Submission re recognising Rural Generalist as a specialty.

I have been a GP for 43 years and started practice in a regional centre where the majority of bed days at the district hospital were managed by G.P.s. Many of these were proceduralists in obstetrics, anaesthetics and general surgery as well as a number having excellent expertise in particular areas such as mental health , dermatology and in those days TB.

With the influx of specialists to regional centres G,P.s were moved out , so to speak.

Having spent the last 2 years doing locums in 2 smaller hospitals I have very been impressed with the skills of the local G.P.s and nursing staff who are routinely managing difficult cases , often in elderly people for whom the local hospital provides better care for their paticular condition than in the regional centres where communication with younger and less experienced medical teams can be problematic. My experience in these hospitals is that it is mostly very difficult to get timely transfer to larger centres and in any case many patients and family's want admission only if they can stay in the local hospital. This especially happens with aboriginal people who have a trusted G.P.
To be able to manage the more difficult cases there is a need for a specialty with a higher degree of training and experience than I had seen in the more recent batches of G.P. Fellows who I have trained , among whom I have yet to meet one who actually wanted to be on call outside business hours , let alone work in a small country hospital.

The doctor I am currently locuming for is trained in radiololgy, ultrasound, can do thrombolysis , intubations, in other words is able to cope with most emergency situations in the ED, is able to do guided joint injections and generally provides a terrific service to his community. The downside is that he and his registrar are providing 24 hour care for 4,000 people on 1 in 2 call, with earnings that are barely more than a city based , care planning , co-billing, 9 to 530 GP looking after a fraction of the number of patients. One hope would be that a higher level of specialist recognition would prompt governments to try and reward these doctors better.

I relieved in palliative care for 4 months last year on the northern tablelands of NSW as many people were being palliated without actually having access to a doctor. I was shocked by the exodus of older G,P,s without any younger replacements. I can also see loss of nursing expertise in these hospitals when often there is no on call doctor and they become simply triage and transport stations.

On a side note, I mentioned the experienced nursing staff, where I have found scores of RNs who perform routine triage , workup, appropriate blood screening, canulation and IV therapy more efficiently than I have seen by doctors in larger centres. Without the support of a doctor none of this can be done and when there is no doctor these hospitals are put on bypass. On a lighter note I asked an RN who had diagnosed and treated an 80 y.o man septic from pneumonia and had the appropriate bloods and cultures done in the 20 minutes it took me to get to hospital, why I needed to come. Answer..you got the expensive insurance.

In summary the 2 points I mainly want to make is firstly, that there is a need to recognise the Rural Generalist who needs to be trained to a much higher level than the level needed for office general practice solely on the basis that these doctors are required to be VMOs in a hospital setting without direct specialist cover.
Secondly the Rural Generalist will always be part of a team involving colleagues and experienced nursing staff which essential to maintaining any rural hospital which is requires a level of expertise and experience greater than standard G.P. training.

Eric Baker