Senate Inquiry into 'The factors affecting the supply of health services and medical professionals in rural areas'

QUESTIONS ON NOTICE

The **RACGP** response to the Questions on Notice taken by Dr Kathryn Kirkpatrick, Chair, National Rural Faculty, and tabled during the Senate Community Affairs References Committee Public Hearing held in Albury-Wodonga on 5 June 2012.

QUESTION 1.1

Senator MOORE: We should have been there. It would have been such a great forum.

Dr Kirkpatrick: It was. What struck me the most was the generosity of the participants in what they shared with us. There were lots of personal stories, not just pie in the sky; it was coming from personal experience.

Senator NASH: Is there an audio recording of that morning that we could have? Did anybody record it?

Dr Kirkpatrick: No. We have a letter that went to the health minister with the information, but I am sorry; we do not have the audio.

Senator MOORE: Can we have the letter?

Dr Kirkpatrick: We can do up a letter. That will be fine.

RURAL STAKEHOLDER BREAKFAST FORUM: MINISTERIAL (COPY OF LETTER)

The RACGP National Rural Faculty

The Royal Australian College of General Practitioners

8th May 2012

Hon. Tanya Plibersek MP
Minister for Health
House of Representatives
Parliament House
Canberra ACT 2600

Dear Minister Plibersek,

RACGP NATIONAL RURAL FACULTY 20TH ANNIVERSARY EVENT

On behalf of the RACGP National Rural Faculty, I would like to thank you sincerely for your video message which was played at our recent 20th Anniversary celebration in Canberra. Your support was welcomed and appreciated by our members, particularly the Government's renewed focus and commitment to rural health.

A Rural Stakeholder Breakfast Forum was held as part of the celebration where over ninety GPs, key stakeholders and medical students had the opportunity to participate in a facilitated discussion about rural health issues and identify strategies to secure and retain the current and next generation of rural general practitioners.

The key themes identified included:

- **Support for rural GPs and their communities**
  - Keep rural hospitals accredited and open
  - Support the families of rural GPs
  - Training and support for international medical graduates (IMGs) and their families
  - Appropriate training for rural GP mentors
- **Rural training issues**
  - Establish processes and funding to enable semi-retired and retired rural GPs to work as supervisors for medical students, interns and general practice registrars
  - Restore procedural skills training to undergraduate medical training so that students use their hands and not just their heads e.g. incorporating obstetrics and general surgery experience back into training
  - Increase the number of rural placements required to be completed by undergraduate health and medical students and post graduate vocational general practice trainees
  - Continue funding for rural GP procedural skills training through the Rural Procedural Grants Program

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- **Targeted rural health services**
  - Ensure health workforce planning is based on patients' and communities' health needs
  - Establish incentive payments based on a dynamic rural and remote classification, not just population size

- **Rural GP self-care**
  - Address issues related to professional isolation and rural GP burnout, including safe working hours

I would welcome an opportunity to meet with you and your Department to discuss these important themes and issues further. For further information please contact Lauren Cordwell, Manager RACGP National Rural Faculty on (03) 8699 0418 or email lauren.cordwell@racgp.org.au

Yours sincerely,

Dr Kathryn Kirkpatrick
Chair, National Rural Faculty

Cc: Ms Jane Halton PSM, *Secretary, Department of Health and Ageing*
Dr Zena Burgess, *CEO, Royal Australian College of General Practitioners*

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QUESTION 2.1

Senator NASH: Could I interrupt one more time and ask you whether you can provide on notice for the committee the reasons that we have lost that ability to be in hospitals?

Dr Kirkpatrick: Sure. The Provost of the faculty has a wonderful history. At our dinner at the faculty celebrations he gave a speech which will give you that information.

HISTORICAL PERSPECTIVE: THE DEMISE OF URBAN PROCEDURAL GPS

Submitted by Dr Peter Joseph

It must be made clear that there was no real planned or agreed change on the part of General Practice to relinquish hospital work. It was imposed; in a process sometimes referred to as the external definition of General Practice. A series of events overtook General Practice, at a time when the RACGP was not numerically strong enough or politically powerful enough nor General Practice united or standardised enough to prevent them.

Until the 1960s GPs were highly competent in Obstetrics, indeed building up an Obstetric practice was the cornerstone of a young GP's success. Many GPs performed Caesarean sections. Anaesthetics were usually performed by GPs, some of whom by "grandfathering" formed the Faculty of Anaesthetists of the RACS, later becoming an independent College of Anaesthetists.

GP surgeons performed Tonsillectomies, Appendectomies, Hernia Repairs, and some Cholecystectomies. Urban GPs tended to refer bowel operations but rural GPs still did whatever was needed. Most Consultants in Teaching Hospitals had spent time in General Practice prior to specialising and were empathetic to General Practice and its training needs. There was one profession.

The AMA was then far more powerful than now, and its membership was almost universal. Most GP postgraduate education was under its aegis prior to the formation and growth of the RACGP, to which it was tacitly opposed.

There was one fee for a procedure, whether performed by a specialist or generalist, equal pay for equal work, but specialists charged large gaps which their clientele could afford to pay. The less affluent could enjoy their services gratis in the teaching hospital.

Most were well served by their GPs who could function in rural and urban practice with small need for any further training. No referral was required to see a specialist. However after WW2 an increasing number of doctors specialised immediately after graduation and much of their training was performed in the very hierarchical British system in which GPs were regarded as those who had failed to specialise. They had a very limited role unlike their Australian colleagues.

The new specialists imported these attitudes to Australia on their return. Not only were they ignorant of the value of Australian training for Australia's far flung doctors and patients, they were hostile to it as a challenge to their superiority and economic success. They demanded higher rebates for the same work that GPs were performing. They started a culture of retaining skills exclusively for their own College trainees despite the needs of rural populations which only their members who wanted tax deductibility for their aviation hobby were prepared to service. Their seniors were ambivalent and some continued to work as usual.

The "Gorton Scheme" gave them what they wanted in the form of higher rebates and led to a serious rift between the AMA and the fledgling RACGP. The sop to General Practice was the so called Gatekeeper Role of GPs. At its inception, this meant that the patient had to obtain a referral to the specialist from the GP. If the GP could perform the procedure referral for rebate processes could be denied so the specialist could charge the full specialist fee but the patient would only receive the GP rebate.

The response of the Conjoint Conference [the AMA and the Colleges of O&G, Surgeons, its Faculty of Anaesthetists, Physicians, & Psychiatrists], was to limit undergraduate and intern training so that there was no chance for GPs to acquire skills to refuse referral.

The procedural undergraduate skills were severely restricted. Where most courses demanded 15-20 normal Obstetric deliveries, students now graduate without performing one. The effect on General Practice was that graduates became fearful of doing anything, and rural recruitment was very difficult.

The next step was for the same specialists to delineate hospital clinical privileges in a process which excluded GP input except in rural areas. Naturally the conditions were defined to limit or eliminate GP input. The prime example was the Clinical Assistant in OPD role in teaching hospitals which were often filled by subspecialised GPs. Once these roles became paid rather than honorary, GPs were suddenly excluded.

In the private sphere the privileging process was used to limit the role of GPs to non-procedural work: in many cases the GPs had been the driving force behind the building of community hospitals from which they were now excluded.

We achieved the Diploma of Obstetrics (Dip Obs) as a direct result of one President [Dr D Game] standing up for GP Obstetrics. He told the RACOG that our Training program would import teachers if their Fellows would not. The RACOG later formed an alliance with Midwives to make GP obstetrics difficult.

The AMA, despite having a policy demanding postgraduate training for General Practice before independent practice since 1986, tacitly and actively opposed its implementation until it was a fait accompli in the early 200s. It tacitly supported a rapid turnover triage and referral model of General Practice against the deliberative and definitive treatment model taught by the RACGP.

The advent of Medicare, later Medibank, (a change of name perhaps recognising the funding rather than caring role of the national insurer), made rapid turnover practice more profitable than the more professional alternative. Many GPs accepted the changed environment and decided to change their modus operandi to take what advantage was left to them. There was coincidently at that time a GP shortage so it was easy to exploit the system.

Various schemes were devised to combat the resulting poor behaviour, none successful. It became uneconomic for GPs to assist at operations on their patients, and they were by now so poorly trained that specialist no longer wanted them to do so - a shocking enlightment of the current system in itself. Also, a large number of patients abandoned private insurance, diminishing the demand for GP Proceduralists in cities. Rates of private Insurance dropped from 75% to 25%. GPs stopped doing their own after hours work, relying on deputising services.

A generation of GP trainees without the concept of true generalism is largely happy to accept the unchallenging status quo in a world where lifestyle has usurped a traditional concept of professionalism. It is a matter of concern that learned incompetence has been imbued by a successful partialist training system in public hospitals.

The coup de grace for urban procedural GPs was delivered by the collapse of the specialist driven Medical Defence Organisations in the late 1990s. The bailout of the failed Qld and NSW MDOs quadrupled the cost of professional indemnity insurance to procedural GPs, most of whom had never suffered a complaint, nationwide.

In urban areas this rendered procedural work for GPs uneconomic. 30 deliveries a year did not pay for the insurance. In the country, State Governments footed the bill to prevent urban public hospitals from being swamped. The Urban/Rural divide over hospital access became almost complete, with very few urban GPs prepared to accept the lifestyle limitation at inferior rates of remuneration.

QUESTION 3.1

Senator NASH: Is it worth giving consideration, in a policy sense, to the tracking of the rural medical students going out on placement? It seems to me it would not be too hard to gauge from them whether they intend to practise in regional communities. Some will say yes and some will say no. Then you could track, down the road, among those who said no, having gone out and done rural placement, who then changed their mind. Wouldn't it be sensible to actually track that data?

Dr Kirkpatrick: I will have to check, but I am sure there is a paper that came out of the clinical school in Toowoomba recently along those lines.

RURAL CLINICAL SCHOOL LITERATURE

Submitted by: Dr Kathryn Kirkpatrick

The following provides a list of a **selection of papers** that have come from the University of Queensland Rural cClinical School in Toowoomba in terms of the tracking of rural medical student placements.

- Eley DS, Chater B, Baker P. The Rural Clinical School Tracking Project: more IS better - confirming factors that influence early career entry into the rural medical workforce. Medical Teacher Submitted 22 August 2008; Accepted 6 Jan 2009. [Available at: http://informahealthcare.com/doi/abs/10.3109/01421590902850857]
- Eley DS, Young L, Prysbeck T. Exploring the temperament and character traits of rural and urban doctors; implications for retention of the rural workforce. Journal of Rural Health (USA) 2009,25; 1: 43-49. [Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1748-0361.2009.00197.x/full]
- Eley DS, Young L, Baker P, Wilkinson D. Developing a rural workforce through medical education: lessons from down under. Teaching and Learning in Medicine 2008; 20(1):53-61. [Available at: http://www.tandfonline.com/doi/abs/10.1080/10401330701542677]
- Eley DS, Young L, Shrapnel M. Rural temperament and character: a new perspective on retention of rural doctors. Australian Journal of Rural Health 2008; 16(1):12-22. [Available at: http://onlinelibrary.wiley.com/doi/10.1111/j.1440-1584.2007.00946.x/full]
- Eley DS, Young L, Wilkinson D, Chater AB, Baker PG. Coping with increasing numbers of medical students in rural clinical schools: options and opportunities. Medical Journal of Australia 2008; 188(11):669-71. [Available at: https://www.mja.com.au/journal/2008/188/11/coping-increasing-numbers-medical-students-rural-clinical-schools-options-and]
- Eley DS, Baker P. The impact of a rural medicine rotation on medical students' intention to pursue a rural career: clear benefits from the RUSC program. Teaching and Learning in Medicine Accepted 1 Feb 2008. In Press: due April 2009 Vol 21 (2).

QUESTION 4.1

Specific additional questions from Senator McKenzie:

Medicine can be seen as a vocation as opposed to a career. A vocation involves more than just a nine to five job; it incorporates a passion for one's role and a commitment to furthering that role for the benefit of society. Those with a vocation may be more inclined to 'give back' to their profession.

Do you know of any research undertaken in relation to this?

ALTRUISTIC FACTORS IN TEACHING (GENERAL PRACTICE)

Submitted by: Dr Kathryn Kirkpatrick

There is a **body of literature** which details anecdotal experience and altruism of GPs with respect to teaching in general practice. However, it is not clear whether Senator McKenzie is referring to only teaching or other aspects of general practice when she says *"give back' to their profession"*.

In terms of teaching and motivators, the **following texts** [and links] may be useful. However, it should be noted that most texts state that the over reliance on altruistic motivation is unsustainable and investment is needed to expand clinical training capacity in general practice, particularly for rural general practice.

- Coleman K and Murray E. Patients' views and feelings on the community-based teaching of undergraduate medical students: a qualitative study. *Family Practice* 2002; **19:** 183-188. [Available at: http://fampra.oxfordjournals.org/content/19/2/183.short]
- Sturman N. Teaching Medical Students – Ethical Challenges. Australian Family Physician Vol. 40, No. 12, December 2011 [Available at: http://www.racgp.org.au/afp/201112/201112Sturman.pdf]
- Pearce R, Laurence C, Black L, Stocks N. The challenges of teaching in a general practice setting. Med J Aust 2007;187:129–32. [Available at: https://www.mja.com.au/journal/2007/187/2/challenges-teaching-general-practice-setting?0=ip_login_no_cache%3Db5e1b7973d136384e245fd39789cbe39]
- Thistlethwaite JE, Kidd MR, Hudson JN. General Practice: A leading provider of medical student education in the 21st century? Med J Aust 2007; 187 (2): 124-128. [Available at: https://www.mja.com.au/journal/2007/187/2/general-practice-leading-provider-medical-student-education-21st-century]
- Laurence CO, Black LE, Karnon J, Briggs NE. To teach or not to teach? A cost-benefit analysis of teaching in private practice. Med J Aust 2010; 193 (10): 608-613. [Available at: https://www.mja.com.au/journal/2010/193/10/teach-or-not-teach-cost-benefit-analysis-teaching-private-general-practice]

QUESTION 4.2

How do GPs fare in their approach to ensuring the ongoing success of their profession when compared with other professions?

THE SPECIALIST OF THE DISCIPLINE OF GENERAL PRACTICE

Submitted by: Dr Kathryn Kirkpatrick

GPs are proud of what they do and where they practice. General Practice is a specialty in its own right. Unfortunately many of our colleagues who work in other specialties and particularly major hospitals do not see us in this light and there is an undermining of general practice and general practitioners by hospital based registrars and specialists.

A supported and enjoyable experience of general practice particularly rural general practice by medical students, junior doctors and registrars can influence the perception of our specialty. There needs to be mutual respect of specialty and profession by all health professionals. General Practice is not the poor cousin.

Attachments or placements in rural general practice need to be positive experiences.

QUESTION 4.3

What consultations were had with your organisation on Medicare Locals? Were there any outcomes of these?

POLICY CONSULTATION ON MEDICARE LOCALS

Submitted by: NRF Policy and Advocacy Unit

The RACGP contributed to discussions regarding the 'functionality and governance' of the Medicare Locals initiative by way of **formal submission** (dated 24 November 2010). This was in direct response to the Government's discussion paper 'Medicare Locals, Discussion Paper on Governance and Functions' (issued 2 November 2010). A copy of the RACGP submission is available at: http://www.racgp.org.au/reports/40299 . It is important to highlight that the College was also involved in the National Health and Hospitals Reform Commission processes several years ago where Primary Health Care (PHC) Organisations were recommended, but that the resultant policy, Medicare Locals, does not capture the intended policy recommendation for PHC Organisations.

A copy of the RACGP's **press releases** (dated 25 November 2010 and 7 November 2011) are available at:
http://www.racgp.org.au/scriptcontent/search/searchracgpresults.cfm?section=search&cx=003378128311287992 97%3Acwnpztvg-0a&cof=FORID%3A11&searchterm=medicare+locals .