

Challenge, Collaboration and Community: The Benefits of Practicing in Rural, Northern and Remote Areas

“I’ll go to the sticks for a year or two, make some money, pay off my student loan, then move home and look for the job I really want.” How often have we heard these words from classmates or other health professionals discussing their plans for after graduation? For many beginning their careers in speech-language pathology or audiology, jobs in rural, remote or northern communities are just that – a way to find a temporary job quickly after graduation and make an attractive remote or northern allowance. While understandable, this attitude does not serve these communities – or the clinicians themselves – in the best way possible. If approached from a perspective of reciprocal benefit and learning, remote placements and jobs offer unique opportunities to work with traditionally underserved populations, to gain a wide range of professional experience, to explore new areas of research and to collaborate with others in a wide range of disciplines to meet community needs.

It is clear that not all Canadians have equal access to healthcare services. Recruitment and retention of health professionals in remote areas is an ongoing challenge. Small communities are constantly dealing with high nursing staff turnover and long periods of job vacancy (Minore et al., 2005). More specialized health professions are in even greater demand; nearly a quarter of Canadians live in districts without speech-language pathologists (SLPs) or audiologists (Canadian Institute of Health Information, 2007). First Nations, Inuit and Métis people living in remote areas may have particularly poor access to speech, language and hearing services (Canadian Association of Speech-Language Pathologists and Audiologists, 2010). The effects of lack of access on patient care are enormous. Long waiting lists, lack of follow-up and referrals, poor continuity of care and lack of trust between clinicians and clients are among the many negative consequences. Clients may become disengaged or unwilling to return for therapy because of having to tell their stories over and over again to different staff (Minore, Boone, Katt, Kinch & Birch, 2004). Clearly, clinicians who commit to working in remote areas are filling a critical gap in services.

In filling this gap, however, clinicians need to carefully consider how best to work in remote environments. Small rural communities often have unwritten codes of behaviour, and offering therapy that does not fit in with local ideas is unlikely to be well-received or helpful to clients (Coleman, Thompson-Smith, Pruitt & Richards, 1999). A lifelong northerner myself, I know that small communities can be wary of or even hostile towards newcomers from the south with plans to “fix” them or their communities. This is not to discourage clinicians from urban centres from working in remote areas, but rather to highlight the need for preparation and cultural sensitivity. Cultural awareness has been shown to be an important factor in the success of community health initiatives in northern communities (Minore et al., 2005). SLPs should be willing to take advantage of any orientation or mentorship opportunities offered, and also to learn from local paraprofessionals and community members. Attending and contributing to community events also goes a long way towards building rapport and trust within a community. SLPs and audiologists who are willing to educate themselves about local cultural norms and to work collaboratively with community members have an opportunity to practice cultural competence while providing high quality patient care to those who might otherwise not receive it.

Not only the communities benefit from hosting clinicians and students; the benefits to the clinicians themselves are also considerable. Working in a remote community affords clinicians the opportunity to “take on multiple roles and become multi-skilled” (Coleman, Thompson-Smith, Pruitt & Richards, 1999, p.41). They are likely to see a wider variety of cases and attain greater self-sufficiency than those working in urban centres. In a recent survey, specialist physicians working in remote areas of Canada cited variety and autonomy as primary reasons for choosing to practice there (Togari, Wong & Roger, 2012). Health professions students in a range of disciplines noted unique cases and greater hands-on participation as motivating factors for choosing rural placements (MacRae, van Diepen & Paterson, 2007). While it may be overwhelming at first to be responsible for assessing and treating preschoolers *and* school age children *and* clients with traumatic brain injuries *and* clients with stroke *and* clients with dysphagia *and* whoever else comes through the door, there are few jobs in cities that build competencies in so many domains of our profession so quickly. And, with improvements in technology

such as online continuing education, Skype and Telehealth, access to the latest information and the expertise of colleagues has never been easier, even in remote locations.

An excellent but often underexplored benefit of working in small, remote communities is the ease of collaboration with other programs and services. At first this may seem counterintuitive; after all, remote communities often lack the depth and breadth of support services found in larger centres. However when you live in a small community, chances are that the local teacher, nurse, librarian, community health representative, early childhood worker or post-natal worker will live close to you, share office space with you or shop at the same grocery store as you. When you know these people personally, forming partnerships among those with similar goals is easy, especially in the areas of promotion and prevention. There is also little chance that you will be unable to refer a client to a service or program because you don't know it exists. The small but close-knit network of a small community invites collaboration with those outside the traditional circle of who we might think of as partners or colleagues, but can produce innovative programs and strategies that are responsive to needs and fit in with community values.

Rural and remote communities also offer an abundance of opportunities for new and necessary research. While the quality and quantity of research in our field is improving, much of it is theoretically based and focussed on majority cultures and languages. We may have learned in our professional training about how to assess dysphagia in a hospital setting with complete videofluoroscopy equipment, but how can it be done at a remote health clinic? Plenty of literature exists about language assessment of children who speak African-American dialects, but there is a critical shortage of information available about language development and assessment of aboriginal children in Canada (CASLPA, 2010). These questions and many others are clinically relevant to SLPs working in remote and rural areas across the country, but are unlikely to be answered in the research labs of universities. Research shows that community-based participatory action research is in fact the best way to understand and address the health needs of rural or aboriginal populations (Minore et al., 2004). Practicing in

rural and remote communities offers immense potential to research questions that are both clinically important and largely unexplored by the current literature.

Given both the need for and benefits of working in remote areas, what should our training programs and professional organizations be doing to prepare graduates? First, our training programs need to prepare us to work independently and to work in cross-cultural contexts. While this is increasingly become an area of focus in health professions, we may not be there yet. In a survey of SLPs working with aboriginal caseloads in Canada, half said they initially felt unprepared to practice with this population (CASLPA, 2010). Rural physicians in Canada also cited a lack of preparation and wish for more training before beginning careers in rural areas (Togari, Jong & Roger, 2012). Secondly, students should be given opportunities for clinical placements in remote and rural areas. A recent survey of physicians in Canadian found that rural experience during training for physicians from urban centres positively influenced their decisions to pursue rural practice (Togari, Jong & Roger, 2012). Providing placement experiences in rural areas has been demonstrated to be an effective recruitment strategy across a variety of health profession in northern Ontario (MacCrae, van Diepen & Paterson, 2007). Finally, continuing education that is both relevant and accessible should be available to help support those working in remote areas to develop their clinical and cultural competencies.

While there are many benefits to working in remote or rural areas for clinicians from larger centres, the lure of home is very strong. In order to create a sustainable workforce of health professionals to work in remote areas, the long-term solution is to recruit and train clinicians from these areas. It is therefore incumbent upon SLPs and audiologists who work in remote locations to build trust in and respect for our fields, and to promote our professions as viable, necessary and rewarding careers. We can do this by bringing competence, professionalism and enthusiasm to our work, while respecting and working within the culture of the community. Working in remote and rural areas should not be seen as “putting in time” or as a last resort, but rather as an exciting opportunity to provide crucial services to clients, build professional skills and become a valued part of a community.

References

- Canadian Association of Speech-Language Pathologists and Audiologists. (2010). Speech, language and hearing services to First Nations, Inuit and Métis Children in Canada, with a focus on children 0 to 6. Ottawa, ON: Margaret O'Hara and John Rowlandson.
- Canadian Institute for Health Information. 2007. Distribution and internal migration of Canada's speech-language pathologist and audiologist workforce. Ottawa, ON: J. Roger Pitblado.
- Coleman, T.J., Thompson-Smith, T., Pruitt, G.D. & Richards, L.N. (1999). Rural service delivery: unique challenges, creative solutions. *American Speech-Language-Hearing Association*, 41(1), 40-45.
- MacRae, M., van Diepen, K. & Paterson, M. (2007). Use of clinical placements as a means of recruiting health care students to underserved areas in Southeastern Ontario: Part 1 – Student perspectives. *Australian Journal of Rural Health*, 15, 21-28.
- Minore, B., Boone, M., Katt, M., Kinch, P., & Birch, S. (2004). Addressing the realities of health care in northern aboriginal communities through participatory action research. *Journal of Interprofessional Care*, 18(4), 360-368.
- Minore, B., Boone, M., Katt, M., Kinch, P., Birch, S. & Mushquash, Christopher. (2005). The Effects of nursing turnover on continuity of care in isolated first nation communities. *Canadian Journal of Nursing Research*, 37, 86-101.
- Togari, C., Jong, M. & Roger, J. (2012). Needs of specialists in rural and remote Canada. *Canadian Journal of Rural Medicine*, 17, 56-62.