

## **General Medicine in a Remote & Rural Hospital: Problems & Proposals – A Personal View**

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Working in a remote and rural hospital can be tremendously rewarding. Being given a licence to become a valued member of a small, close community is a privilege few have the opportunity to enjoy. Practising rational and safe 'hands-on' clinical general medicine without the immediate local presence of specialist colleagues or on-site high-tech investigations and treatments is often a challenging and highly satisfying job with the probable benefit of more freedom and autonomy than in a larger unit. The style of medicine is more personal, and in some ways more holistic, as there is the necessity to get to know many of the patients and their families through multiple episodes of care and over many years, perhaps giving the hospital doctor a taste of the style of practice a traditional family GP would have enjoyed.

Compared to surgery or obstetrics, remote and rural medicine currently suffers fewer of the problems of falling workloads, reliance on high technology and infrastructure, and the need for immediate on-site specialist help. Indeed, general medical acute admissions have risen inexorably in recent years, mirroring the pattern elsewhere in the UK. There is no indication that the service is becoming unused or unnecessary.

Nevertheless, rural hospital consultancies have often been difficult to fill, relying on a small number of doctors who find the type of practice and social life attractive. During times when consultancies have been in demand it has of course been easier to fill posts seen as unattractive. Over the past two decades there have been dramatic changes in medical practice, working patterns, the lifestyle that doctors find acceptable, and in public expectations. For these reasons, single or even two-handed consultant partnerships are often no longer professionally viable or personally acceptable. The dwindling supply of doctors looking for rural posts is now insufficient to meet the increased demand.

One response to this difficulty is to find ways of working without local consultants, but this may lead to a downgrading of hospitals towards 'cottage hospital' status at a time when government policy and public expectation is to improve both the quality of care and access to care for rural communities and to try to provide equity of service. The need, therefore, is to find ways of changing remote and rural services, so that consultant posts become sustainable and attractive to well-trained doctors who will stay in post and remain professionally motivated and up-to-date.

There are some fairly obvious attractions of work in a small close-knit rural community in an area with low population densities, low-cost housing and ample space for outdoor pursuits often in outstanding 'natural' surroundings. Nevertheless, for most doctors who will have trained and worked in large hospitals in large conurbations for several years at least, and for their families, the disadvantages may outweigh the advantages. Significant changes in work patterns and practices, and attractive incentives will be needed to change this view.

The disadvantages of rural consultancies can be roughly divided into two groups; medical or work-related, and socio-economic. These factors and some possible solutions are discussed.

### **Medical or work-related disadvantages**

***Onerous on-call commitments*** Although in general the workload when on-call is much lower than in large hospitals, the frequency and duration of on-call duties is much greater leading to considerable restraints on family and recreational time. There is little attraction in coming to the great outdoors if you can never get to play in it!

Increased staffing levels, so that rotas do not drop below 1 in 3 (perhaps higher) are needed to allow realistic timetabled time off during the working week which would

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help to compensate and produce a big improvement in lifestyle. However, locum cover is often difficult to find and sometimes of variable quality. Cover provided by consultants from other hospitals within the health board has not been a viable option, because it is viewed as having a detrimental effect on those posts.

A system of working for a continuous block of days followed by a block of days free of clinical commitments (with similarities to the work pattern of offshore workers) has been tried locally. The non-clinical time is used to provide a mixture of compensatory rest, holiday, study leave, time for catching-up and for external meetings or networking. It has been well-received by a number of local clinicians and produces some improvements in the way the on-call service is provided; it may also allow compliance with the European Working Time Directive, though it is not a complete panacea!

**Professional isolation.** This can be demotivating, but even more importantly makes it much more difficult to keep up-to-date. Regular time spent working with colleagues in a larger centre would go a long way towards meeting this need and, by backfilling general duties at the centre, could allow central consultants time to provide a much-needed specialist outreach service. Good quality well-serviced accommodation that could take families at the central site would facilitate this interchange and avoid the constraints of using local hotels or bed and breakfast accommodation.

There are also good arguments for an increased guaranteed study leave entitlement and funding to allow not only for the extra time and cost of travel from a remote base, but also for the lack of local educational activities.

**Difficulty learning new techniques or keeping updated.** The normal study leave allowance usually gets used up on short one- or two-day courses or a week at the most. This is not sufficient to allow for the acquisition of new skills requiring supervised practice.

Sabbatical periods of between two weeks and two months available occasionally for specific service-led reasons could have large benefits in re-skilling remote consultants to meet defined needs. The main obstacle to this happening is the need to provide locum cover for longer periods of leave.

**General Medicine with a lack of speciality practice.** Most aspiring consultants have trained as specialists from an earlier stage in their career than was the case fifteen or more years ago and so are less willing to take on mainly general medical work. They are also keen to maintain their special interest. There is already an awareness that shorter and more specialist consultant training may not be an advantage for any consultants, but the Royal Colleges and Postgraduate Deans may need to ensure that some training programmes continue to give broad experience in general medicine.

In most specialities, it should be possible to practise some local sub-specialisation, but it should also be possible for peripheral consultants to provide specialist services at the nearest large hospital particularly for clinics, one-stop-shops and outpatient or day case procedures and surgery. In practice, the tendency to base a service around individual consultants rather than looking at the whole service and the staff able to provide it hinders this development.

**Lack of high-tech facilities** It is inevitable that a small hospital will not have the range of facilities available at a larger centre. Nevertheless, it could be argued that even small hospitals could have, for instance, CT scanning, endoscopy and up-to-date monitoring equipment, as well as adequate radiologist's time locally to meet urgent (as compared to emergency) requests.

A realistic model of the services and facilities that should be available in a remote or rural acute general hospital needs to be agreed and planned nationally rather than the present situation where each hospital fights for whatever resources it can, sometimes ending up with an unbalanced and inequitable service. In Highland, for instance, there has been the situation where one hospital has state of the art radiology equipment, but a struggling laboratory service, while another hospital has had the opposite pattern! Historically, the tendency to view remote and rural hospitals as 'mini-district general hospitals' may not have been helpful in their development, and a set of core services that need to be provided locally could be a better foundation.

## Socio-economic factors

**Lack of large local shops and mainstream entertainment.** For some, this is a very major disadvantage of remote living whilst others see it as an attraction! Facilitating easier travel and accommodation would go some way to meeting the problem, perhaps by using central hospital facilities at weekends for families to spend time in the big city at a reasonable cost.

**Increased travel costs and time.** With increasing fuel costs, this has become a major factor in remote living. The provision of a family-sized lease car and perhaps some 'free' private miles per year would help to offset the extra costs and difficulties involved.

**Capital risks and disincentives** Although the pattern is beginning to change, housing in remote areas is cheaper and the housing market less buoyant leading to a loss of capital gain (which may be many thousands of pounds) compared to doctors with houses in more popular areas. The loss of capital can mean that moving to a rural area is a one-way ticket with the equity trap making it impossible to move back into the housing market more centrally.

Owning a larger property than could be afforded centrally is certainly a big advantage of a rural move, but cannot offset all of the loss. Facilitating new consultants to rent good local housing at a reasonable cost, rather than having to sell their houses in urban areas, would at least reduce the risk.

**Risk of getting stuck in a remote area.** Many consultants and their families considering work in a remote or rural area fear that such a move would be a one-way ticket and therefore a risk they should not take in case the work or lifestyle was not to their liking. The guarantee of relocation to a larger hospital within the same, or a linked, health board if requested within a few years of appointment would provide an escape route, and reduce the risk of trying out remote and rural life.

**Reduced earnings** Some may view lack of private practice as an advantage, while others see it as reducing their earning capacity compared to a city consultant. Historically too, peripheral consultants have been less likely to receive distinction awards. It may not be realistic to expect all of this loss to be offset, but a significant incremental financial incentive will probably be needed to make remote posts attractive.

## Conclusion

Several remote and rural acute general hospitals are at, or close to, crisis point largely due to staffing problems. There are ways in which some of the difficulties of recruiting and retaining

staff could be tackled, though not without a significant financial cost. There may also be other ways of providing a good and appropriate service using different models of care, although if there were easy answers they would probably have been discovered already. A more coordinated national debate about the appropriate provision of remote and rural medical services, and a more strategic view which sees such services as an integrated part of regional healthcare is urgently required.

Scotland's wilder areas are a national, and indeed international, resource. Vigorous rural communities are essential if these areas are to remain available and accessible. High-quality local healthcare is one of the vital ingredients, but it needs thoughtful, sympathetic, support and nurture if it is to survive.