

RCPE symposium: Remote and Rural medicine

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The Remote & Rural conference 2019 – Creating a Community of Care was held on 11 November 2019 at the Centre for Health Sciences, Raigmore Hospital, Inverness, UK.

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Remote and Rural (R&R) medicine is a key area of interest for the Royal College of Physicians of Edinburgh. This conference rapporteur report is based on the RCPE's R&R Conference 2019 and serves as a record and 'call to action' to understand and address the unique health needs of people residing in rural areas.¹ Numerous organisations including Royal Colleges, academic centres and Allied Health Science Networks are developing programmes of work relevant to R&R medicine. The reason is that while health care needs are not inherently different, delivery and accessibility of care varies greatly between urban and rural environments. In addition to the impact of ageing populations and increasing chronic disease, rural populations have higher rates of poverty, deprivation, social isolation, and drug and alcohol abuse. This report first summarises discussion from the conference and then proposes solutions spanning policy and research and aimed at improving rural health.

Session 1: Training for remote and rural healthcare

Professional life in R&R health and social care can be difficult; those in post can become isolated from peers and feel unsupported in their practice. A number of training programmes have been developed to increase recruitment and retention in R&R medicine. Dr Mike Jones (RCPE Director of Training) opened the proceedings by providing an overview of the current R&R medicine curriculum. Each of the programmes Dr Jones presented have had some degree of success in increasing recruitment. There is, however, an overall lack of consistency in the programmes with no standard path into the specialty. The emerging enhanced training and degree opportunities were showcased by the following two speakers. Professor Graham Leese (Ninewells Hospital, Dundee) outlined the new core training programme

for Scotland: Broad Based Training.² This programme offers two years of six-month rotations in paediatrics, general practice, general internal medicine and psychiatry. This approach offers the chance to experience and learn from the four specialty practices that are important in R&R medicine. Flexible training programmes were presented by Professor Cathy Jackson and Professor Stuart Maitland-Knibb (National Centre for Remote and Rural Medicine, University of Central Lancashire). The medical degree programmes in the curriculum offer flexibility in learning through online study with the students selecting the modular courses they want to study for their degree.

The session ended with a discussion on other learning and development activities. Dr Cormac Doyle and Dr Pauline Wilson (Gilbert Bain Hospital, Shetland) shared their research based on canvassing consultants and juniors working in rural general hospitals (RGHs) on the current R&R medicine training. Two future training routes were identified: general internal medicine with a specialist interest in R&R medicine and a post-CCT modular credentialing system. Mentorship schemes and opportunities were presented by Dr Patrick Byrne (Belford Hospital, Fort William) who shared the placement scheme he developed for junior doctors at his RGH. The programme provides learning and development activities, by giving one-to-one access to three consultants and gives the trainee FY2s experience. The students gain insight into a physician's role and mature decision making.

Session 2: Credentialing for remote and rural healthcare

Professional scope of responsibility, closer collaboration between rural-specific stakeholders and enhancing a group's status was frequently a topic of discussion during the second

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and third sessions. The General Medical Council is currently formulating a rural credential.³ Its authors, Professor Alan Denison (NES) and Miss Rose Ward (GMC) shared that the aim is to address practice and safety areas not covered in specialty training and to provide a training framework for general practitioners to provide acute care in hospitals. The RCPE's R&R Committee are providing feedback on the report before its submission in June 2020.

Session 3: QI in a remote and rural setting

Dr Charles Siderfin (NHS Orkney) and Dr Kirsty Brightwell (NHS Western Isles) presented their GP recruitment initiative supported by the four Highland health boards.⁴ Coordinated by the Scottish Rural Medicine Collaborative with funding from the Scottish Government, the project's aims are to standardise emergency care and training, and to recruit doctors to vacant positions. Based on an 'oil rig model' of three weeks on, six weeks off, 27 GPs have been recruited to cover 90 weeks of care.

With a prefecture including more than 600 outer islands and a large percentage of its population over 65, Japan faces many of the same rural healthcare challenges as the UK. Professor Shimokawa (University of Nagasaki) shared the collaborating work done between the university and the island of Goto.⁵ Since 2015 the partnership has provided community medicine to the island through attachments of third and fourth year medical students, while other university departments have provided advice to islanders on sustainability in energy, fisheries, and agriculture.


Expanding team-based care is another way to improve access. Dr Karen Le Ball (Broadford Hospital, Skye) discussed her Rapid-Assessment Clinic initiative launched in response to the redesign of the health and social care services on the Isle of Skye. Funded by the Value Improvement Fund, a consultant,

two GPs, an occupational therapist, a physiotherapist and a pharmacist meet in a local centre to provide a 'carousel model' for treating patients. This team-based care saves travel, increases early referrals and diagnosis.

Dr Kirsty Griffiths (Caithness Hospital) outlined a collective action project she instigated based on simulation training for medical staff. Doctors learned from a true-to-life learning environment and their confidence was increased. The training was facilitated by rotating acute medical consultants and simulated scenarios including acute exacerbation of COPD, a fast atrial fibrillation secondary to sepsis, and a floppy baby. This successful project continues two years later.

Conclusion

The RCPE believes that addressing the unique needs of rural populations is critically important for the overall health and well-being of the nation. The causes of rural healthcare inequalities are multifactorial, intersectional and highly complex. A full discussion of the details of proposed solutions is beyond the scope of this document. Broad, innovative, and sustained approaches are needed that address the tough underlying structural, social and policy issues. Improving rural health will necessitate new approaches to care delivery, complementary policy reforms, and supporting research. Below we have summarised the key actions suggested by the conference. We hope they will inspire you to take action:

- Expanding the workforce and fostering team-based care
- Developing new rural-specific care models
- Ensuring that scope of practice laws facilitate rural workforce development.
- Telehealth and digitally enabled healthcare
- Rural-specific care delivery sites
- Broader economic development in rural areas 

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