Basic Nursing Education and Rural Health

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Although it could be perceived that the transfer of nursing education to universities reduces access for those living in rural areas, it can be argued that the change opens up a new range of possibilities which need to be exploited to improve the position of rural and remote area nursing. Perhaps more importantly, we need to retain and develop the incentives that have made rural and remote area nursing attractive to at least some nurses.

The bush nurse is as much a part of the legend and reality of Australia as the squatter, the swagman, the drover and the shearer's cook. The Bush Nursing Association, set up in 1911, preceded the Flying Doctor (1928). For early nurses in search of adventure or matrimony, or simply wishing to escape the tyranny of the matron and doctor to exercise their skills more autonomously, the bush proved a powerful attraction. Some became matrons and general factotums of their own small bush hospitals, while others, in more remote regions, adapted to the combined role of doctor, nurse, midwife, and veterinarian. They are an honorable, and relatively unsung part of Australia's history - the Women of the West not mentioned in the poem of that name.

Nurses are, of course, the most numerically predominant of health-care workers, and possibly the most versatile. No rural health policy can be put in place without them, so it remains important to ensure that at least an appropriate number of them continue to see the attractions of "the bush" - that some will continue to "go bush". However, with rising expectations, it is also important that they are better prepared for the work.

Recent changes in nursing education have centralised education and training in capital cities and major regional centres, but this is only the end step in a long process which closed the smaller country hospitals as training-schools. For example, when Armidale CAE (now UNE - Armidale) took over basic nursing education in the New England region in 1985, it replaced only two hospital training-schools, Armidale and Tamworth, separated by only 70 miles - an easy commute on the New England Highway. However, freeing nursing students from any particular hospital meant that such students could be placed in hospitals that had never been training-schools, as well as in community health-centres and nursing homes - and this was done, as it has been elsewhere in rural NSW. So, although the educational programme was more centralised, clinical placements were extensively diversified. City-based students could also elect to do clinical experience in the country - impossible under the previous system. If experience in working in the smaller rural centres during the educational programme means that graduates are more likely to opt for rural experience, then, overall, the movement into tertiary institutions can be seen as a plus.

The involvement of virtually every university in Australia - and certainly every rural university - in nursing education means also the development of improved possibilities of postgraduate education and rural nursing research. The developing Distance Education
Centres are providing nurses in rural and remote regions with ongoing education possibilities that, before 1975, simply did not exist. But, with current developments in distance education, there is also the possibility of providing basic nursing education in such a mode, allowing people who are not geographically mobile to obtain registration. This area of distance education is more problematic than providing courses for registered nurses in rural and remote areas, but is worth considering. Supplementary funding to make the problems more manageable might be worth considering.

The university-based nursing programmes have moved considerably toward a primary health approach, emphasising community health as well as hospital work, and this trend is likely to continue. Whether rural health is specifically addressed or not, such an approach seems to fit better with the sort of diverse needs that arise in rural settings. I think all institutions recognise that we cannot prepare nurses for all specific settings and the aim has therefore become to produce flexible and versatile practitioners with a high level of problem-solving skills – people who know how to access the information and resources they need in their practice. In this, we are unlikely to be 100% successful, but this emphasis seems to be generally in the right direction, particularly as far as rural and remote nursing is concerned.

It has been suggested that universities provide some sort of affirmative action for people from rural areas seeking to enrol in health professional programmes. The need for this does not seem as strong in the case of nursing. Nursing has always recruited disproportionately from rural areas in England, the USA and Australia, perhaps because nursing seems more coherent with more traditional views of womanhood which have been slower to change in rural areas and perhaps because rural teenagers have less idea of other possibilities open to them. But, in the past, nursing has also been seen as a respectable escape from small town living. This may be now diminishing, as lifestyles for women free up. In principle, I have no objection to such affirmative action, but just wish to point out that it has been operating in nursing for many, many years – although in an ad hoc sort of way. Such a policy may be more relevant to other health professionals. Perhaps before we rush in, we need some figures on where our current students are coming from.

In summary, I see the movement of the preparation of nurses into universities as offering positive benefits for rural health in terms of:

1. the orientation of the new programmes
2. the possibility, yet to be fully explored, of increasing access through distance education
3. the development, particularly in regional institutions, of rural nursing research
4. affirmative action policies in place in most institutions for the enrolment of students from aboriginal and Torres Strait islander groups
5. increasing opportunities for postgraduate study and ongoing education, again through distance education.

What is needed are incentives built into the system which would include improved career-structures for those who choose to work in the bush, better recognition of the sort of knowledge gained by such experience, better housing and more opportunities for conferences and short courses to reduce the isolation of such work.

I was involved from 1975 until last year in distance education for nurses and saw at first-hand, during residential schools, the benefits to be gained from a sharing of experiences and the development of supportive networks. I am convinced that this spin-off was just as important a part of the programme as its overt educational content, important though that was.
Nursing programmes have been trying to move away from the high-tech emphasis, and that is to the benefit of rural and remote health nursing. The more important question remains:

How you gonna keep 'em down on the farm
After they've seen Paree?