Remote and Rural Medicine in Scotland

Dr Brian Tregaskis, *Consultant Physician, Belford Hospital, Fort William and Team Doctor, Lochaber Mountain Rescue Team*

Scotland's smaller consultant-led hospitals provide a wide range of medical services to varying populations in the more remote parts of Scotland. From island-based services on Shetland to mainland areas such as my hospital in Fort William (Belford Hospital), local populations are small (20–30,000) and static, but the beauty and recreational resources of these areas ensure that the local population can be increased massively by tourism (Figures 1 and 2). Sailing around the west coast and climbing and outdoor pursuits in Fort William are very popular. Fort William's steady population of 22,000 is doubled most weekends in winter by skiers, climbers, walkers and Saga tours (holiday tours for people aged over 50) and quadrupled at the height of summer. These activities bring with them their own morbidity and keep the hospital services busy. Beautiful mountains, for example, bring injuries to hillwalkers and mountaineers (Figures 3 and 4), and Belford Hospital provides the immediate support for the Lochaber mountain rescue team (Figure 5). Fort William is 110 miles (176 km) from the teaching hospitals in Glasgow, 140 miles (224 km) from the teaching hospitals in Edinburgh and 65 miles (104 km) from the nearest large District General Hospital (DGH) in Inverness. These are long distances when you are ill, and at the farthest edge of our patch patients may already have travelled 70 miles to reach our hospital.

Scotland's small rural hospitals and their staff are under threat of closure and those of us who work in them feel under siege by a variety of government and European Union directives that assume such hospitals are not viable or render them so. In this short article I will examine the charges laid against small hospitals and suggest ways in which we have tried to answer them.

Remoteness

First, however, the definition of remoteness has to be set and challenged. Is remoteness geographical (for example, distance from a centre of excellence), professional (isolation from peers), or psychological (only in the mind of the remote doctor)? Remoteness is also a two-way street. Doctors in small hospitals may well be remote from large central hospitals but those living and working in large central hospitals may also be remote from the ways of working in small hospitals and in understanding what they can and cannot do. A cardiogenic shock in Lewis is often too unfit to transfer, should we, therefore, stop all treatment or work at consultant level to stabilise the patient given the resources and skills available locally? What the Commission for Health Improvement (CHI) requires of a big hospital is not necessarily relevant to practice in a small hospital. Standards for small hospitals are necessarily different (but not worse) and need separate definition. In the rush to uniform standards we have lost sight of what is possible given distances and specialist availability. However, the patient with cardiogenic shock will be better served by a well-managed stay in a small hospital, aided by networked colleagues elsewhere, than dying on a remote mountain road *en route* to excellence.

Professional Isolation

The first of the common charges laid against smaller hospitals is that their practitioners are professionally isolated. This is no longer the case as telephones, faxes, mobile phones, the internet and video-conferencing transcend geographical boundaries. Most of us who work remotely have referral and support systems from colleagues in major hospitals in all specialties which have grown up over many years and are the functioning forerunners of the 'suddenly discovered' managed clinical networks of today. Indeed, the very size of our small hospitals often leads to earlier effective transfer of sick patients to a tertiary facility when perhaps patients in a DGH might wait longer. Professional isolation is also countered by running in-house teaching and professional exams. The latter often proves very educational

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for our visiting examiners when they see the broad variety of medical patients presented. Rural consultants should also take their full part in professional bodies and in national duties.

Maintaining Skills

Another common charge is that there is an inadequate clinical workload to maintain skills. Peers who work in larger hospitals often fail to realise that the patients presenting to a small hospital are the same as those presenting to their own hospitals. Anything can come through the Accident and Emergency or clinic door and has to be managed, particularly those too sick to transfer. A population of 20,000 yields 1,400 emergency admissions and 500 new out-patients a year in medicine in the west Highlands. These patients are seen by the two consultants who cross-cover each other in our hospital. This compares favourably with anyone's workload and is truly general medicine.

Specialisation

The advance of specialisation causes some to lift eyebrows in our direction. Yet often the acute medicine in larger hospitals is seen by very junior doctors and handed on to specialists without much thought, while specialists see less and less general medicine in an ageing population with multiple pathology. General medicine is increasingly neglected, and there are very few general medical clinics. I submit that small hospitals are very good places to learn general medicine, a term which is not synonymous with acute medicine. We have unrivalled opportunities to remain inquisitive 'doctors' sorting out problems and referring on as necessary. We have time to contemplate, our patient base is strong and, given good networking skills, no patient will miss out on big hospital investigation when required. Visiting doctors are often surprised at how well we know our patients and state that they don't have time to get to know theirs. I usually suggest that perhaps they, rather than us, have got the balance wrong. We also have time to teach and this resource should be used more. Remedial training for the terminally apathetic doctor is also offered. There is an alternative to medicine by numbers.

Hermann Boerhaave (1668–1738), the founder of modern clinical teaching, had but 12 beds in his hospital at Leiden but made it the clinical centre of Europe. He, however, did not have NHS Quality Improvement Scotland, CHI or the National Institute of Clinical Excellence (NICE) advising him with standards impossible or even irrelevant to rural medical practice.

The answer to the problems of specialisation is good triage and good networking against a broad general knowledge of medicine. Linked to this, opportunities for visiting big centres and sabbaticals would be appropriate. We would also like to see a two-way opportunity with specialists from big centres attending general clinics or spending a week working in general medicine in the more remote, smaller hospitals. The flow of registrars eager to work as locums in our hospital has dried up. Many tell me they are too specialised to work in general medicine! If this is true, many doctors in training will find themselves unable to understand the totality of their patients' problems. How sad.

Recruitment Attitudes

In the current trend to dumb-down or close small hospitals, much is made by the protagonists of centralisation of difficulties in recruitment and retention. There is a widespread misunderstanding of posts in small hospitals which are perceived as being of low status, a barrier to professional progress, and the repository of misfits and alcoholics. This negative view is first encountered at medical school and is perpetuated by people who have never worked in a small hospital. Since we improved opportunities for students, house officers and senior house officers to work in our hospitals we have engendered enormous interest in our posts. Many of our students return as house officers and senior house officers and, indeed, we cannot keep up with the demand. Why? Perhaps there is something good which benefits

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doctors and patients about a slower pace and an emphasis on sorting out problems rather than referring every time. This exposure should be increased. Proleptic appointments with additional training built-in would also enhance recruitment. Improved job-directed training for rural practitioners and the innovative use of multi-disciplinary local medical talent would help solve local staff shortages. Accommodating senior clinicians who want a change before retirement has its attractions and has worked well for us in the past.

Bureaucracy

The European Working Time Directive will perhaps prove to be the killer blow to small hospitals, as more people are needed to fill legally time-constrained rotas. This is also a serious risk to smaller services in DGHs. I hope my colleagues in DGHs realise that if we go, they will follow until we are left with just five big hospitals in Scotland. In Scotland, if our small hospitals in Fort William and Oban close there will be no care at consultant level between Glasgow and Inverness (the entire western seaboard above Glasgow). Resources are often quoted as a problem but if the NHS is for everyone in Scotland surely some areas costing a little more need to be supported so that medical care will still be available for those who travel and play in these areas.

Standards

The last charge commonly made against us is that we cannot maintain the same standards as a centre of excellence unit. However, are these standards universally appropriate? As yet there are no standards for small hospitals and these should be set by Colleges and professional bodies recognising what is possible; we cannot look at standards without also taking circumstances into account. We are not afraid of standards, but we want appropriate standards policed by those who understand rural problems rather than those with a 'tick box' mentality.

In summary, small hospitals are different and not yet dead. The younger generation does not seem to want to work here, but no effort is made to make remote and rural medical practice known to medical students and young doctors. Old preconceptions die hard particularly in Colleges and corridors of power. Meantime, rural populations value their hospitals as evidenced by a local turnout for a discussion on the future of the hospital at Fort William. A turnout of 200 was anticipated and the meeting was attended by 2,000 people (with a further 1,000 outside, unable to get in). Think about it.

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