Rural and remote general practice

Michael Clements

IT IS A PRIVILEGE TO INTRODUCE THIS ISSUE, dedicated to rural and remote general practice – the communities we serve, the clinicians who serve them and the systems that must do better by both.

For the College's rural faculty, no advocacy priority has loomed larger in recent years than workforce. The shortages are real and the numbers are stark: fewer doctors per head of population the further you travel from our cities, longer waits and practices closing their doors for want of adequate funding and staff. The consequences are written in the health of our communities – outcomes worsen with every step away from the city, with a higher burden of chronic disease and lower life expectancy for the very Australians who contribute so much to this country. Several articles in this issue confront this directly, from an innovative hybrid model for sustaining care in remote communities,[1] to the sobering reality that many rural doctors must travel hundreds of kilometres to access healthcare of their own.[2] Workforce is not an abstract policy problem. It is the difference between a community with a doctor and a community without one.

Yet this issue is not a lament, because rural general practice is not a story of deficit. It is, in my view, the best of our profession on full display – and, when the settings and supports are not right, a warning to the whole general practice community of what is at stake.

Rural general practitioners (GPs) and rural generalists are leaders in developing innovative models and workflows to overcome the challenges of isolation – stretching resources and coordinating care across vast distances. They show the best of GP behaviour in adapting their skills and learning to meet community need, whether that means upskilling in emergency care, obstetrics and mental health, or stepping up when disaster strikes, as they have done through bushfires, floods and pandemic – in car parks, paddocks and evacuation centres, and quietly in their own practices long after other responders have left.[3]

Rural clinicians have also led the way in genuine team-based care. In small communities it is an all-hands-on-deck approach: the cleaner applying plasters, the gardener assisting with cardiopulmonary resuscitation (CPR), the wardsman supporting a psychiatrically distressed patient. This is not a compromise – it is a model of trust, shared purpose and community ownership of health that the rest of the country could learn from.

The patient voice in this issue reminds us why it matters. The retrieval, as one contributor writes, is only the beginning;[4] it is the rural GP who picks up the pieces in the months and years that follow, as the calm in the chaos and the constant coordinator of care. Continuity and relationships are the quiet superpowers of rural practice.

But devotion has a cost, and this issue does not shy away from it. A deeply personal reflection on the cumulative toll of decades of small-town practice[5] sits alongside evidence that our rural doctors, too, often go without care themselves, and a timely piece on the changing face of the rural workforce – increasingly female and seeking flexibility, connection and equity.[6] Caring for those who care for our communities is not optional; it is workforce policy, patient safety and basic decency all at once.

I finish where I began: with pride. Being a rural clinician is one of the great privileges of medicine – varied, skilled, deeply embedded in community and profoundly rewarding. Rural clinicians show the best of the profession, and by constant attention to the workforce and personal needs of our rural clinicians, they can continue to light the way for GPs of every postcode, in every variety of workplace, to carry out their profession with dedication and devotion to the communities they serve.

I commend this issue to you.

Author

Michael Clements MBBS B.Econ (Hons), MPH, MHM, DAvMed, DGovt (Mgt), AdvDAFStud, FRACGP-RG, FARGP, FRACMA, FACAsM, GAICD, Associate Professor, Board Member, The Royal Australian College of General Practitioners (RACGP); Chair, RACGP Rural Faculty; Rural Generalist Advisor, Queensland Health, Townsville, Qld

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correspondence **ajgp@racgp.org.au**

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