What Symbolises Rural and Remote General Practice: the Practitioner's Perspective

Richard Lawrance

6th National Rural Health Conference
Canberra, Australian Capital Territory, 4-7 March 2001
What symbolises rural and remote general practice: the practitioner’s perspective

Richard Lawrance, Royal Australian College of General Practitioners, Rural Faculty

This paper argues that the failure of rural general practice research to address the value orientations of rural general practice, and the cultural experiences of rural general practitioners, on any basis other than a sociological framework drawn from structural-functionalist thought results in policies and programs based in the same framework. These policies and programs are essentially behavioural in focus and aim to alter material circumstances in order to motivate a behaviour or behaviour change in general practitioners (GPs) and GPs in training.

The paper questions the sustainability of such changes. It proposes an augmentation of the structural-functionalist approach based instead upon an appeal to professional identity. It argues that without change at the level of identity, behaviour change is unlikely to endure. The identification of rural and remote general practice as a discursive field of symbols and signs with which GPs identify makes possible the promotion of rural practice as a culture to which GPs might aspire as professionals, rather than as a set of functional advantages, disadvantages and/or ethnographic traits which may or may not motivate them to enter and/or remain in the same. The paper draws upon research into GP behaviour change by Fox, Mazmanian and Putnam which shows that learning is integral to GP change. It asks where the education is in current rural workforce recruitment and retention strategies that enables GPs, registrars and medical students to “learn” this professional identity in a manner that makes recruitment and retention professionally attractive. It also draws on research by Davies and colleagues which indicates what might constitute effective education in this respect.

WHAT SYMBOLISES RURAL AND REMOTE GENERAL PRACTICE?

In 1997 and 1998, respondents to the qualitative and quantitative phases of the Royal Australian College of General Practitioner’s (RACGP) Rural Quality Assurance and Continuing Education (QA&CE) Needs Assessment were asked, amongst other things: What symbolises rural and remote general practice to you? A list of 21 options in answer to this question were presented in a quantitative survey of 900 rural and remote GPs in 1998 (N=706). These were derived from responses to the open question, put without value-loading, in focus groups and structured interviews in 1997. Respondents to the survey could nominate as many choices as they wished and the top dozen all rated at over (or almost over) 50%:
These “symbols” are similar in meaning to many value orientations explored in previous research. What is interesting is the difference in their ranking to similar value rankings in previous research. “Independence and responsibility”, for instance, ranked highly in research conducted by Strasser amongst GPs in rural towns of less than 20,000 in population — third highest at 20%, compared to a top ranking of environment and lifestyle at 47.7% of respondents. Strasser’s findings are echoed by research in Queensland, WA and on a national basis. In research conducted on perceptions of the RACGP’s QA&CE Program in 1992, Booth found a significant association between the values of “individual professionalism” and “autonomy” amongst general practitioners, rural and urban. Professional autonomy might thus be seen as a core rural GP value. How is it, then, that in the RACGP survey “professional autonomy” ranks only 18th in an order of 21 choices? Admittedly this is 27.7% of respondents, but then the highest ranking value orientation, “all-round professional competence”, rated with 69.7% of respondents. Could it be the use of the term “symbolises” in the survey questionnaire? If so, why? Is there a difference useful here to the recruitment and retention of GPs in rural practice?

**RURAL GP VALUES AND CULTURE**

Not all values “symbolised” in the RACGP 1998 Rural Needs Assessment are at odds with existing research. Strasser, for instance, finds that “variety of practice” rates second, and this concurs with the RACGP study (ranked 2nd at 69%) as well as other research. Moreover, value rankings vary between other studies. Providing “continuity of care” ranks first in GP satisfaction with “quality of life” in the 1997
National Rural General Practice study, and third in terms of GP “quality of life” priorities. In the RACGP study “continuity of care” ranks 8th at 59% of respondents. Related concepts of “cradle to grave care” and “holistic practice” rank 6th (61%) and 10th (54%) respectively. Strasser’s research finds “whole-patient/community care” ranking lowest in his 1991 Victorian rural GP study at 12% of respondents. Other value orientations such as the rural lifestyle, country environment, community contact, professional isolation and personal privacy also rank, but rank variously, in two or more of these Australian studies.

It should be stressed that in terms of research data these comparisons are merely interesting. Strasser’s 1991 research was with GPs in rural towns of less than 20,000 people and was expressly concerned with workforce issues. Other research cited in Queensland and WA was also workforce-oriented, as was the 1997 National Rural General Practice Study. The RACGP research in 1998, on the other hand, was expressly focused on the QA&CE needs of rural and remote GPs. In addition, sampling methods differ from study to study, as do the questions asked of respondents. Nevertheless, what is significant about GP value orientations such as those nominated above is that not only do they “slide around” in relative rankings from study to study but they also regularly fail to appear on recommendations resulting from these same studies. There are no recommendations emerging from these studies to ensure for rural general practitioners:

♦ their professional autonomy and independence;
♦ continuity of care/whole patient/community care;
♦ variety of medical and procedural skills practiced;
♦ maintenance of the rural lifestyle;
♦ freedom from professional isolation; and
♦ personal privacy.

The reason for this is not explicated in any of the research. It is clear, however, that most of this research is framed in a highly functional and structural construction of knowledge. In their original 1987 research in WA, for instance, Max Kamien and colleagues note:

The main problem for solo doctors is lack of a medical colleague with whom to talk medicine, discuss problems or seek help. This was succinctly stated by one solo practitioner, “One thirsts for the opportunity to talk to another doctor about that which is such a dominant part of one’s life.” Isolated doctors feel they would be breaking professional confidences to discuss non mutual cases with other health professionals. Many doctors also express a fear of talking about their medical problems with nursing staff lest there be a breach of confidence, or else that this may be construed as an expression of doubt about their medical ability.

There is no recommendation relating to these issues, as there is for others. Just a concession to criticism of the RACGP and AMA for not “doing” something. The recommendations are task-focused and, where no task or function can be found — only cultural experiences, fears, and a sense of professional isolation — they are omitted. Similarly, in the section on privacy and culture, the authors write:
A country town is both a microcosm of Australian society and a type of goldfish bowl. Unlike the city, the doings of the doctor and his family are common knowledge. Many doctors reported that they would not drink any alcohol at a social gathering to protect themselves from any possible accusation that they were less than fully alert on all occasions. Unlike city doctors the country practitioner has to live with his mistakes, both real and imagined, since these are a topic of community discussion. Doctors also complain that they are often stopped in the street or at social gatherings for an informal consultation. In short, it was difficult to get away from always being in the role of the doctor.  

Again, there are no recommendations here. This sub-section comes under the general heading of “Social Problems”. The doctor is consigned to their “role” without any analysis of its sociological or cultural basis that may lead to a solution. This failure to address the sociocultural features of rural general practice that may either make it attractive to GPs or a disincentive to recruitment or retention occurs again and again in studies and reports on the subject in Australia over the last twenty years. Recommendations tend to focus on income, housing, educational opportunities for spouses, educational opportunities for children, access to continuing professional development for the GP — highly functional domains which can be addressed at a structural and functional level by agencies of government and social and professional governance. The problem with these material measures by government is that they are only likely to affect GP behaviour as long as they remain in force. As soon as the stimulus stops, there is no need to maintain the behaviour.

SYMBOLS, CULTURE AND CHANGE

Bob Fox, Paul Mazmanian and Wayne Putnam in the United States focused a range of studies on what motivates change in the practice of medical physicians. Whilst they produced a range of personal, professional and social motivators one might expect — such as financial well-being, career stage, peers, regulations, the desire for greater medical competence and the clinical environment — they also showed that the success of change depends upon the extent to which the individual is able to imagine that change and how it might look. In particular, doctors are influenced by this image’s:

♦ complexity;
♦ relative advantage (both clinical and financial);
♦ observability (to see it in action before adoption);
♦ compatibility (does it fit in with current practice?); and
♦ trialability (hands on try-out).

They also found that education and learning was crucial to at least two thirds of the behavioural changes they documented. A review of over 6000 articles or studies of the effectiveness of CME conducted by Davis, Thomson, Oxman and Haynes in Canada reveals what makes for effective education — education which enables learning, such as interactive and hands-on sessions, as well as simply predisposing the learner to information and concepts; and education that reinforces learning back in the GP’s practice such as follow-up, academic detailing, recall and reminder systems.
There are currently an increasing number and range of opportunities for upper secondary school students, medical undergraduates, and GP registrars to experience rural general practice in a hands-on fashion. But where is the data set that spells “rural general practice” that these students and doctors can “learn”? What is rural and remote general practice such that they can “identify” with it, make meaningful their experience such that they can commit to it as a change they can imagine? Where is the “culture” of rural general practice spelt out?

The 1998 RACGP Rural QA&CE Needs Assessment questionnaire did not ask respondents to make a judgement about what they value in rural general practice. It asked what symbolises rural and remote general practice. This term was specifically chosen to connote a realm of meaning that exists outside the respondent, as well as within the respondent’s own conceptualisation of the world. It is reasonably well-established in academic disciplines of cultural studies such as semiotics and anthropology that it is the symbol that gives culture agency. It is symbols that enable culture to be transmitted from one generation to the next. It is symbols that enable groups to establish and maintain their identity. It is symbols that enable society or group to express its identity through celebration and art. Where symbols differ from other signs and signifiers is in their ability to fix meaning both in the domain of public discourse and in the mind of the individual. Symbols enable identity — individual and group — to be understood in the same act as it is maintained, and visa versa. As noted American anthropologist Clifford Geertz writes, symbols are the “positive content” of “cultural activity”,12 they provide the “programs for the institution of the social and psychological processes which shape public behaviours”13.

To ask GPs to rank what symbolises rural and remote general practice for them is thus radically different from asking for a value judgement. It asks them to rank what makes up the culture of rural and remote general practice for them without asking them to pass judgement. Potentially, it collects a verbal picture of the “positive content” of that culture — what makes rural and remote general practice meaningful to them individually, as well as meaningful in the public domain as they understand it. This may explain why professional autonomy ranks so low in the RACGP study — because, while it may be a core professional value for rural GPs individually, in the context of other aspects of rural general practice culture it does not rate very highly. It may rate strongly as an individual motivator, but in terms of the “positive content” of rural general practice it does not mean very much.

This is, of course, a conjectural explanation. But potentially, investigating what symbolises rural and remote general practice, rather than what practitioners value about it or what motivates them to enter or remain in it, has the capacity to generate that image required in the Fox, Maxmanian and Putnam model of change — the positive image of, in all its cultural detail, what it is about rural general practice that makes it attractive to rural general practitioners: something with which they identify. Promotion and formulation of rural general practice at this cultural level may thus also extend to students, GP registrars and other doctors membership of a distinct, recognisable professional identity. Doctors who identify professionally with rural general practice are far more likely to make the step to enter it, and remain there, than doctors who are motivated solely by material incentives. For when the material incentives stop,
potentially so does the motivation. Whereas, as most politicians understand only too well, it takes a lot to shift identity.

Promotion of rural general practice in terms of professional identity and “positive content”, then, may prove a useful augmentation of current recruitment and retention strategies. Similarly, a more detailed analysis of the culture of rural general practice may enable the development of strategies that can assist rural and remote GPs in overcoming some of the cultural difficulties they expressly experience, such as professional isolation and loss of privacy. To begin with, however, what is required is the establishment of that cultural data-set that is rural general practice. A more rigorous examination of what symbolises rural general practice than has been documented here may well provide the way in.

REFERENCES

11. op cit:40.
Richard Lawrance is an Education and Development Officer with the Rural Faculty of the RACGP. He studied medicine for a year at the University of Tasmania but gave it away when he kept falling over at the sight of blood. Instead, he trained as an English, speech and drama teacher (much safer, no blood) and has worked professionally as an actor and writer. He has also tutored in communications at TAFE and tertiary levels, and worked as a consultant in organisational and management development in private enterprise. He holds a Master of Education (Honours) from the University of New England, and lives in the Barossa Valley of South Australia (so he must have something going for him) with his partner, Chris, and 9-year-old daughter, Daisy. They also have a dog, Polly, but it’s not wise to talk about her in the local neighbourhood.