Chapter 5.1.5

PROFESSIONAL DEVELOPMENT PROGRAMMES FOR RURAL DOCTORS

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Introduction

Residency programmes for general practice speciality training in the United Kingdom (UK) train medical graduates to broad national levels of competence to work as family physicians/general practitioners/primary care doctors. While none of these programmes addresses rural issues as a training requirement, they aim to certify graduates as fit for independent professional practice in a broad range of locations, which could include inner city or rural practice.

Rural medical training, recruitment and retention

Worldwide problems of recruitment and retention to remote and rural general medical practice have suggested that extra, specialised training and support is required to encourage enthusiastic doctors to live and work, and remain long enough, in remote and rural locations to make a contribution to rural health (1,2,3,4,5). It is important for this kinds of practice to find doctors who have extra procedural skills (including emergency work) and additional professional skills in order to deal with professional isolation (6, 7) - but this only adds to the difficulties of recruiting and retaining practitioners in these areas.

Recruitment and training policies should recognise that the pathways into remote and rural practice might include young doctors fresh from professional training schemes as well as mature doctors wanting a change of professional practice and location at the mid-point or end of their family doctor careers (6). Thus any professional development programme needs to be flexible, individualised and relevant to a range of professional competence and maturity.

Needs assessments and planning the curriculum

In the case of an experienced urban GP planning a new, mid-life rural career, an educational needs assessment might comprise a simple peer discussion with an experienced rural doctor. This might help to reduce any anxiety s/he might feel as well as result in their agreeing to attend a pre-hospital emergency care course. In the case of the younger doctor who has less experience, however, their confidence in pre-hospital care and obstetric emergencies needs to be considered as well as more subtle learning needs about planning for professional isolation and developing clinical and professional support networks.

Any professional development programme for remote and rural practice must consider the educational framework according to the country's prevailing methods. Thus a curriculum mapped out for general practice/family doctor residency training with assessments and exams becomes the starting point to consider any further rural professional development programme.

Curriculum planning needs to consider the differences between the country's remote and rural practice and the basic level of training under the existing framework. This means that professional bodies and doctors in training can recognise a common thread and logic to the professional development programme which builds on previous curricula and professional confidence (8).[1]

A professional development programme curriculum for remote or rural practice has to address the breadth of the scope of work needed in such practices - which reflects the very problem it is trying to solve. In remote practice the focus may be much more on professional and social isolation whereas in rural practice the focus may be more on community hospital skills which provide simple emergency care and rehabilitation for chronic illness. Thus a professional development programme should attempt to include experience and competence across both remote and rural family practice.

[1] See http://www.rcgp.org.uk/gp-training-and-exams/gp-curriculum-overview.aspx.

The learning context

Most professional development programmes will aim to provide rural experience and training to young doctors, without needing them to make a long-term commitment to being a rural practice. Experiencing geographical and professional isolation with mentoring and supervision at a distance becomes an important learning experience and opportunity for reflection and discussion with the educational supervisor. Educational mentoring is best provided both within the clinical environment as well as separate from it, through an academic framework of supervision (7).

While individual appraisal, feedback and mentoring remain the formal cornerstone of any professional development programme, informal opportunities can be just as important. These can be accessed through groups of trainees within a region through establishing a peer network both in residential workshops as well as through networking electronically. This became a template for their future careers to deal with geographical isolation.

Content

Skills training

Skills training courses in pre-hospital emergency care, obstetrics, major incident response, advanced life support and advanced paediatric life support will give clinical confidence for future remote practitioners Rural trainers also need to take account of the differences between initial skill acquisition and skill decay, and the educational methodology of 'clinical fire drills' (6) [2].

Psycho-social and occupational health

Rural training has to consider and reflect upon the psychological impacts of big events in small communities in advance of their occurrence. A rural road accident which includes fatalities of young local teenagers may devastate small communities where there are complex networks and relationships. Industrial accidents on farms or fishing boats may take the young fit men from a small community with far reaching consequences. Mutilated or missing bodies may

[2] The term 'clinical fire drills' has been suggested (6) to cover the planning, training and organisation of emergency skills courses for rural practice. The concept of fire drills in a building to prevent loss of life requires regular practice, co-ordination, organisation and reflection for a rare event which everybody hopes will never happen. When an event does happen, everyone must behave calmly, methodically and on autopilot in order to save lives. Thus the same concepts can be applied to rare clinical emergencies in rural practice.

cause abnormal grief or post traumatic stress disorder. There might also be cases of suicide and substance abuse. How does the local doctor respond in these circumstances and what are their wider networks for support and help? One form of assistance would be to have rural training include mental health issues (8).

Knowing about occupational health – about related clinical knowledge, health promotion and prevention of an illness - is important in farming and rural communities. Doctors need to clearly understand the diagnosis and clinical management of local zoonotic and infectious illnesses (9).

All professional development programmes for rural practice must include consideration of health care and support for the doctor, their families and support staff. In addition issues around emergency responses and confidential help and advice for health matters will always be important considerations in advance of settling into a rural job.

Clinical governance

Clinical governance can be a challenge in remote and rural practice with smaller numbers of patients and less practice-based peer support and appraisal. Existing remote and rural practices can be enhanced if regional training programmes are used as a mechanism to do so – for example through visiting trainees conducting audit projects or significant event analysis as project work. Prescribing projects, referral projects and reviewing clinical guidelines can be powerful ways of adding value and of encouraging governance activity in smaller practices within a region.

The professional development programme aims to produce clinically confident generalists who understand their strengths, weaknesses and limitations. Managed clinical networks with secondary care specialists can be an important way of providing good care locally in rural environments.

Funding

Regional and state funding agencies may fund professional development programmes as a solution to recruitment and retention issues in remote and rural practice. A well organised programme which adds value across a region by enhancing clinical governance has clear attraction to a regional funding board.

Capital

When considering the place of the individual doctor or practice within a rural community it is useful to consider the concepts of *personal, social, community and educational capital*. Most general practitioners will recognise the concept of monetary capital and business assets. They will often be investing *personal capital* in their business and generating *social capital* by goodwill and understanding within their community. So, for example a wise medical business might not charge for everything in a small community and in so doing will generate a lot of social capital at the expense of a small amount of *financial capital.* Business aspects may include dispensing and the management of small rural practice teams.

Reliable health care is part of the glue and fabric of any small rural community as it is essential for its wellbeing and *economic capital*.

A rural practice which is also a training site generates *educational capital* with networks of grateful and inspired students. A practice might invest educational capital in university departments thus generating *personal and professional capital* for the rural doctor and their business. Time taken to teach and letting trainees practice on patients may risk losing social capital in a small community unless the community is an understanding co-partner in the enterprise.

Evidence

The evidence base for rural education has been clearly defined in the undergraduate training for rural practice with rural streams and education (3). However there is very limited evidence regarding the value of professional development programmes at postgraduate level in rural practice.

Broader applicability

Training programmes for rural physicians, rural surgeons, rural dentists and other professions all have similar challenges and solutions.

The smaller numbers of rural participants present some difficulty for such programmes as the hospital accreditation systems requires a minimum number of procedures in order to be able to declare competency. So, for example, schemes which encourage rural GPs to provide anaesthetic support to visiting surgical teams may come under threat as national bodies demand minimum numbers of anaesthetics per year to maintain competencies.

Thus those doctors who wish to provide services in primary and secondary care to patients in remote and rural areas may need to collaborate to retain, preserve and develop these services – especially as this may be in opposition to politically powerful urban professional bodies whose rules and regulations which preserve professional boundaries in urban practice seek to undermine rural practice.

Practice pearls

What to do

- Have a curriculum.
- Encourage the principles of adult learning.
- Allocate a rural educational mentor.
- Provide 'taster' rural experience without long term commitments.
- Promote a sense of rural identity.
- Promote electronic networking.
- Encourage experience across a network of rural locations to add value to the learners and the network of practices.

What not to do

- Don't provide experience without mentoring and reflection from outwith the clinical setting.

Conclusion

- Rural clinical generalism is a challenge for urban health care professional systems.
- Increasing specialisation and requirements to evidence technical competence in the urban environment proved a direct challenge to rural training, service delivery and recruitment/retention.
- In the rural context, numbers are smaller and geographical distance will always be a barrier. Modern communication technologies and transport systems may mitigate some of these effects. However, paradoxically, rural health care is the educational opportunity for urban health care. The urban systems desperately need generalism to solve their service delivery problems in frail elderly care and multi-morbidity. Rural practice has the unique educational asset of easy visibility and understanding in medical training. The learner can see the whole patient, their journey of health care and social support networks with ease.

- Rural health care education needs urban health help but in many ways the modern urban world of health needs rural health care more!
- Rural health is an important new speciality for all doctors to experience and understand if they wish to improve patient care, understanding and safety.

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