

BRIEF COMMUNICATION

Early Barriers for University Rural Clinical Placements

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KEYWORDS *Rural health, pre-graduation, clinical learning, multi-disciplinary, tertiary education.*

Introduction

Rural clinical placements are increasingly considered a vital component of modern education of university students in the health sciences (Liaw *et al.*, 2005; Van Hofwegen *et al.*, 2005). Although the original impetus came from shortages in the rural medical workforce, shortages in rural nursing and allied health professionals have also been recognized. Rural clinical placements as a targeted strategy have been shown to have a positive potential for increasing the rural workforce in many disciplines and countries (Denz-Penhey *et al.*, 2005; Kippenbrock *et al.*, 2004; Richards *et al.*, 2005).

With the growing emphasis on multi-professional and team-based healthcare, it is becoming increasingly important to support students across all health disciplines. Current support is believed to favour medical students with less assistance being provided for the other health disciplines, although there is little if any published evidence for this. The present report aims to compare support given to medical and health science students going on rural clinical placements to identify potential barriers and areas for improvement. The study was conducted as a pilot for further research in this area.

Method

Data for the study was obtained by consent given surveys of tertiary health science students throughout Australia. The administering body was the

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National Rural Health Network (NRHN) which currently represents 19 university rural health clubs (RHCs) across Australia and encompasses 15 health science disciplines with approximately 5000 student members. Rural health clubs comprise of interested students who host activities and projects aimed at encouraging rural health careers. They are government-funded and operate independently of university curricula.

The self-administered questionnaire consisted of nine groups of questions relating to whether a placement had been undertaken or not, placement description, transport, accommodation, facilities, academic support, clinical support, and resulting impressions (documentation available upon request). The majority of questions were dichotomous (e.g. presence or absence of various facilities, received any travel reimbursement, enjoyed placement) while others were rated on a scale of one to five (e.g. level of support given by university). The question requesting a reason for not having undertaken a rural placement required selection of an option from the five provided with enough space to include "other" reasons.

Survey forms were emailed to the rural health clubs in May 2004 and only completed hard-copy forms returned by participants at the 7th National Undergraduate Rural Health Conference (NURHC) by 30 August 2004 were accepted for the final analysis. All information was de-identified and participation was on a voluntary basis. Data were collated and analysed using Microsoft Excel.

Results

Only the 385 NURHC participants were eligible for the survey, representing around 8% of the student membership of the rural health clubs. All 385 returned surveys and only six were discarded as being incomplete. The remaining 379 completed surveys were separated into medicine (26%), nursing (28%), pharmacy (11%), and allied health disciplines (35%). Allied health included 12 distinct disciplines that were grouped together for the analysis. All 15 disciplines and 16 of 18 rural health clubs recorded responses.

Overall, it was found that medical students were supported to a greater degree than non-medical students (Table 1). Of particular note was accommodation: the vast majority of medical students received accommodation that was paid for, in contrast to less than two-thirds for pharmacy students and less than half for both allied health and nursing students. Medicine and pharmacy also enjoyed substantially greater transport cost reimbursement compared with nursing and allied health.

Of the students who had not taken a rural placement but who had the opportunity to, nearly three-quarters indicated that this was due to barriers in deciding on taking such a placement.

These included rural placements not being offered (28%), no supported rural placements offered (13%), and a rural placement not being financially possible (34%). These barriers were particularly high for nursing and allied health students but substantially less for medical students (Figure 1). Of interest was that no pharmacy respondent reported any of the above barriers to their placements. The lack of opportunity to take a rural placement was the major barrier for allied health students, whilst financial pressure was the primary reason that nursing students did not undertake a rural placement.

This was also reflected in the number of nursing students who indicated “other” reasons which included “being unable to work during placement duration” and “not practical with children”. Additional themes from the “other” reasons were lack of awareness/information about rural placement opportunities and efforts required to organize such placements.

Table 1. Student responses for support and outcome questions

Survey question	Medicine %	Nursing %	Allied health %	Pharmacy %
Support for placement organization	80	68	80	83
Accommodation provided	92	60	56	61
Accommodation paid for	95	48	48	61
Transport costs reimbursed	75	28	28	72
Identified mentor	82	76	64	94
Identified support person	90	88	92	67
Enjoyed placement	98	92	94	100
Would consider working rurally	82	80	78	83

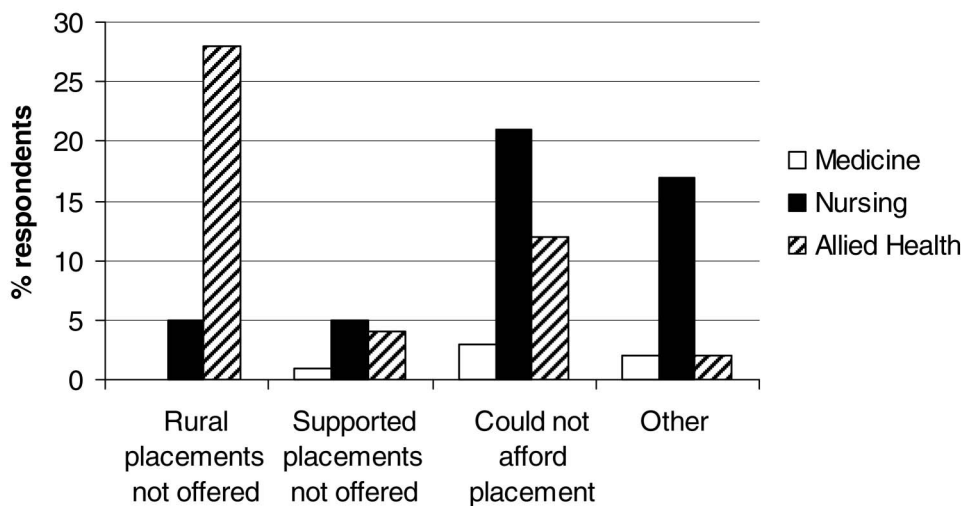


Figure 1. Reasons for not going on a rural placement.

Discussion

The results presented are consistent with previous studies that note the need for improved resources and facilitation of rural placements for health science students (Jones *et al.*, 2003; Neill & Taylor, 2002). In addition, this survey identifies the greater lack of support provided for students of non-medical disciplines compared with support given to medical students. Although evidence is presented from Australia, similar barriers being present are described in other parts of the world for various health science disciplines (Adamson, 2005; Van Hofwegen *et al.*, 2005). Results in the present study demonstrate that of those students who had undertaken a rural placement, the great majority report having enjoyed their time and would also consider future rural practice (Table 1). Although a direct relationship cannot be drawn, the combination of rural clinical exposure coupled with positive experiences underpins several current strategies aimed at rural workforce recruitment and retention (Dunbabin & Levitt, 2003). The higher expense associated with rural clinical placements is supported by the higher likelihood of practising in rural areas after graduation (Brown & Birnbaum, 2005; Wilkinson *et al.*, 2003).

Barriers to undertaking rural placements were found to be both logistical and financial in nature. University departments have a central role in implementing a curriculum that enables rural placements to be undertaken as well as in providing administrative and organizational support.

Financial constraints are a central barrier due to the nature of the rural clinical placement itself. Over and above the costs mentioned previously, students must also accept being unable to maintain employment on placement, as well as making additional arrangements for family to come and/or be looked after if they stay at home. These financial issues may also contribute to the psychological burdens associated with organizing placements, in addition to potentially more complex clinical situations, and the isolation of unfamiliar surroundings. All these costs are considerable, especially when contrasted to taking local clinical placements for which these barriers are largely absent.

The relatively small sample size of the present study was offset by all disciplines and nearly all health clubs being represented. Although a limitation in the present study, the representation was sufficiently broad to qualify results presented. Further research in the area is indicated by the present study which could be strengthened by a more quantitative questionnaire being developed to enable comprehensive statistical analysis with a broader distribution to avoid bias and ensure adequate representation.

Conclusion

A crucial component to addressing the rural workforce shortage is providing facilitated educational opportunities for university health science students.

Barriers to adequate rural clinical teaching differ between disciplines and broadly include curriculum exposure for allied health students and financial assistance for nursing students. Increased funding from government or other sources is required to enable university support to be given, and to reduce the burdens associated with rural placements. The level of funding should be maintained for medical students who are currently well supported and aimed at increased assistance for allied health and nursing students.

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