# The challenges of remote area medical education

Louis G Peachey and Kristin E McBain-Rigg

*To what extent should we cushion the realities of remote area living for young people who are seeking challenge and inspiration?*

There is some evidence that exposure to good learning opportunities in rural and remote areas will influence medical students to more strongly favour rural or remote careers.[1-3] Recognising the potential for this outcome, a cadre of academics and rural clinicians began a program of planning and lobbying universities and governments more than two decades ago. As a result, there has been a significant growth in rural and remote teaching facilities, with the development of rural clinical schools (RCSs) and university departments of rural health (UDRHs).[4,5] The process of establishing and maintaining facilities for rural and remote medical education has required sustained effort from rural and remote educators, with the political will to undertake the programs often seeming more subject to whimsy than good planning. There have also been numerous practical challenges, some of which are reflected in the adverse student experiences outlined by Patel and colleagues in this issue of the Journal (*page 497*).[6] Their findings raise genuine concerns about the adequacy of clinical supervision and organisation for remote area placements, but also provide an opportunity to consider what we expect our students to bring to, and take away from, the remote area experience.

Establishing a remote area educational facility requires a holistic approach to the needs of both the student and the community. In large metropolitan centres, universities can concentrate their efforts on delivering quality education to students, while the students bear responsibility for their own domestic needs such as housing, transport, nutrition and socialisation. This is generally not the case for remote units where, as well as considering the quality of education, it is often necessary to make provision for these basic needs.

This has created some unforeseen challenges. With housing, for instance, federal grants were used to build new accommodation for the remote units from the late 1990s but, 10 years down the track, it became apparent that there had been no allocation of funds for their upkeep. Communications infrastructure was also in need of upgrading, as internet-based educational resources from the mother universities are not always effective when carried through the old copper wiring on the other side of the black stump. Few vice-chancellors would concern themselves with wondering if their students have access to good sanitation, clean running water, reasonably priced food, and safe areas for social activities, but these have been the day-to-day concerns of the directors of the UDRHs and RCSs. It also seems that many of the students arrive from their mother universities with little warning that, in a remote community, $10 for a head of lettuce can be a bit of a bargain — or of many of the other realities of remote life that await them.

Transport is another challenge. While the sandstone universities can reasonably expect their students to avail themselves of the many and varied public transport options to travel from their housing to their place of training, remote area units often have to bear this responsibility and expense themselves. This is in addition to the vast distances that may need to be travelled to reach the remote education centre. For example, the distance from Brisbane to Queensland's UDRH at Mount Isa is about 1600 km (about the same distance as from Brisbane to Adelaide, or Adelaide to Mount Isa). Once students arrive in Mount Isa, they will then spend some time in one of the outlying centres, which could be Boulia (300 km by road), Mornington Island (460 km by air) or Longreach (660 km by road).

Students' experiences of clinical placements are highly influenced by their teachers and supervisors, as well as the location of the placement.[7] In remote areas, teaching and supervision are likely to be delivered by a specific individual. We have managed to acquire gifted teachers in a number of remote areas, and universities have sought to support these teachers, in addition to developing the next generation of teachers, with various graduate certificates and masters degrees now available in medical education. However, putting infrastructure in place, only to have the pivotal individual subsequently leave the area, creates enormous difficulties in placing the student load.

Along with these kinds of practicalities, the article by Patel and colleagues raises a philosophical quandary for remote educators and medical schools. To what extent do we wish for the students to experience the joys of remote education without the sorrows of remote area living? We celebrate the courage of folks who try their luck at bungee jumping but, when the rope breaks, we are outraged that the proprietor had the audacity to place patrons at risk. We also forget that bungee jumping did not start as a middle-class pastime, but as a sacred rite of passage for the young men of Pentecost Island.[8] The rope was a vine, and it was not purchased and tested by the jump-tower proprietor, but selected, cut and self-attached by the jumper. When a vine snapped and injury or death ensued, there were no lawsuits against the Great Spirit for creating an inferior-quality vine. A rite of passage that has no risk to the initiate is no longer a rite of passage; it is simply an amusement park ride. How much of a genuine disincentive are the risks of the rite of passage to the young person endeavouring to express independence and explore his or her courage and endurance?

The primary goal of the UDRHs and RCSs is to increase the rural health workforce. However, there are also benefits for students who choose not to return to the bush. These students will have had their consciousness raised to the idea that working as a rural health practitioner can be a challenging and rewarding career option, and will have acquired a better appreciation of the circumstances and environment in which their rural counterparts need to deliver health care — and of course to where their rural patients will return after receiving tertiary care in the city.

Audits such as that done by Patel and colleagues are important tools to improve the quality and safety of students' experiences in remote communities. But there is a danger that, in focusing only on possible harms, we underestimate the power of difficult circumstances to enhance the very attributes that are required for the long haul in rural and remote practice. When one of us (L G P) worked as a medical educator at the Mount Isa RCS, there was a background assumption that the young people coming to the school were so fickle that allowing them to experience the realities

of remote area living would ensure that they never returned. This, however, has not been our anecdotal experience of this generation of caring, compassionate and committed health professionals. Nor is it borne out in the early data from James Cook University School of Medicine, which appear to demonstrate the successful ruralisation of the school's students, and a larger proportion choosing rural careers.[9] Rising to the political and practical challenges of educating medical students in the bush has seemingly been worth the struggle.

A lack of trust on the part of older generations in the commitment and good intentions of young people would appear to be as old as the species itself. However, as Edmund Burke noted in a letter to Frances Burney after reading her novel *Cecilia*, "The arrogance of age must submit to be taught by youth".[10]

## Acknowledgements

Thanks to Dr Ruth Armstrong (*MJA*) for assistance in writing this article.

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## References

1 Wilkinson D, Laven G, Pratt N, Beilby J. Impact of undergraduate and postgraduate rural training, and medical school entry criteria on rural practice among Australian general practitioners: national study of 2414 doctors. *Med Educ* 2003; 37: 809-814.
2 Laven GA, Beilby JJ, Wilkinson D, McElroy HJ. Factors associated with rural practice among Australian-trained general practitioners. *Med J Aust* 2003; 179: 75-79.
3 Kruger E, Tennant M. Short-stay rural and remote placements in dental education, an effective model for rural exposure: a review of eight-year experience in Western Australia. *Aust J Rural Health* 2010; 18: 148-152.
4 Humphreys JS, Lyle D, Wakerman J, et al. Roles and activities of the Commonwealth Government University Departments of Rural Health. *Aust J Rural Health* 2000; 8: 120-133.
5 Wearne SM, Wakerman J. Training our future rural medical workforce [editorial]. *Med J Aust* 2004; 180: 101-102.
6 Patel A, Underwood P, Nguyen HT, Vigants M. Safeguard or mollycoddle? An exploratory study describing potentially harmful incidents during medical student placements in Aboriginal communities in Central Australia. *Med J Aust* 2011; 194: 497-500.
7 Price DA, Milfin BM, Mudge PR, Jackson CL. The quality of medical teaching and learning in rural settings: the learner's perspective. *Med Educ* 1994; 28: 239-251.
8 Attenborough D. The land-diving ceremony in Pentecost, New Hebrides. *Philos Trans R Soc Lond B Biol Sci* 1966; 251: 503-505.
9 Veitch C, Underhill A, Hays RB. The career aspirations and location intentions of James Cook University's first cohort of medical students: a longitudinal study at course entry and graduation. *Rural Remote Health* [internet] 2006; 6: 537. Epub 2006 Feb 10. http://www.rrh.org.au/publishedarticles/article_print_537.pdf (accessed Apr 2011).
10 Burke E. To Miss Frances Burney — 29 July 1782. In: Mansfield HC Jr, editor. Selected letters of Edmund Burke. Chicago: University of Chicago Press, 1984: 107.

***Provenance:*** *Commissioned; externally peer reviewed.* ❑

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