The struggle to grow our own doctors in rural Western Australia

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He is currently a GP in Claremont, an external clinical teacher for RHW and a Buddy to OVAHS in Kununurra. He is a Corlis Fellow of the WA Faculty of the RACGP.

Thank you, James. It's very good to see students that you have taught who are now taking up leadership positions in rural health.

I am going to tell you a West Australian story, and it is going to be a witness seminar where I am the witness. What I want to say is that history matters and that the current rural health activists and educators need to know how the current rural health movement began. This is because you are not always going to live in a golden era. Rural medical workforce problems will swing up and down and to keep them on the up you need to know what has happened in the past and why it happened.

The West Australian Medical School was first mooted about 1912 and in the following 45 years there were many false starts. There are many then influential people such as the neurosurgeon JP Ainslie and the Vice-Chancellor of UWA, GA Currie, who persistently pushed for a Medical School. But the pivotal person in organising The Medical School Appeal was Joseph Griffiths, the Administrator of Royal Perth Hospital. He came from the UK, and he had worked on the setting up of a new 800-bed teaching hospital in Sheffield. He also had a flare for organisation. He was a Rotarian and he influenced the Perth Rotary Club to be the organising club for a State-wide effort that recruited 858 Rotarians to work for the Medical School Appeal.[1]

The themes of the Medical School Appeal were "Grow Your Own Doctor" and "Worth, not Wealth." The latter slogan referred to those people who wanted to study medicine but whose families could not afford to pay for their accommodation and upkeep in Adelaide or Melbourne. The Appeal went from 1955 to 1957. It collected £650,000. The State Government added £250,000. By today's figure, that would be about $100 million.

I came back to WA from Adelaide in 1959, in order to complete the fifth year and the sixth year of the new medical course. There were only 15 of us. There were more teachers than there were students. It was an exciting time.

Professor Eric Saint was the Foundation Professor of Internal Medicine and an opinion leader in the new medical school. His ideas on modern medical education were influenced by the innovations occurring at Case Western Reserve University in Cleveland. Also he had done his doctoral thesis in Industrial Medicine and had been the Flying Doctor in Port Hedland. He was an advocate for the importance of social medicine and community health. One expression of this educational direction was absence of formal classes on Wednesdays. The general idea was for medical students to use that time to learn how other people lived and what they thought about their daily lives and the people and circumstances that impacted upon it. Wednesday was called 'Commingle Day'.

We would invite our guest to start off with a talk and would then follow them to their place of work. We had all manner of people. When we invited a lion tamer and a Miss World we had a full house. The lion tamer took us to Worth's Circus and six of us were taken into the lion's cage and taught the principles of not getting eaten by a lion. Miss World tearfully told us that she was going to devote her life to the welfare of spastic children. A week later she married a wealthy car dealer and was never heard of again.

Looking back on Commingle I am now aware that we didn't invite a farmer, a Flying Doctor, a rural or remote doctor, a country shire president, a politician, an Aborigine or one of the many migrants who were struggling for professional recognition. Being in my 51st year of medical practice, I have treated lots of farmers, Aboriginal people, shire clerks and rural doctors, but I have yet to be consulted by a lion tamer or, sadly, a Miss World.

Commingle didn't last very long. It gradually gave way to lectures and laboratories on the 'hard sciences'.

As a fifth-year medical student, I was aware that we had no exposure to city or country general practice or to Aboriginal people and patients. I went to see Eric Saint. He said, "All right. You can do half your medicine term in Collie". That was where I first began to learn what medicine was all about.

I graduated in 1960, went on my medical travels and, in 1976, was appointed the Foundation Professor of General Practice at UWA.

In those 16 years, little had changed in the UWA Medical Curriculum. There was a student option of two weeks of general practice. It could be taken in the country or the city. About a third of the students took it. The few who went rural came from the country or had a family friend who was a country doctor. There was still no exposure to Aboriginal or migrant health issues.

I thought I had been appointed to add such experience and knowledge to the curriculum. I managed to insert four hours of lectures on Aboriginal health issues into the curriculum and was accused of making the UWA medical course irrelevant. And I started to try to understand what happened to this intention of 'Growing your own doctor'? As I travelled around the countryside, I was accosted by some angry people. One was the president of a wheat belt shire who said, "In 1957, I gave £10,000 to the Medical School Appeal" (the country people actually gave 75 per cent of all the private money) and, he went on, "I have yet to see one of your doctors."

One of the most enthusiastic and hard working Medical School Appeal Committee members was Harold Nash, an ear, nose and throat surgeon. He visited every single one of the 130 Roads Boards in Western Australia and he promised them that we would grow our own doctors. And there are West Australian born and educated rural doctors in nearly all the coastal rural towns. But in the wheat belt, Pilbara and Kimberley there are still Medical School Appeal donors who have yet to see a UWA medical graduate.

"So what went wrong?" Well, I think what went wrong was that the appeals committee had done its job. They had done excellent work, they had got the money, they had money in reserve in an endowment fund, and they retired and they left it to the new professors. And many of the new professors came from, or had done postgraduate training in, the United Kingdom. So they set up a new medical school similar to what they already knew. They were somewhat blinkered about the needs of the people in the vast geographical region outside of Perth. And there was no one in the new Faculty who championed the cause of rural and remote people. And the rural leaders who sat on the boards of the Agricultural Society, the Sheepbreeders' Association and the Senate of UWA, knew that it took a decade or more to produce a well rounded doctor and they held their tongues and remained patient.

To be fair, the Faculty academics were few in number and had more than enough to do to practise their branch of medicine, teach and establish a new school and research programs. They also had to cope with the inevitable and enervating town-gown demarcation disputes. And in order to gain universal recognition of its degree, the UWA curriculum had to be approved by the General Medical Council of Great Britain. That body was very conservative and was about two decades behind the curriculum intentions of UWA (eg. social and community medicine) and indeed modern developments in medical education being pioneered in the USA.[1]

When I started to try to broaden the education of future UWA doctors, I was well aware of a 1975 statement by TE Chester a professor of business administration at Manchester University who said,

"It is easier to win a war than to change a medical curriculum by even one half hour." But, to my absolute amazement, the professor of surgery said, "I've got this four-week period that's supposed to be Casualty Medicine but we don't have the staff to do anything with it. You can have it." So I used that time to give all final year students a four-week experience of rural and remote medicine.

The difficulty was that there was nowhere for our students to stay because the dean's secretary had, for the previous nine years, organised for between 40 and 50 German students a year to go to rural areas for two to three months as part of their medical schools' elective. The Health Department cooperated with her and employed them as hospital orderlies with free accommodation. At that time UWA students did not have time allocated for an elective. So I had to get rid of the German students, which was not easy. One of the German students inadvertently helped me. He was attached to the Flying Doctor in Derby. They were doing a clinic at a remote settlement when he saw a wild brumby. He was a horseman and managed to jump on the brumby that promptly took off. He didn't reappear and the Flying Doctor had to leave. There was a four-day search before student was found, somewhat dehydrated but still alive. And that was the end of the German students.

Not much else happened in the world of rural medical education until the mid-1980s when the medical plight of rural people, rural doctors and rural nurses started to get some media coverage. 'Letters to the editor' followed but each letter always contained some minor error that a dean, deputy vice-chancellor or bureaucrat could latch on to and so ignore the substance of the writer's argument.

In 1985, there was a State election and the result hinged on six marginal seats of which four were rural. I wrote to the doctors in those four electorates urging them to contact their sitting member about the shortage of rural doctors and locums. And enough of them did so to worry their Member. The Minister of Health diffused the situation by ordering a Ministerial Inquiry into the Recruitment and Retention of Country Doctors and I was appointed to chair that Inquiry. After two years of research and hearings that report was handed to the Minister at the end of 1987.

We found that, between 1963 and 1986, the rural origin entry into our medical school was 1% of entrants. Also, only 30% of the teachers in the medical school had ever spent longer than one week in a rural area. We recommended affirmative student selection, decentralised medical education, rural student clubs, and an organisation—the West Australian Centre for Remote and Rural Medicine—to drive all of this.[2]

Everyone was pretty happy with this report except the Minister of Health and the Faculty of Medicine. The Minister was badly advised and refused to print and distribute the Report. After some lobbying within his rural electorate he changed his mind and agreed to print 800 copies (I had requested 1500). The Faculty of Medicine Executive argued that our recommendations would lower standards. They also stressed that the shortage of doctors in the country was not their problem. It was a problem for the Health Department of Western Australia.

1987 was a pivotal year for rural health care. Complimentary to the academic activities in the West, the New South Wales Rural Doctors set up the Rural Doctors' Association (RDA) and withdrew their services from country hospitals. The New South Wales Rural Doctors' Strike came about because the Commonwealth Government was trying to curb the Sydney-based activities of the entrepreneurial Dr Geoffrey Edelsten and his after-hours clinics. And so they said, "Right, there's going to be no after-hours fee." They completely ignored the effect this would have on the genuine providers of after hours care. So if a country doctor was called to the local hospital at 2 am he received $14.95, the ambulance driver that drove the patient into the hospital got $100, and so forth.

The inaugural President of the RDA was Geoff Cutter, an English trained GP then working in Bourke. The Premier of New South Wales at the time was Barrie Unsworth and he had come up through the Union movement. He said, "I know how to deal with these Pommy union bastards." But he didn't understand the depth of the rural doctors' sense of injustice. The following year he lost the State election partly because of the rural doctors' issue but mainly because of another rural issue, the right to keep guns.[3]

Back in WA, the Western Australian Centre for Remote and Rural Medicine started in 1989 with a grant of $2 million from the then Minister of Health, Keith Wilson. We were very parsimonious with the money and because of the prevailing high interest rates we didn't touch the capital for three years.

The Faculty of Medicine was softening its hard line stance and agreed to a trial of taking in six rural high students on an affirmative entry program. Most of them are still working in rural and remote areas.

Colin Bartlett, who was a storekeeper in the very small town of Mingenew, with a population of about 400, came up with the idea of the Country Medical Foundation, and that was the precursor to the Rural Australia

Medical Undergraduate Scholarship scheme (RAMUS), that provided scholarships for doctors and nurses. So things were beginning to happen.

In 1991, the first National Rural Health Conference was held in Toowoomba. Brian Howe, who was the Commonwealth Minister for Health and also the Deputy Prime Minister spent three days at that conference and he was a good listener. He encouraged rural doctors to fight for changes that would benefit rural patients. I also learned that a politician's own doctor is really influential because that politician assumes that what happens to him and his family is the norm. It usually isn't. Brian Howe thought highly of his long time GP who had provided much help for his family. His doctor had very rundown rooms and whenever Mr Howe asked what he could do to help was told, "Nothing, I'm perfectly happy." But, whenever he visited an expensive hospital he was inundated with complaints. So the incongruity between the wants of the Minister's doctor and those of the teaching hospitals got the Minister thinking.

From then on progress was gradual but in a positive direction. In 1992, the National Rural Health Alliance had its first meeting. The first rural training unit, the Cunningham Centre, started in Toowoomba. This was followed by the Monash University Centre of Rural Health at Moe with Roger Strasser as Australia's first Professor of Rural Health. Seven university departments of rural health (UDRHs) were funded. The WA UDRH was in Geraldton.

In 1993, the Commonwealth Department of Health and Aging funded the GP Rural Incentives Program. Ten per cent of the $25 million dollars was earmarked for the Rural Undergraduate Steering Committee. They allocated about $250,000 per year to medical schools that would guarantee that 25% of their intake would be of rural origin and that all students would receive a minimum of eight weeks of rural exposure. No university refused the money. Some were amazingly creative in accounting for it. For example, Sydney University declared Canberra to be a rural area. And Tasmania defined rural as having a home address more than 10 kilometres from the Hobart GPO. This made 90% of their intake rural and lead to peons of praise from the then, Federal Health Minister, Dr Wooldridge.

Part of that Rural Undergraduate Steering Committee money was available for 'Projects of National Significance'. Paul Worley from Flinders Medical School had begun the Riverland Decentralised Education Program. The Committee gave him $1 million. He showed that students who went through this program were not blighted for life and, in fact, did pretty well in their exams.

Other major events for rural health were the inception of the Australian College of Rural and Remote Medicine in 1996, the University of New South Wales Rural Entry Scheme in 1997 and first Rural Clinical School in Wagga Wagga, run by UNSW, in 2000.

And then there was Jeff Kennett. In 1999, Jeff Kennett was a confident, somewhat arrogant, high profile, Premier of Victoria. Psephologists predicted that he would have a landslide victory in the forthcoming election with up to, an unheard of, 70% of the primary vote. But they forgot about the rural areas. And Jeff Kennett was very Melbourne-centric and had done nothing for the rural areas. He lost every single rural seat, and he lost government. And that was good for rural endeavours because the Commonwealth Government really started to take notice and a lot of money became available for rural projects.

Back in WA the Faculty of Medicine still had difficulty in comprehending that they were supported by taxpayers' money, and that taxpayers, including rural ones, want a return for their money. It requires a paradigm shift for a conservative and elitist medical school to understand that in addition to providing a good medical education (which they did), they have a social responsibility to try to produce the sorts of doctors that were required by the State.

Despite the published educational evidence that rural exposure improved students' examination results, the usual conservative objections and prejudices carried greater weight. The Professor of Cardiology stated that if students missed his lectures on cardiac arrhythmias, they would be, "*blighted for life*". Hospital-based specialists said it was impossible to teach in rural areas. I had been through this before. This was my fifth iteration. At a meeting on December 7, 2001, (Pearl Harbour Day), I suddenly realised it was time to retire. I couldn't stand it any more. I thought I'd give the University plenty of time to select a successor. I thought it symbolic to retire on American Independence Day, 2003. And on that day my university advertised the position.

But money for rural clinical schools became increasingly available and, in 2003, Campbell Murdoch was appointed to run the Rural Clinical School in Kalgoorlie. And, from there, things have really moved on and in WA there are now 12 rural centres and one 'rural' metropolitan centre. This situation is mirrored all over Australia.

The Rural Medical Education Movement did not come into being through the initiatives of Deans of Faculties of Medicine or from Federal or State Departments of Health. It arose from the long opposed efforts of a few champions or pathfinders, aided by some unexpected State election results that resulted in increased funding for rural endeavours. Universities and their medical schools are not known to refuse funding even when it is tied to guarantees with which the majority of faculty would disagree.

The 'tsunami' of medical students has also helped. Medical schools are struggling to provide their students with educational opportunities. The rural clinical schools are a saviour. And the students realise that their rural educational experiences are more personalised and their examination results better than their city based classmates. Their rural year is also an adventure.

But, these golden days will not last forever. The hospital-based sub-specialists are still the elite and the power base in the older established medical schools. Their raison d'être, and that of their universities, is research, funding and world ranking. Their models are Harvard, Stanford and the Massachusetts Institute of Technology. They regard community-based practice and learning as a soft and inferior occupation, unworthy of their attention or support. Already Melbourne University is reverting to its pre-1993 position by making it harder for rural applicants to get admitted to their medical course unless they become $220,000 fee-paying students.[4]

And in the not too distant future, the Commonwealth funders and the doctor deficient rural constituents will be asking medical schools: "How many of your graduates are working in rural and remote Australia? How many are working in Aboriginal health services? What proportion of the doctors in isolated and rural areas are West Australian graduates?" And if the numbers are small, then the funding will be cut.

And so for those of you who champion rural health, it is very important to have data. The Office of the Committee of Deans is supposed to be gathering this data. Make sure that this is actually happening and get access to that data and/or keep your own. The common statement that, "We are doing such great things that we haven't had time to collect any data", cuts no ice with auditors. Nor does it in a town that has never seen a graduate of an Australian medical school.

So my message is that initiatives don't always succeed through planning and logic. Pathfinders also need to have good maps, be able to read them and make the most from (hopefully lucky) political events. And pathfinders need to constantly defend their innovations, not with hype and spin, but with good data. Without it, the self-interested power brokers in medical schools will claw back your hard fought gains.

Thank you.

Sources

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