

Surgical services and referrals in rural and remote Australia

Many rural and remote parts of Australia will continue to need appropriately trained and supported rural GPs to provide acute surgical care

FOR BOTH HUMAN AND SYSTEMIC REASONS, there is a chronic shortage of general surgical and obstetric–gynaecological specialists in some parts of rural and remote Australia. There is also a shortage of other specialists (eg, ENT, urology, and plastic surgery) in some regional centres. Additionally, many rural towns with one surgeon have a workload that would support two, and some two-surgeon towns could sustain more. The Royal Australasian College of Surgeons (RACS) and most State health departments have a policy of, or preference for, at least two surgeons in appropriate towns with populations and resources to warrant these services.¹ This allows manageable “on call” hours, safe-hours work practice and professional support.

Most of the major remote centres in Australia have two resident general surgeons or one surgeon with backup and support (or relief) from an appropriate regional or metropolitan centre. These surgeons may not always be Australian-trained, but they play an important role in “areas of need”. These days, for mainly social and family reasons, surgeons may not spend their entire professional life in these towns, so an ongoing supply of trained replacement surgeons is needed.² The RACS Rural Surgical Training Programme, which has now been functioning for four years, is starting to fulfil this need, providing up to 10 appropriately trained surgeons to go into rural practice each year.

Logistically, or for geographic reasons, some remote and rural towns will continue to rely on GPs for “on the ground” initial assessment and management of patients with surgical problems. Optimally, this occurs not in isolation, but with professional support from the regional surgeons to whom these GPs refer, and with the backup of regularly provided outreach specialist services.³

As a generation of broadly trained older and experienced GPs approach retirement, there is an obvious need for suitably trained replacement GPs. The Advanced Surgical Skills Training Programme for Rural GPs is a joint initiative of RACS, the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM). Unfortunately, this program has foundered because of the tardiness of implementing more decentralised training schemes under the auspices of the RACGP and the ACRRM, but it is hoped that it will be re-introduced soon. Intensive training courses provided by various State Rural Medical Support Agencies into all aspects of emergency medicine (including surgery, obstetrics and ophthalmology) provide some level of appropriate training and capability for GPs going to rural and remote areas (and those already there) (for example, the Queensland Rural Medical Support Agency).⁴

These courses are important and not universally known about. But does the chronic under-resourcing of rural surgeons and the geographic location of GPs influence surgical referral patterns? This interesting question is addressed in this issue of the Journal by Gruen and colleagues (*page 111*).⁵ Their findings, based on data accrued by the Bettering the Evaluation

and Care of Health (BEACH) program, suggest that rural and remote GPs without resident surgical services refer patients at about the same rate as their regional and metropolitan colleagues. However, these GPs manage more obstetric and ophthalmological patients locally. This probably reflects their training and expertise made necessary by their geographic isolation. However, many rural and remote towns in Australia have regular surgical services (from weekly to quarterly) provided by outreach services from regional and metropolitan centres, and these services may not be reflected in the BEACH data.

Many Australian rural and remote hospitals now have teleconferencing, telemedicine and satellite communication facilities. These are used particularly for educational purposes, but also increasingly for clinical applications. They are not usually available at short notice or for 24 hours a day, which limits their use for acute surgery and obstetrics. The telephone remains the communication medium of choice. Telephone support is particularly valuable for GPs if the specialist at the other end has an ongoing relationship with and a knowledge of the capabilities of the facility, and the expertise available in the rural or remote town.

A variety of models and methods will continue to be needed to provide specialist surgeons to all the centres that need them:

- The Flying Surgical Service in Queensland (based in Roma and Mt Isa) provides outreach services to many Queensland country towns;
- The University of Adelaide Department of Surgery provides a rotating specialist surgeon to Port Augusta;
- The University of Western Australia outreach program provides a cost-effective service to many small rural towns;³ and
- The New South Wales Department of Health is trialling a “mobile surgical bus” fully equipped to provide specialist surgical services (particularly elective services in ENT, urology and ophthalmology) to rural centres in New South Wales where these surgeons or the facilities required are not otherwise available.
- It is vital that any outreach service does not lead to de-skilling of rural GPs (or general surgeons), but rather is an enhancing, educational experience.

Despite advances and improvements in the availability of aeromedical evacuation services, many rural and remote parts of Australia will continue to need appropriately trained and supported rural GPs to provide acute surgical care. These GPs will know when it is best to refer on to larger centres. These larger centres will continue to need professional onsite specialist services, staffed by local surgeons, with appropriate financial resources to provide their rural or remote general practice colleagues with ongoing support and advice.

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