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Prioritising rural authenticity: Community members' use of discourse in rural healthcare participation and why it matters

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Abstract

This paper uses discourse analysis to explore individuals' use of two discourses in Scottish rural health community participation. It explores interview texts from a community participation project to design new services. Findings show that some community members employ discourses of rural localness and tradition to augment their credibility and gain influence. In particular, community members employ discourses that prioritise the voices of those perceived as local, and when discussing doctors and nurses, prioritise those who display idealised characteristics associated with local traditional provision. In examining these prominent discourses, the paper suggests that community participation involves more complex power-plays than simply those between health service managers and the public, that tend to be portrayed in health policy. Power-play between community members could affect processes and outcomes of community participation.

Keywords: rural health, community participation, power, community engagement, representativeness, rural services

1. Introduction

Contemporary policy about state health service provision, internationally, invokes the concept that 'ordinary people' e consumers, the public and tax-payers should play an integral role in shaping service design and provision. NHS Scotland, for example professed a desire to be a world-leader in having consumers inform services (Scottish Government, 2007a). It has participation standards for health services (Scottish Government, 2007a) and explains an ethos of partnership between state, providers and the public that: "...brings together our commitments to public participation, improving patient experience, patient rights and enhanced local democracy and expresses them in terms of a more mutual approach to health care..." (Scottish Government, 2007a: p.3)

Adapting Arnstein's (1969) classic typology of citizen engagement, health services may involve citizens in health service design and provision through: informing, consulting, involving, collaborating with, or devolving power to, citizens (NHS England, 2013; p.30). Operationalising public participation in health service design, as depicted in health policy, involves engagement activities led by health services, with 'communities' (NHS England, 2013; Commonwealth of Australia, 2012). In these activities, state actors invite the public to provide input into designing services within a locale and context known to them. Despite an occasional dearth of robust evidence to substantiate claims, public participation with communities is said to lead to contextually appropriate services plus local capacity-building, enablement, knowledge and confidence about using local services (NHS England, 2013; Department of Health Victoria, 2011). While acknowledging that there are diverse ways to define community (Barrett, 2014), in this paper, we conceptualise communities in a way that we believe health service managers do when they endeavour to engage with consumers, that is, geographically: as the people that live within a radius of service provision. In reality, this is a loose

notion because locations tend to be imprecisely bounded, and people may move away or in, are itinerant, and/or work, but do not live, in a place.

In health policy, portrayals of community participation tend to be presented simplistically as (England, 2013; Scottish Government, 2007b). That community engagement is most frequently portrayed as involving a health service acting to stimulate local people's involvement in health service activities (and not the other way around), implies, from the outset, that the health service is the more powerful party. Within community participation, the issue of whether an appropriate and prototypical group of community members has been engaged (representativeness) is often raised as a key criterion of success (Kenny et al., 2014). The demand for a 'representative sample' to take part in engagement raises the idea that there are diverse views among people and groups of people, living in a place, that are consistent and can and should be represented. There is a tendency for stakeholders to question whether the right range of demographic categories has been canvassed and idealised groupings may be proposed from which greater input is required; for example, young people, people with disability, or disadvantaged people. Renn et al. (1993) suggest representativeness comes from inviting a random sample; but even then, only those willing and with time will actually present. Others dispute the need for a traditional representative sample, suggesting a requirement for a range of expert views to inform a decision, with experts including 'lay' people (Martin, 2008). These ways of discussing who participates suggest participant's views as fixed, consistent and associated with their demographic grouping. They neglect that participants' views may be emergent, evolving or changing or that context could affect perspective. This concept of fixed ideas among categories of people over time is questioned with ideas of changing interpretations of individual identity (Cassidy and McGrath, 2015) and rural mobility and fluidity (Goodwin-Hawkins, 2015). There is a dearth of evidence that explores, in depth, the concept of a 'community member's view', what it is, what affects it, its fluidity and the role of individual's views in health community participation.

Here, we explore the discourse of individuals considered to be the least powerful within rural health community participation - community members. Providing focus for exploring community participants' discussions, we consider how community members appear to be applying particular discourses to distinguish their views as superior to others (and thus more valid to be heard). Findings inform a discussion about who is involved in rural community participation and how their views might be received and understood. The findings are novel in that they investigate, at a micro level, how power is applied by citizens within a context of rural healthcare community participation. Findings resonate with those of Johansen and Chandler (2015) who considered applications of power within participatory rural planning. Like them, we found that dichotomous portrayals of state versus community are over-simplified; we suggest that community members themselves are vying to prioritise their views by applying discourses, resonant in rural settings, for the purposes of a participation exercise. Findings suggest that an emphasis on the representatives of idealised demographic groupings is one-dimensional. Appreciating the tensions between individuals and real or perceived factions within communities could be useful in employing community participation and understanding what happens and why, in participation processes.

Our paper uses data from a rural health community participation exercise in Scotland. This project sought to involve citizens and service providers in methods to design future local health services. Power dynamics within rural communities are explored, as they play out through language used by

community members. We used discourse analysis, informed by theory about power and language (Gaventa, 1980; Foucault, 1971; French and Raven, 1959) to explore in-depth interviews with seven citizens living in three communities. Using quotations, we highlight how citizens applied certain discourses when addressing questions in rural health community participation and we consider how these discourses could influence community participation exercises.

2. Background

A requirement for health services to engage communities in service planning has arisen in many countries (Australian Commission for Safety and Quality in Healthcare, 2012; Scottish Executive, 2001). This is despite a lack of clear rationale for participation or strong evidence about associations between community characteristics, and types of interventions and outcomes. Community participation has become a loose 'policy storyline' (Needham, 2007), which is generally unchallenged. In the abstract, its portrayal is almost uniformly normative, but its enactment is likely varied in practice. Literature and some policy guidance provide examples of how it might be done and tools to use, but participation standards feature output measures and are purposefully vague, to allow for different circumstances (e.g. Australian Commission for Safety and Quality in Healthcare, likely, therefore, that for health service managers, processes that work to achieve what they want are being discovered through experiments and experiences. There is little evidence or analysis that considers how to navigate the dynamics of different contexts or to apply participation for different purposes such as designing or providing new services.

Involving citizens is overwhelmingly portrayed in policy as beneficial (Victorian Auditor General, 2012; NHS England, 2013). Literature reviews reveal a relatively sparse and non-systematic evaluative evidence base suggesting benefits of engagement including the design of more locally-appropriate services (Kenny et al., 2013; Attree et al., 2011). It has been suggested that participation is ideologically motivated to stimulate localised governance (Shucksmith, 2009), with responsibility for problem-solving handed to communities (MacKinnon, 2002; Horne et al., 2013). This is confirmed by health policy that portrays public participation as existing within a new welfare environment where citizens have rights to service, but where they must also assume some responsibility for that service (Scottish Government, 2011). The name of community participation has been applied to activities ranging from gathering opinions and ideas, through to involvement in coproducing services (Farmer and Bradley, 2012). In this particular participation project, community members were asked to participate in designing new rural services alongside health service representatives. Within this project, participation involved the inclusion of multi-stakeholder perspectives, differing priorities and 'languages' (Healey, 2009) combining to produce consensual decision-making about the most appropriate local services. It focused on creating mutual and informed decisions about future service configurations within the confines of a set budget and stipulations about safety, quality and health practitioner roles (Scottish Government, 2007b).

Community participation may be difficult to enact in reality (Nimegeer et al., 2011), with a key problem being the need to motivate diverse and many local citizens to engage in formal processes, to obtain a range of views (Karpowitz et al., 2009). Representativeness is a thorny issue in that health service managers may be reluctant to define, at the outset of participation exercises, exactly what community members should represent. Who to include or how to decide who to appeal to, is an ill-defined issue in policy and guidance. Ideally, should participants be demographically

representative or ideologically representative (Quick and Feldman, 2011)? Collectively, should participants encompass 'every-person' with their experiential knowledge, or does the citizen perspective render him/her the holder of a different type of (expert) knowledge (Martin, 2008)? Are community members most representative when they have little formal knowledge of healthcare systems or when they come with a rich experience of previous participation and technical processes? Minimal academic and practical dissection of these issues makes representativeness open to interpretation.

Health policy assumes that the health service takes the lead in engaging local people, immediately producing a power mismatch between exogenous technocrats (Rose and Miller, 1992) and local, lay people (White, 1996; Rifkin, 2003; Popay, 2006). This portrayal neglects the diverse perspectives on both 'sides' arising from individuals' different experiences, knowledge, positionality and opinions (Moore, 1982; Leeuwis, 2000). Regarding local people as a homogenous bloc that engages with health service managers is problematical. It neglects the diversity, power dynamics and sources of perceived and real differences within the community, negating the concept of the 'community view' juxtaposed with a management view.

Producing consensus from community participation might be regarded as easier to achieve where there is a small number of people, generally known to each other, living within a shared socioeconomic context. There is evidence of rural community members working for collective benefit, to generate social capital (Hofferth and Iceland, 1998) and volunteer their time (Woolvin and Rutherford, 2013). Health services research tends to regard rural simply as a spatial category distinguished by small populations and distance from service centres (Mason, 2013). This neglects the complex social dynamics of communities as made up of people engaged in relational, embedded transactions, situated in longitudinal timeframes (Bonner, 1998); as well as new forces in rural places such as increased numbers of older people (Winterton and Warburton, 2012), international immigration (Hedberg and Haandrikman, 2014) and other impacts of engaging in a global economic milieu (Woods, 2007). As Cohen (1985) notes, rural social interactions are handled in circumstances where people will "confront each other repeatedly and frequently" (p.28), calling for nuanced ways of negotiating social activity, and it is to these mechanisms of negotiation that we as social researchers should also turn our attention. Language and communication, in particular, play a role in the norming of acceptable behaviour through constructing and reinforcing subtle and enduring social practices. Shubin (2010), for example, notes the inequalities suffered by socially excluded people in rural Ireland and Russia whose communities deprive them of voice and cultural capital. Shucksmith (2012) implies that such activities of in-community othering may entrench generational disadvantage as it is socially difficult for disadvantaged people to rise out of marginalisation. Rural development literature offers perspectives warning that involving communities in decision-making can serve to enhance the power of existing elites rather than uniting diverse citizen perspectives (Shucksmith and Chapman, 1998; Potter and Shortall, 2009; Shortall, 2004). Thus, far from being an easier context in which to enact community participation, rural places might bring a specific set of challenges.

The community participation project that features here was located in the Scottish Highlands and Islands. The health service approached researchers to produce a community participation process that would suit the characteristics of small, remote communities. These communities often have stable population numbers, but the populations are ageing and changing in character, with relatively

affluent older people moving in to reside for some or all of the year, and living alongside ageing long-term locals (King and Farmer, 2009). Changing population demographics along with changing healthcare ideology (Scottish Government, 2007b) have meant that the local health authority has moved progressively to change service delivery models and, prior to the project, had met with situations of community protest (Thomson et al., 2008; Farmer et al., 2010). The health authority sought a method to engage with remote communities that had been tested in these contexts. Studies of the region suggest perceived disconnection from policymakers (Shucksmith and Chapman, 1998). Nostalgia for a romanticised past has been reported (Jedrej and Nuttall, 1996), with incomer/local duality proposed as an enduring perceived social dichotomy (Jedrej and Nuttall, 1996; Burnett, 1998; Macdonald, 1997). Conceptualisation of local-ness as “natural, yet ancestral”, and innately moral has been raised by previous research (Rye, 2006). Sutherland (2012) critically analyses the (re)gentrification of UK rural areas, with an influx of rich in-migrants often not needing local employment, but desiring to exert local influence. It is within this space that project researchers worked with local people and health services representatives to develop and apply a community participation process to design future health services.

3. Methods

In the course of the community participation project we reflected that, as well as an assumed dichotomous power struggle between the community and the health service, we were involved in conversations that raised the issue of power-play between community members. Foucault (1994) proposed the idea of people practicing power to gain status through use of language rather than gaining power/status through their formal position. This idea has been studied in rural participatory planning by Johansen and Chandler (2015). We considered this a relevant issue to discussions about representativeness as it questions assumptions that consensus might be gained from community participation exercises if only the right mix of views is included and ideas are debated, deliberatively, by citizens of a place with health service stakeholders. What if ongoing power-play within communities could frustrate capacity to produce consensus? And what if discourses drawn on to express difference have little to do with health or service needs? We used data that we collected as primary researchers from the participation project to explore these issues. Much of the analysable data generated within the participation project existed in the form of summarised notes from public workshops, but some were individual interview data, recorded and transcribed verbatim, and it is these that we refer to in this paper.

3.1. Discourse analysis and power

Discourses define “systems of meanings which reflect real power relations...[that are]... a consequence of the material and economic infrastructure of society” (Wooffitt, 2005 p.146). Discourses can be said to be both emblematic of underlying social power structures, and the vehicle by which those power structures are enacted in everyday life (Foucault, 1971). Examining discourses that arise from particular contexts can indicate where and how power is being exerted. To investigate the power dynamics among rural community members within a formal exercise to design future health services, we needed an analytical frame to penetrate the subtle play of power processes within a highly relational context. Gaventa (1980) suggests studying local “social myths, language and symbols” to understand how power is shaped and manipulated in communities (p.15). We were specifically interested in highlighting discourses that arose in considerations of

health service change, a vexed topic for rural residents as directly and symbolically associated with community sustainability (Prior et al., 2010). We considered the text of individual interviews conducted within the participation project to be suitable for discourse analysis as they represented in-depth recorded and transcribed discussions that gave opportunities for analysis of rich, verbatim texts.

Power and its application within community participation was not overtly discussed within the interviews, so we needed a discourse analytical milieu that would assist in interpreting underlying messaging about power in verbal communication. We considered theories about language and power that would help both intellectually and methodologically given the relatively submerged ideas about power that we proposed may lie within our data (Foucault, 1971; French and Raven, 1959; Gaventa, 1980). Foucault's thinking about power and its transmission through language, drawing on wider societal power structures for influence, were considered useful. Thus we adopted a broadly Foucauldian perspective on discourse analysis as a way of accessing messages about power, social symbols and myths, and their application in community members' discussions. We note that Johansen and Chandler (2015) also drew on Foucauldian notions of power applied through discourse to interpret their data on rural planning participation.

Taking a post-structuralist perspective, Foucault suggests that language both portrays and simultaneously constructs a speaker's social reality, in other words language is not a neutral vehicle for communication. People create and enforce realities by drawing on previously existing discourses. For Foucault (1971), discourse denoted a group of words or phrases which, when used together, form a social, political or other type of 'object' (for example, the use of medicalised terminology may constitute a medical discourse). Identifying the discourse a person is employing can give insights into what they are trying to convey in a given situation, consciously or unconsciously.

As well as inductively exploring data, we were interested in Gaventa's (1980) proposal that individuals may express power within discourse to influence the behaviour of others, to exclude others, and/or affect how others view decisions and their own decision making. These ideas appeared relevant within a community participation situation where options were considered and decisions made. Within Gaventa's conceptualisation, it is not sufficient to study power by looking at who makes decisions, but who chooses to be involved in decision-making, and in what ways power manifests itself. For this reason, we chose to examine participants' use of language, symbol and power via discourse analysis.

3.2. Data within the context of the participation project

As explained, we applied post-structuralist discourse analysis to a selection of interview transcripts from the participation project. Overall, the project employed a conceptualisation of community participation framed within a pragmatic health service context. One goal of the research was to develop a method that health services would use in the future so, to an extent, it had to reflect the somewhat positivist, bureaucratic style of health management. Researchers were tasked with developing a method that managers would use, in future, so researchers acted to organise and facilitate various methods of community engagement including group participatory events and individual interviews. Researchers also conducted ongoing evaluation using satisfaction questionnaires, to be completed by participants, at public forums; and gathered informal evaluation data through ongoing conversations with community members and health service participants. The

project included communities selected by health managers, due to being 'very remote' (Scottish Government, 2012) and having 'fragile' services (i.e. delivered by one or two resident health practitioners). Participation was essentially a 'top-down' exercise, with community members invited in e primarily to a public workshop series, in participating locations. Project goals were to: a) design a community participation process that health managers could use in small, remote communities; and b) produce new service designs for participant locations that might, or might not, be implemented, depending on stakeholder enthusiasm (Nimegeer et al., 2011). Community members, including local healthcare practitioners were invited through advertising including via local newspapers, posters, noticeboards and community websites. In addition, individual interviews were offered because we were alerted by local healthcare practitioners and other community members that there were some people that did not want to give their views in public, that could not participate due to mobility problems or that might have a useful perspective, and had not yet come forward for involvement. The opportunity to participate via interview was advertised along with workshops. We also asked healthcare practitioners and community members that participated in public workshops to identify people that might be unable, unwilling, or unlikely to attend a public meeting. These participants, suggested through referral by community members or healthcare practitioners, were initially approached for consent to participate by researchers. Thirty-nine individual interviews, taking place in all communities, were ultimately conducted.

Interviews were intended to complement the public workshops and covered the same topics, but as questions to an individual rather than as interactive group discussion. The interview topic schedule included topics such as: What is good about health in this community? What do you think are challenges to health? How do you think health could be improved in the local community? What are your priorities for health improvement locally? What service options could be considered that would improve local health? Attempts were made to ensure that two researchers were present at interviews and written consent for recording was sought in all cases. Thirteen participants consented to audio-recording and their interviews were transcribed verbatim. Data were anonymized and nVivo software was used to manage data.

For this analysis we have purposively selected seven interview transcripts for discourse analysis. Our intention was not to establish generalizability of themes, but rather to highlight how discourse can be, might be, and is, used by some individuals, to propose power dynamics. We thus approached selection with the intention of including transcripts that included references to governance structures within the community or attempted to distinguish their view from others using ideas implying power and/or distinction, but that also included different 'types' of people (from different communities, occupying different community positions, selfselecting versus referred).

We acknowledge this means inclusion of a small number of selected transcripts which may be considered a limitation of this study. As noted, we are not attempting generalisation, rather to highlight that there are tensions ongoing within communities, involving power-play that could affect community participation exercises. This participation project was classified as a service improvement initiative by NHS Highland Ethics Committee. Participants were provided with an information sheet and signed a consent form indicating their willingness for information provided to be used in publications. Because the study involves small communities, identification of individuals is always a risk and thus, for ethical reasons, we provide only minimal description of individuals here and have eschewed gendered pronouns or pseudonyms.

Participants from Community A included Participant A1 (retired individual, self-selected), Participant A2 (local business owner, community member referred) and participant A3 (locally active parent, community member referred). Participants from Community B included Participant B1 (retired individual, community member referred), Participant B2 (healthcare practitioner, community member referred) and Participant B3 (single, employed individual, self-selected). The participant from Community C was Participant C1 (local business owner, community member referred).

The challenges of post-structural analysis have been raised elsewhere - "how can one remain open to poststructural "undecideability"... without being accused of unsystematised speculation?" (Graham, 2005: 4). A post-structural approach eschews claims of objectivity or knowable truth (Graham, 2005) but it was still necessary for us to employ a describable and potentially replicable analytical structure. It was helpful, contextually, that one or both of us, as researchers, had been present at the interview. This meant that as well as the un-contextualised words in transcripts, we had experienced the interviews, spent time in the communities, and often carried out reflective post-interview discussions between researchers. We thus had words, but also nuancing and context to draw upon.

Analytical rigour in this context relates more to application of a consistent, iterative and verified process (embedded within memories of the actual interview and context), rather than the allocation of truth-status to quantification of repeated words, themes or phrases. This methodological approach has been broadly used by others (Kantor, 2006; Mackey, 2006; Heartfield, 1996; Heaton, 1999). Our analytical framework is outlined below, based on Graham's (2005) suggested guideline for consistent interrogation of transcripts:

1. Initial close reading of transcripts carried out to identify any overt references to power (i.e. references to formal and informal positions and structures, including references to community governance structures and individual positions).
2. Second close reading carried out to identify use of groups of words or phrases which, when used together, form a social, political or other type of 'object' (this was about scanning for all/ any potential discourses). For example if, hypothetically, a participant used descriptive phrases such as 'cardiac arrest' rather than 'heart attack', this would be considered part of a medical discourse. Primarily, this stage was about identifying narratives that were recognisable as belonging to particular ways of thinking or being, and relating to existing societal power structures.
3. Detailed analysis of identified discourses was carried out, looking at how these were used, identifying trends in discourse use by individuals and across the set of participants, analysing which discourses were dominant (i.e. used frequently and in a way that conveyed them as accepted fact), and considering how discourses were used to either empower or censure objects within the text.
4. Finally, discourses were grouped into themes and subject to reflective discussion by two authors together, considering whether and how the use of discourses had potential to influence community participation.

Following these guidelines, texts were analysed first by AN, checked by JF, and then ideas discussed jointly. In what follows, we highlight two emergent discourses that are potentially particularly 'rural' as they resonate with previously identified discourses of rural othering and authenticity (Pitkanen et

al., 2014; Cassidy and McGrath, 2015; Scott and Hogg, 2015). We consider the implications of these for community participation and how discourses that have acceptance as 'truth' discourses (Cheek and Rudge, 1994), are used by participants to frame whose input into informing future health service developments is legitimate and whose is not.

4. Findings

In this section we explore how participants in a rural health community participation exercise drew on existing discourses in their societal context to try to distinguish their voice as more worthy of being heard. We propose this highlights the tensions within community, in community participation, and shows that these exercises involve a more complex power-play than them (health service managers) versus us (the public).

The two discourses that we highlight here were employed frequently and repeatedly by the participants included in this analysis, although once again this is not to say that this is representative of wider community use. One discourse suggested a 'locals versus incomers' dichotomy. The second discourse juxtaposed ideas of authenticity and tradition, with modernity and bureaucracy, in relation to rural health practitioners. How these discourses that have been well documented as pre-existing in rural Scotland were adopted and used and what this might mean in health community participation is explored. Importantly, we are not suggesting that there is an incomer-local or traditional-modern categorisation of people that is real or that could allow identification of individuals into one group or another; rather that people engage with these structural societal symbols and (re)produce them. This is potentially sub-consciously done, rather than deliberate, and is applied in such a way as to prioritise one individual's voice over others.

4.1. Application of a locals and incomers discourse

An incomer versus local discourse was used to imply that only true local people could know local issues and that true locals should be listened to in the decision making process, out of respect for their localness. Frequently the incomer/local discourse was raised in the context of either bolstering the credibility of the individual being described as local, or undercutting that of the individual being described as an incomer. Localness, in this context, was proposed as an intangible, tacit authenticity of voice that allowed participants to speak for the wider rural community as truly 'one of them.' By way of context, only one participant of the seven was locally born and raised within the community they now inhabit. This is not to say that the other six self-identified as 'pure' incomers, rather claimed local-like status through relationships, nearby birthplace, or other mechanism. Some noted that other community members might perceive them as incomers, but this claim was always nullified. For example, to distinguish themselves from other incomers who wanted to see change within the local area, Participant A3 (a young person who moved to a rural area with their partner and a long-standing community member and accepted 'local') stated: *"I moved to A [area] with somebody who was from A [area], so maybe I have a different outlook on it than other incomers"*. Connection with place was used by Participant A1 to claim local credentials:

"We've had a tremendous influx of people from elsewhere. I come from about [#] miles away, [name of town]. We've been here for hundreds of years in this area and my family's from all the other areas around us. So there's this sort of cultural thing about people that come from this area, the west coast of Scotland and the islands, and it's unspoken, much of

it, it's there. And we can talk like that. I can see someone on a train or a boat that's from out here and we'll have a conversation right away, we know, you know, it's just an immediate thing. And so for someone that's not from here it takes them quite some time, possibly another generation before they can sort of get into the ways, the unwritten ways." (A1)

Participant A1, an older retired person, referred to themselves as local despite originally being from "miles away", using a broad definition of local to claim local credentials based on heritage, and knowledge of "unwritten ways", suggesting intangible authenticity that is nonetheless present and cannot be taught.

Participant B3, an older professional person, described how many in-migrant retirees are "entirely inappropriate", implying a certain standard held by true local residents. This perception is echoed by Participant A2 who derogatively described incomers who had adopted a crofting (small farming) lifestyle: "*They've come here with plenty money, bought a bit of land, and keep a few sheep and call themselves farmers*" (A2). Thus, even when incomers attempt to engage in local rural activities, they are still described as incongruous, reinforcing the proposal that incomer and local are distinct categories.

Participants discussed how incomers had affected their communities. Descriptions of incomer behaviour conformed to the typology previously identified by Burnett (1998) in her work on social constructions of the incomer/local dichotomy in the Scottish Highlands and Islands as: those taking up space and not contributing; and/or those who are overbearing and bossy. Retired or wealthy incomers were portrayed as contributing little by Participant B1 (an older retiree):

"There's a lot more people who have come into the community late on, come to the [area] rather than the community, to retire, they don't particularly want to get involved, they don't contribute very much ...it's brought new people [into the area] but they're probably people with money, who don't want to work, don't have to work, and they don't necessarily contribute anything to the community" (B1).

The categorisation of incomers as bossy or disruptive was also evident in other transcripts. Several examples within the texts related to incomers (inappropriately) seeking positions of community authority. Participant B3 (an older, retired individual) recounted a disturbance when a newcomer had attempted to start an ill-fated community enterprise. Participant B3, elaborated that the new resident "*ha[d] only been here five minutes, ha[d] decided to be in charge*" (B3). Similarly, the participant went on to describe certain community leaders whose actions they disapproved of, as being "*very vocal but...not local*" (B3) (although they, like Participant B3 were permanent community residents). With regards to participation in local decision making then, incomers are described as being not worth engaging with (as they lack community mindedness or the desire to contribute) or as contributing inappropriately (being bossy and loud but not representing the interests of the 'real' community).

By first establishing the inherent 'wrongness' of allowing incomers to influence local governance, and then positioning oneself on the 'right side' of a local/incomer discourse, participants may attempt to influence the authenticity or representativeness of their view in relation to others. By harnessing the power of this pre-existing social construct, participants position themselves discursively in a desirable symbolic category - in a way aligning with bureaucratic ideas of including

participant 'types' to gain representativeness. To be clear, we are not suggesting here that local people were more powerful in the community than incomers; that distinct categories of incomers and locals actually exist; or, that participants strategized about how they could be described as locals and portrayed themselves as such to consciously authenticate their voice compared with others. Rather, we are suggesting that the incomer versus local dichotomy is so accepted in rural conversations that participants applied it with ease in these discussions about future community services.

4.2. Application of an authentic and traditional versus modern and bureaucratic discourse

In rural Scotland, the lone healthcare practitioner has been portrayed as a romanticised heroic figure, vital to community sustainability (Shucksmith et al., 1996). They are also in the difficult position of being both participant in, and their work the subject of, any participation process leading to service change. The way that community members discursively position healthcare practitioners within this type of process is therefore doubly interesting, as it both suggests the amount of credence that should be paid to the views of existing practitioners (based on how they are framed), and sketches out the narrow parameters in which practitioners would be expected to operate in an ideally redesigned service. Within the data, a second key discourse exists which highlights a tension between the idealised authentic rural doctor or nurse persona (depicted in discourse as dedicated, instinctive, and committed to the common good, a 'Dr Finlay' type practitioner), and a modern practitioner, portrayed as bureaucratically-focused and selfishly prioritising work/life balance and career development through training courses. This discourse was applied by some participants to belittle local practitioner voices, but also to subtly define what an acceptable future service must look like.

Participants suggested that rural practice *"is what you can't train people for"* (A3) and *"it's either in them or it's not"* (A3), alluding to an inborn quality that genuine practitioners possess. Contrasting with their modern counterparts, Participant C1 described how, residents had felt secure previously, because there were *"very very good district nurses"* - who were constantly available. This was compared to current practitioners who were perceived to be preoccupied with career advancement rather than community service. Similarly, contemporary doctors who have *"been given a lot more money to do a lot less"* were compared with, doctors of: *"twenty years ago... they were kind of somebody to be admired and looked up to"* (Participant C1). The notion of the respected, traditional practitioner was contrasted with a modern example who lacked diligence and dedication and was not worthy of respect.

The authentic health practitioner was portrayed as providing a 24 h service, and yet capable of navigating boundaries between people as neighbours and patients. Participant A2 questioned current practitioners' capacity to deal with professional boundaries, stating: *"if you are friendly with the doctor, you get a better service"*. While 'friendliness' could be perceived positively, here it was implied as unprofessional for doctors to engage in friendly relationships with citizens, because it led to varying care standards. Participant A2 described their perception of self-serving motivations of current practitioners:

"... people who are not really needing attention, [health practitioners are] flocking around them like bees round a honey pot - to clock up their hours. I'll take it a stage further. When most of the elderly people [in this community] sadly died out, and there was quite a lot of

work, and they were doing round them doing this and that, and now that the people have died out and they're not there, we wonder who the next victim is going to be, is going to be pestered to allow them to fill their timesheets" (Participant A2).

In this quotation, Participant A2 characterises current health practitioner behaviour as inappropriate and ascribes their motivations to the bureaucratic filling of timesheets and making work for themselves, rather than providing an appropriate level of care as past practitioners did. In this case, even when providing 'above and beyond' care, practitioners are described as bureaucratic modern-type practitioners.

One aspect of modern healthcare practice considered inappropriate was practitioners' leaving the local community to update their skills. Participant A1 suggested displeasure with the local nurses: "*For years they've been sent off on courses, community nurses, then some other kind of nursing, then some other kind of course*", a state of affairs that precedes A1's description of service deterioration. The implication is that the traditional district nurse role was an appropriate fit and that role change is viewed as service deterioration, rather than progress. Nurses are suggested as no longer in their rightful place: they are learning more, but doing less. Nurses, within this discursive frame, belong within the rural community and should not aspire to professional improvement.

Another aspect of the traditional, romantic figure of the rural practitioner is that of unwavering community service. However, the health practitioner's dilemma is that they are expected to function for the community while at the same time being one of the community. Participants occasionally mused that it may be unreasonable to view doctors and nurses as simply community assets. When discussing the local healthcare practitioners, Participant A3 said:

"We're very lucky, we take it for granted. We use and abuse them, we do. I mean, it's so irritating to walk in the shop and see somebody say "Oh [GP's name] can I just tell you...[District Nurses' name] can I just tell you...", and you think for goodness sake, leave them alone, they're not at work. You know, I dread to think how many times [District Nurse's name] has put her life on the back burner for the community."

In this extract, the nurse was described as taking on the traditional rural practitioner role, expected to be available at all times, but to their personal detriment. "Using and abusing" suggests a liberty taken, with community members viewing the health professional as owned object rather than as a fellow resident.

Within this section we have shown that, in a rural healthcare community participation exercise, some participants drew on a traditional/authentic/self-less versus modern/bureaucratic/selfish discourse to downplay the opinions of experts (local health practitioners) in relation to their own opinions of what an acceptable rural service looks like. The participants successfully placed discursive limitations on what is and is not appropriate behaviour for a rural health care practitioner, undermining practitioner medical expertise, with the importance of rural traditional and authenticity as defined by themselves.

5. Discussion

In this paper, we selected and analysed a sample of interviews from a rural healthcare community participation study, to explore emergent ideas about participants' expressions of power through

discourse. Our research indicated that, inherent in collectives of people in place, pre-existing discourses were used by participants in such a way that prioritised their opinions over others. Community participation, as portrayed in health policy, tends to imply a top-down process where healthcare managers invite consumers to engage in decision-making, for example about future service provision (Scottish Government, 2007a). Policy implies the key challenge is bringing together state authority perspectives, on the one hand; and community views, on the other (Scottish Government, 2010). Previous studies have also suggested a key challenge is uniting dichotomous management/policy and community, perspectives (Farmer et al., 2010). Debate continues around how to engage representatives to provide diverse local perspectives, with a consensus community view potentially arising (Taylor et al., 2006). In contrast, we use data from a 'real-life' community participation exercise, to describe how there are tensions within the community that arise from social, sensitive, and ill-defined othering categorisations applied by community members, that could/should not be used by health services in selecting representatives; and that by their ill-defined but pervasive nature mean that tensions are likely to perpetuate under the surface of publicly-accessible debate. We found individuals, in the privacy of face-to-face interviews, using well-worn rural discourses to prioritise their views and downplay those of others. Overall, this study illustrates that there are voices within the community drawing on discourses that are indirectly related to service change that could disrupt the most carefully planned community participation exercise, and that those undertaking engagement should be cautious about how they attempt to achieve 'representativeness' of rural voices.

5.1. Study limitations

The study used data from a small sample of interview transcripts of informants in a rural health community participation process. We selected texts to represent participant diversity on several criteria and we acknowledge that we specifically identified texts that mentioned power structures or the salience of their voice/perspective over others. We were not aiming for representativeness, comprehensiveness or generalizability, rather to illustrate what we experienced as part of a participation project: some community members exerting power by drawing on existing societal discourses. While our participants raised these issues in the privacy of an interview, application of these underlying discourses in daily life could disrupt community participation exercises. What goes on outside identifiable acts of community participation (e.g. public meetings), is seldom reflected on in health policy or research literature. We have not exhaustively described all of the discourses we detected, rather we chose to highlight two, around rural authenticity, that aligned with evidence about discourses previously found (e.g. Winterton and Warburton, 2012; Scott and Hogg, 2015). Participants' opinions that we have highlighted could represent a minority view; nonetheless, these views exist. The interview texts provided an opportunity to explore discourses applied in relation to rural healthcare community participation. Community participation often involves public meetings and thus it is hard to gather verbatim texts and people may be more guarded about what they express openly. In this paper we have tended to present discourses as distinct, consistent and dichotomised; in reality, discourses are over-layered and mutable (Pitkanen et al., 2014; Goodwin-Hawkins, 2015). Our findings might be specific to rural Scotland; however, they resonate with studies suggesting that rural community engagement can surface, and even reinforce, existing power divisions (Shortall, 2004; Shortall and Shucksmith, 2001). We acknowledge that the paper is based, to an extent, on our interpretations of participants' discussions. As we have studied in these communities over a period of months we were able to engage in extended reflective discussions and

we have presented these findings and discussed them with other researchers, affording elements of testing and verifying conclusions.

5.2. Using discourse to consider power

Within our analysis, we uncovered examples of community members appearing to use discourse to prioritise their views over others; that is, to endeavour to give themselves more power in decision-making. We propose this is one way of understanding how subtle power-plays within rural communities are enacted, and how they can surface in rural community participation.

Discourses drawing on concepts of local, rural, traditional and authentic were used as a subtle way of prioritising participants' voices. Participants keenly expressed their credentials as a local or with authentic rural characteristics to distinguish themselves as attuned to determining the community's future. The emergent emphasis on rural authenticity resonates with literature describing the enduring power of the mythologised incomer versus local discourse, in rural communities (Burnett, 1998; Brown et al., 2008). It is unclear whether people specifically identified this discourse and deliberately placed themselves within it or whether its application is subconscious and constructed from their values and representations of themselves as a rural person (Winterton and Warburton, 2012).

While it is interesting that participants used an incomer/local discourse to augment their own authority, participants' use of discourse to create a dichotomy between traditional rural doctor/nurses and modern bureaucratic practitioners is even more intriguing. Community members apply a discourse of the traditional and authentic, which serves in this instance to trump a medical discourse. Indeed, medical discourse has long been held as a venerated form of 'truth' discourse. That is, medical discourse, along with certain other discourses, has reached a dominant status that has the power to override other discourses when employed within modern Western society, and its use can legitimise the power and authority of those who employ it (Cheek, 2004). It is, therefore, all the more interesting in this remote and rural context that a discourse of rural 'tradition' can be used to counter a discourse of medical expertise which often relates to a key source of social power (French and Raven, 1959).

Rural health, indeed rural community sustainability, is frequently portrayed as dependent on skilled local health workforce (Smith et al., 2008) so we might expect rural residents to appreciate and even defer to the expertise of healthcare practitioners. To some extent such esteem was evident, but only to the extent that practitioners were perceived as conforming to rigid idealised notions of appropriate (traditional) behaviour. In fact, the health practitioner roles, as portrayed by some participants, would be impossible to operationalise due to inherent contradictions. Practitioners were discursively positioned in a difficult liminal space; needing to treat all citizens equally, but also helping those in particular need. They must fit in, but not be overly friendly. They must work whenever needed, but should not be exploited. They should be leaders in the community, but not of the community lest their professional discretion be called into question. This discourse of history/tradition and its expression of the expectations placed on health practitioners resonates with literature describing the norms tacitly decreed by rural communities on their members (Shubin, 2010).

While blurred professional/personal boundaries are an acknowledged difficulty for resident rural health practitioners (West et al., 2004; Prior et al., 2010), the unforgiving critiquing of their day-to-day professional life by some of their fellow community members, has not been highlighted so vividly before. It is important to recognise the application of this discourse which serves to constrain the relevance of healthcare practitioners' perspectives in rural community participation. Practitioners are caught in the middle, neither solely community members, nor solely health service representatives - and with their current and future roles often under scrutiny. They are variously appreciated as providing accessible services, but may be castigated for transgressing discursive limitations, their jobs described by community members in a discourse juxtaposing tradition with modern, to prioritise citizen voices over expertise, and to protest any potential changes to their idealised role(s) within the community. It is also interesting that the two dominant discourses described here (incomer/ local and traditional/modern practice) often overlapped in such a way as to progress the view that a) only local people know what is needed in a rural health care system, and b) what is needed are traditional ways of practice.

Overall, considering use of discourses suggested here, it can be seen that their application by some in community participation might have a problematic role in the future of rural communities. An ongoing discourse of denigrating healthcare practitioners who adhere to modern medical practices and incomers, who either participate locally or do not, could serve to detract from people moving to rural areas for work. In community participation, these discourses might be perceived as overly negative, unfair and unrealistic by healthcare managers, potentially building opposition to engaging with community members.

6. Conclusions

Our findings highlight that rural health community participation is even more complex than has been raised by previous studies suggesting representativeness of participants or community versus state power, are key challenges. By exposing that some citizens draw on enduring rural discourses to prioritise their opinions in private, it highlights the challenge of having community members work together in endeavours to reach a consensus community view in public. Findings show that the power-play in rural health community participation is much more complex than one between health services and the community, but that there is a messy and subtle power-play at work within the collective of people living in a place. Health policy suggests including representative voices as a way of surfacing the community view in community participation, and this is often interpreted in terms of demographic categories such as young/old, affluent/disadvantaged, well/sick, but the categories rural community members use to differentiate people are socio-political and too sensitive and nebulous to incorporate as categories of people to include.

Health policy exhorts those enacting community participation to pay attention to inclusiveness of participants, although it suggests that precisely who should be invited depends on context (Australian Commission for Safety and Quality in Healthcare, 2012). Pragmatically several ways of including a wide range of participants have been suggested, in order to gain a range of views (Renn et al., 1993; Quick and Feldman, 2011). Gaining a representative sample has been presented as the gold standard; with concepts of categories to include often focussing on demographic characteristics e.g. older/younger people (Renn et al., 1993). Yet in this study, discourses applied suggest categories of residents that would be problematical to include, particularly incomers and locals. These

categories may be prioritised by community members but would be impossible to identify objectively. Findings highlight the problematical nature of the concept of representativeness in rural healthcare community participation. If community members have their own, impossible to apply notional categorisations of people and their views, to what extent can health services managers attain representativeness in their invitations to or selection of, participants? Random sample invitation may come closest, but with caveats about little control over who actually attends.

This paper therefore questions the concept of representativeness and asks - what does representativeness mean in the context of rural community health service decisions? It also questions the idea of community participation as unproblematically 'a good thing' as it may be a vehicle for some to try to (re)enforce their power over others, surfacing damaging othering. Our analysis of how community members, possibly unconsciously, draw on underlying discourses reveals community participation is by no means a simple process or simply a process, especially when it is an externally-driven political process brought into communities that may encourage division. Our findings can be used to understand that there may be discourses within communities that mean involvement in a decision-making process and consensus decisions from community participation, are difficult to obtain. Recognise it or not, we are all influenced by societal discourses and, in rural communities, there are enduring discourses that are applied for distinction, even in contemporary times. If lofty social democratic goals of community participation are to be realised, it is important to interrogate the prominent discourses that arise in different contexts, and to understand the ways in which they impact on the potential for all citizens' contributions to be heard and legitimised.

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