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REPLY

Reply: Cost and returns related to medical education in rural and remote locations

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Dear Editor

Dr Walsh in his letter[1] comments on two important aspects in community-based medical education in rural and remote locations (cost and long-term return on investments) that the Medical School at Aristotle University of Thessalloniki (AUTH) also encountered when implementing the attachment in primary care.

The main educational aim of our primary care attachment is to advocate community primary care oriented to the health needs of the population. In the case of the Greek National Health System, only Rural Health Centres (RHCs) offer community based health care. In urban areas primary care services are delivered from private physicians and social insurance funds' health units (polyclinics)[2].

The cost of travel and accommodation for medical students is a matter of continuous consideration, especially in a time of economic recession such as the one Greece is currently facing. Collaboration with RHCs in the areas of students' family residence was preferred, as well as RHCs that could provide free accommodation. Even though such an approach might raise more organisational issues, it also drives to the increase of collaborating teaching RHCs, necessary in the case of medical schools where more than 300 students practise each academic year.

Developments in Information Technology (IT), used more and more in education, can be very helpful in remote primary-care attachments[3]. The AUTH Medical School minimised software costs by selecting freeware applications for creating an asynchronous e-learning environment. Costs

for hardware in remote locations are addressed by using the RHCs' IT infrastructure, so medical students can remain in contact with the medical school and its resources during their attachment. Actually, the e-learning environment is evaluated by our students as one of the strongest points of the attachment.

In Greece, where a traditional apprenticeship model is followed, educating students or residents is not considered a task for which physicians should be remunerated. In order to compensate the tutors, their support remains a complex issue for our department to manage. Not only it is necessary to provide feedback, audit sessions and meetings on restricted financial resources, but it is also essential to meet their educational needs and offer them both skills enhancements and incentives.

Issues of loneliness or isolation are easily resolved for students who choose an attachment close to their family's residence. However, for students attached to remote RHCs the situation may be more complicated, and the local tutor assigned to the student usually takes up the task to help the student, even though it should be the department's responsibility.

In a pre- and post-evaluation of the attachment we found a 12% increase in our students' intention to follow general practice as a future career[4], which in Greece is mainly associated with practising in rural areas, due to the structure of the health system. Therefore, 4 years after implementation, our assumption that the primary-care attachment would tempt students to return in rural areas as fully qualified professionals has been reinforced. A long-term follow up will demonstrate whether these results have been sustained.

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