The Allied Health Perspective

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Non-metropolitan Allied Health Professionals are likely to work with larger case-loads, over vast distances, in sole positions, with little access to education. Isolated positions frequently are filled by new graduates. Formal recognition of practical coping techniques which evolved, is required, since mismatch between expectations following primary training and the realities of the workplace create stress and despondency. Training, resource development and support structures are needed in such areas as case management and service delivery, specific rural health concerns professional and industrial issues, specific intervention strategies and education techniques.

Medicine and nursing approach ‘postgraduate’ education from the perspective of professions with a recognised place in rural and remote communities. ‘Rural Practice’ can be viewed, in those professions, as an evolving specialty. Key aims appear to be attracting and proficiently educating personnel for a life long commitment to rural health issues and a rural lifestyle.

The perspective, for the allied health professions, is different and diverse. The founding professions represented on the Queensland Council of Allied Health Professions, for instance, included: Audiology, Nutrition and Dietetics, Occupational Therapy, Physiotherapy, Psychology, Social Work and Speech Pathology. Other professions have since joined the council and yet others may be regarded by health service providers as tertiary trained ‘allied health professionals’ for administrative purposes, including such diverse personnel as the Pharmacist, Radiographer, Recreation Officer, Medical Records Administrator and Medical Librarian.

For allied health professionals, the question of postgraduate education is bound inextricably to the more basic issues of:

(a) Providing more staff to service rural and remote communities at planning level, and

(b) Evolving efficient and coordinated service delivery models to gain maximum benefit from whatever allied health services are provided.

Some states (e.g. South Australia, Victoria) appear to have some structures in place and, for them, attracting and retaining staff is an issue. Other areas (e.g. Northern Territory, Queensland) tend to report a lack of recognition and provision for services in the first place, that is there are no available positions to fill because of lack of funding for allied health positions. Recent graduates enquiring about employment prospects in non-metropolitan areas frequently are rebuffed, a fact which should be of concern to the health consumers who need and want their services.
Positions outside the major metropolitan centres may evolve in an isolated and unstructured way, for example, because the wife of a local property owner happens to be a therapist. Surveys undertaken in Australia (e.g. The Australian Association of Occupational Therapists' survey) show that staff members in non-metropolitan areas (including rural areas and the neighbouring urban centres which service them) are more likely to work with larger caseloads, in sole positions, for lower rates of pay, for longer hours. They are more likely to hold a second or other job which does not use their professional skills and are less likely to have access to further education. In addition, many isolated positions are filled by inexperienced new graduates who have no orientation towards service delivery over vast geographical distances.

Postgraduate education might be sought, therefore, by three different groups within the allied health professions:

(a) People with a commitment to ‘rural practice’ as a chosen career – while many such individuals exist, this group will not yet be as prevalent in allied health as it is in medicine or nursing;

(b) Allied health professionals who ‘marry’ into an area or ‘come home’ to be near their families for varying lengths of time – because of the role women have played, historically, in the allied health professions this remains an obvious form of recruitment outside the major metropolitan centres;

(c) Recent graduates seeking short term experience and adventure before ‘moving on’ – as noted in the medical field, undergraduates who have undertaken ‘country’ clinics increasingly are seeing the advantages, in terms of professional and personal development, of seeking employment away from capital cities.

These three groups all have valid educational and support needs. These may vary from wanting an educational qualification in ‘rural practice’, to catering for flexible working and training arrangements for women moving in and out of the workforce, to recognising the special, immediate needs of an ill-equipped new graduate. There is nothing shameful about having a staff turnover every 2 to 3 years. The important factors are to retain staff for at least eighteen months (employers appear to lose trust when turnover is more frequent than this), to create a happy, positive and stimulating environment in which the professional’s skills are being used to maximum advantage, and to have people ‘knocking at the door’ wanting the opportunity of working in ‘rural practice’, so that continuity and stability of service is ensured.

Several postgraduate training issues are involved. Long term, there is the question of having special postgraduate qualifications in ‘rural health’. The medical concept of specialist training in a particular field of interest does not apply directly to allied health and there are differences in orientation to training between the various allied health professionals. In the therapies, for instance, clinical skills usually are imparted at an undergraduate level. Postgraduate courses are likely to be research orientated and individuals become ‘specialists’ in a particular area because of their work histories and personal academic interests. In other professions (e.g. psychology, social work), becoming a health clinician may itself be a postgraduate endeavour, with training occurring after the completion of a liberal undergraduate course. Promoting discipline specific postgraduate training in ‘rural practice’ within the allied health professions is to enter troubled and murky waters.

On the other hand, it is possible to envisage the development of special multidisciplinary courses, which any suitably qualified health professional could enter, leading to a postgraduate
qualification in 'rural practice'. The prospect of undertaking core subjects across disciplines combined with more discipline specific electives is an attractive prospect to some allied health professionals. The possibilities of providing 'locums' to release isolated professionals for study at designated training institutes and of establishing suitable external courses have been raised.

One comment must be made in regard to this. Health planners, large metropolitan training institutions and even the professional associations themselves are taking a belated (but hopefully well meaning) interest in those professionals living and working 'in the country'. Allied health professionals employed outside the large capital cities frequently have experienced feelings of degradation and unwarranted devaluation of their skills and knowledge base, because of the administrative structures in which they work. They have learned to be resourceful, self reliant and supportive of each other, with communication networks outside the major capital cities. Given the accumulated anger and resentment which exists over past wrongs, it is unlikely that any training institution centred in a coastal capital would be viewed as a creditable place for specialised training in 'rural practice'.

The most immediate educational needs identified by a range of allied health professionals canvassed around Australia concern:

(a) Preparation and orientation for employment in non-metropolitan areas;
(b) Continuing access to information, support and communication networks.

Adequate preparation can be addressed, to some extent at the undergraduate level. Ongoing needs, however, can be divided into:

(a) Means of facilitating the continuing education which all professionals require to keep their knowledge base current – while 'country placements' impose demands for a greater range of skills and job duties, the technologies, library facilities, support services and access to services needed for professional development tend to remain in the metropolitan area.

b) The postgraduate education required to fulfil a specific job effectively – it is this issue which is being considered currently.

Using the field of speech pathology as an example, recent graduates may be trained according to the concept that the recommended treatment ratio is 27 speech pathologists per 100,000 population, or that 1 speech pathologist should be employed for every 8 inpatients being managed for feeding and/or communication disorders in an acute facility. They may be taught that, for every paediatric case they see, it is negligent not to undertake a detailed assessment requiring up to 10 hours of analysis. On arrival in their new 'country' positions, they are faced with caseloads of hundreds of clients. They may be given a list of schools to cover which would allow them 1 hour per week in each school on their list.

They may be asked to undertake procedures, in an acute setting, for which they are inadequately prepared. Because of lack of community resources, they may be responsible, not only for acute care, but for the ongoing management and support of the disabled and aged. There is the additional burden of trying to find ways of providing adequate follow up and support to patients and clients who are geographically isolated. Equipment and resources considered basic to the practice of their profession may not be provided.

For one fifth of Australians, English is not the first language. While the assessment of migrants is receiving more prominence in speech pathology, isolated therapists in Western Australia and the Northern Territory, in particular, report that they were unprepared for
having to learn Aboriginal languages and culture in order to carry out their work. Not being able to cope with their caseloads according to the standards established during primary training leads to feelings of frustration, inadequacy, stress and despair.

Feedback from Allied Health Professionals around Australia concurs with research findings in American and Canadian studies, in particular. Service delivery must be restructured to allow more ‘clustering’ of professionals in specified centres, with at least one senior being available for each profession in each region. The establishment of separate adult and paediatric complete multidisciplinary teams, support for staff from visiting consultants, more use of outreach services, improved transportation arrangements and access to central resources and kits are recurrent themes. Such reorganisation is an essential first step in postgraduate training and support.

Isolated professionals want to receive specific orientation in how to survive effectively, when they are first appointed. They want the opportunity to attend regular ‘in-services’ at a designated central location to enhance their coping strategies. The content of such training for allied health professionals is perhaps a matter for research but it could include such topics as case management and methods of service delivery, specific rural health concerns, professional and industrial issues, specific intervention strategies and education techniques for the appropriate dissemination of information.

At the informal level, allied health professionals have developed techniques in delivering services over vast geographical distances. Varying degrees of success are reported in the use of (for example) volunteer schemes, ‘parents as therapists’ schemes, the provision of home programs, the evolution of non-traditional intensive treatment patterns, the training of multi-purpose health personnel. Research into those elements which can make such schemes more effective is required (e.g. appropriate selection, sufficient training, adequate follow up), as well as the formal transmission of this information as a legitimate body of knowledge.

Postgraduate training should include the development of mobile units, resource kits and equipment for

(a) Enhancing the skill with which allied health professionals can deliver a service;
(b) Assisting allied health professionals in the education of their fellow professionals and the health consumers.

‘Care of burns’ in occupational therapy, ‘teaching transfers’ in physiotherapy or ‘swallowing assessment’ in speech pathology might be specific examples.

Last, allied health professionals must ask: What will their input be into the training of medical practitioners and nursing staff for ‘rural practice’? American needs surveys have shown that the greatest needs among rural communities appear to concern mental health, preventive care and health education, home health care and long term care for specific disabilities. The most common health problems reported by rural people included arthritis, speech problems, visual problems, limb impairments and hearing problems (along with heart conditions, kidney ailments and allergies), all conditions in which management by allied health personnel is central. The successful utilisation of allied health services must include a recognition of the variety of specialised knowledge that allied health professionals possess, a raising of awareness about the roles of the allied health professions in rural and remote communities, and sufficient communication of information to other health practitioners to improve the general standards of care, especially in cases of prolonged disability, amongst residents of rural and remote areas.
References


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Unpublished information and opinion canvassed from a selection of allied health professionals in all States of Australia is gratefully acknowledged.

Access to submissions made to the National Rural Health Conference on allied health matters is acknowledged also.