IMPROVING PREHOSPITAL CARE IN RURAL AUSTRALIA - TIME TO BORROW FROM OVERSEAS MODELS?

Dr Tim Leeuwenburg
Kangaroo Island, South Australia, Australia

Presented at SMACC2013 'Social Media & Critical Care 2013' Sydney, Australia

Background

Concentration of specialist services in cities, as well as long distances mean that access to experts in prehospital medicine is invariably lengthy in rural Australia, despite the excellence of existing services. There is a direct relationship between remoteness and trauma deaths, with time between trauma and initial prehospital care being most important [1]. One may similarly extrapolate for other time-critical illness in rural Australia.

Australian rural doctors provide frontline primary and emergency care, but are at best 'enthusiastic amateurs' rather than experts in prehospital medicine. Understandably there has been a focus on improving existing paramedic and retrieval services across Australia, often bypassing existing medical resources in favour of dedicated retrieval services [2]. Such approaches do not take into account the contribution to critical illness that can be made by rural doctors.

Methods

Rural GP-anaesthetists were invited to complete an online survey regarding their involvement in prehospital medicine.

Principle Findings

293 of 461 rural GP-anaesthetists responded (65% response rate). Of these 58% reported that they were called upon to provide prehospital services by other agencies. Only 7% reported that such involvement was through a formal arrangement. Formal training in prehospital medicine was uncommon (12%). Only 37% reported use of same protocols as retrieval services.

Discussion

Given the considerable distances inherent in rural Australia and the increasing reliance on volunteer paramedics in rural/remote areas, the rural GP-anaesthetist is well-placed to value-add prior to the arrival of retrieval experts [3].

Models from overseas such as the UK's BASICS and NZ PRIME recognise the value of tasking doctors to support paramedics in certain circumstances [4, 5]. That such schemes are considered necessary even in a high-density area such as the UK begs the question as to why arrangements to formalise callout criteria, equipment and training for rural doctors has been neglected in Australia despite the tyranny of distance.

1. Fatovich, D.M et al (2011) A comparison of metropolitan vs rural major trauma in Western Australia. Resuscitation 82 (2011) 886–890

2. Anon. Kerang medics ignored. The Age, 14 July 2011. (Online) 2011. Available: http://www.theage.com.au/victoria/kerangmedics-ignored-20110713-1hebl.html (Accessed 21 October 2012).

3. Leeuwenburg, T (2012) Access to difficult airway equipment and training for rural GP-anaesthetists in Australia: results of a 2012 survey. Rural and Remote Health 12: 2127

4. British Association for Immediate Care (BASICS UK). Home page. (Online) no date. Available: http://www.basics.org.uk

5. Hore T et al (2003) Is the PRIME (Primary Response In Medical Emergencies) scheme acceptable to rural general practitioners in New Zealand? http://journal.nzma.org.nz/journal/116-1173/420/