MODELS OF RURAL PRACTICE

They provide procedural services such as surgery and anaesthesia and carry a higher level of clinical responsibility in relative professional isolation.

There are three broad components to rural medicine. The first is broad, all-round general practice/family medicine. The second is procedural care, where dealing with emergencies is an unavoidable part of rural practice. The third is the provision of public health care and education. This includes preventive health care, through immunisation and education on subjects such as hygiene and nutrition.

Characteristics of models of rural practice
The first of three characteristics of models of rural practice is teamwork. In my experience real teamwork is more likely to occur in rural areas than urban. It is encouraged by rural culture and by the special relationship between rural practitioners and their communities.

The second is the relationship between local generalist health care providers and distant specialists. Experience shows that specialists play a useful and productive role when they provide clinical support and teaching for rural practitioners. Co-operation, mutual respect and trust between the specialist and the rural practitioner produce high quality care.

The third characteristic is the use of technology. Rural practitioners learn to be selective in their use of diagnostic and therapeutic technological interventions. In contrast, urban models of practice tend to be specialist-centred, fragmented and more costly.

Seen in this light, models of rural practice are clearly not standard or second class in comparison to urban models of practice.

The potential of information technology
Information technologies have the potential to reduce isolation in rural and remote areas. Satellite links, audio and video conferencing, the Internet and other forms of high speed data transfer provide the means to improve education and support for general practitioners. Specific telehealth applications may provide rural practitioners with rapid access to clinical specialist support.

On the other hand, there is a danger that the development of information technology will be driven by city-based, centralist enthusiasts who have no understanding or respect for rural cultures, health services or practitioners. Effective use of information technology must be based on mutual respect between urban and rural practitioners.

Rewards of rural practice
For rural practitioners there are major professional rewards and satisfactions. These include the variety of practice, ranging from obstetrics and surgery to emergency medicine, the provision of whole-patient, whole-family community care on an ongoing basis and independence. The country environment and outdoor lifestyle, as well as community standing and respect are also cited by rural doctors as important.

Surveys in rural areas show a high level of patient and community satisfaction with localised health care. In general, rural communities prefer local services provided by their own family practitioners.

As we have seen, the specifics of rural health care are determined very much by the rural context. The term “best practice” suggests “one right way” to manage any clinical problem, based on the way a particular problem may be managed in a city teaching hospital. Optimal care is always context specific.

Models of rural practice are determined by rural realities and take many different forms and styles. When compared with urban health services, rural practice models tend to be more diverse, yet more coherent and cost effective. It is critical for the benefit of people in rural and remote communities worldwide that models of rural practice are recognised as distinctive and specific to the rural context. They should not be forced to conform to uniform, urban-derived models and standards.

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October/November 1997