Transcript

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**Rural and remote healthcare**

**Tash Miles:** Ahpra acknowledges the Traditional Owners of country throughout Australia and the continuing connection to lands, waters, and communities. We pay our respect to Aboriginal and Torres Strait Islander cultures and Elders past and present. Welcome to Taking Care, a podcast of Ahpra and the National Boards. I’m Tash Miles. In this episode, pack your bags we’re heading out of the city to talk about the unique world of rural and remote healthcare. Living away from a metropolitan centre can affect the way we access healthcare. And it can make for unique partnerships between patients and practitioners. We’ll hear much more from our three guests who all have strong connections with our rural and remote healthcare system. Carolyn Becker is a rural health consumer and advocate. Peta Rutherford is CEO of Rural Doctors Association Australia. And Dr Angus Bowman is a cardiologist. Welcome. Angus, could you tell us a bit about your practice and where you work, please?

**Dr Bowman**: I’m a cardiologist in Central Australia and I’m based at Alice Springs Hospital which is a great place to work. But we do a lot of outreach outside Alice Springs all through Central Australia as far north as Elliot, which is halfway to Darwin, and as far south as the South Australian border. We go into Western Australia. So we’ve got this huge area we service. And yeah. My background is from country New South Wales and then I trained in Adelaide but I’ve been here for 18 months and I love it.

**Tash Miles:** Carolyn could you tell us a bit about yourself, where you live, and also the consumer advocacy work that you do?

**Carolyn Becker**: Well way back in early 2008 I was recruited from the then Queensland Office of the Adult Guardian, now called the Public Guardian, to the Office of the Director General in Queensland Health, to start up a small consumer body. I was one of a small team of four tasked with setting up this health consumer body in Queensland to represent the rights, interests, and voices of Queensland health consumers following the Bundaberg Hospital enquiry. After leaving Queensland Health I signed up for the HCQ consumer network to advocate for the rights and interests of health consumers across Queensland. I am currently the consumer representative on the Queensland Rural and Remote Clinical Network and the steering committee. The Queensland Health Rural and Remote Workforce Project which is FORCE and the Consumers Health Forum of Australia. It’s a rural and remote special interest group. I have lived experience of being a health consumer and of being a carer for my late mother and my late husband. And I’m currently the carer of two sons with disability who live in nearby regional Toowoomba.

**Tash Miles**: Thanks, Carolyn. Peta, could you introduce yourself and tell us a bit about your role please.

**Peta Rutherford:** I’m the Chief Executive Officer for the Rural Doctors Association of Australia. And we are a membership body representing the interests of rural doctors across Australia that work and live in rural and remote communities. It’s a privilege to work with the doctors who have a genuine and true commitment to their communities. And we often see them go above and beyond on a regular basis to ensure that their local community continues to have access to medical services. And it’s challenging and certainly over the last couple of years the challenges have increased. The pressures have increased. I joined the Rural Doctors Association after working as a hospital manager in Kingaroy in the South Burnett region and prior to that out in Charleville. And even before that a number of years in Queensland Health as well. So it’s something that I’m passionate about and consistently as I meet more and more rural doctors some of the old hands that have been in the game for a long time but also the next generation coming through, I continually am inspired by their commitment, their energy, and their innovation. And it keeps me motivated and I love the job. And it’s a privilege to work with them every day.

**Tash Miles:** Thank you and welcome. Peta, looking at our health care system could you tell us about some of the differences of distribution that you see when looking at rural and remote healthcare versus metropolitan?

**Peta Rutherford:** The distribution of our medical workforce, the challenge is real. And we see well over 400 full time equivalent doctors per 100,000 head of population working in our capital cities and even our largest regional centres. But the more remote you go, and the rural and remote you go, we see those numbers significantly drop off. And while we have GP’s often in these communities, there are also doctors that are working in general practice that provide the service to the hospital. They’re also within the hospital doing every element of medical service. A lot of these doctors don’t have junior medical staff to provide them the support that consultant specialists enjoy that work in the cities. We have very very few consultant specialists. So what we often see is rural doctors work to their top of scope to enable care to be provided close to home. And it’s not to say that they’re better but their role in rural medicine is different from what their, say, GP colleagues would have in a capital city. And there is more access to Allied Health Services. There’s more access to consultant specialists to refer on. It is different. It’s not better. But it’s different.

**Tash Miles:** And, Carolyn, could you add to this? Could you speak to this from your experience and maybe from the experience of those patients and communities who you advocate for?

**Carolyn Becker:** I’m consistently hearing consumers say they want their small local hospitals to stay open and to be better resourced. Beds, staff, equipment. And a greater range of diagnostic services. One of the quotes was they want to grow old at home and stay in the community they’ve dedicated their lives to.

**Tash Miles**: What are some of the examples of things that you would like doctors to understand about where you live?

**Carolyn Becker**: One of the things of course, particularly if you’re looking at some of our Indigenous population or some of the people from culturally and linguistically diverse populations that have moved, that there is an understanding of what is important to those people particularly that connection to country. Each community is different. There’s no one size fits all and so they need to be able to be immersed. Whether that’s a community when they welcome a new doctor, that they have an orientation program where they are involved, they meet the community leaders, they meet other people. So it becomes a two way street where they’re working together in partnership for the best outcomes for everyone.

So certainly for me, and from what I’m hearing, is when we go into a practice and we’re told your doctor is not here today, he’s off in a course, or he’s having a much needed sabbatical, you see someone new. And they may not be so conversant with the local system. And sometimes you’ve got to rephrase the way you speak to this person to get them to understand your own particular health needs. And maybe some of the treatments that you’re having. And particularly if you’re travelling to a major metropolitan hospital or a regional hospital. That they’re familiar with those practices.

One example I can come up with was being discharged from a major metropolitan hospital to the care of GP’s. Unfortunately the person that I saw he was a locum. Didn’t understand the whole referral system. And how the hospital was able to help. It was in relation to cancer care. And all the services that were available. And in fact I felt like at times I was wasting my time going. So it’s how they learn that. And I’m saying, like all of use, we have to learn. It’s getting them to understand where you’re coming from and where your community is coming from as much as possible I believe.

**Tash Miles:** So, Angus, what’s your take on the different types of relationships between patients and doctors in rural and remote settings. For example I imagine where you work you must have fly in fly out or FIFO and also practitioners who live in community.

**Dr Bowman:** I think of course you need people who are going to live in the community and live in rural areas but you also do need people who can fly in and fly out and have a long term relationship. So somebody might fly in and fly out not necessarily for three months or six months but who might do that three times a year for ten years. And we’re lucky enough to have a cardiologist here at Alice Springs Hospital – a number of cardiologists – who have done that for ten or twenty years. Who have visited Alice Springs for that period. And I think that’s really important. They provide the service that way. And then you also need people who can live in the area and provide the service. So I think that’s important. And that’s a challenge to get people to come out. But we’re lucky in Alice in some respects too that people are willing to come here because it’s somewhat of a unique place in terms of culturally and then the landscape and patients coming from remote areas.

I think the other thing too though is even here at Alice Springs Hospital and probably throughout the country you know, my practice is based in a base hospital really and we can provide services here. We’re providing really good services here. For cardiology we do everything apart from angiograms and pacemakers. We can do cardiac MRI here. We can do echoes and stress echoes, TOEs, we see patients. But even then we are a really long way from a lot of our patients. So we can provide the services here but you’re still asking a lot of patients to get there and often I think the system puts the onus on the patients. So a really good example of that is some patients – we organised CTCA for a lady and she said, “No problem. I’ll come in.” And she lived in a remote community. And we knew she was going to have to catch the bus in three or four hours to come in.

But it just so happened that her test happened at a time we had a lot of rain in Central Australia and all of the remote rivers had flooded. And the bus got caught at the river. So it had got about halfway. So she didn’t have a car. Her husband joined her. They managed to hitch a lift to the river. Got out swam across the river. And then got on the bus and got the bus into town. Come in town. Had their CT scan. And that’s really all they needed and I felt a little bit bad that we couldn’t do more for them but they were quite happy to have got the scan, hop back in the bus, went out and then crossed the river again, went back to their community. And I think that just kind of shows the lengths that patients will go to access services are incredible.

And then maybe it’s incumbent on us sometimes too to think about, well what can we do to make that a little bit easier. Can we book other appointments at the same time as a matter of routine? Can we try to integrate services? And that can be pretty difficult I think. But the idea of being able to integrate services especially between departments – if you’re coming in for your cardiology appointment and you’ve got an obstetric appointment perhaps that would be a really good thing to link up. We’ve had examples of that as well. Of patients having those appointments three or four days apart and travelling five hour drive each way back and forth rather than asking for the appointments to be rescheduled. Again because I think patients often feel the onus on them to make the appointments and not necessarily willing to ask the system to bend and change to perhaps help them. And I think in a lot of instances we’d be happy to do it but maybe we need to be proactive and say, “Hey this is an option. And we can change the system to satisfy you a bit and work in with you if you’re travelling 600 km down a dirt road.” Especially from remote Indigenous communities. It’s a huge thing we ask of people.

**Tash Miles**: What is the proportion of patients that you see who live say “locally” to that they need to be travelling five plus hours to come and see you?

**Dr Bowman:** Oh, probably 50 – 50. Not a small proportion live in remote communities and travel a good distance. We do outreach and we go to remote communities to see patients to try to relieve that burden. We do an outreach trip on average once a fortnight. But even then a lot of these investigations we can offer are in the city in Alice Springs. In some respects we’re in a rural area in Alice but we’re also the city in some ways. So we kind of see both sides of it. Yes. It’s a rural area. But we can provide services and patients have to come from a remote area in.

I saw a patient yesterday who had come from Elliott – which is halfway to Darwin – and he came into my clinic at 9 o’clock in the morning with his overnight bag and his pillow which he had had on the bus. And he’d got on the bus 9 o’clock the night before, travelled on the bus the whole way down to see us. Came in. I saw him and then signed his PATS form and he was getting back on the bus that night to go back up. Which is incredible. And I think, again, it’s another example showing that he values the health care but sometimes the system doesn’t necessarily recognise what we’re placing on patients and asking of patients. And maybe we could be a little bit more flexible. It’s nice in retrospect. It’s hard to be proactive about that though and head it off at the pass.

**Tash Miles:** I wonder, Carolyn, whether you have an example of the other side of the coin where you might have had a rewarding experience that typifies the experience of accessing rural and remote health care when it’s really meaningful and valuable?

**Carolyn Becker:** I’ve probably had a few of those. I’m just thinking back. Probably two or three years ago I went to a practice in the Lockyer Valley and unfortunately he misdiagnosed my cancer. He had actually said oh it’s just a condition of aging. And it took me a few weeks to get the courage and the encouragement from some colleagues at Ipswich Hospital to go back. And this time I requested to see another practitioner. This person really listened to me and he examined me thoroughly without presuming what could be wrong with me. And in fact he said, “I believe it’s such and such. I’m going to organise a whole lot of tests for you and we will see. And as soon as the results are back, come back.” And when I did get the results – and they weren’t wonderful results – went back. He was very compassionate. Very caring. He said, “I will get this referral through to” what was then the Ipswich Hospital. And he made sure that referral got into the right people’s hands. And from there I was able to feed through to the major tertiary hospital in Brisbane. I guess Brisbane South. And a pretty good outcome ensued from that.

**Tash Miles:** Angus, is there a difference in your relationship between the FIFO patients versus the ones who come to visit you?

**Dr Bowman:** One thing that’s unique where I work is that you’re FIFO-ing into remote Indigenous communities and you’re FIFO-ing into people’s Country. It’s their land, it’s their County, and I think there’s somewhat sometimes a little bit of a different dynamic there. Patients often feel a lot more comfortable. And even coming to Alice Springs can be an imposition and I imagine perhaps I think sometimes a little bit of a difficult and unwanted thing to do for patients. So when you get to go to patient’s Country, patient’s communities, and see them on their terms I often find that that’s actually a really nice thing. And you get a really nice insight too into people’s culture and what Country is like and have nice discussions about what life is like in that area.

For instance, I go to Kintore on the Western Australian border once a year, and I love it. And it’s a three hour flight to get there from Alice Springs in a RFDS plane. And you get out there. You spend the whole day there. Patients are a long way from Alice. Pintupi Luritja people and you hear their stories and hear what they do. And you just get a totally different perspective. So that’s fantastic and my patients are really relaxed and happy because they’re in their own environment.

**Tash Miles:** When you go out and see patients on Country, do you learn anything about the bush medicine or integrating that as kind of like a holistic care? Is that at all part of what you do?

**Dr Bowman:** I haven’t spoken to anyone specifically about bush medicine on remote trips. I’ve spoken to them about Dreaming stories or what created the mountains behind a certain – in Kintore there’s beautiful hills and mountains behind there and you get a little bit about those stories. I do have patients that want to see a ngangkari first.

**Tash Miles**: I imagine ngangkari are not unusual for the work that you do where you do it but for our listeners, ngangkari are traditional Indigenous healers. Go on, Angus.

**Dr Bowman**: I’ve had a patient in particular before an operation he wanted to see two or three ngangkaris. He wanted a second and third opinion. Which I thought was good. And which we completely facilitated and did. And at the end of going through that this patient was really happy that surgery was what was needed. And so we try to integrate into our practice. I haven’t spoken a lot to patients about it specifically other than trying to facilitate that and we bring that into our management which I find really helpful.

**Tash Miles**: Peta, do you have any other anecdotes that paint a picture of what rural and remote healthcare is like.

**Peta Rutherford**: I was out for dinner one evening with a senior doctor from Roma who had actually had a tree-change and moved from Brisbane. He had been a very renowned paediatric surgeon in Brisbane. A family came and was just so thankful to him. And I was like why? What’s going on? And basically it was if he wasn’t there, they would have been travelling to Brisbane for their child to have a procedure. And it’s like my own experience. Well my husband he was very ill when we moved to Charleville. He had been seeing a regular GP when we were living in Brisbane for many years and not really seeing any change in his health condition. And then he was lucky enough to access one of the GP’s in Charleville who is an absolute renowned legend of the bush. He turned my husband’s life around.

**Tash Miles:** Could you talk to us about the unique partnership that exists between a patient and a practitioner when they’re in a rural or remote setting and how that might be different?

**Peta Rutherford:** So for a lot of rural doctors it’s not just that it’s – you’re not an anonymous person in a rural community. The community will know who you are. And that can come with challenges. But rural doctors very quickly learn how to separate work and social. But a lot of rural doctors they get to know their community really well. They get to know the family. We hear stories of doctors who have birthed three generations or two generations but they provide care for children, for the parents, and for the grandparents. And that’s amazing. It comes with challenges though because then they’re very close. When you’re providing care to your child’s best friend because they’ve come into the hospital. When you’re providing care to the parents of your closest friends in your community that comes with additional pressure and challenge. But it’s something that rural doctors are very aware of. And the beauty of knowing the whole family and knowing your community well is something that a lot of rural doctors value and treasure and think that that has a significant impact on the way they provide care and do their medicine.

**Tash Miles:** And Angus, since living and working rural and remote do you have any stories or examples that give us a glimpse into what you do?

**Dr Bowman:** A week after I got here I knew one couple when I moved to Alice Springs who were friends from medical school. And when we got here within a week one of them had had a cardiac arrest on his mountain bike and was with a doctor and was with another friend and they did CPR on him for half an hour and because it’s a small community they could call a friend who worked in the emergency department who came straight to them. Called their friend who had the ambulance. Got straight to them down the trail, put in the back of the ambulance, took him straight to the hospital where everybody knew him and looked after him and he woke up and survived and has done incredibly well.

Tash Miles: I guess that a patient isn’t just a patient. They’re a person.

**Dr Bowman**: Also it goes the other way. When you’re the patient. You live in a country area. But I went for a mountain bike two weeks ago, fell off my bike, knocked myself out, and then had to come into hospital and spend the night here. And the doctor that comes to look after you is your friend. You know you went to the pub with them on Friday night and I got taken around to CT and I play golf with the radiographer who said, “What have you done to yourself?” And I’m not really sure. And it was actually quite lovely in a lot of ways and really nice and everyone looks out for you and knows about it. So that’s not something I would have experienced before I came here.

So yeah. You get these unique experiences being from being in Central Australia from a cultural perspective. But also just in any rural or regional area there’s just that really tight close relationship and you’ve got to be prepared to treat or be treated by friends. And I think that’s actually one of the nice things about living here.

**Tash Miles**: I got to say, this isn’t an endorsement for mountain biking this conversation.

**Dr Bowman:** No.

**Tash Miles**: Carolyn, from the patient perspective, could you speak about some of the advantages and maybe also some of the challenges for patients in rural and remote areas.

**Carolyn Becker:** One of the advantages is that you do have that closer relationship happening between health practitioners and the patients and the extended families. Because when they’ve been there and as mentioned some of those doctors have been there for two or three generations of the family so they are enmeshed in their community and they have contributed so much. So to me that is definitely one of the advantages. Because I do believe rural health care can be very community focused. And patients and practitioners do develop an interdependence in a lot of ways as long as those boundaries are kept. And I think each cohort can become enmeshed but – particularly from the professionals point of view – knowing where the boundaries lie is so important.

I heard at the recent RDAQ conference in Gladstone, countless stories of doctors being supported by community in things like picking up the children from school or a sporting match when the doctor was called to the hospital or there was an emergency at the practice. Or they had to travel out to a rural farm or something. Or answering a knock at the door because they’d been so busy and having a casserole handed to them. So it’s each giving to the other which is so important.

Some of the challenges I think are insufficient frontline staff. I heard that there are insufficient medical students wanting to take up GP roles. And particularly so many of them are not wanting to go bush because life on the coastal fringe seems attractive for so many of them. And it’s how we can change that perception. Maybe a bit of stigma about working in the bush. To actually making it an exciting prospect. A career path that is lifelong and can be rewarding for not only the practitioners but I also think for their families.

**Peta Rutherford:** One of the key things we talk about with a lot of junior doctors and medical students is that you don’t have to rural forever. We think that everyone should have some exposure to rural. And not just as medical students but as a junior doctor and because regardless, it will make you a better doctor. And it sort of links into what Carolyn was talking about before in that you need these doctors - whether they’re in the city or in the largest regional centres – to understand what a rural patient goes through. I mean one of the pet hates from rural doctors is when they ring a big city hospital and the first thing they ask them over the phone is, “Oh well can you get an MRI or can you get a CT scan?” And they’re like, “Well, no. Because we don’t have one.”

So it’s a challenge with some of those things. So we do think you know any exposure as a doctor in their junior years can actually have a huge impact. We’re obviously very passionate about it and think there’s no better career. And there’s lots of options. Whether you want general practice, whether you want to be a rural generalist, whether you want to be a physician or a surgeon, there is training opportunities and job opportunities for all of those areas of medicine plus heaps more. But the opportunity awaits. And people just really need to be willing to take that step and give it a go.

**Tash Miles:** Thank you. And now I wanted to put a final question to the three of you but I’ll start with you Carolyn, about what you think the priorities are? What you think is important for patients and families accessing health care in rural and remote settings?

**Carolyn Becker**: Well I think essentially we need to have a shift from an illness to a wellness model of care. And that goes also for our urban. But definitely out in the bush where people’s livelihoods so often depend on being healthy. I think we need to move away from that mere medical model of care which treats patients’ illness to a holistic predictive approach to health care with person-centred solutions in partnerships with the whole healthcare team. And the communities of interest. So involving the family members particularly in our small communities and in our Indigenous communities. In the ongoing care for people. So once they’ve left the GP practice or they’ve been discharged from the small hospital, when they go back to their communities, that the people that are there to support them know about their medications. Know about their condition. Know about the contraindications of medications and things. So that they actually have that support network. And that’s where if we can, in our rural communities, focus more on that holistic approach to make sure that the best outcomes for our rural and remote people will happen. Because living outside the capital cities has so many benefits.

**Tash Miles**: Thank you. Peta, do you have anything to add about any priorities for change?

**Peta Rutherford**: As a must, must put the patient at the centre. And if we can do that then we’ll get good policy. There’s certainly things from a medical (workforce). We want to see the right doctors with the right skills being trained and remunerated appropriately so that rural is an attractive option for them. And looking at the systematic issues and the bureaucracy which actually creates unnecessary barriers. It’s not adding to the quality or safety. We need to remove any unnecessary barriers from the system which prevent an easy path for young doctors but other health care professionals going rural. And we need to make sure that they’re well supported. They’re well remunerated. And that they’re given the opportunity to work to their top of scope and use all the skills that they’ve learnt and established over a number of years.

**Dr Bowman:** Yeah. That idea of systems changing and patients being at the centre of everything obviously that’s something that we always talk about and I think patients are at the centre of what we do but beyond just the decision making for the clinical problem, the whole experience with the system. The whole interaction with the system. Always do it that way. And you can see how important that is. I find too being in – been hearing and when you see patients, the things patients share with you. Living here I see a patients much more regularly and you get to know a little bit more about patients. And as I’m sure anyone would say who have had that longitudinal relationship with a patient, what you learn about them and their lives is amazing. And yeah you get that perspective of course of your patient beyond their medical condition of the whole person. And I’ve kind of learned a lot by thinking about that and outside medicine and hearing people’s stories of living in Alice Springs in the 60’s, 70’s, 80’s and growing up and bringing up their family and overcoming all sorts of barriers to success and how people have succeeded and strived; it’s amazing. So that’s something I didn’t necessarily expect actually beyond medicine. It’s just really special.

**Tash Miles**: Thank you, Carolyn, Peta, and Angus for joining me today. I particularly loved hearing your examples and stories which really demonstrate how diverse and complex rural and remote health care is. So, thank you.

**Carolyn Becker**: Thank you, Tash.

**Peta Rutherford:** Thanks, Tash, for having me. And I really appreciate the opportunity.

**Dr Bowman**: Thanks for having me.

**Tash Miles:** And thank you for listening to Taking Care. We are so pleased you joined us for this episode but we’d love you to have a look at our archives and also to subscribed by searching for Taking Care wherever you listen to your podcasts. And if you have any feedback or ideas, email us at communications@ahpra.gov.au. Take care.

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