Language, politics, influence and regard; how representations of rural doctors and their work have advanced their political positioning in the Australian rural and remote health sector

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Abstract

This paper draws on research that explored the ways in which language has been used by Australian rural doctors to establish their identity, promote their role, and advance their political claims during the period 1990–2000. It explores the strategies that have been used in this process and considers how such activities have influenced policy and political and professional recognition, thereby shaping the structure of the Australian rural and remote health sector. The paper argues that the way language-based representations (and the agendas hidden within them) are developed and used in personal accounts, the media and in policy texts, influences the recognition and understanding of the role of the various professions and approaches to health care, and shapes the sector in ways that reflect differently valued roles and approaches to health care delivery.

Introduction

A political awakening over the last decade has seen rural and remote health become a national issue in Australia; an outcome that is evident in accounts in the media and other domains. But those who are familiar with the sector recognise that the public and policy profile of rural and remote health is not even-handed and reflects a fragmented sector that is being shaped by differently valued approaches to health care.1 In particular, media representations of rural and remote health issues are often characterised by the depiction of rural and remote medical practitioners as combating isolation and extraordinary odds to ‘save’ others. Headlines such as “Rare specimen cures bush ills”2 and “Top doctor answers town’s emergency call”3 feature larger than life individuals and draw upon the Australian mythology of the frontier hero.4 These images are often juxtaposed with depictions of rural and remote health care as “… a basket-case, with stories of doom and gloom”.5 Headlines such as “Things are crook, no care in Cook”6 and “Doctor-deprived land in critical condition”7 highlight the workforce shortage and its impact on health and related services in rural and remote communities. The way such language-based representations (and the agendas hidden within them) are developed and used, influence the recognition and understanding of the role of the professions and health care delivery, thereby shaping service provision.8

This paper draws on research9 that explored the ways in which language has been used by rural doctors to establish their identity, promote their role, and advance their political claims. It also considers how such activities have influenced policy and political and professional recognition, thereby shaping the structure of the Australian rural and remote health sector.

The study

The study on which this paper is based was framed on a cultural studies approach which “… treats culture and systems of meaning in connection with questions of power and politics”.10 The study examined print media, policy documents, and interviews with rural doctors, to determine how medical practitioners and health services in rural and remote areas of Australia were represented in language—and the consequences of those representations. The conceptual tools and research methodologies employed reflected the assumption that governments, the media, and special interest groups, use cultural values to define and promote particular needs and political goals.

The examination of these dynamics drew particularly on the work of the critical and post-structural theorists, Nancy Fraser11 and Ruth Wodak.12 Both developed approaches that enable investigation into
language use as an artefact of power relations and as a way of reading how the cultural framing of a particular sort of work can influence a professional field. Wodak’s theories were used to identify how linguistic strategies are used to develop identity and to advance political goals. Fraser’s work on how social groups (particularly special interest groups) are formed; how the success of dominant groups in society is attained and challenged; and what possibilities these processes offer for political influence and social change, also shaped the approach.

The data and its analysis

The study used textual representations of rural and remote medical practitioners generated from: semi-structured interviews with peer-identified, ‘exemplary’ rural and remote medical practitioners; selected stories gathered from the print media; and, policy documents generated by governments. The interview data provided insights into how rural and remote medical practitioners viewed and represented themselves and their role, while media texts provided data on the linguistic representations that were generated for the public domain. The sample of government-generated policy texts encapsulated much of the political activity in rural and remote health during the period covered by the study (1990–2000). They offered evidence of political positions and solutions that successfully infiltrated the policy process and were endorsed and funded by government to address rural and remote health needs in Australia.

Critical Discourse Analysis was employed to analyse the texts and to identify discursive relationships that reinforced or challenged existing political, cultural, institutional and occupational power relationships. Using adapted tools the texts were analysed to determine how rural doctors have developed a distinct cultural and professional identity; a process considered critical in the formation of special interest groups and in establishing their capacity to influence the political process. In particular the analysis investigated the alignment of professional identities and issues with culturally and historically significant values and constructs. It examined how these textual representations formulate and represent the work, roles and concerns of rural and remote medical practitioners, and how they produced and privileged a particular identity for this professional group.

Themes evident in the texts

Five themes were identified during the analysis of the texts. As well as the themes developed and used to focus the research (‘narration and alignment with a common past’, the ‘identity of rural and remote medical practitioners’, ‘a common and different culture’ and ‘a different political present/future’), an additional theme ‘the tradition of rural and remote practice’ is evident in the interview texts.

Linguistic formulations that advanced the inter-related themes of the ‘tradition of rural and remote practice’ and ‘narration and alignment with a common past’ contained content that: aligns rural and remote doctors with Australian legends and with pioneer-like attributes, for example:

Spread thinly through the outback are living pioneers for whom Australia Day will be anything but a celebration. They are explorers not so much of a still harsh land but, often alone, of the spirit of make-do.

identifies and describes archetypes; for example:

… Lou Ariotti is probably the archetype of the super doc …

… Col [Colin Owen] was out in Charleville with Lou, and was an apprentice learning at the knee of the master …

refers (at times) to the notion of the ‘super-doc’;

... doctors in the country, in my opinion, are several echelons higher than doctors in cities. The doctors in cities don’t have the problems, they hand them on. The country doctor ... has got to be
able to handle everything himself; fractures, operations, obstetrics … Well, he’s pretty game, you know, to go out there.25

includes personal and clinical narratives; such as:

I can remember removing slugs from a kid’s ankles with one of the [medical] students holding bloody Grey’s Anatomy out in front of the table for me so that I could make sure that I didn’t hit anything of any significance. Because of the fact is that there is no way if you do these sorts of things uncommonly, that you will remember the complex details of an anatomy book … it all worked fine and the kid went on and lived happily ever after.26

and, emphasises mateship and other venerated Australian character traits, for example:

The situation is you’ve got to stick together so mateship is a really important thing. In the city competition makes sense, in the bush it doesn’t make sense, so it’s more about cooperation, about mateship … I think there is a real mateship; there is that frontier type feeling to rural medicine.27

Identity formulations that focused on the ‘identity of rural and remote medical practitioners’ and the ‘identification of their common and different culture’ drew on: the nature of rural and remote practice (especially its complexity) and the difference between rural and urban practitioners and practice, for example:

For a city practitioner the ectopic pregnancy … is the easiest consultation of the day ‘cause they just send it up the road to someone who’ll fix that up. [For the rural doctor it is more difficult] … not in terms of being able to treat it … but difficult as in, God we’ve got to get the anaesthetist, the blood … all those things organised”. 28

the personal and professional characteristics of rural and remote doctors and their unique experience and experiences;

… the Australian way of life talks about mate for mate. Now within my profession … this translates into ANZAC traditions … I heard a recent ANZAC address … talking about the Australians in the trenches at Gallipoli … It’s very similar to that; when Col [Owen] and I over so many years single-handedly took care of this little pocket of Southern Queensland where no Flying Doctor and no specialist came. Now when all hell broke loose we were in the trenches for each other. And there was just no two ways about it … we evolved from this convict community and in such a harsh environment, if people weren’t looking after each other, it just didn’t happen.29

the superior clinical competence of rural doctors;

Dr Marshall said there were distinct differences in the way medicine was practised in the city and in the country. Rural GPs relied more heavily on their clinical skills, necessitated by the lack of sophisticated tests and equipment. In addition, rural GPs performed a range of procedures - from giving anaesthetics and delivering babies to surgery and post-mortems.30

and, the common interests of rural doctors:

… we all know each other by bloody reputation … I like the fact that they know a lot; some of them I like because they are good mates or have been trainees or all of the above … it is nice to be able to yap with people who have got common problems.31

Two types of content were favoured to progress the fifth theme; the identification of ‘a different political present and future’. The content centred on political activity and/or on concerns for the discipline of rural medicine and its future. Such content included: political analyses and political activities and success stories for example;

We went to Howe in 1990 and just said, ‘… we want some equity in this whole process and we’re willing to work with others to do it’ … bureaucrats, particularly city based bureaucrats are devoid of solutions for the bush; they don’t understand it at all. So we brought to them an
understanding and a willingness to … put together some ideas … And I think the bureaucrats found that refreshing … ; when there is a crisis you can actually make change … at the political level …; I used to say give the politicians the problems and the bureaucrats the solutions.32

the different political concerns of rural and remote doctors and communities; for example,

The rebates paid by Medicare do not acknowledge the greater expense of running a practice in the country about 30 per cent higher –or the midnight calls that city GPs can avoid but which rural doctors must attend.33

and, problems in advancing political goals (including the sense that rural issues are no longer an important political concern for politicians).

… [When] the National Party came back into Queensland, they’ve tried to [respond to rural health issues] but I don’t believe that their heart’s in it; I don’t believe that that [they think] there’s political kudos in doing things for the bush … and I think federally, the Coalition Party that’s been in government since 1966. Initially it saw that there were votes in regional areas, but if you look at the figures there aren’t anymore; votes are all in outer metropolitan areas which is why [there has been a] shift in emphasis from rural and remote to outer metropolitan … they’ve done the political numbers. And this is why I believe that the rural stuff has gone off the agenda to a large extent.34

Content related to professional matters incorporated references to: skill deterioration (in general practice in particular and in rural practice due to structural and workforce changes); the relationship between rural medicine and other disciplines (mainly general practice) and professions; and, a perception that the super-doc identity is no longer valid, for example,

And it [traditional rural practice] doesn’t work anymore because of three reasons. The first one is the economics of the health system in terms of supporting that single doctor doing all these things; it just isn’t there any more. Secondly we’ve come up with standards and accreditation and you can’t do a lot of those things now-a-days especially surgical and procedural things unless you are accredited and have all the accredited gear; and the third thing follows from the second which is the litigation stuff … So I think because of those three things, the super-doc who does everything and is all things to all people all the time, ah I think everyone has realised that is not the way it is.35

The context underpinning formulations that advanced the themes of the ‘tradition of rural and remote practice’ and ‘narration and alignment with a common past’ were predicated on the importance of rural and remote medicine/doctors in terms of: the provision of essential services to rural and remote areas; maintaining the viability of rural life and rural traditions; ensuring continuity with the past; and, as exemplars of Australian national identity. These notions are based on the different nature of rural and remote practice—a style of practice that reflects traditional values positioned within an approach deemed to have practical and cultural significance, for example:

Yes, in the old days the rural GP did everything and the metro GPs; coughs, colds, referrals … Yeah, certainly [metropolitan] medicos that I come in contact … a lot of them have like a far away look in their eyes when I talk to them and they say, ‘oh I’d love to do that ‘… So a lot of [city] practice medicos I see are interested in the latest dramas we’ve had and how we cope …36

The context within which identity formulations that advanced the ‘identity of rural and remote medical practitioners’ and the ‘identification of a common and different culture’ are set reflected: a belief that rural and remote doctors are altruistic in their commitment and response to community needs;

For example the ones who were really sick; I might have … done a very major operation … Now the lowest point of our BMR [basal metabolic rate] is the early morning; two and three o’clock. That’s when we’d be at our lowest. You know the heart is at its lowest and everything is at its lowest. And so is a person’s spirit … I’d just put a dressing gown over my pyjamas and I’d go up [to the hospital] and I’d sit down on a chair next to the patient’s bed, and I’d hold their hand.
Talk to them. And tell them ‘you’re getting better, you’re going to get better. You’ll be all right.’. It worked; brilliant—terrific medicine that.

a capacity and willingness to deal with the necessary blurring of personal and professional roles in small communities;

But they, they [rural doctors] contribute significantly in two ways; one is to the health, but also as thinkers in the community, cause often they’re some of the better educated people … People know them warts and all so they know what their limitations are as well, and your reputation is a very precious thing in life and particularly in a community; and it can easily evaporate if you are doing wrong things to people … They’ll trust you implicitly … So it’s a very close relationship; you are under close scrutiny. But so is everyone else … it’s a characteristic of small towns. You get supported very closely too.

the importance and strength of mutual support within the rural medical community and between the doctor and the community; and, the crucial role of the doctor’s family in the viability of this support structure. These value based assumptions and stereotypes align the rural and remote medical practitioner with notions of self sacrifice and heroism, for example:

Yesterday humanity flocked in numbers to his waiting rooms, along with their year’s end aches and pains, coughs and strains and other maladies … In surgery or at the bedside he comes across as a blend of Hawkeye and Trapper in the TV series MASH — mischievous wit vying with homebody compassion. But in that invariably jeaned, booted and sports-shirted frame he can never entirely conceal an underlying fatigue. It is not performance-threatening but when he rests he tends to sag. It figures. For most of this decade he has worked alone in a community of nearly 4000 people.

The contexts against which the fifth theme is set reflected the complexity of the rural and remote health sector. Identity formulations that worked to identify ‘a different political present and future’ sat within the milieu of: the workforce crisis (and recruitment, retention and remuneration issues); shifting health care delivery parameters (including the impact of technologies, changed community expectations, increased litigation, changes in standards, credentialing and education requirements, and the capacity to provide quality services); the unique skills and attributes required in rural practice and for its continuation; and, the different policy approach and support structure required for the survival of rural medicine and the provision of services to rural and remote communities. These are key political concerns for rural and remote medicine which flag transition problems in a system in which approaches to practice, and professional identities, are changing.

Use of discursive linguistic strategies

Discursive linguistic strategies were employed in all three textual sources formulating representations of rural doctors that built a common past, present and future, and a common culture. As well as developing cultural identity, the discursive strategies positioned rural and remote medical practitioners as different to other practitioners. The following table outlines the linguistic strategies and the frequency of their use.
Table 1  Linguistic strategies used in the formulation of identities of Australian rural and remote medical practitioners

<table>
<thead>
<tr>
<th>Category</th>
<th>Usage Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>CONSTRUCTIVE MACRO-STRATEGIES—usage frequency 45%</td>
<td></td>
</tr>
<tr>
<td>• build identity by promoting unification</td>
<td></td>
</tr>
<tr>
<td>• build identity by promoting identification and solidarity</td>
<td></td>
</tr>
<tr>
<td>• build identity by promoting differentiation</td>
<td></td>
</tr>
<tr>
<td>PERPETUATION STRATEGIES—usage frequency 8%</td>
<td></td>
</tr>
<tr>
<td>• maintain threatened identity</td>
<td></td>
</tr>
<tr>
<td>• reproduce a threatened identity</td>
<td></td>
</tr>
<tr>
<td>• preserve a threatened identity</td>
<td></td>
</tr>
<tr>
<td>• support or protect a threatened identity</td>
<td></td>
</tr>
<tr>
<td>TRANSFORMATION STRATEGIES—usage frequency 31%</td>
<td></td>
</tr>
<tr>
<td>• transform an established identity or components of it into another identity</td>
<td></td>
</tr>
<tr>
<td>DISMANTLING OR DECONSTRUCTIVE STRATEGIES—usage frequency 16%</td>
<td></td>
</tr>
<tr>
<td>• dismantle or disparage parts of an existing identity formulation</td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from a taxonomy developed by, Wodak, R., deCillia, R., Reisigl, M., & Leibhart, K. 1999.

Overall, the texts presented a positive story through a preference for constructive linguistic strategies that build identity by promoting unification, identification, solidarity and differentiation. Within the strategies available in this category, singularisation was favoured above all others. It was used to align rural and remote medical practitioners with iconic images and cultural values through reference to a common past and shared history. In particular, it was used to link them with figures of national significance by associating the characteristics, values and significance of rural and remote medical practitioners with legendary Australians of the past.

After singularisation, the constructive strategies of unification and cohesion were favoured. They promoted group identity by focusing on common professional experiences, particularly those dealing with procedural medicine, accidents, emergencies and patient retrievals. Formulations of this type figure prominently in the reflections of the interviewees and in the media texts and focus on colourful stories relating exceptional situations and circumstances unique to rural practice.

Transformative discursive strategies (promoting the survival of rural and remote medical practitioners through a different approach to practice) were the second most common group of linguistic strategies employed. They are evident in all data sources with a particularly strong presence in the government generated documents. They emphasise different approaches to practice to ensure the survival of rural health services, the need for political and structural change to achieve this, and an acceptance that the past approach to rural and remote practice is obsolete and must be replaced with effective and sustainable service models. Transformative strategies are also used to stress the importance of autonomy and independence to rural medicine, and to challenge government interventions and policies (such as onerous credentialing requirements, Medicare rebates and funding structures, and reductions in services to rural communities etc.).

Dismantling and deconstructive strategies are used less often but when they are, discontinuation (emphasising the disruption to rural life if health care services close) and the Cassandra strategy (predicting dysfunction in rural and remote communities due to the medical workforce crisis) are preferred. While these strategies are evident in interview texts they are primarily used in media texts. In general, these strategies are employed as a lobbying tool to define and highlight ‘needs’, and influence public and political opinion to support and retain an adequate workforce through a range of interventions, particularly the provision of additional resources. Dismantling and deconstructive strategies also flag the likely outcome of political subjugation or subordination, and target metropolitan practitioners through negative presentation and de-valuing of their role and work.
Dismantling and deconstructive strategies also figure in formulations that flag ambivalences, contradictions and identity fragmentation. They are apparent in texts that deal with political concerns and the future of remote and rural health care. They focus on: discrediting the structural organisation of rural health and other approaches to practice; negative presentation of aspects of rural practice; and warnings against the consequences of not supporting rural and remote health care delivery and the role of doctors within it.

Perpetuation strategies were employed most frequently in the government generated documents. They were used to promote the continuation of a distinct rural and remote identity compatible with, and dependant upon, new approaches to health service provision. Advanced as a way of reducing intra-national differences in health outcomes within Australia by providing better services in rural and remote areas, the current situation was often represented as obsolete and unsustainable. At times in these texts, perpetuation strategies are used for political self-promotion.

In summary, the linguistic manoeuvres in the texts singularise rural doctors by aligning them with cultural archetypes and emblematic settings and activities. They promote differentiation by emphasising the unique challenges of bush practice and demanding recognition of a distinct discipline of rural medicine, with different approaches, needs and support requirements. They advance unification and cohesion within the rural and remote medical community by normative emphases on shared attributes, experiences and concerns. They work to dismantle, deconstruct and destabilise the status quo by challenging policies, programs, government understanding, and hegemonic bodies. They also advocate for the transformation of the sector and the survival of rural and remote medicine through changed support levels, remuneration and recognition. And, importantly, they seek to perpetuate a way of life and medical practice through maintaining professional dominance and promoting rural medicine as a living tradition of practical and cultural importance to Australia.

“… it’s the same as the Australian myth isn’t it, people identify with the stockman although not many of them are [stockmen], and if you look at the doctor community; the doctors’ community identifies with the rural doctor what they all think general practice should be”.40

**Influence on policy and funding**

To understand the downstream effect of these linguistic strategies it is useful to turn to the government generated documents used in this study; *More Doctors, Better Services: Regional Health Strategy 2000*; and *Horizons 1999–2003: A Framework for Improving the Health of Rural, Regional and Remote Australians*. These documents represent the culmination of the political activity and policy development in the rural and remote health sector over the ten year period (1990–2000) in which the study was set. *Healthy Horizons* was developed by consumers, health professionals, academics and community and government agencies to provide strategic direction for the development and provision of health services in rural and remote communities. It was endorsed by all states and territories in 1999. *More Doctors: Better Services* was released by the Commonwealth Government as part of its health budget the year after *Healthy Horizons* was launched. *More Doctors: Better Services* outlines a four year funding package for rural and remote health care.

*Healthy Horizons* positions health broadly within a primary health care paradigm and highlights the roles of all health professions and disciplines in the provision of sustainable and responsive health services. Its conceptual underpinnings are very different to the paradigms of medical dominance and the needs and solutions promulgated through the media texts and the interview texts. As *Healthy Horizons* was the collaborative product of governments and rural and remote health interest groups, it should follow that the budget released by the Commonwealth in 2000, *More Doctor, Better Services*, would closely reflect the *Healthy Horizons Framework*. This is not the case. It does, however, provides an indication of the ‘needs’ that successfully navigated the policy development and lobbying process and achieved political endorsement through funding. In excess of $562 million dollars over a four year period was provided through the *More Doctors Better Services* funding package; 58% of the resources were allocated to three programs aimed predominantly at medical practitioners. The programs and the resource allocations are summarised in the table below.
Table 2  Funding allocations for the More Doctors, Better Services: Regional Health Strategy (Commonwealth Government, 2000)

<table>
<thead>
<tr>
<th>Program</th>
<th>2000–01</th>
<th>2001–02</th>
<th>2002–03</th>
<th>2003–04</th>
<th>Total ($m)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Growing and Strengthening the Rural Health Professionals Workforce</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>New General Practitioner Registrars</td>
<td>10.1</td>
<td>20.6</td>
<td>31.6</td>
<td>39.7</td>
<td>102.1</td>
</tr>
<tr>
<td>More Allied Health Services</td>
<td>10.5</td>
<td>11.4</td>
<td>12.6</td>
<td>14.9</td>
<td>49.5</td>
</tr>
<tr>
<td>Medical Specialist Outreach Assistance</td>
<td>5.0</td>
<td>14.3</td>
<td>14.5</td>
<td>14.7</td>
<td>48.4</td>
</tr>
<tr>
<td>Workforce Support for Rural General Practitioners</td>
<td>2.1</td>
<td>2.6</td>
<td>2.7</td>
<td>2.7</td>
<td>10.2</td>
</tr>
<tr>
<td>Enhancing Rural Education and Training for Health Professionals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Training—Additional University Departments of Rural Health and Clinical Schools</td>
<td>8.7</td>
<td>25.3</td>
<td>38.1</td>
<td>45.6</td>
<td>117.6</td>
</tr>
<tr>
<td>HECS Reimbursement for medical practitioners</td>
<td>0.3</td>
<td>0.6</td>
<td>1.3</td>
<td>2.0</td>
<td>4.3</td>
</tr>
<tr>
<td>Scholarships--Medical Students Practice in Rural Areas</td>
<td>3.2</td>
<td>6.2</td>
<td>9.7</td>
<td>13.3</td>
<td>32.4</td>
</tr>
<tr>
<td>Enhanced Rural Medical Undergrad Scholarships (RAMUS)</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td>2.0</td>
<td>8.0</td>
</tr>
<tr>
<td>Better Health Services for Regional Australia</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional Health Services Expansion</td>
<td>4.9</td>
<td>14.1</td>
<td>21.6</td>
<td>28.3</td>
<td>68.9</td>
</tr>
<tr>
<td>Enhanced Rural and Remote Pharmacy Package</td>
<td>8.0</td>
<td>11.5</td>
<td>11.1</td>
<td>11.0</td>
<td>41.6</td>
</tr>
<tr>
<td>Bush Nursing, Small Community and Non-Gov Hospitals</td>
<td>4.1</td>
<td>7.6</td>
<td>8.2</td>
<td>10.4</td>
<td>30.3</td>
</tr>
<tr>
<td>Chronic Disease Rural Strategy</td>
<td>2.5</td>
<td>2.1</td>
<td>3.7</td>
<td>5.9</td>
<td>14.2</td>
</tr>
<tr>
<td>Aged care—Grants for Small Rural Facilities</td>
<td>4.6</td>
<td>7.2</td>
<td>9.4</td>
<td>9.6</td>
<td>30.8</td>
</tr>
<tr>
<td>Communications Strategy</td>
<td>2.0</td>
<td>1.0</td>
<td>0.5</td>
<td>0.5</td>
<td>4.0</td>
</tr>
<tr>
<td>TOTAL—Regional Health Strategy</td>
<td>67.9</td>
<td>126.5</td>
<td>167.1</td>
<td>200.6</td>
<td>562.1</td>
</tr>
</tbody>
</table>

Based on Table 2, the needs endorsed through More Doctors: Better Services strongly favour initiatives that support the rural and remote medical profession. The Growing and Strengthening the Rural Health Professionals Workforce Program addresses recruitment and retention issues. Seventy-six per cent of the total allocated to this program area ($210.2m) was targeted at medical training places and funding to medical workforce support organisations such as Rural Workforce Agencies and Divisions of General Practice. In a telling use of language, the underlying intent of the ‘More Allied Health Services’ component of this program is to support the role of the remote or medical practitioner. It endorses the central role of the doctor in health care provision in rural and remote communities and represents them as dedicated and overworked:

Many rural and regional communities don’t have the range of allied health services that are available in metropolitan areas, so many rural doctors have to compensate and provide these services on top of their day-to-day work load.43

The second program in the More Doctors: Better Services package, Better Health Services for Regional Australia, is underpinned by $185.8M of funding for the support of rural and remote health services. Again the description of this program is framed around the role of the doctor:

Many country towns in rural and regional areas often suffer from a lack of health services. This, together with a shortage of doctors, is one of the biggest problems facing our towns and regions. New, restructured and more flexible services will support doctors and be responsive to local needs.44

The third program, Enhancing Rural Education and Training for Health Professionals, focuses on the development of the workforce. The funding allocation responds the political call for more qualified medical practitioners in rural areas. It provides an increase in medical school places, additional University Departments of Rural Health, the waiving of Higher Education Contribution Scheme (HECS) fees for doctors willing to work in rural areas, more medical scholarships, and improvements
in current scholarship schemes which bond medical graduates to work for periods of time in rural areas.

As is evident in Table 2, while *More Doctors, Better Services* refers generally to broader areas of need and a broader understanding of health as explicated in *Healthy Horizons*, the funding allocations are biased towards the medical profession and show little support for other professional groups which face similar practice and sustainability issues. This outcome reflects the conjunction of the dominant discourses and hegemonic influences of the time.

**Discussion**

The language used by and about rural doctors has been employed to differentiate the practice of rural medicine from provincial and urban general practice and has been seminal to the progression of rural and remote health care in Australia. It has a specific role; to develop an ‘establishment’ identity that was, and is, central to the differentiation of rural doctors and rural medicine from other kinds of doctors and other kinds of practice. This need became critical as the differences between rural and urban health widened, not only in terms of the style of practice required, but also in terms of health outcomes. The linguistic manoeuvres used to counter this disadvantage served their purpose well. They established the unique attributes and concerns (both cultural and political) of the Australian rural and remote health sector generally (and of rural doctors in particular), in the media and the political sphere. Many other professional groups and alliances have ridden on the coat-tails of this achievement and there have been benefits for rural and remote health generally, and for communities.

The identity formulations have been important in framing claims and positions in order to establish particular ‘needs’ as justifiable political concerns. The process through which this has occurred reflects established patterns that are used widely. Special interest groups develop ‘needs talk’ and use it as a strategic political tool through three steps: 1) working to validate the need as a legitimate political concern; 2) engaging in a struggle with other groups over the interpretation of the need including vying for the power to define it determine how it can be addressed; and, 3) advancing strategies to satisfy the need such as obtaining or withholding the resources required to address it. These activities usually advance the interests of powerful and dominant social groups and disadvantage subordinate or oppositional groups. Evidence of this can be seen in the outcomes of this process in the Australian rural and remote health sector as encapsulated in the following quote:

... There has sometimes been a feeling from others ... [health professionals] that it’s ... all been about doctors ... Um, I think to be honest, it [the rural doctor movement] probably helped nurse organisations and other organisation more than the city doctors would have. That’s maybe a justification but my feeling has always been that the picture we had early on that we’d tarmac the middle part of the road but it was up to other people to tarmac the sides of the road but at least then ... we would have developed the base ...; if the government comes and says ‘we want to give you a Rural Incentive Program for rural doctors’, we are not going to say, ‘well of course that should go to rural nurses instead’. There is sometimes an attitude that that is the way we should have done it, and the world doesn’t always work that way.

The texts clearly illustrate that rural doctors have established a mandate to institute authoritative definitions of, and solutions to needs within the Australian rural and remote health sector and have claimed the power to shape the political agenda. The patterns of representation, recognition and communication initiated by them have influenced government funded programs which in turn have shaped the structure of the sector. Discernable ‘down-stream’ effects of these processes are evident in *More Doctors: Better Services*; a testament to the success of the rural doctor movement which has advanced its needs agenda through the media, and through domination of the policy process. Effectiveness to this end is not so much in challenge and conflict, but in instituting an environment that is conducive to particular outcomes. It illustrates how socio-economic and cultural values embedded in identity formulations and linguistic manoeuvres work to benefit already powerful groups whose views are normalised in the media and thus perceived as central to policy decisions.
Without doubt there is inequity and bias in the issues and interests that are promulgated through the patterns of representation, recognition and communication. These have their genesis in the way the media works and in different levels of economic leverage and cultural regard experiences by the various professions and interest groups involved in the provision of rural and remote health care. Institutionalised economic systems do not facilitate equal and full participation in debate and policy development; they tend to privilege groups of higher status. Likewise, a taxonomy of cultural values denies equal recognition to some professional and social groups and undermines their capacity to be active and equal participants in political processes. The texts gathered for this study illustrate a scale of differential regard for the roles and needs of various health professions and interest groups and the community itself. The voices of rural and remote communities, allied health professionals, nurses, Aboriginal health workers, and overseas trained doctors are rarely, if ever, represented. Thus socio-economic and cultural values influence the remedies that are advanced in ways that benefit the most powerful and highly regarded groups who also enjoy better coverage in the media and access to policy makers.

At the commencement of the study, it was anticipated that the insights gained into the ways in which the rural doctor movement has represented its issues and influenced the social and political agenda, would identify transferable strategies that could be used to benefit rural and remote health generally and other professional groups. While it is likely that the differentiation and linguistic strategies used could be adapted by others, their by-products have negative, as well as positive consequences on the balance and shape of a sector. This process also has also had some negative outcomes for the discipline of rural medicine, the details of which are not dealt with in this paper. Regardless of altruistic motivations, the politics of identity and differentiation are based on an approach that undermines the redistributive goals of justice and equity and work primarily to develop and advantage groups that enjoy professional and/or social dominance and higher social and political regard. If better health outcomes are to be realised for rural communities there must be sufficient equality in power and influence to ensure that communities, individuals, and all interest groups have an opportunity to advance their perspectives. The disproportionate focus and support given to rural medicine in the texts diminishes and misrecognises the roles and worth of other professional groups and interests, and does not recognise that past and current structures cannot adequately meet health care needs given the current workforce crisis.

Focusing redistribution predominantly on the medical profession, in order to achieve better health in rural and remote areas, is an approach that is fundamentally flawed. Many rural or remote communities don’t have a doctor and those that do often do not have sufficient numbers of medical practitioners to meet service demands. Medical workforce shortages, the uneven distribution of doctors in remote and rural Australia, and the failure to direct resources to support other professional groups that are important in relation to the health of rural communities (eg dentistry, speech pathology, occupational health, physiotherapy etc.), compounds the health disadvantage that remote and rural communities face. In order to craft a better, healthier future, the Australian rural and remote health sector could work to ensure that the frames used for decision-making facilitate parity of participation for all professional groups and rural people. This would assist in minimising misrecognition, and would facilitate redistribution and equity of support and regard. Without this change, communities and some interest groups in rural and remote health will be “… framed out of the discussion of their own fate” and the development of an inclusive, sustainable and viable rural and remote health care system will be compromised.

**Conference recommendation**

To reduce the continuing fragmentation of the rural and remote health sector evident in inequitable policy focus and funding support of some professional groups and approaches to health care, the Conference calls on state governments and the Commonwealth to ensure that policy development processes and frames used for decision-making facilitate parity of participation for all professional groups and for rural people.
References


15. The rural doctors interviewed for the study were Drs Louis Ariotti, Bruce Chater, Desley Marshall, Col Owen, Chester Wilson and Shane Sondergeld

16. The newspaper media texts used for the study were gathered by identifying articles on rural and remote health published in *The Australian* and the *Courier Mail* during 1990 and 2000 using key word searches of the web-based *Newstext* archival data base which stores archived copies of both publications.

17. The government generated texts used as a data source in the study were *Healthy Horizons: A Framework for Improving the Health of Rural Regional and Remote Australians 1999–2003* (Australian Health Ministers Conference, 1999), and the *Regional Health Strategy; More Doctors: Better Services* (Commonwealth Government, 2000).


20. These themes were adapted form the work of Ruth Wodak et al (91999) They explored the ways in which nationalist sentiments were used by the Austrian nation to re invent its national identity after World War II.


30. Bush doctors defend a country practice, The Australian, Mon 31 March 1997, p.4


33. Bush doctors defend a country practice, The Australian, Mon 31 March 1997, p.4


46. Fraser, N (1997)

47. Fraser, N (1997)


49. Fraser (1997)

50. Fraser (1997)


**Presenter**

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