Dr Ian Kamerman, president of the Rural Doctors Association of Australia, only has to open his practice door to forget the frustrations of politics and reconnect with his community.

Dr Ian Kamerman enjoys talking about rural practice at the best of times, but ask him how he would persuade graduating medical students and junior doctors to go bush and he positively beams.

“I love what I do”, he tells the MJA.

“At the end of the day, there are very few disciplines in medicine that actually provide continuity of care.

“Every discipline other than general practice provides interval-based short-term care, looking after only specific facets of a person’s disease and or life.

“The wonderful thing about general practice is that you can actually look after someone over long periods of time, getting to know them and getting to know how everything interacts for them as a person.

“The difference between that and being a rural doctor is you also very much look after someone over long periods of time, getting to know them and getting to know how the health of the community goes.

“That’s not only from a public health point of view but it’s also things such as how the economy’s going, how the harvest is going, what the local mining community is up to, the impact of something catastrophic like a motor vehicle accident or a suicide.

“It’s that relationship which basically does it for me and probably does it for most of my rural colleagues. There is nothing else in medicine that does that.”

Dr Kamerman is president of the Rural Doctors Association of Australia (RDAA), the national body formed in 1991 to represent the interests of rural medical practitioners.

He is a GP based in Tamworth, New South Wales, and has been president since November 2013.

When it comes to advocating on behalf of rural doctors, Dr Kamerman has plenty to talk about.

The scrapping of the successful Prevocational General Practice Placement Program (PGPPP) is a case in point.

The PGPPP was seen as an effective way to give junior doctors experience in rural medicine.

Under the program, junior doctors were offered the opportunity to spend a 3-month rotation away from full-time hospital work in the GP environment.

So when it was announced early this month that the federal government had spent $21 million attracting the production of the latest Pirates of the Caribbean movie to Australia, Dr Kamerman was quick to respond.

“We have been asking the Government for the continuation of [the PGPPP] only for them to say there isn’t enough money to fund it”, he said at the time.

“I enjoy Pirates of the Caribbean as much as the next person, but it is ridiculous to spend that sort of money to attract the production of a movie with one hand, while pulling money out of the health system with the other.

“The PGPPP succeeded in attracting many young doctors to the bush and many of these would never have had this opportunity without the program.

“The PGPPP rotations also created intern places, the loss of which will...”

continued on page C2
result in Australian medical graduates having to undertake their intern placements overseas, losing them to Australia forever.

“We were very disappointed to find that it had been scrapped in the federal health budget without prior consultation, and have been vocal in our requests for its reinstatement — but with no success to date”, Dr Kamerman said.

“We’ve suddenly pulled what is about 1200 to 1500 rotations out of the system in the junior doctor years that were very valuable community-based positions”, he tells the MJA.

“For the government to do that at the same time as the increased numbers are hitting the junior doctor years, I think it shows that so little thought has been put into these budget reforms.

“I’m really glad that the states are realising this and are funding, in small numbers, community-based junior doctor placements.”

The PGPPP scrapping is just one major policy of the Abbott government’s first Budget. Another is, of course, copayments.

“Having discussed it with state and federal health ministers and the department, my understanding is that systems are going to be put in place so that the copayment must be taken on virtually all occasions and rules will be put in place such that you cannot universally not accept the copayment”, Dr Kamerman says.

“Everyone is going to be forced to wear it, if it happens.”

The consequences for the bush are predictable, but dire.

“We’re used to seeing patients later and sicker in the bush, but even more, people will choose not to seek medical attention”, he says.

“Why you would put a price barrier into the most highly evidence-based, effective health service within Australia — seeing a general practitioner — is beyond me.

“It makes no sense.”

And the pain will not just be felt by patients, he says. Doctors are, after all, small business owners, particularly in rural areas.

“All [the copayment does is] put extra stresses onto an already very stressed private business model”, Dr Kamerman says.

“So much for a government that says it’s supporting small business.”

There’s also the vexed question of the troublesome General Practice Rural Incentive Program (GPRIP) and the Australian Standard Geographical Classification – Remoteness Area (ASGC-RA) which defines who gets the incentive payments and how much.

“We’ve been complaining about it since it first came out and it’s largely fallen on deaf ears”, Dr Kamerman says.

“The Coalition said one of the first things they were going to do [once elected] was review and change the ASGC-RA, and of course there’s been absolutely no progress.

“I think they struggle with dealing with the inequities of it, the fact that it does advantage certain areas, and the obvious problem is what do you do with the people who are already collecting the money for those incentives which are now in very nice, very well populated centres of Australia.

“Those incentives do need to be delivered to those people who are providing comprehensive continuing care, looking after the care of complex patients and also operating at an extended skill level, doing the work specialists would be doing, because there are none around.”

A conspiracy theorist would have a field day with the adjustments rural practitioners are being asked to make under the Abbott Government, perhaps?

“The expression has been used a lot by my colleagues — it’s very much as if a perfect storm has been created to try and disempower, disenfranchise, just remove general practice out of the Australian health system”, Dr Kamerman says.

“No one has sat back and looked at what all these budget measures mean to individual practitioners and towns and the system as a whole.”

At the end of the day, however, for Dr Kamerman it comes down to the most basic of statements — he does indeed love what he does.

“I can put aside all this other stuff that goes on and certainly what I say to the doctors who are concerned in my own practice is — patients still get sick”, he says.

“It’s your relationship with those patients that is going to make them come and see you. It’s your relationship with a rural town, with that community, that’s going to be protective of you.

“When there is political uproar, it’s not just your voice but the voice of your community that hears that.”

A podcast of the full interview with Dr Kamerman is available at https://www.mja.com.au/multimedia/podcasts

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Balancing act

Dr Liz Marles has just ended her stint as president of the RACGP and can now go back to full-time practice. She has loved her time in the “big chair” but her first love is calling

DR Liz Marles sits back in the armchair on the fifth floor of the Royal Australian College of General Practitioners’ Melbourne headquarters and gazes out at the view.

“I’m going to miss all this, to be honest”, she says.

The view is stunning — the Melbourne Cricket Ground in post-grand final peace, AAMI Park across the rail lines, and parklands stretching away to Punt Road and the Melbourne Tennis Centre — but it’s unlikely Dr Marles means just the locale.

As of 9 October, at the start of the RACGP’s annual conference, Dr Marles is the immediate past president of the College, passing the baton to West Australian GP, Adjunct Professor Frank Jones.

“It’s been a hectic two years in the big chair for Dr Marles.

“It has been a bit of a roller-coaster ride, but I have really enjoyed my time”, she laughs. “Being president means being in the fast lane and you never quite know what’s around the corner.”

A change in government, major changes in health policy, changes to funding support for general practice and training, not to mention keeping a lid on the public perceptions of Ebola, have all been part of the ride.

“It’s been a fantastic learning opportunity for me and I’ve certainly done things that I would never have done otherwise.”

One of those things was appearing on SBS Insight recently, sitting next to the representative from the Pharmacy Guild — an attempt by the broadcaster to generate a little conflict over pharmacists’ desire to take over some things, like vaccinations, that have been the purview of GPs.

“Yes, SBS were keen for that to develop into something”, she says, “but I think we did okay with it and managed to avoid trouble”.

Now that her stint as RACGP president is done, Dr Marles is keen to get back to her surgery in North Sydney where she has “a few little projects” of her own on the go.

Her path to medicine was a little longer than most. She was a high school teacher in Melbourne, teaching biology and maths, before moving to NSW to study medicine at the University of Newcastle at the age of 28.

“I was always pretty keen to be far more hands-on with my science”, she says of her teaching days. “But I think it takes a fair bit of maturity and I was probably far too young when I left school to make that kind of decision.”

Studying medicine as a mature age student has its benefits, Dr Marles believes.

“I think it’s a lot easier to do medicine when you’re older, in terms of dealing with people and their lives and their complexities and not getting too flustered by it”, she says.

“The downside is that medical training is so long that you’re still training into your forties, and that means that other things like having families and making some of those other life choices need to somehow integrate with that.

“We are getting better at adapting to that. There’s more opportunities for women to job share in specialty training.

“Medicine is also about life experience. And coming to it with a little bit of life experience does make it a whole lot easier.”

Part of surviving medicine is about balance, Dr Marles says.

“It’s about having other interests, about having friends who are not doctors, it’s actually being part of a community.”

General practice was always going to be the path she followed once she started out on the medical path, however.

“I really love talking to people”, Dr Marles says.

“I enjoy their stories. I feel like I learn as much from them, probably more, than they get from me.”

There’s an intellectual facet to that decision as well as a gut feeling, she maintains.

“I’ve got broad interests. I found most things really interesting and the thought that I would never do [those things] again — that I would have nothing to do with obstetrics and family medicine, or that I wouldn’t do any mental health again — I felt like I’d be losing something.

“So general practice had huge appeal.”

Just like Dr Kamerman (see page C1), Dr Marles particularly values the unique nature of general practice over other specialties.

“We’re very privileged really. We have long-term relationships with our patients. The trust and the confidence that you get from that is huge”, she says.

“People tell me things that I don’t think I would ever hear in any other context. They come to me at the most vulnerable time in their life and to be able to really assist people then is a huge privilege.

“It’s something that I value every day when I go to work.”


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