What is rural? Keynote speech at the XI EURIPA Forum 2022*

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A – research concept and design; B – collection and/or assembly of data; C – data analysis and interpretation;
D – writing the article; E – critical revision of the article; F – final approval of the article

Advances in Clinical and Experimental Medicine, ISSN 1899–5276 (print), ISSN 2451–2680 (online) *Adv Clin Exp Med*. 2023;32(1):9–12

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Funding sources
None declared

Conflict of interest
None declared

* A lecture provided during the 11th European Rural and Isolated Practitioners Association (EURIPA) Rural Health Forum (Catania, Sicily, Italy, October 6–8, 2022), https://advances.umw.edu.pl/en/abstract-book-2022-euripa

Received on October 8, 2022
Reviewed on November 16, 2022
Accepted on December 28, 2022

Published online on January 21, 2023

Abstract

Background. In order to consider the question of "what is rural", the author chose to use examples from her journey as a rural family doctor (general practitioner) in Australia.

Objective. To consider the diversity of rural practice settings and medical practice styles in primary care that can all be considered to be rural medical practice. In doing so, to consider the size and population density of Australia, compared to Europe, from where the audience of The European Rural and Isolated Practitioners Association (EURIPA) originates.

Results. In discussing rural locations where the author has practiced, the Modified Monash Model of classifications of rurality, used in Australia, is introduced. It will be shown that rural medical practice varies significantly even in places of similar classifications of rurality. In some towns, the family doctors do procedural work or admit patients to hospital. In other towns and remote communities, an unwell patient may need to be looked after in the primary care clinic for hours before they can be evacuated. These are however all variations of rural practice. Does population or the occupations that workers engage in make any difference to rurality? Does distance from a capital city matter?

Conclusions. Rural medical practice is diverse in location, cultures and work undertaken. Rural medical doctors use different names for themselves such as rural family doctor, rural family physician, rural generalist, rural primary care doctor – we are all rural.

Key words: rural, family medicine, rural medicine, rural doctor

Cite as
Flegg K. What is rural? Keynote speech at the XI EURIPA Forum 2022. *Adv Clin Exp Med*. 2023;32(1):9–12. doi:10.17219/acem/158782

DOI
10.17219/acem/158782

Background

In order to consider the question of "what is rural" and the diversity of rural practice settings, I have chosen to use examples from my own journey as a family doctor (general practitioner), and in particular as a rural general practitioner, in Australia.

The World Organisation of Family Doctors (WONCA) past president, Prof. Michael Kidd, was a guest speaker at the WONCA World Rural Health conference held in Gramado, Brazil in 2014. Professor Kidd asked the question "Why is rural family medicine important?" The answer was simple: half of the world's population live in rural areas, but half of the world's doctors do not. He pointed out that most of our colleagues in other specialties are based in cities or in large regional centers, but it is family doctors who are based in rural communities and provide medical care and advice to that half of the world's population.[1]

The Australian rural situation

It is interesting to compare the size and population density of Australia, where I come from, and Europe, the home of EURIPA.

Australia's area is a total of 7.69 million km^2 compared to Wikipedia's estimate for Europe of 10.18 million km^2.[2,3] Roughly comparable.

The population densities are given by World Population Review as Australia 3.4 persons per km^2 compared to Europe's 72.9 per km^2. Not at all comparable, with Australia only exceeded in the sparseness of population density by Mongolia and Greenland. Iceland is similar to Australia with 4 persons per km^2, and next in Europe are Norway with 15 and Finland with 18 persons per km^2 respectively. Monaco with 19,497 persons per km^2 is Europe's most densely populated country.[4]

The majority of Australians live in major cities (72%), and much of the country is sparsely populated.[5] The population is concentrated around the southeast and east coast and southwest corner of the continent. It's easy to 'go rural' in Australia.

My rural GP journey begins

I was born and raised in Sydney, where I went to Sydney University Medical School. I signed up to the General Practice specialty training program, a postgraduate program for 3 years, mostly spent in community general practice.

"Where do you want to go for your training?", I was asked.

Perhaps it was not wise, but my reply was "about as far from Sydney as possible". I did not dislike my hometown, Sydney; however, I had a desire to try something different to what I had known. Now, some 30 years later, I have tried many contexts of work as a rural GP with some specializations including Aboriginal health, management and teaching.

Where did I go for that first general practice placement? Warialda, 600 km from Sydney, with a population of 1300 but also drawing patients from the surrounding farming community. It is a strong sheep and wheat farming area. As well as work in the general practice clinic, the 2 doctors who supervised me ran a 25 bed hospital and we performed uncomplicated obstetrics, anesthetics and minor surgery. The nearest large hospital was 2.5 h by road ambulance.

Was this rural practice? Even those in my country with narrow definitions of rural practice would agree – definitely rural!

Measures of rurality

Australia uses the Modified Monash Model[6] to define rurality for medical workforce purposes. The model classifies metropolitan, regional, rural, and remote areas according to geographical remoteness, as defined by the Australian Bureau of Statistics (ABS), and town size. In this model, MM1 is a major city and MM7 is very remote. Warialda rates as MM5[6] – small rural town (conf. Table 1 and Fig. 1).

In recent years, I have spent my time in Central Australia (MM6 and MM7[6] – remote and very remote) working in the medical team which serves isolated Aboriginal communities. These communities have a population of between 100 and 1000, and can be 800 km from the nearest large hospital in Alice Springs. The remote health clinics are nurse-led, and nurses see acute patients and are on-call after hours. Doctors generally visit the smaller places for 3 or 4 days in a month.

Retrievals of emergencies and very sick patients are done by the well-known Royal Flying Doctor service, or by road if within 2 h of Alice Springs. To get to work, our doctors travel in small charter airplanes for up to 2 h or drive up to 4 h, often on unsealed roads, in a four-wheel-drive vehicle. In our clinics, there was no obstetrics (except antenatal care and unintentional deliveries), no surgery and no general anesthetics. However, we did have to take care of the very sick in our well fitted out emergency rooms, until retrieval – at least 2 h but often much longer.

Was this rural practice even without procedural work? No arguments – not just rural, but remote or isolated!

Strangely, I do not consider Central Australia to be the most isolated place where I have worked. Every working day, doctors, nurses and Aboriginal health workers in these remote communities have the support of a telephone service manned by experienced colleagues who can advise on the day-to-day issues. Out of hours and for emergencies, it easy to call the Alice Springs Hospital retrieval service – so you always have support.

Another training placement I took was in Eugowra, a small town of 670 people, 350 km from Sydney, but with only 1 doctor – me! In that town, there was a 30-bed

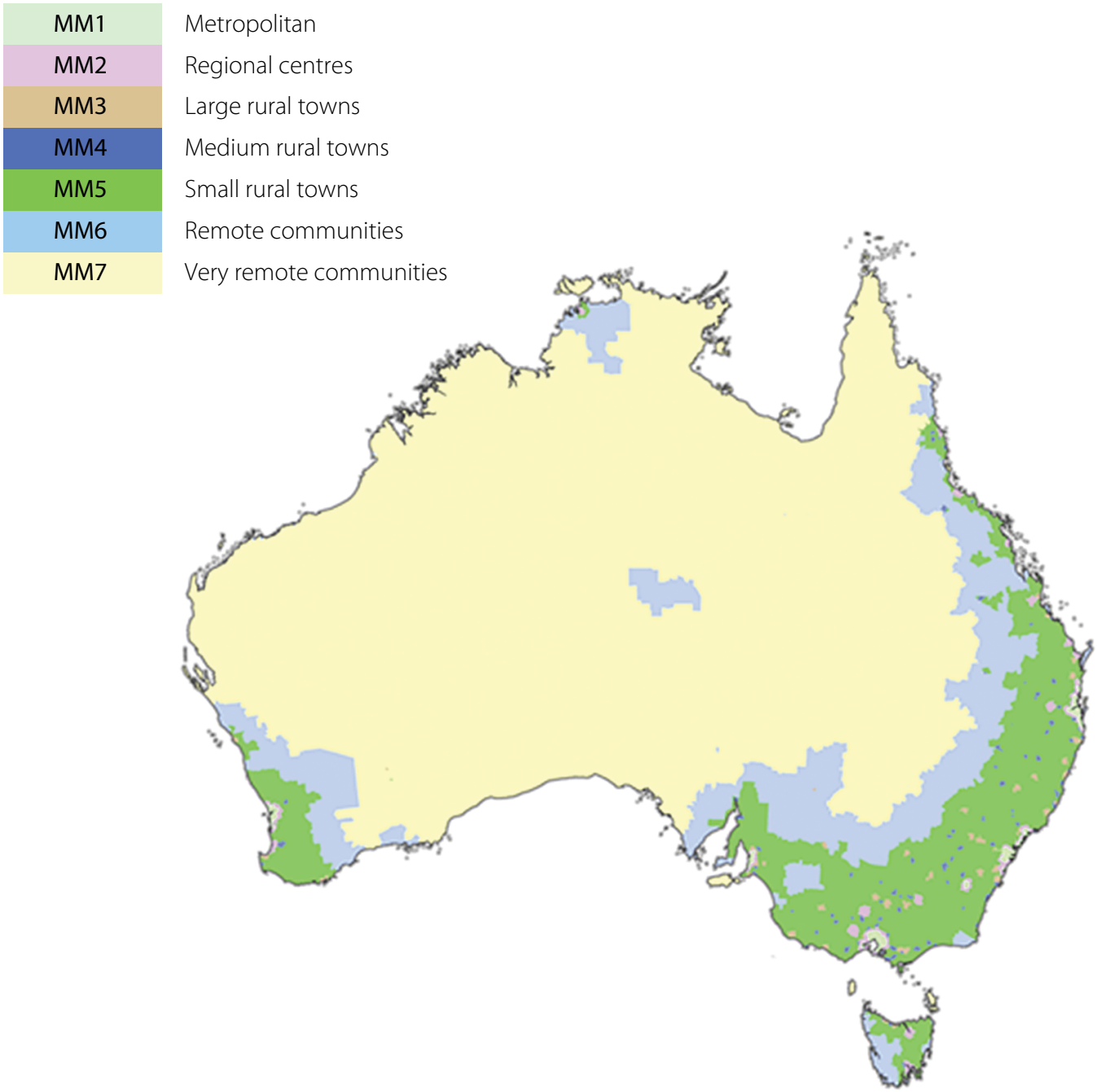

Fig. 1. Modified Monash Categories distribution on map of Australia[6]

Table 1. Modified Monash Categories of remoteness and description[6]

Modified Monash Category (MM)	Description
MM1	**Metropolitan areas:** Major cities accounting for 70% of Australia's population.
MM2	**Regional centres:** Inner and Outer Regional areas that are in, or within a 20-kilometer drive of a town with over 50,000 residents.
MM3	**Large rural towns:** Inner and Outer Regional areas that are in, or within a 15-kilometer drive of a town between 15,000 and 50,000 residents.
MM4	**Medium rural towns:** Inner and Outer Regional areas that are in, or within a 10-kilometer drive of a town with between 5,000 and 15,000 residents.
MM5	**Small rural towns:** All remaining Inner and Outer Regional areas.
MM6	**Remote communities:** Remote mainland areas and islands less than 5 km offshore.
MM7	**Very remote communities:** Very remote areas. Remote island areas more than 5 km offshore.

hospital, mostly aged care beds, but also 5 acute beds to manage. MM5[6] – but no anesthetics, surgery or obstetrics, and with only 1 doctor available. The nearest colleagues were 30 km away and nearest large hospital – 80 km. In case of an emergency, you could call a specialist colleague in the large hospital – or send the patient in our volunteer ambulance[7] staffed by local volunteers, whose day job was as a farmer, a butcher for example.

I felt alone, very alone. With only 80 km to a regional hospital, no one would consider this remote or isolated; however, for me it felt that way.

While researching this topic, I noted Wikipedia[8] provides Indian definitions of rural: a town with a maximum population of 15,000, and 75% of the male working population involved in agriculture and related activities.

I remembered working in Muswellbrook in the wine-growing areas of eastern Australia. It had been a very strong farming community, but by the time I was there, many workers were involved in the mining or power production industries, and its population was just over 15,000. By the Indian definition of male occupation and arguably population, not rural! Yet our 10 doctors did on-call, and worked in our local hospital, admitting patients and performing obstetrics, surgery and anesthetics. I say rural and it ranks as MM4[6] – medium-sized rural town.

My final example is Bungendore, only 38 km from Australia's Parliament House. I had known colleagues who say "How this can be rural?" Until recent years, there was no ambulance in town, so you have to wait up to 1.5 h for an unwell patient to be collected, as you do in remote Central Australia. No procedural work. Rural? I think so, and so does the Modified Monash Model, which rates it as MM5[6] – small rural town.

Rurality is a question of perspective. A farmer will say "real rural isn't living in towns". However, most rural family doctors need to live in their town in order to be available to the patients and their community. The government defines rurality[6] in order to consider statistics on rural health. They look at numbers of primary health care professionals; they consider health spending; they are concerned about death rates being 40 times higher for heart disease and 3 times higher for type II diabetes.

Conclusions

For me, rural has meant diversity of locations, cultures and health problems. Defining rural is challenging within Australia and certainly between countries.

I finish with another reference to the words of Prof. Michael Kidd from 2014. "How we describe who we are differs from place to place. What matters is the common work we do, the vision that we share, the outcomes that we achieve for our patients and their families and for our communities."

We call ourselves rural general practitioners, or rural family physicians, or rural generalists, or rural primary care doctors. We work in diverse settings with diverse people.

We are all rural doctors.

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References

1. Kidd M. The World of Rural Family Medicine - address to WONCA World Rural Health conference, in Brazil. 2014. https://www.globalfamilydoctor.com/AboutWonca/PresidentsBlog/TheWorldofRuralFamilyMedicine.aspx. Accessed January 11, 2023.
2. GeoScience Australia. Area of Australia States and Territories. Canberra, Australia: GeoScience Australia; 2004. https://www.ga.gov.au/scientific-topics/national-location-information/dimensions/area-of-australia-states-and-territories. Accessed October 2, 2022.
3. Wikipedia. Europe. 2022. https://en.wikipedia.org/wiki/Europe. Accessed October 2, 2022.
4. World Population Review. Countries by Population Density 2022. 2022. https://worldpopulationreview.com. Accessed October 2, 2022.
5. Australian Institute of Health and Welfare (AIHW), Australian Government. *Rural and Remote Health*. Canberra, Australia: Australian Institute of Health and Welfare (AIHW) & Australian Government; 2022. www.aihw.gov.au/reports/rural-remote-australians/rural-and-remote-health. Accessed October 2, 2022.
6. Australian Government, Department of Health and Aged Care. Modified Monash Model. Canberra, Australia: Australian Government, Department of Health and Aged Care; 2021. https://www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm. Accessed October 2, 2022.
7. Ambulance New South Wales. The Volunteers. Eugowra Volunteer Ambulance Officers. Sydney, Australia: Ambulance New South Wales; 2014. https://www.youtube.com/watch?v=d3FitoXGA10. Accessed October 2, 2022.
8. Wikipedia. Rural area. 2022. https://en.wikipedia.org/wiki/Rural_area. Accessed October 2, 2022.