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EDUCATION AND TRAINING

The benefits of rural training: Producing the expert generalists of the future

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ABSTRACT

Most doctors in the UK train in urban areas and tertiary centres are considered centres of excellence for training, with rural district general hospitals often seen as a training backwater. However, there are huge benefits to training in rural areas, particularly with an ageing population, increased medical complexity and a shift of care from hospitals to the community. This article examines the benefits of rural training and looks at its role in producing the 'expert generalists' of the future.

KEYWORDS: Rural training, junior doctors, expert generalism, realistic medicine

Introduction

Five years in the city was enough for me. After finishing medical school, I wanted to return to my rural roots. I applied to do my foundation programme in Cumbria and over 10 years later, I'm still there, now working as a general practitioner (GP) in a small village in north Cumbria.

Training in a rural area was an obvious choice for me because I wanted to be there, but training rurally has benefits for healthcare professionals regardless of their backgrounds. I believe my decision to train in a rural area has given me breadth and autonomy in my career that might have been harder to achieve in an urban area.

The benefits are reciprocal: rural areas also need and deserve good doctors and these places have a huge amount to gain from the education and training of healthcare professionals.

Expert generalism and realistic medicine

My foundation programme was wholly within a district general hospital (DGH). I had experience in general surgery, acute and general medicine and emergency medicine. It felt like a proper consolidation of my medical school education. I spent 2 years in the same hospital, experiencing every nut and bolt of this intricate instrument of healthcare provision. I knew the consultants, the porters, the nurses, the physiotherapists, the canteen staff and, of course, my own peers. Just as importantly, these people knew me and we felt like an important little cog in the running of that DGH for our 2-year stint there, we were part of the team. Although the days of firms had long since gone, what we had was the closest to a medical apprenticeship that it was possible to get.

Regardless of what I'd gone on to do next, this experience was vital; a down-to-earth education in the fundamentals of medicine and surgery, communication, compassion, continuity and an unarguably solid base, whether my path had been neurosurgery, medical oncology or general practice.

The Royal College of Physicians identified in a report in 2013 that hospitals were going to need more consultants with skills in acute, general and geriatric medicine to cope with an ageing population.[1] The term 'expert generalist' has been around even longer and this concept is summed up excellently by the Medical Schools Council, quoted by David Oliver in 2016: 'doctors prepared to deal with any problem presenting to them, unrestricted by particular body systems and including problems with psychological or social causes as well as physical ones.'[2] I would argue that training in rural DGHs provides exactly this kind of experience, and these hospitals are best placed for producing the expert generalists of the future.

Expert generalism goes hand-in-hand with realistic medicine. Realistic medicine is what the vast majority of patients need, most of the time, and is a term initially coined by Scotland's chief medical officer, Catherine Calderwood, in her 2014–15 annual report of the same name.[3] It is an approach focused on delivering true value for the patient, with doctors spending more time listening to what patients want in order to avoid unnecessary treatment.[4] I am absolutely thrilled that some of my peers and former colleagues have chosen to pursue super-specialist careers and will be there for people who need an organ transplant, experience major trauma or need immunotherapy in cancer treatment. Ultimately, most doctors need to be more general than that, to have an understanding of patients' wants and needs, particularly in later life, and apply this to the options available: medical, social, psychological, spiritual or otherwise. Training and experience need to be broad to allow this.

Flexible training

I also had a lot of choice as a junior doctor. After spending some time in New Zealand after foundation year 2 (F2), I returned to Cumbria to do my GP training. The training programme was small and my hospital jobs were tailored to my needs – what would make me a good GP – not just to service provision. There were only eight of us on my intake to the GP training programme and once again I felt the benefit of a small peer group. We quickly got to know each other which allowed for more openness and frank

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discussion in teaching sessions and, in our last year, we formed a study group and supported each other through the final exams, all ultimately passing and qualifying as GPs.

We were lucky, many hospital jobs in GP training programmes are service provision oriented, with little thought being given to previous experience or to producing well-rounded doctors at the end, just anonymous matching up of trainees with jobs to fill the rota gaps. This isn't just a problem in GP training, and I suspect that many trainees in other specialties have the same issues. It's vital to remember that junior doctors are being trained to be the GPs, consultants and healthcare leaders of the future. In order to produce good doctors, training should be more trainee-centred, with choice, flexibility and breadth of training given equal, if not greater, precedence over service provision and filling rota gaps. While service provision is still an important part of a junior doctor's role, more flexibility should result in happier, better trained doctors and hopefully improve job satisfaction and doctor retention. For GP trainees in north Cumbria, the small size of the training programme has allowed this type of personalised training to thrive and is a good demonstration of the value of training in rural areas.

Location

Sometimes, when I am driving to work past Bassenthwaite Lake, going over the Uldale commons or negotiating a rutted farm track on my way to a home visit, I find myself listening the travel news on the radio; jams on the M6, an accident on the M62 or a downright standstill on the M25. It is immensely satisfying to know that these things are of no consequence to me. Choosing to live and work in a rural area right from the beginning of my career means I haven't even had to escape the rat-race; I never experienced it in the first place. There are plenty of people who have no choice, and who do have to commute on busy roads and in cities for work, but many doctors do have the chance to avoid this by choosing to work in a more rural setting. I feel very grateful that my choices have led me to be able to live and work in this beautiful part of the world. Lack of proximity to the city doesn't mean that rural areas necessarily lack culture, shopping and entertainment, although what's on offer may be very different to city life. We also benefit from less stressful commutes, wonderful scenery, easy access to the outdoors and networks of small towns that offer shops, restaurants and café-culture, perhaps of a higher quality than the average city dweller might expect.

Downsides

Of course, there are downsides to training in rural areas, with recruitment and retention being one of the biggest challenges. Recruitment is a problem across the NHS but I think it is felt particularly acutely in rural areas. My foundation programme had many doctors who ended up there because they missed their first choices elsewhere. While some of them embraced and enjoyed the experience, many didn't and left after foundation year 1 to find alternative F2 work, which left gaps in the rotas. We worked with some fantastic consultants in our rural DGH, but there were a lot of staffing gaps at that level as well, this made for lack of continuity and some patchy clinical supervision. Finding locums in rural areas is difficult because there are no large urban centres where regular locums are likely to base themselves, rural areas are not logical places to live if you are wanting to experience working in different hospitals and different environments. Similar problems exist among nursing staff, paramedics and allied healthcare professionals.

Rural areas can also lack diversity and I think this is felt by the many staff who come from non-UK or different cultural backgrounds. In Cumbria in 2019, only 1.5% of households were black and minority ethnic and only 1% of residents stating a religion other than Christianity.[5]

Lack of work for doctors' partners is also an issue, which may prevent doctors who want to work in a rural area from being able to do so. In the future, it may be possible for more people to work from home (particularly those in IT-based jobs), which will allow more flexibility in working location and may be a factor for more doctors with non-medical partners to be able to work rurally if they wish. With this vision in mind, it is vitally important that rural areas get the same priority as urban areas for high-speed internet and good transport connections.

Rural areas need good doctors

Rural areas also need good doctors. It was identified by Bill Kirkup in his independent report into poor standards of maternity care at University Hospitals of Morecambe Bay NHS Foundation Trust that one of the problems was the isolation of the town of Barrow-in-Furness, which is relatively inaccessible and serves scattered rural communities.[6] Medical staff were hard to recruit and there was little opportunity for joint working, which allowed clinical practice to drift away from standards in other places. It is therefore vital for rural areas to continue to host and support clinical education and training. A regular influx of trainees, with up-to-date medical knowledge and fresh ideas, forms part of a check and balance system to ensure that more isolated units are keeping up-to-date and avoiding the 'drift' described by Kirkup. Kirkup also suggested that permanent staff (eg consultants) in more isolated units could look at shared experience and joint working with other sites, to keep their own skills up-to-date. This model may potentially inspire trainees to look at consultant jobs in rural areas, with all the benefits of expert generalism and rural living with a strong connection to a tertiary centre to keep knowledge and skills up-to-date.

Conclusion

Rural areas are best placed to train the expert generalists of the future. With an ageing population, increased medical complexity and the shift of care from hospitals to the community, we need well-trained and highly skilled physicians and GPs who have the ability to manage this complexity and multimorbidity. Doctors who are unphased by patients whose problems spill over multiple traditional medical specialties and who are able to practice realistic medicine in hospital or community settings. To do this, it is vital that junior doctors get breadth, variety, choice and flexibility during their training.

The healthcare model of the future is perhaps most exciting in rural areas, with hospital specialists and GPs working closely together to manage more medical complexity in the community, keep people out of hospital and help them make good-quality decisions about their own care. We have our challenges in Cumbria, but some of this collaboration is already happening and I remain optimistic about the future of our rural health community and the potential to lead the way in expert generalism. ■

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