

## **Theme: Evidence, access and equity: how do we measure up?**

### **'Us and Them': Does rural health education create unwilling practitioners?**

#### **AIM**

Including rural health subjects in undergraduate health education is seen in some quarters as a panacea for addressing the shortage of health professionals in rural and remote areas. Education is a process through which students construct foundations of thought and behaviour on the basis of acquiring knowledge and this is theoretically known as socialisation. A known outcome of educational socialisation is identity formation and this is an important driving factor in students' decisions about career choice. Rural health education research has ignored this opportunity in favour of measuring students' knowledge of key rural facts. Furthermore, measuring long term outcomes such as rural career uptake has been hampered by temporal constraints therefore researchers often rely on superficial indications of students' intention to practise in rural areas. In this paper the authors draw on the findings of doctoral work that is nearing completion about the socialising practices of rural health education regarding students' identity formation.

#### **METHODS**

In order to gather information about how rural health education works as a socialising process, interviews were conducted with academics teaching undergraduate students of nursing, pharmacy and medicine. With these data it was also necessary to gather information about how undergraduate students' identity formation occurs. To achieve this undergraduate nursing, pharmacy and medical students were observed and interviewed during their rural placements. The observational field notes and transcripts of semi-structured interviews were analysed using critical discourse analytic techniques. Foucault's writings about 'the gaze' as an effect of power is used to examine the inherent values and meaning systems in rural health education which shape undergraduate students' construction of their personal and profession identity. Such an analysis has value because it allows us to better understand existing rural education strategies, and what is required to improve them.

#### **RESULTS**

In rural health education it is normal to understand rural communities as different from mainstream society because they are disadvantaged in terms of health status and resource distribution. These normalised assumptions manifest in the pedagogical work of rural health education. The efforts of educators to demonstrate the uniqueness of rural health, rural communities and rural practice create distinctions between them (rural) and us (not rural). These distinctions perpetuate relations of difference between those who are not from rural areas (which represents the majority of undergraduate students) and people who live in rural areas, which is reinforced by many people at all levels. Some of these relations of difference do not appear to be productive for an implicit goal of rural health education: to encourage undergraduate students to consider rural practice as a

positive career choice. The majority of undergraduate nursing, pharmacy and medical students participate in short term rural placement experiences that are part of other subject units. By simply 'adding in' a rural dimension to undergraduate programs, rural health education in Tasmania is contributing to an 'us and them' dichotomy active in the formation of students' professional and personal identities. In these data, this 'us and them' dichotomy shapes students' experiences of the rural placement, their view of their future as a health professional, and their personal and professional identities.

## CONCLUSIONS

Research examining undergraduate medical, nursing and pharmacy students' intention to take up rural careers have mixed and inconclusive findings. While some studies indicate students who participate in rural health education may take up rural practice others show students are not interested in rural careers. The findings of this research suggest that instead of encouraging new graduates to take up rural careers, current rural health education practices seem to be counterproductive to achieving this goal. Current delivery of rural health education and the discourses that influence and support it contribute to the development of a personal and professional identity in which students are at ease in a framework that normalises urban primacy and rural difference.

## INTRODUCTION

In Australia many health science schools are currently strengthening their rural programs. Increasing numbers of undergraduate nursing, pharmacy and medical students are participating in rural health education and undertaking rural placements. Rural health education is hailed as the panacea for addressing the lack of rural professionals in rural and remote areas across all health disciplines in response to poor health outcomes in rural and remote areas.<sup>(1-6)</sup> It is also seen as a solution to the difficulties academics are having in providing large numbers of undergraduate students with clinical and professional learning opportunities as traditional teaching sites are no longer able to accommodate this.<sup>(7)</sup> Rural health education is a complex pedagogical activity that is uncomfortably inserted into other subjects in undergraduate nursing, pharmacy, and medical education. It is designed to educate students about rural health, rural practice and rural life. The broader subjects in which it is situated are designed to provide students with clinical and professional knowledge and experience necessary for them to develop as health professionals. Short term experiential learning opportunities for undergraduate nursing, pharmacy and medical students in actual rural health care agencies are known as rural placements and are considered to be a cornerstone of rural health education.<sup>(8)</sup>

Undergraduate medical, nursing and pharmacy education is known to influence the formation of student's personal and professional identity.<sup>(9-13)</sup> Research shows that in health science education values are based on objectivity and authority and scholars argue these reinforce hierarchical social orders and legitimise scientific meaning systems.<sup>(14-16)</sup> Whenever hierarchical social ordering is supported in education, alternative perspectives for understanding the world become marginalised. There is no application of critical, political or education theory in the rural health education research therefore the field has not been able to benefit from critical analysis of how it understands itself: that is, how rural health education, in operation, produces and

reproduces particular constructs of rurality, rural communities, and what rural practice means. The result of this is that other ways in which rural health education can construct itself, and in so doing, offer students different kinds of professional and personal identities as rural practitioners, have scarcely been considered. In short, if we do not understand what we are, we cannot consider what else we might become.

In this paper, we examine the ways rural health education is spoken about in undergraduate nursing, pharmacy and medical education, consider its enabling assumptions and focus on the construction of student identity through rural health education considered as a set of techniques for shaping that identity. The goal of this analysis was to examine how the notion of social difference, which arose from a comprehensive search and critical analysis of the literature, impacted upon undergraduate nursing, pharmacy and medical students' identity formation. The value of such analysis is the extent to which these identities are conducive to an implicit goal of rural health education can be considered: health professional graduates who are amenable to working in rural and remote Australia.

## **METHODS**

Data were collected using standard ethnographic data collection methods. Using participant observation and field notes a total of nine undergraduate students (five nursing, two medical and two pharmacy students) were observed as they participated in rural placements. The periods of participant observation paralleled the length of rural placement time for each group of students: it was therefore one week for pharmacy students, two weeks for medical students and five weeks for nursing students. Three academics, three health professionals (a doctor, registered nurse and pharmacist), two nursing students, one medical student and one pharmacy student were invited to talk about their accounts of rural health education in semi-structured interviews.

Critical discourse analysis (CDA) is a methodology that is concerned with how language functions to constitute both individuals and the social domain, and to reproduce or change social practice while accounting for how people contribute to this process.<sup>(17)</sup> Three CDA techniques were used to analyse the data by examining how common assumptions in undergraduate nursing, pharmacy and medical education influence how rural practice can be understood, and examining how these assumptions are regarded as normal by academics, health professionals, and students and therefore legitimise them in the use of language. Drawing upon Foucault<sup>(18-20)</sup>, this paper argues that cultural identities are always constructed with relations of power: rural health education creates power to create student identities of difference. Power is therefore not understood as coercive but as being constitutive because it emanates from and is exercised through various technologies.<sup>(19)</sup> Such technologies are structures of knowledge that are understood as normal and monitoring students through an ever present gaze works to ensure they conform to the goals and agendas of the overseers. This paper uses the writings of Foucault to consider the operational detail of rural health education, as a set of techniques of power for forming students' professional and personal identities.

## **RESULTS**

## Rural health education: an uneasy fit in health science education

Rural health education as a distinct topic area does not fit easily with the organising assumptions in undergraduate nursing, pharmacy and medical education. The academic interviews show that the purpose of undergraduate nursing, pharmacy and medical education is for students to work toward gaining competence as generic health professionals, as illustrated by the following excerpt:

*“we appreciate that anybody that goes into any setting . whether it be aged care rural remote or acute . that somebody who has had a fall whether it’s a young person or old person . so we can’t be anything but generic in terms of our approach to um the care of any individual with a problem so that everybody in every setting can engage” (academic)*

The academics organise the subjects so that students are able to acquire knowledge and skills that will enable them to adapt to various situations and contexts. This typically requires students to learn how to assess clients as individuals and respond to their health care needs regardless of the context of the health care situation. One academic explains:

*“we adopt a case study approach were we may look at the care of anybody whether it be a patient with respiratory illness or anybody with a cardiac illness wherever they may be and each week we look at a different case study . so it may be a young guy who has fallen off a ladder with a head injury and we look at how to take neurological observations and the care of someone with neurological deficit but then we also go into aged care where someone has had a stroke or it might apply to a student going to a rural or remote area where they actually come across some one who may come into their environment having fallen off something a got a head injury so we look at it as emergency nursing and in terms of the first 24 hours or we look at it 20 years later if some who has had a stroke in an aged care facility” (academic)*

In this excerpt the academic’s use of language is characteristic of the medical ideology, which is based upon values of objectivity and authority. It is language use that legitimises the dominant scientific biomedical meaning systems that prevail in health science education that have been well theorised. As Foucault<sup>(20)</sup> points out, the client seen from the perspective of a *clinical gaze* reveals disease rather than a unique individual. This prevailing meaning system in undergraduate nursing, pharmacy and medical education means that academics recognise rural health topics in a way that does not fit with how they conceptualise their subjects. Talking about rural health education as a distinct topic breaks the rules for what is accepted as appropriate curriculum content in the academics subjects therefore they deflect this tension by renaming it rural placement, as illustrated by the following excerpt:

*Researcher: Would you mind spending a few moments talking about the unit in which pharmacy students participate in rural health education?*

*Academic: The rural placements are situated in a unit called {name} which - - is more or less what they call the clinical units . so in that you have got a week of hospital . a week of community and a week of rural . plus a whole stack of other things which are actually part of um . clinical rounds in the Royal and centre around therapeutics*

This subtle shift in language carries with it a significant shift in associated meaning. Rural health education cannot be acknowledged because of the connotation of it being a distinct topic however the idea of a rural placement allows academics to conceive it as an opportunity for students to develop clinical and professional knowledge through

experience in actual health care agencies that happen to be in a rural context. By having students engage in rural placements medical and pharmacy schools are able to satisfy the Rural Undergraduate Support and Coordination Program requirements for funding to support rural health education in their programs while using the rural context as a learning environment for students to experientially engage in a way that aligns with the pedagogical purpose of students developing as emerging generic health professionals. One academic stated:

*"...the rural program is about integration its about having to think on your feet . its about clinical practice in the real world without all the backup and support"*

The reconstitution of rural health education as a rural placement in academic discourse suggests there is actually no real body of knowledge known as rural health in the undergraduate programs but rather health in a rural context. Education is not about rural health but is all about learning about professional knowledge and gaining clinical experience in the rural context. Not only does this excerpt illustrate how academics regard the rural context as a learning environment for undergraduate students to develop as emerging health professionals, it introduces the way 'rural' is constituted as 'other' in undergraduate nursing, pharmacy and medical education.

### **The rural 'other' in rural health education**

The academics, health professionals and students who participated in the study used language in ways that construct rural as 'other'. It is a language use that is consistent with the way in which rural is prioritised as socially different<sup>(21)</sup>. During the interviews academics argued the need to prepare and support students for learning in the rural context, as illustrated by the following excerpt:

*" ... Um it depends on how much time we have spent preparing the students for an isolated experience . so . I went to the desert over the summer . so now I know what its like to be isolated . so we make a big deal . {name} and I . are getting up to . we start three weeks before the students go out . every week we speak about what does it mean to go to a smaller environment . what does it mean to go some where isolated . what does it mean to go somewhere where your mobile telephone does not work and there is one shop . we hope that by the time the students get there they realised they might be isolated . they realise that they have to integrate"*

The mundane and conventional practice of preparing the students for their rural placement sets up the notion of difference between prevailing social constructions and constitutes a group known as 'rural'. This use of language propels rural health into visibility and at the same time renders it as 'other' through a process of objectification. Othering is an ambiguous term and in this paper it is used to refer to ways the study participants used language to represent the rural group. Some theorists<sup>(18, 22)</sup> argue that othering sets up two binary categories, being 'us' and 'them' and represents the two as different from each other and this functions to shape society within a particular social hierarchy. The silence surrounding urban health and high visibility of the rural other in rural health education has direct relevance for the way students constitute their social identities: the act of identity construction is relational. From this perspective it can be argued that the academics use of language defines collective identity in terms of difference from the objectified other and this is illustrated in the following excerpt:

*“... um yeah normally its putting city kids in rural areas . I just read some of the things this morning . their reflective pieces and for some of them it has opened their eyes as to yeah well maybe I could work here . whereas before I didn't think I could . maybe not live here but I could work here for a short time . and um . so that's what it does . and it gives them an awareness of the rural people . I don't think they actually knew before . now whether they - that sort of awareness is particular to rural or not is something that is not really explored in any other part of the course”(academic 3)*

If identity construction is relational then the formation of a 'me' or 'us' can only be accomplished by bringing into being a 'not me' or 'them'. Mouffe<sup>(23)</sup> observes “collective identities can only be established on the mode of an us/them”. On this interpretation, members of the group known as rural (rural people, rural practitioners) are excluded from the taken for granted social order for the assumed collectivity to exist. This use of language in rural health education is indirectly contributing to the reproduction of unequal social relations in society by normalising a social hierarchy that gives primacy to urban and places rural as other. In this study the academics' authority went largely unchallenged and the students rarely questioned the validity of way knowledge about rurality had been arranged. Rather, the notion of rural other informed the students' subsequent actions and choices during the rural placement and had a profound impact on the way the constituted their personal and professional identity.

### **Students' personal and professional identity formation**

Once the students embarked upon their rural placement, the health professionals also used language that reinforced the notion of the rural 'other'. Throughout the entire rural placement people exemplified and disseminated meaning about rural culture to students, all the while assuming the students to be cultural outsiders. The construction and sharing of these meanings was codified within people's interaction, despite not always being the focus of the conversation. The most immediate structural concepts people used to position students as cultural outsiders were time and space. Health professionals often asked students how long they intended to stay in the rural community or referred to them as visitors, as illustrated in the following excerpt:

*nurse: hi there . our visitors are here . these are pharmacy students and they have just had a tour of our place”.*  
*manager: how long will you be staying with us?*

Although these instances were often social gestures designed to make the students feel welcome, they are examples of language use that highlighted the temporary nature of the students' stay in the rural community. There is strong evidence that students who have rural backgrounds are more likely to return to work in rural locations after graduation because they have some affiliation with the rural context.<sup>(3)</sup> Three students in this study spoke about their rural backgrounds however all the students found their arrival to the rural community a confronting experience, as illustrated by the following excerpt:

*student 3: {laughs} . okay we will go up there . wherever there is*  
*student 4: nice of them to give us an address or something hey*

*student 3: yeah . that would have been handy*  
*student 4: well where is it?*  
*student3: well you head up this street and turn right and the surgery is half way along opposite the supermarket*  
*student 4: will we walk man yeah come on lets walk . then we can get a feel for the place and we can shake off the nerves (medical students)*

Upon their arrival to the community all of the students quickly set about orientating themselves to the new surroundings. Time and place have been argued as basic conditions of human activity<sup>(24-26)</sup> and for the students in this research these important dimensions continually reinforced the idea they were transient visitors to this different place. In line with the legal requirement that students remain under the supervision of a registered health professional during experiential placements students were under a continuous gaze. The result of this was the students were continually witness to instances of language use and behaviours that produced representations of cultural difference, as illustrated by the following exchange between a nurse and student:

*nurse: that pig is really annoying*  
*student 1: tell me what the pigs name is?*  
*nurse: no . I don't want to really*  
*student 1 why what's the big secret*  
*nurse: no . no your're not from round here like us . you won't get it (nursing student)*

This reference to a cultural in-joke emphasises the outsider status of the student. It reinforces the dyadic 'us and them' and highlights the reciprocal relationship that is based on opposition and difference. No matter how friendly and pleasant community members were to the students and no matter how good a time the students had with the health professionals the relationship had already been established. Furthermore, the nature of this relationship between the students and the rural community was continuously reinforced by the way health professionals used the pronouns 'we' and 'you' when talking with the students. Although these words seem a benign use of language they are linguistic choices that continually signified to the students a clear distinction between rural cultural insiders (we) and rural cultural outsiders (you). Using these pronouns as binary opposites constitutes an 'otherness', which is defined by negation. The outcome of continually positioning students as rural cultural outsiders resulted in the students recognising and defining themselves within this dichotomy. In other words the students took on this othering and became complicit in constructing it thereby a social relation of difference and opposition was created. Such oppositions are hierarchical and unstable and attempts to stabilize them result in reinforcing their hierarchical nature.<sup>(27)</sup>

The students' recognition of their cultural outsider identity was apparent in their use of language, as they too used a binary classification device that was directly relational to the group in which they considered themselves members as one student illustrates in the following excerpt:

*student 1: yeah I am really interested in the staff*  
*student 2: I like sitting at the cigarette table that's where they talk to us the most . they are really interested in what we are doing and what we have to say . but the conversations are always on a grand scale . about nursing as a whole and there is never talk about while you are here in a practice setting in a specific location . there is never detail or discussion on a bigger level . but I do like talking to them*

In this excerpt the students accept the idea that rural group is different as normal. During the entire rural placement the students privileged their own social positions and subjected the community and its people to formal examinations. It was argued earlier in this paper that the rural space is objectified in rural health education and this is one of the crucial mechanisms in process of rural othering because of its effects on the students practice decisions during the rural placement. The objectified gaze caused students to look on as if they were in a theatre observing the rural community. In doing so, the students faced the task of considering themselves as being part of rural culture. In doing so they began to define rural differences and establish their significance within a given perspective of signs without critically examining the meaning of those differences. Within the broad classification of rural other the students isolated particular attributes they considers characteristic of rural people and organised them into more specific categories, as illustrated by the following excerpt:

*student 2 : here you can walk into a shop and they are really friendly . any one will talk to you*  
*student 3: but you can find that in Hobart though .*  
*student 2: yeah but its different here*  
*student 3: I know what you are saying . you are not afraid to say hello here because you know they will say hello back (medical students)*

Although the students sometimes viewed rural people in positive terms (closely connected, friendlier and warmer than what they understood people to be) the attributes they spoke about were always through the notion of difference. For the majority of the time the students' accounts of rural people were negative and portrayed a sense of disdain that took on a derogatory tone:

*student 1: ... the people do reinforce the outside perceptions though . the expectations we had about the people . they are you know rural .*  
*researcher: Can you explain what you mean by outside perceptions?*  
*student 1: well {pause} you know just the rural . they are scrubberish*  
*student 2: just different to what I was expecting . definitely more flannel . yeah more of the flannel*  
*student 1: they are rougher round the edges . but that's rural isn't it {get out of the car and begin walking up the street to the supermarket}(nursing students)*

The students understood the social reality of the rural context as backward and rural people as deficient, as illustrated by the following excerpt:

*"... like it began a long time ago someone came here and begun to talk through their nose and that has just continued on through time . its not because they are rural it's a class difference . you can find the same thing in Hobart . its an IQ relationship . not because all people here have a lower IQ . some had a lower IQ and found their way to the country and then procreated and you get clusters of it" (medical student)*

In this excerpt the medical student argues that rural people speak differently. By highlighting language differences the student identified perceived deviations from their understandings of normal and, by doing so, took for granted their own perceived positions of dominance. In this instance the students put forward issues of lower class, socioeconomic status and education as explanations for the perceived social difference. The functions and universality of social categorisation are well documented sociological canons and have been argued as omnipresent aspects of life.<sup>(28-30)</sup> The explicit purpose of this process of social categorisation was for the students to orientate themselves and make decisions about whether they 'fit' or 'not fit' into this 'rural' group. The majority of students in this research decided they did not fit into this rural group, as illustrated by the following excerpt:

“...he must of thought because we were city girls we would only want little drinks of beer . he was a funny local man . mind you I am a city girl . there is no way I am a country girl” (pharmacy student)

When rural health education is studied as a set of techniques of power, for the students in this study the outcome was that they dis(identified) themselves as rural group members. This suggests that rural health education may be having a negative impact on students' decisions to work in rural and remote areas and this is of some concern. There is an urgent need to test these findings through further research. This study shows how rural health education is a socialisation process and everything that academics and health professionals do and say is absorbed by students. It is precisely this dimension of academia that introduces a critical opportunity to improve the pedagogical practice of rural health education: the acts of speaking and doing should be critically questioned by academics, health professionals and students. If influential role models are to generate empowering practices in rural health education they have to first enhance their own reflexivity. Reflexivity is the ongoing process of questioning ones premises to identify alternative framings of reality in order to increase the potential of different outcomes.<sup>(31)</sup>

## CONCLUSION

By theorising rural health education as a socialisation process and examining the language used by academics, health professionals and students while participating in its pedagogical work it is possible to expose the invisible assumptions that shape practice and theoretical foundations. Not only can education be regarded as a professional socialisation process for undergraduate students who are making the transition to health professionals but it is a socialising process that prepares individuals for their roles in society. The high visibility of rural health education in undergraduate nursing, pharmacy and medical programs serves to constitute rural health education, and rural populations, as different and other. In doing so, the institution of higher education through undergraduate nursing, pharmacy and medical education produces and reproduces social discourses of inclusion and exclusion and creates the rural other. In its current form rural health education is impacting upon the way some undergraduate nursing, pharmacy and medical students are shaping their personal and professional identity in ways they perceive as intellectually superior and more culturally sophisticated than the rural other. In this instance it appears that rural health education is therefore working against its best intention: while students may be developing as *able* health professionals they are not necessarily emerging as health professionals who will be *willing* to work in rural areas.

**Recommendation:** There needs to be more open and critical dialogue about the relations of power and discourse in rural health education at a theoretical level and a more vigorous attention to and discussion of the attitudes, language use and behaviours with students, academics and health professionals at a faculty level.

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