

Rural doctors and medical rosters

RURAL DOCTORS, like their colleagues elsewhere, are thinking individuals whose main aim is to provide timely, appropriate care to the patients living in their local communities. More often than not, they are small-business operators running a practice which is becoming more complex, both in the clinical sphere and in the myriad requirements associated with accreditation, indemnity, practice incentive payments, vocational registration, the Pharmaceutical Benefits Scheme and Medicare, credentialling at the local hospital, the *Privacy Act 1988* (Cwlth), and the *Trade Practices Act 1974* (Cwlth). Non-compliance with any of these regulations and requirements can lead to severe penalties — in the case of breaches of the Trade Practices Act, exposure to \$500 000 fines for individuals. The Productivity Commission's recent enquiry into red tape in general practice¹ and the Wilkinson Review of the impact of Part IV of the Trade Practices Act on the recruitment and retention of medical practitioners in regional Australia are two demonstrable consequences of the general concern.

In rural Australia, the medical workforce faces a special subset of challenges in providing a broad range of medical services to small communities with limited resources and

support facilities. This is in an environment where there is a relative shortage of medical practitioners and an increased workload.^{2,3} Administrative and bureaucratic requirements can make the difference between staying in and leaving rural practice.^{4,5} The size of isolated rural practices does not allow for the management processes, information technology, and support staff required to meet the bureaucratic requirements.

Pengilley's article⁶ is a timely reminder that government reviews may not solve the questions faced by doctors in their everyday work in their efforts to comply with the law. Grey areas of the law will only be resolved by changes in the law itself, not by reviews. Pengilley has given an example of rostering for 16 hours out of 24, which would almost certainly be in contravention of the law and bring the full force of the Australian Competition and Consumer Commission (ACCC) down on those doctors. There are real examples happening in Australia today of doctors struggling to provide services in a sustainable manner so that they do not become exhausted, which may lead to disruption of their family, social and professional life and ultimate cessation of practice in that community. For example, a consensus of opinion is that rural doctors require a one-in-four

roster to ensure sustainability. How is this to be achieved in a three-doctor town where it recently took three years to replace a doctor? The doctors may choose to advise their communities that, if they are to have sustainable medical services, it may be necessary for the community to have no doctor available one weekend in four. The trade-off for the community is that their doctors will stay longer. The ACCC has never given a clear opinion in relation to such an arrangement, but, if consumers complained, then almost certainly the ACCC could take the view that the arrangement breaches section 4D(1)(ii) of the Trade Practices Act: "The provision has the purpose of preventing, restricting or limiting the supply of services to particular persons or classes of persons." Similarly, a cluster of four small towns, perhaps 50 km apart, with one doctor each, may not be able to form an after-hours roster, because services would be reduced to three of the communities after hours on any particular night. The result may be that no doctors service such towns. Authorisation under the Act is both costly and complex — from the doctors' viewpoint, why bother when there is work at the larger town 100 km away?

Yet, Pengilley argues that even more straightforward rosters may in fact breach section 4D.

The rural doctor's job is difficult enough without continued uncertainty over whether the Trade Practices Act will be brought to bear on well-meaning practitioners doing the

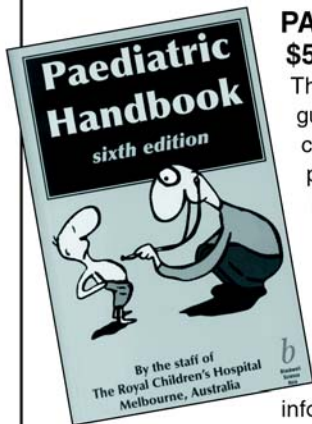
best for their local communities in difficult circumstances. The persisting uncertainties are likely to hinder further recruitment and may lead to exhausted doctors leaving their communities.

David Mildenhall

Senior Vice President
Rural Doctors Association, Albany, WA
dmhall@inet.net.au

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4. Woodcock R, Kamiem M. To stay or not to stay in rural practice 1996 outcomes of 1986 intentions. Perth: University of Western Australia, 1997.
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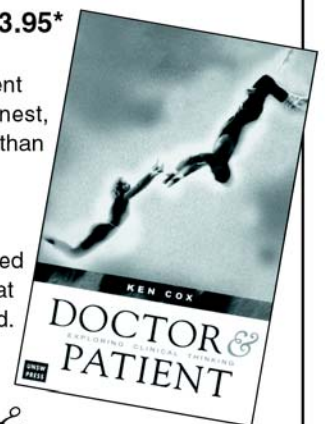
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