The National Rural Faculty Bursary Essay

To promote remote: a positive approach to rural general practice

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Australian Family Physician is proud to publish the winning essay in the inaugural National Rural Faculty Bursary, an award offered by the National Rural Faculty (NRF) of The Royal Australian College of General Practitioners to a medical student who is a member of a Rural Health Students Club at an Australian University.

It is well documented that life expectancy varies with geographic location; the explanation for this is simply that access to health services, facilities and resources varies geographically. Developed countries such as Australia have an excellent standard of living and health care system. This leads to long life expectancy when compared with developing countries. Within each country, however, there are different standards of health care provided in different locations. The most notable contrast is between metropolitan and rural (or remote) regions – even in Australia.

Australia is primarily an urban society. More than 70% of the population lives in a metropolitan zone with the remaining 30% in rural zones.[1] An issue often mentioned is the national shortage of general practitioners especially in rural areas. This can be accounted for by the following explanations. In Australia, as with many countries, there is an inevitable process of urbanisation causing a gradual shift of rural people into cities in search of a better life and opportunities. This is also true of aspiring rural doctors who must undertake their medical degree at universities based in major cities. On top of this, a medical degree takes at least 5–6 years to complete followed by an internship, residency and specialist training – with the majority carried out in an urban environment. This is especially true for specialist training as the opportunities for some specialities are limited in rural areas.[2] After spending lengthy periods in the city, it is possible this may influence future doctors to stay in urban environments. There is also a perceived socioeconomic disadvantage associated with rural life (eg. resources, education, occupation).[3]

The underlying problem with rural health care and, in particular, rural general practice, is the shortage of GPs for the above reasons. The lack of rural GPs means that those currently in place are aging and being overworked; many averaging over 50 hours per week. Over 60% are working in areas of GP shortages.[4] A significant proportion of these GPs are from overseas. These working conditions induce stress and continuing anxiety, low self esteem, and social and family isolation which are cumulative and increase chances of poor mental health. This does not make rural general practice seem viable.

These facts have been noted by medical associations around Australia and by a government that has since introduced initiatives to encourage an influx of rural GPs. These initiatives include providing a rural student entrance scheme, scholarships to rural students, scholarships for students to visit rural practices, and more recently, bonded medical places.[4] Medical schools now have a requirement that 25% of their intake must be students from a rural area.[5]

There are several reasons why these incentives may not work. Even though students with a rural background are more likely to return to practice in rural areas,[3] the rural entry scheme may still lose future rural doctors to urban settings. If these students spend a decade or more of their time in

urban environments and grow accustomed to its lifestyle and better opportunities, they may be reluctant to return to rural regions. This decade is often a time for life pairing, and factors such as where their partner is from and what occupation they have can influence whether they move to a rural area.[3]

Scholarships to visit rural areas tend to be offered to rural students, negating the whole purpose of raising awareness and promoting rural practice and community. Perhaps some rural scholarships could be tailored specifically for urban students to introduce them to the benefits of country living.

Some students might accept a rurally bonded medical place just to get into medicine. These students may no longer be willing to complete their compulsory 6 years service in an area of unmet need when the time comes. It is questionable that these students, some of whom are just out of high school, are adequately informed to make these decisions – decisions that will affect their life 5–10 years in the future when they finish their training.[6,7] This could result in students paying back money, or serving their 6 years against their will. Neither is a good outcome.

What I would like to see changed in rural general practice is its approach to attract more doctors to combat the shortage. A greater proportion of money should be spent promoting rural general practice and focussing on the positives of rural life rather than just offering more financial incentives.

General practitioners enjoy being a prominent part of the community and building relationships with its members. Therefore, the warmth and strength often found in rural communities should be the target for promotion to future GPs. The community lifestyle factors are just as important – if not more so – as the job.[8] This is what scholarships such as the John Flynn Scholarship Scheme, cadetships, Bush Bursary, and trips away sponsored by rural medical societies are starting to promote. If a doctor is given the opportunity to build a commitment or loyalty to a town, this increases the likelihood of that doctor staying there to practise medicine.

A lot of emphasis is currently placed on student placements or scholarship visits to rural and remote areas. However, it would also be worthwhile investing in rural GPs visiting major medical universities to present their experiences of rural general practice. This not only offers greater exposure to more medical students, but can also give the visiting rural GP a greater sense of job satisfaction. The GP could correct misconceptions and clear up any myths surrounding rural general practice and rural life. Instead of bringing the student to a rural community, a rural GP can bring a part of his or her community to students.

The introduction of medical courses to rural universities, or even the creation of more rural universities, would also be worthwhile. Rural students could then study medicine in an environment closer or similar to home, reducing the likelihood of losing students to major cities and creating more opportunity in rural areas. Rural students are more aware of the pertinent medical issues in rural life compared to someone from an urban background. It is therefore wise to develop future rural GPs in rural Australia rather than in the major cities (and possibly running the risk of losing them). This is, however, limited by resources and teaching facilities available in rural areas, especially for the provision of specialty teaching in the latter years of the medicine program.

Better educational and occupational opportunities should also be provided for the rural population in Australia. It should be realised that the problem is a holistic one and not purely centred on the shortage of doctors. General practitioners considering the shift to rural areas would need to evaluate the education and employment options of their future children and partners.[3] Improving schools and employment opportunities in rural areas should perhaps be given just as much attention for a more long term solution. In fact, there are certain advantages of rural education that should be promoted. For example, small community schools in rural areas may not have the same resources as schools in urban areas, but they can provide 'more one on one time with the teacher and a more intimate and friendly environment'.[8]

An influx of more GPs into rural areas is vitally important. It can start a series of events leading to better working hours, facilities and standard of care. The increase in health and welfare can then translate to increased population and wider improvements in life opportunities. The means of achieving this goal should be prioritised and new ideas continually fostered. There are many initiatives being used by commonwealth, state and individual universities, however, the effect of these will not be seen until the current cohort of medical students graduate and complete their training. Once this occurs it will help in making current initiatives more effective as well as in planning for new strategies.

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