Editorial

Not being there

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None of us will easily forget *Nine-Eleven* (Wednesday, 12th September 2001 – New Zealand time). We looked in horror and disbelief as breakfast television showed us a real life version of the movie *Independence Day*. For me worse was to follow.

The same morning in Winton, a two-year-old boy was found dead by his parents; the diagnosis, meningitis. This little one was really special to me. I delivered him in the birthing unit in June 1999 and since then the three-way relationship between me, the doctor, and him and mum, the patients, had been warm and affirmative. Through prolapsed piles, postnatal visit, six-week check, otitis media and respiratory infections we met only a dozen times, but I had news of him through his great-grandfather's visits and when the other family members came. I was not there when it happened, but when I phoned the next day to express my sorrow, his mother said, 'I thought about you a lot yesterday.'

A few days later a letter came from her husband, demanding to know why none of the doctors were around when they were needed. No, they hadn't called the doctor, but they would have done if the doctor had been on call in Winton and not 30kms further away in Invercargill. He was sure that if we had been there, things would have been different. 'What's wrong with you guys? Why can't you provide a service to your community? I've got a small business and I have to provide a service to my customers and be on the phone round the clock.' Letters followed from Plunket and concerned friends asking the same kinds of question – not being there is a difficult charge to answer in rural general practice.

Months before, faced with the prospect of a one-in-two rota to cover 7 500 people, two of us had taken the decision to join the Urgent Doctor Service in Invercargill after a lot of consultation with local groups. Before that, three of us had given a 24-hour a day, seven day a week service, including intrapartum obstetrics. Paramedics arriving at three in the morning to cardiac arrests were always astonished to find us there and claimed that Winton was the only place they saw such a thing. Everyone thought it was wonderful, but we, and our families, were the ones who paid the cost.

Images of Winton

The loneliness and isolation of the night hours between 6pm on Friday and 8am on Monday earned us an average of $5 per hour on call. For two years we had been advertising without a single reply for a fourth partner which would have enabled the 1:4 rota which is now recognised as the acceptable minimum, but now we were facing the unacceptable.

It is bad enough seeing 40–50 people a day without having to face alternate nights on call. So we moved the contact point for after-hours to Invercargill which is 30–45 minutes away, lost our rural bonus by having a 1 in 12 rota and made ourselves a sitting target for criticism by not being there when something went wrong.

As it turned out, it was all for nothing. Six months later we have made the decision to leave and, as from 1st April 2002, there will be no full-time doctors in Winton.

However much we heard others trumpet the imminent boost to primary health care funding or the adequate provision of locums, we had to make our own decisions and there was not even the distant sound of cavalry coming over the hill. The outcome has left the community in a state of shock and the question posed by a grieving father is still requiring an answer: what is wrong with us – politicians, Health Ministry and the general practice community – that we cannot provide the rural communities of New Zealand the health service which they deserve? As a recruited but not retained country doctor it has also left me to reflect on what can be done to create a more stable medical workforce.

First the good news. Rural general practice is still a viable option for any practitioner looking for a satisfying career. In general, rural peo-

ple are friendly and appreciative, although the country has its own share of ratbags who can make life difficult once in a while.

The clinical challenges are still there and people across the age groups still regard the doctor as their primary clinical contact. In an area like Southland, where the nearest specialist help is in Invercargill and occasionally Dunedin, I have found my clinical acumen considerably extended, especially in areas such as orthopaedics, ophthalmology and, until recently, obstetrics. After three years I feel clinically rehabilitated and this is entirely due to a satisfying clinical environment.

The working relationships with fellow professionals have been excellent. In small town practice, the nurses and receptionists provide the backbone of the service and much of the continuity of care, and you have to learn to work with other professionals such as midwives, district nurses, physiotherapists, pharmacists, ambulance volunteers, fire service, police, rest home staff, funeral directors and many others. The income is good by national standards and it is certainly not lack of money that is driving me away.

So where are the problems and the solutions? Of course there are no final solutions. As James Willis rightly says: *We do not make progress by looking for final solutions, but by making successive improvements to the world, and to our image of the world.*[1]

The first improvement is to become more realistic about what we can offer as country doctors. In the first two years at Winton we were able to offer comprehensive primary care to all our patients. We were collectively on call seven days a week, 365 days a year. We held a pager so that every time the Winton ambulance was called, so were we. All admissions to the birthing unit were notified to us. We could only do it because three independent practitioners were prepared to share that burden, as well as income. It turned out to be a fragile arrangement although not as fragile as situations in which there is only one practitioner. However the real problem was that we had assumed a responsibility which was not really ours at all. We handled all the trauma, all the illness without sharing with the community or the health department what the cost of that was. Eventually the burden of being there became too much and when we got round to consulting with community groups and confessing that we could not continue, we were amazed to discover that they were totally sympathetic; indeed they were astounded that we should even think that was our responsibility.

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Long ago, the late Eric Elder confided to Niall Holland[2] that the worst thing that ever happened to rural practice was this concept of 24-hour cover. His philosophy was that he lived in the community and if he was around, he could be called, if he had to go to Winton to play cricket, or to Invercargill to teach registrars, he wasn't there. Since that time the burden of being there has increased with modern communications as well as modern approaches to resuscitation, and it is doubtful whether we can do it all. We have to ensure that involvement in after-hours care can be a voluntary choice for the rural doctor rather than a blanket responsibility. Hopefully the Medical Practitioners Disciplinary Committee and the Health and Disability Commissioner will be aware of these changes and modify some of their decisions which assume that being a general practitioner implies 24-hour responsibility when things go wrong.

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The second improvement is that we have to improve communication about what a rural generalist is and does. If rural generalism is to succeed in bringing a service to the people then we have to persuade the powers that be that whatever solution is adopted, it has to be recognised that the general practitioner is the predominant provider of health care in our rural communities. No other professional can deliver the range of services which enables 95% of the patient's problems to be solved at one sitting, enabling him or her to return almost immediately to productive activity. Currently the service is delivered at an absurdly low cost to the great satisfaction of individuals and communities. Having a GP on a rural site provides support to a range of other professionals such as practice nurses, district nurses, midwives, pharmacists, physiotherapists, rest homes, to name but a few. The problem is that no one in our health system can affirm that position, plan around the fact and fund us properly.

We are not getting that message across, partly because rural generalists are too busy providing the service to lobby, and partly because the organisations which purport to lobby for us tend to become entangled in bureaucratic ritual dances rather than being frank about what needs to be done. It seems that you now cannot make claims for the pre-eminent role of the doctor without upsetting other professional and lay groups, hence the reason why Working Parties and their reports cannot even describe what we do. The latest report[3] is quite revealing when it says: *The core rural pri-*

mary health workforce includes doctors, nurses, pharmacists and ambulance personnel, although this may vary from region to region. Alongside these are Mäori community health workers, midwives, allied health workers and community volunteers. All are valuable members of the primary health care team.

It then goes on to say that there are only seven places in New Zealand where nurses provide first contact care. Virtually everywhere it is the vocationally-trained family physician who underpins the sector. So why do we have to plan on the wishful thinking of those who wish to see the role of the general practitioner eroded, even abolished, rather than the reality that there is still time to encourage and develop a trusted and reliable solution? There is a desperate need to institute workforce planning for rural generalists and this cannot be done while our Ministry of Health continues on its 'final solution' which seems to want to phase out general practice as the underpinning clinical speciality in rural areas.

Finally there has to be an improvement in the financial rewards available to rural generalists. It is patently obvious that government cannot afford to give these services free of charge and those in rural areas know that they are going to have to pay for them. It alarms me that some of our representatives believe that all of this is going to be funded centrally by capitation. Already there have been some ominous indications that those who go into rural practice should accept a lower income for the privilege. The rural generalist often provides services in competition with the urban specialist and should charge accordingly. We have to recognise that the only way we are going to have general practitioners and other health professionals survive and prosper over the long term in our communities is to encourage their development as a profit and risk taking business enterprise. Our rural communities understand this because they are there because of private enterprise in dairy, sheep and deer farming, forestry, fishing and tourism. However, in the health sector there is still a hard left attitude which regards making a good living from medicine as almost obscene. If general practitioners wanted to set up as possum farmers, offering to employ staff, they would be given grants and great encouragement. In contrast we are subjected to a process akin to being employees in state collective farms. The possibility is still there to make a decent living and a good life in rural practice, but we have to become creative about how the systems are going to be set up and survive.

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There are signs that, at long last, rural communities are mobilising to improve the state of their health services. However they seem to be liaising more with locum agencies than with doctors' organisations and are paying heavily for the privilege. On our part we seemed to have been beguiled by national initiatives such as participating in Expert Groups in Rural Health and producing reports which do not even acknowledge the existence of general practice. If we wish rural medicine to survive in New Zealand we will have to act locally by creating joint ventures within our local communities. It is an area in which we have been successful in the past and the important issue is that our local communities wish to be there with them still.

In Winton now there is a realisation that 'you never know what you're missing till it's gone'. I went there in 1999 because it seemed to me that it represented all that was best in rural medicine. It now is underpinned by superb practice nurses and administrative staff who will have to re-educate new locums every few months. The chilling feeling is that if this can happen to Winton it can happen anywhere. When it happens perhaps we will also remember the words of David Loxtercamp in his original paper:[4]

The barriers to being there for our patients are not bound in the red tape of reimbursement schemes and managed care contracts. Nor do they necessarily arise out of rotations in the call schedule, the compressed demands of our patient load, or the Brownian motion of modern society. They lie in our presence of mind, our inclination to linger and listen, our rigor to puruse some grasp of the patient's narrative and thereby catch a subtle signal for help.

References

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