3 weeks over Christmas/New Year and then to do a locum in Temora, including some hospital VMO work. I was willing and able to work for 2 weeks for Lake Cargelligo Hospital from 28th Dec 2020 then 2 weeks for Temora. I was also able to do some on call shifts for Grenfell Hospital in Dec.

However, for each of these hospitals, the paperwork required to obtain approval from NSW Health to work in their hospitals was so onerous that I have declined (I have attached part of the emails detailing these requirements). I do not believe any of the paperwork is necessary – I have been working for NSW Health for almost 40 years – why on earth do they require another copy of my graduation certificate or proof of identity, etc, etc, etc. No one from these hospitals or NSW Health has made any attempt to contact me to ask what is the problem – I suspect they already know but are unwilling to fix it.

I know Grenfell hospital ended up without a doctor in town – not ideal for a population of 3-5000.

As it turns out, the media apparently heard of the situation and made an enquiring phone call to Murrumbidgee Local Health re Lake Cargelligo. The following day (22nd December 2020) I was phoned and advised that I could get a contract to work at Lake Cargelligo without the paperwork after all. The contract was available 2 days later and, fortunately, I was still able to help Lake Cargelligo out for 2 out of the 3 weeks, at very short notice. The same process the flowed on to allow me a contract at Temora as well. It seems wrong that it took a media phone call, rather than the community need to create a solution.

The other huge fact in NSW Health is that the introduction of electronic health record and especially the electronic medication record is extremely inefficient and time consuming. As a GP VMO working in a small rural hospital, I have estimated that the time taken to see, assess, treat and document a patient at a hospital has at least doubled and in some cases quadrupled. I suspect it is similar for nurse time and that even the hotel services now have a very significant time cost associated with their paperwork. There has been no recognition of this time cost to GPs, no compensatory increase in payment, and no attempt to minimise the effect – just more demands.

Policies, paperwork, boxes to tick and a very inefficient and no doubt costly computer system have all added a huge time burden to front line workers. I see no evidence for any increase in resources or manpower to manage this – the extra time must come from direct patient care, which consequently must suffer, despite the valiant efforts of frontline staff to maintain standards of care – they push themselves to be more efficient, are pressured and frustrated. GP VMOs spend more time at the hospital (without direct benefits to patients) and therefore less time at their private surgeries – which limits the primary care they can offer and reduces patient care and the viability of their business. More doctors are needed but less are forthcoming.

In 2017, there was a locum position in Hillston for 3 weeks. I was able to do 16 days of this locum, and, as the doctor had no other offers, he accepted mine. The position was to be the solo GP/VMO for Hillston, working in this doctor's general practice and covering the hospital round the clock for inpatients and outpatients for the period I was there.

The Murrumbidgee Local Health District then emailed me the long list of documentation required before they would allow me to work in Hillston Hospital. I applied 6 weeks before the locum started.

I donated 4 hours of my time to completing this initial documentation – but there were more emails, more demands, and more time – I was hassled about being immunised for pertussis and assessed for tuberculosis – neither of which I felt were necessary or relevant.

I very nearly reneged on my offer, but honouring my commitment to the doctor and the town, I set off on the 7 hour drive to Hillston still not knowing if the MLHD was going to approve a contract – I had just decided that at least I could offer a GP service to the town. The contract was emailed during my trip.

I arrived at the hospital, after dark. Contractually, I was not due to start till the following day. I immediately consulted a patient in emergency, to save them having to be transferred.

I could not log in to the computer system to record any notes for another 2 days. I was given a key to accommodation that took me half an hour to find in the dark.

My concerns were shared by her nursing colleagues. I tried to alert the supervisor to my concerns – and was thanked and assured I would be informed of the outcome – but nothing happened whilst I was there and I was never given any further information.

Whilst working in Hillston, there were at least 2 patients that would have been most appropriately treated by admission to Hillston Hospital – but I was not allowed to admit them because of "policies" – one was a policy that children could not be admitted to Hillston and the other was that a patient could not be kept on a heart monitor overnight in

Hillston. Both patients elected to go home, against my better judgement – they were not quite sick enough for me to insist on a transfer to Griffith Base Hospital but it would have been far safer to keep them in hospital overnight, where rapid re-evaluation could have occurred if they deteriorated – especially for the child who lived 30 minutes from town. These are not the only situations I have faced over the years where burgeoning policies have got in the way of best patient care.

I asked the MLHD to pay me a flat retainer rate for my VMO services – an average of what they normally paid as a fee for service rate – but they refused. I donated a further 8 hours of my time entering my hospital account onto Health's non-intuitive computer programme – several hundred dollars of my legitimate claims were rejected and never paid. Of the 4 privately insured patients that they insisted I bill privately, only 1 ever paid their bill at all – months later – I did not have the heart, the time or the resources to chase up any of this - I gave it all up as a job that had required a lot of extra admin work on my part with only poor treatment in return.

Thankfully, I helped to achieve a few good outcomes for patients, which is why we keep trying. The patients were grateful.

In 2019, I accepted a locum position in Gundagai – this time the contract again appeared only after arrival but at least without as much time wasted on emails. However, for my first VMO shift at the hospital, a ward round and outpatient assessment that should have taken 2 hours, took 6 hours, due to multiple computer glitches and no nursing staff allocated to assist me or orient me or even give me the computer passwords – with the end result that I was quite psychologically distressed by the time I made it back to the private general practice to see the patients that were booked in.

Which brings me to my recent offer to work in Temora and Lake Cargelligo – when I saw the long list of requirements, none of which I consider relevant, and the name of the workforce, I could not risk further severe stress before I even started.

I feel that NSW health gives lip service to trying to get doctors onsite in small hospitals, but the processes are so obstructive that many doctors such as myself withdraw their services in frustration. We are capable of providing great clinical care but are not interested in admin demands that waste our time.

I believe that much of what I have said can also be said for nursing staff and other frontline staff in rural hospitals. I can no longer speak for metropolitan hospitals. I believe it would improve patient care to vastly streamline requirements, and improve on-the-ground support – front line staff should be acknowledged as valuable assets and treated with care and respect.

Those of us who put ourselves up to work in these small towns, with minimal resources, do so mostly for the sake of the communities we serve. We see a need and we want to help. We are clinicians. We thrive on providing good, direct patient care and achieving good outcomes. I believe that the administrative hurdles are most obstructive to the doctors who are best at direct patient care. The hurdles have worsened since I first moved west 30 years

ago – this is not a problem that can be fixed just with a new rural generalist training program.

It is well known that there are insufficient rural doctors. Many rural towns are struggling with locums and or telehealth where once they had their own residential Rural GPs/VMOs.

I believe there are many things that could be done at an administration and ministerial level that could remove some of the obstructions and disincentives that are driving current doctors away prematurely and preventing enough new doctors from taking up these positions. For example, I see no need for the multiple documents required for credentialling. It is easy to check if a doctor is registered and whether there are any conditions associated with the registration. We have to maintain CPD and medical indemnity to remain registered. We also have to have a medical degree to be registered. Relevant questions could be confined to 1 page and referee checks should be conducted per phone but could be easily limited to 5 minutes or less – it is very easy to ask pertinent questions that establish if there may be any issues. A WCC and police check could be conducted every 5 years, at Health Dept expense and lodged nationally or copies sent to the doctor so that other states have access – to allow doctors to easily move between states to work. This alone would save the health dept many dollars in Admin costs and be far less obstructive to doctors willing to take on these VMO roles.

I believe these things would also save money, without adversely affecting the safety or outcomes of patients – in fact outcomes would be improved because there would be more resident doctors in these little towns. Then the Rural Generalist Training Program will have a leg to stand on.

I hope my suggestions are helpful. I'm happy to expand where necessary, for further understanding.

Background: I graduated from Sydney University medical school in 1981 and worked for the first 9 years as a doctor in Sydney, mostly at Royal North Shore Hospital, mostly in the emergency department, but spending intermittent periods on secondment to country hospitals.

In 1990, having married a rural man, we moved to the small town of Lake Cargelligo, in the Far West of NSW, to assist the one other doctor in that town.

In 1990, when I was the only doctor in town, I was called at midnight, to a car accident, 8 km from town. I arrived on the scene to find the one ambulance officer on duty already there, along with police and volunteer SES crew. The car had left the road and hit a tree, head on. The male driver was deceased in his seat. His front seat passenger was sitting upright in the seat, deeply unconscious, with a smashed face, noisy, laboured breathing, a likely fractured femur and unknown other injuries, trapped.

The car was cut open by the emergency crew, to allow us to extricate this young man and we arrived at the hospital with him 2 hours later. There was 1 registered nurse, 1 nurse assistant on duty for the night, joined by the hospital matron (who was always called for emergencies) and myself. We worked on this young man for the rest of the night until retrieval arrived by fixed wing aircraft at 6am and airlifted him to ICU at RNSH.

We intubated him, stabilised him on a ventilator; gave him IV fluids and antibiotics ; stabilised his fractured femur in a splint; assessed him repeatedly for other injuries; got a chest Xray (I was the nearest thing to a radiographer the hospital had). When we had him as stable as we could manage, we started to suture some of his less serious wounds and his aunt baptised him whilst we did.

I attended his friend's funeral, along with the community, a week later and regularly rang the hospital for updates on his condition. I actually had cause to go to Sydney a month later. I visited him in RNSH ICU, where he was still unconscious and ventilated. He remained unconscious for many weeks and eventually made a recovery, though with some brain damage.

I give this as an example of the type of incident that would occur about 4 – 6 times a year in this little town – I estimated that I would personally deal with a harrowing situation such as this 3 or 4 times a year in the 8 years I was at Lake Cargelligo and then over the 16 years I was in Forbes. I'm sure they occur regularly all over rural NSW. I know what can arrive on our doorstep anytime – That we may be thrown suddenly into a seriously stressful situation at a moment's notice and then deal with it as best we can. I know that we cope best, and achieve the best outcomes, with a cohesive, respectful, and preferably experienced team, with a high care factor.

Could paramedics and virtual doctors do what I did that night – partly– they could certainly intubate, insert IVs and splint the broken bones – and possibly these days a helicopter could reach this scene within 1-2 hours. There still value in having a residential GP able to respond, in person.

Ambulance paramedics and virtual doctors may not be as good at managing the unwell 9 month old boy who presented at 9pm one evening, rapidly deteriorating, who turned out to have septic haemophilis meningitis – thankfully responding to rapid IV antibiotics, transfer and care in Griffith Hospital. I do believe it is much harder to accurately appraise a seriously unwell patient, particularly a small child, and a missed or wrong diagnosis is certainly more likely –having tried both, I know that I am more accurate with face to face consulting.

I know NSW Health says that they would prefer onsite doctors to virtual doctors, but I believe their actions are obstructing on site doctors, as detailed in this letter.

This incident impressed on me the value of being known and trusted by your community.