An interview with Adjunct Professor Ruth Stewart

Ruth Stewart is the National Rural Health Commissioner, and a keynote speaker at ASMIRT 2022. Ahead of the conference in May, we asked Ruth some questions about her career and what can be done to help improve the health of people living in rural Australia.

What is your role?

I'm the National Rural Health Commissioner, a statutory office independent of the Department of Health and Minister of Health, reporting to the Minister of Regional Health I have direct lines of communication with senior executives and ministerial offices. My role is to consult with key stakeholders to formulate advice to the minister and assist in policy creation to improve the health of people living in rural Australia.

Who or what inspired you to become a doctor?

I was a rural kid who became a rural doctor. I grew up in a country town in rural Victoria and wanted to be like the two GPs we had in town, who were rural generalists. They delivered babies, performed surgery and administered anaesthetic. I was impressed by both their knowledge and the respect they were held in by the community.

When my grumbling appendix finally gave in, the doctor was feeling my stomach (and what I now know was my liver) and I asked him what he was feeling for and he said, "your liver". And I was like 'wow, he knows what's inside me and I really want to be like that'. I was seven at the time and knew then that I wanted to be a doctor.

Can you briefly describe your career progression?

I studied medicine at the University of Melbourne, and eventually took on a junior hospital position in Geelong. After I married, my husband and I went to Scotland to get obstetric training for the life we wanted as rural GPs. We then worked in southwest Victoria for 22 years as GPs and rural generalists in private practice, and as visiting medical officers at the hospital working on the emergency and obstetric rosters.

Along the way I ventured into medical training and became the inaugural Director of Clinical Training Rural with the Deakin Medical School. My role was to establish the rural program. I then took on the role of Director of Rural Clinical Training at James Cook University. I've been on the board of ACRRM for 20 years and several other boards, including hospital boards.

What are your views on the future of integrated rural practice in Australia?

I think that one of the reasons we have trouble attracting clinicians and practitioners to rural practice is that we expect them to work in urban models in communities, which doesn't work. There is good evidence that strong multi-disciplinary teams are what makes working life (and high-quality service and sustainable work) in rural and remote communities. The future of rural and remote health care must be multi-disciplinary teams with strong integration. It is not in the public's interest to have practitioners working in different silos. We have plenty of evidence that demonstrates that practitioners working in separate silos creates risk for the community and discontinuity of care. The solution to that is strong integrated teams with clear lines of communication and co-operation and moving away from hierarchal roles to strong co-operative team models. You have the whole team and can support each other and it's the more productive and resilient team than having the same mono culture. Everybody should have equal opportunity and work to increase diversity so everyone has a chance to participate in society and contribute, however without diversity of teams you can't achieve as much because you have a more limited repertoire in problem solving ideas.

What work is being done to address the equity of care for rural patients, particularly cancer patients, to the same facilities of their city counterparts?

You need different approaches for the high frequency conditions to the lower frequency conditions. High frequency conditions such as bowel, prostate and breast cancers, there should be a lot of rural and remote clinics in centres that have a large population to run that. When I say 'clinic', it doesn't have to be a permanent clinic, and it doesn't have to be the only thing it does. You need to have generic skills that can be applied so you use generalists with their generalist skills. You may need to give some specific training for that clinic and bring them together and then you fly or drive in the specialist expertise when needed. That works well, if you think the only time care will be given when the specialist flies in, that's when you have a poor and low functioning clinic and you need to upskill the local generalists – the GPs, nursing staff, radiographers – so that they can do the work, the easier high frequency work that is needed and save the more complex cases for when the specialists visits. That's the way I see the optimal care for high frequency conditions and by that you build links with clinicians and develop referral pathways for the low frequency conditions.

What are your views on the newly announced scheme whereby medical graduates and nurse practitioners who agree to work in rural and remote settings have their university fee debt wiped in return for service? Are there similar schemes planned for allied health?

Before the announcement was made, there was plenty of discussions along those lines. The minister and department are interested in seeing the impact of this for doctors and nurse practitioners and, rest assured, there has been strong advocacy for allied health professions to have access to a similar scheme.