Training for rural practice
Lessons from Australia

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Lessons from Australian experiences suggest similarities between Australia and Canada.[1] This paper explores key issues in training for rural practice.

Importance of rural training
Training for rural practice has become critically important in the context of continuing serious shortages of family physicians in rural areas and in recognition that "the overflow effect" does not happen. Producing more physicians and expecting the excess to spill over from the cities into rural areas has been shown not to solve shortages in the rural medical work force. In fact, no single strategy is likely to be successful. Rather, many strategies are required at different levels of education and training, each of which contributes to an overall substantial change.[2]

When compared with their metropolitan counterparts, rural practitioners carry a heavier workload, provide a wider range of services, and carry a higher level of clinical responsibility in relative professional isolation.[2] Rural medicine has three broad components: first is all-round family practice; second is procedural care, particularly dealing with emergencies; and third is rural family practitioners' important public health role that can span from clean water and sanitation to community health education.

Principles of rural training
Many attitudinal and perceptual barriers discourage students and graduates from entering a career in rural practice. Most of these are misconceptions, and others have a basis in reality. The key misconception is that rural practice is somehow of a lesser standard or "second class." Another attitudinal problem is that of "learned helplessness." Senior specialist teachers give the impression that only they should be managing clinical problems in their specialty field. Consequently, the highest aspiration of many new medical graduates in dealing with medical problems is being able to assess to which specialist they refer patients, rather than managing problems themselves.

Evidence shows that the three factors most strongly associated with entering rural practice after completing education and training are a rural upbringing, positive clinical experiences at the undergraduate level, and specific postgraduate training for rural practice. Successful training for rural practice requires enhancement of facilitators to entering rural practice and a specific focus on overcoming the substantial barriers.[3]

Preparing for rural practice is best seen as part of a continuum of education and training that begins at the secondary school level and continues through undergraduate education and postgraduate training to continuing professional development and university graduate studies. It is useful to conceive of this continuum as a "career pathway for rural practice," which is initiated through recruiting students from rural origins into undergraduate courses and is helped at each stage by rural-based academic units.[3]

Lessons from Australia
The first lesson from the Australian experience is that it is essential to promote medicine and the health professions to rural secondary schools in order to recruit students from rural origins into medical school. Some career advisers in rural secondary schools are not necessarily helpful and discourage high school students from aspiring to medicine, suggesting that the students should not set themselves up for disappointment.

In regard to selecting students from rural areas for the medical course, there are two key lessons

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learned from the Australian experience. First, it is essential to have some form of "affirmative action" built into the selection process in order to achieve a target number of rural students in the medical school year equivalent to the proportion of rural people in the population. Some Australian medical schools achieve their rural intake target by having a "special admission scheme" that treats rural applicants differently from others. This stigmatizes rural students because it encourages the view that they are academically of a lesser standard and are being given special treatment.

At the undergraduate level, the first lesson is that a strong emphasis on student support is very important. This occurs through rural students' clubs that provide social support and networking and encourage an interest in rural practice among city students. A rural mentor scheme is also of great value. Rural mentors provide support, encouragement, guidance, and role models for students as they work their way through the medical course.

In terms of curriculum content and rural placements, a key lesson is to ensure that students have high-quality clinical and educational experience. In the past, some medical schools have rotated students to rural hospitals, which has made the students feel they were moved "out of the way" in teaching hospitals. Clearly, this type of rural attachment is counterproductive, as it tends to encourage students' negative perceptions of rural practice.

Improving education

Over the last 10 years, Australia has gained experience from a variety of initiatives aimed at improving education and training for rural practice. These include the following.

- Recruitment of a substantial proportion of students from rural origins into the undergraduate medical course.
- Overt and covert endorsement of rural practice as a career that is professionally challenging and rewarding, and personally satisfying.
- High-quality clinical and educational experiences at different stages of undergraduate education, as well as postgraduate training. Ultimately, it is impossible to learn to be a rural practitioner without substantial clinical experience in rural settings.
- Rural clinical teachers who are rural practitioners, trained and supported by rural-based academic units.

Another lesson from the Australian experience is that, as much as possible, the negative aspects of rural clinical attachments should be neutralized. Consequently, accommodation for students on rural placements should be of a high standard and be provided at no cost to students, and travel costs should be reimbursed.

After graduation, the lesson from Australia is that training for rural practice must occur in a rural context. Successful Australian regional training programs have three key features. The first and most important is supporting hands-on family practitioners as the primary teachers in the training program and having them more actively involved in all aspects of the program. The second is that specialist teachers during hospital placements are encouraged to focus their training on the residents' future in rural family practice. The third feature is vertical integration whereby educational activities link undergraduate students with postgraduate trainees and practising physicians' CME activities.

In relation to continuing education and professional development, the main lesson from Australia is the importance of accessible and appropriate education programs. Accessibility is achieved through a combination of distance education methods and seminars and workshops held in rural regional locations. Appropriateness is achieved by having rural practitioners develop and implement education programs for rural practitioners.

Providing graduate studies by distance education has proved particularly successful for rural practitioners in Australia. Many rural family practitioners have undertaken graduate studies in family medicine and in rural health offered by Monash University by distance education. These programs allow rural practitioners to acquire new academic and clinical skills while remaining in rural practice. Also, they have helped provide a pool of academically trained rural practitioners able to contribute to further development of rural medical education.

Framework for successful rural training

Successful rural training requires acknowledging and even adopting rural culture and committing to "do the necessary" to achieve desired outcomes. And "the necessary" involves many strategies at various levels, each of which contributes to an overall substantial change.

Curriculum development for rural practice education and training encompasses six domains[4]:

1. rural and remote context: psychology, sociology, demography, geography, politics, and economics of rural and remote communities;
2. comprehensive clinical medicine (core medical practice): reflects the breadth of rural medicine;

3. in-depth (extended) clinical care: diagnostic, therapeutic, and clinical management skills, which, in urban areas, are generally the province of specialists;
4. indigenous people's health: encompassing indigenous people's history, culture, and primary health care issues;
5. emergency care: rural communities' "safety net"; and
6. population health: from clean water and sanitation to community health education.

Conclusion

Successful training for rural practice requires a commitment to people in rural communities and to training (students and residents) through a variety of strategies that contribute to producing well trained, highly skilled rural practitioners working in sustainable high-quality rural health services.

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