Letters

Why can't we get permanent general practitioners for our country town?

To the Editor: A rural general practitioner's workload is significantly larger than that of his or her urban colleagues, and this is attributable to work activities in rural public hospitals.[1] A GP who provides after-hours on-call service to the community through the local hospital or emergency department is not only valued, but also more likely to be retained in the rural workforce.[2] However, on-call commitments and the unrelenting nature of after-hours care can negatively affect professional and personal wellbeing, family life and opportunities to enjoy the rural location.[3]

I currently work in the city, but did much of my training in rural and regional areas. Doing GP locums allows me to stay in touch with rural and regional practice. However, working as a locum has highlighted to me how arduous on-call commitments can be. When you are working as the solo town doctor, or one of two, there is not much opportunity to share the on-call roster as recommended by the Rural Doctors Association of Australia.[4]

In my experience, some hospitals have restrictive service contracts, which further contribute to the GP's burden. For example, the doctor is mandated to be within 10–15 minutes away from the hospital at all times while on-call, and must attend, when requested, within the times specified in the contract. These times are the same as those expected in large urban hospitals.

In large urban tertiary teaching hospitals with on-site doctors, the median time taken for a doctor to attend patients whose condition has deteriorated unexpectedly is 13 minutes. One in five episodes had a recorded response time longer than 30 minutes.[5] By requiring on-call GPs to meet or better the expected response times of urban tertiary hospitals, "on-call" in effect becomes "on duty".

An on-call weekend results in being confined to home from 8 am Friday to 8 am Monday. I empathise with GPs working permanently in a country town and having to cope with such restrictions.

Given what we know about the negative impact of onerous on-call and after-hours commitments on doctors, including GPs, and the subsequent negative effect on workforce retention in rural and remote Australia,[2] why are we still setting ourselves up for continuing failure?

Chee S Koh Lecturer and General Practitioner

Department of General Practice, University of Sydney, Sydney, NSW.
chee.koh@sydney.edu.au

Competing interests: No relevant disclosures.

doi: 10.5694/mja13.10201

1 McGrail MR, Humphreys JS, Joyce CM, et al. How do rural GPs' workloads and work activities differ with community size compared with metropolitan practice? *Aust J Prim Health* 2012; 18: 228-233.
2 Russell DJ, McGrail MR, Humphreys JS, Wakerman J. What factors contribute most to the retention of general practitioners in rural and remote areas? *Aust J Prim Health* 2012; 18: 289-294.
3 Humphreys JS, Jones MP, Jones JA, Mara PR. Workforce retention in rural and remote Australia: determining the factors that influence length of practice. *Med J Aust* 2002; 176: 472-476.
4 Rural Doctors Association Australia. Viable models of rural and remote practice: stage 1 and stage 2 reports. Canberra: RDAA, 2003.
5 Adelstein BA, Piza MA, Nayyar V, et al. Rapid response systems: a prospective study of response times. *J Crit Care* 2011; 26: 635.e11-e18. ❑

Telehealth and equitable access to health care

To the Editor: I write in protest about the short-sighted decision of the Australian Government to remove outer metropolitan areas from eligibility for Medicare rebates for telehealth from 1 January 2013. Since then, there has been a 29% drop in the number of video consultations, with 9476 recorded from 1 January to 28 February 2013, compared with 13 311 from 1 November to 31 December 2012.[1]

Telehealth is usually proposed as a tool suitable for the rural and remote locations of Australia, providing lower costs, increased access to specialists, improved collaboration, increased quality of local service and greater access to professional development.[2] Yet barriers to care are more than geographical; they can be temporal, financial and cultural.[3] In particular, the health care system remains inequitable while patients with disabilities face a range of barriers in achieving access.[4] Telehealth assists in overcoming these barriers, enabling improved access to care in urban areas.[5]

> "An on-call weekend results in being confined to home from 8 am Friday to 8 am Monday"
>
> Koh

We instituted a telehealth service in psychiatry and pain management to a general practice super clinic located in the City of Playford council area in Adelaide's outer northern suburbs. This area is underserved, with a low socioeconomic status and poorer health outcomes.[6] The South Australian branch of the Royal Australian and New Zealand College of Psychiatrists, and the Australian Pain Society, informed us that there were no private locally resident or visiting specialists in this area, and the referring general practitioners said that the particular patients seen would not otherwise have accessed specialist care. They included patients who were homeless, patients with disabilities or those who lacked their own transport.

I understand that the boundary changes were intended not to undermine existing outer metropolitan private specialists but, in this case, we were clearly able to bring private specialist resources into the area with benefit to patients. Additionally, we recruited health care students on clinical attachments to assist patients with their teleconsultations. At the same time, the students were able to learn from the specialists during the video communication sessions.

I propose two recommendations that would result in telehealth increasing equitable access to care: first, that underserved outer metropolitan areas of low socioeconomic status be reinstated for