The Doctor podcast | Episode 7 | Special job, special people

Dr Neil Shepherd: Why should we have rural health care? Why don't we all just live in towns? People have the right to choose where they want to live – rural Scotland's a beautiful place to live.

If we didn't live in rural areas, there'd be no food because there'd be no farmers. There'd be little electricity because there'd be no offshore wind turbines.

So, these rural areas do provide a lot to the society that we live in. And people need to live there to staff these services. We absolutely need to have people in rural areas.

Voiceover: When picturing a clinical work environment, you might not imagine a backdrop of a Scottish mountain range, or an isolated coastal town – but that is the reality for doctors working in remote and rural areas of the UK.

We spoke to Dr Pauline Wilson and Dr Neil Shepherd about their experiences working as doctors across Scotland's more remote areas; how it might differ from the expectations of the job and what kind of doctors might thrive in a similar role

Dr Pauline Wilson: I'm Pauline Wilson. I'm a consultant physician based in Shetland, and I'm associate postgraduate dean for NHS education for Scotland, for the remote and rural credential.

Neil: I'm Neil Shepherd, I'm a GP in Orkney and I'm a rural emergency physician in Caithness General in Wick.

Voiceover: Welcome to the seventh episode of The Doctor podcast, brought to you by the British Medical Association. Each month we bring you conversations inspired by stories featured in *The Doctor* magazine.

This episode builds on the feature article 'Special Job, special people' by Jennifer Trueland.

You don't need to have read the article to enjoy this episode but if you'd like to do so you can find a link to it in the show notes and at thedoctor.bma.org.uk/podcast

Pauline: After studying biochemistry at university, kind of really interested in medicine, so I decided I'd like to be a medic. I was really keen, as I went through medical school, but would there be an opportunity for me to come home and live and work as a doctor in the Shetland Islands?

And I suppose that concept to most people in terms of where they want to go in their career would be more straightforward. However, in terms of doing rural medicine, there

wasn't an awful clear path as to how I was going to go from being a junior doctor to being a consultant because I wanted to stay in hospital medicine.

But thankfully, the associate postgraduate dean who was in charge of my programme at the time really understood the vision of what I wanted to do – to be a doctor in a rural setting.

I was going to need to be a generalist, so I spent quite a lot of time just going round different specialties and spending time with different teams, gaining a lot of breadth of skills rather than as a specialist, that kind of in-depth skill in a particular area.

I really enjoyed my time training in Aberdeen. But I think the rural context is different. I'm obviously a Shetlander who came home so I actually understood a little bit about what it means to live in a rural area.

Thankfully, there was a job that came up in Shetland and I was able to apply for that. I've been back in Shetland as a consultant physician now for the past 20 years. The pathway to rural medicine for me was, I suppose, an ambition to come home and work and live with people that I knew.

Neil: I had a very different approach to rural medicine. I grew up in mainland Scotland and married an Orcadian. And as a result, spent a fair bit of time in Orkney through my training, just visiting her family and whatnot, and thought this is quite a nice place.

I did my training in the Central Belt in Scotland and then worked abroad in Australia in a suburban setting for a couple of years and didn't really enjoy it as much as I thought I would. This was doing general practice.

Interestingly, in Orkney in my wife's friend group every single one of them has returned to Orkney when they've had their children. And so that's what we did. When we had our kids, we moved to Orkney.

Yes, it was very much unplanned. And I'm sure if I'd met someone from London, I'd probably be living in central London doing a very different job. So, it's funny the way sometimes you can't plan your life. It just ends up with you who you meet and where you are.

I had a rough idea of what to expect. I didn't have the experience of having worked in it. I'd only ever done one or two weeks as a locum GP in in the West and Jura and a week in Orkney just to sort of have a wee taster in it which was fine, although it wasn't what I ended up doing.

I'm now working in hospital medicine as a as a GP, but within the hospital. I think having lived in Australia for a couple of years and met doctors who were GPs but also worked in rural hospitals gave me the idea that it was possible.

I was aware that there were doctors in Skye doing a similar job, so that there was a set-up in in Scotland to do that. So, when it came to Orkney, I kind of had the idea that maybe that was something I wanted to do. I wasn't really loving my time in general practice.

I knew that there were these interesting jobs in other places where you could do a bit of hospital medicine, a bit of general practice, a bit of emergency medicine. That had caught my interest.

I thought it was a career I'd like to do in that. That's what I've ended up doing, split between various rural sites and it works very well.

Voiceover: Some may argue that healthcare resources should be prioritised for more populated areas, however Dr Wilson and Dr Shepherd point out the importance of supporting rural healthcare, keeping it going for future generations and pushing it as a specialism in its own right

Neil: Why should we have rural healthcare? Why don't we all just live in towns? People have the right to choose where they want to live – rural Scotland's a beautiful place to live.

There's a large number of people who live in rural areas. And if people live in rural areas, you've got to provide them healthcare.

If we didn't live in rural areas, there'd be no food because there'd be no farmers. There'd be little electricity because there'd be no offshore wind turbines.

So, these rural areas do provide a lot to the society that we live in. And people need to live there to staff these services. We absolutely need to have people in rural areas.

And then when they're here, they'll get sick or the fall off things, or they'll have children who will then get sick. So, we need to provide healthcare for them.

Pauline: In terms of rural areas, around 20% of the population is regarded as being rural. And that accounts for around 12 million. Now, when you classify rural, there's rural and then there's remote and rural. So, there's obviously a lot less people within that bracket.

Within the Scottish context, when we think about remote and rural, we often think about the Highlands, and we think of the islands. But also, it's really interesting speaking to other colleagues, people in the Borders feel quite remote in terms of medicine and policy.

And so, when you talk to English counterparts, they often talk about remote and rural and coastal. So, I think definitions matter but why is it important?

We will depopulate these areas, as Neil says, if we don't provide healthcare, and remote and rural healthcare is essential in keeping people in an area.

So, if you don't have schools and you don't have hospitals and you don't have healthcare, you depopulate and centralise your population.

Voiceover: Every healthcare role comes with its own set of unique circumstances, but the impact of a rural doctor greatly differs from those in more populated areas. Dr Wilson and Dr Shepherd discuss some of the quirks of their trade and how interactions with patients are more focused on their longer-term health journey.

Pauline: The experience of working in a rural area is different in that you are very answerable on a very personal level to the people that you treat.

And I think there is a bit of an anonymity when you maybe live and work in a bigger centre. You still answer to your patients, of course, you've got that patient- doctor relationship.

I think the difference of living and working in a rural area is that it extends beyond your job and extends beyond your role in the hospital. It goes out into your personal life.

You meet your patients anywhere you go out. So, whether you're in Tesco's trying to get your weekly shop or you're attending a concert, you are still very much identifiable as the doctor.

And that brings challenges sometimes, but I think it's an immense privilege actually as well. It makes you want to keep your standards really high because you do have this very personal accountability for the people that you treat.

And I think also the beauty of the job is you treat generations of the same family. So, you know, our job is completely unselected. So, we have to cover off children right through to end-of-life care.

So, you may meet the child in the family. You then might meet the mother or even the grandparent in that whole family. So, you can treat generations of the same family, which I think is an immense privilege.

You know, sometimes we can't make every situation better, but you are invested in that person and trying to find some sort of solution. Even if that solution is a palliative one, you're there with them through that journey. So, there are those challenges but also immense privileges. 20 years later, I wouldn't change that for the world.

Neil: I often think that Orkney and Shetland with their, you know, as you say, populations which are small and you know them, we're just like a big GP practice.

There's only 20,000 people living here. There's GP practices in cities with more patients. But for those 20,000 people, we do all their primary care and nearly all their hospital care as well.

If they if they get sick in an emergency, whether they're two years old or 102, they come through the front door of our hospital, and we see them. We treat them, we follow them through the hospital and then we can discharge them back to the GP, where I may then see them as a locum GP once they've been discharged.

So, you get the benefit of continuity of care in a hospital setting and a hospital job that you may not get in a larger centre. And that knowledge, that local knowledge of the families and the social backgrounds and the jobs that they do is deeper in these rural areas than in medical roles in larger centres.

Pauline: And I think that's true for our resident doctors and trainee doctors that come through as well. And I think every doctor should try, if they can, to do some sort of more rural placement. I think they see the continuity, and the person as a whole.

They're in the ward and they're also responsible for the decisions that have been made at the front door. So, they're also seeing that patient in the ward setting. They're having to write that discharge letter for that individual.

And then of course, we sometimes will be able to get that resident doctor into clinics. So, they may be following up with that patient up several weeks later to see the outcome of the treatment.

And I think that is a tremendous part of the rural training that we offer – seeing the actions of decisions, seeing how our decision-making can affect patients and how the choices they make in terms of the context of their illness is really important.

It's not just you're making a decision and then passing that out on to a specialist colleague. You're there for the journey with that patient's illness and beyond.

And I think, if anybody is listening – it's really about encouraging your trainee workforce to think about how can we get them into rural areas so that they actually get that holistic care?

Voiceover: The challenges faced in rural settings means doctors must find solutions that work for both their practices and their patients. Dr Wilson and Dr Shepherd discuss the challenges they've faced, and how thinking outside the box helps them offer great healthcare services despite limited resources.

Neil: What are the challenges we have in rural healthcare? We've got the resource issue, in terms of tests, labs, specialist services. And we also have the resource issue in terms of people.

Some of them you can spin as a positive. For example, you can't ask a neurologist to come and give you a specialist opinion on the patient's unusual symptoms. You've got to do a very thorough examination and then phone the neurologist and explain your neurological examination findings to them, which makes you very good at doing a neurological assessment.

In our hospital, if somebody comes in at 6 o-clock in the evening with breathlessness, we have to phone the radiographer in from home, and they can take 45 minutes or an hour to come in because it's an on-call service after five.

We have to manage this patient using our clinical skills and maybe spend a bit more time looking at their JVP than we would otherwise because it's not easy to get that X-ray and get the diagnosis quickly.

That then forces us to learn and use other techniques like ultrasound and develop our history-taking skills a bit more and rely on our clinical medicine more.

There's also then the resource issue of people we recruit. So, there's vacancies in most departments. And we have to be a bit more creative with recruitment programmes, job planning, rotational staffing models, choosing the right individuals for the right roles and maybe working a bit harder to network and recruit people than other places would.

But we generally succeed. And if we can't recruit, we've got locums and we've got very good locums who often come back because the role's very good. So, we certainly have those challenges, but they can be opportunities as well. The low resources just make the job more interesting.

Pauline: Totally, and I think it's that part that is really interesting, you're right, we're reliant on an on-call service and resident doctors that rotate round about.

We were just having a chat about it this morning because, you know, we do have a small lab service and actually, we do have to think do we need this test now? Will it alter the patient's management in the next six hours if we wait to call somebody in the morning? Do I actually need this test? Why am I doing this? You're exactly right Neil.

What we also teach is the context of what you're asking for and in actual fact that's realistic medicine in a nutshell – using the resources you've got appropriately, rather than that blanket throw-out. Our resources are different.

I think you're absolutely right about recruitment and retention. In rural areas we've had to innovate. One of the innovations is a role that you're in in terms of that rural emergency practitioner role. I think it would be really interesting to hear a little bit more about what that rural emergency practitioner physician is.

Neil: Absolutely. So, I'm a GP, my training is in general practice. But it's sometimes hard to summarise in one sentence what I do.

My other title is a rural emergency physician and there's six of us, we all have a GP background, and we cover the emergency department from 8am to 9pm, providing support to the residents.

In addition to that, we participate on the consultant on-call rota for medicine overnight, enabling us to act access as the senior on. We don't do the ward rounds.

By doing the night shift, it means the consultant gets an uninterrupted night's sleep, which helps our recruitment and retention because the physician jobs are generally more sustainable as there's more people participating in the on-call rota.

That role, I think, was set up in Skye initially in NHS Highland, and it's been rolled out across all the Highland rural general hospitals, so in Oban and Fort William.

And it really helps provide some stability to the hospital that we're there permanently. There's less reliance on locums. And then once we're in the door, we can do all the other things that permanent doctors do, like audit and quality improvement and supervision and training.

There's been a lot of work done by NHS Education for Scotland, led by yourself Pauline –so, thank you for that – to give us the qualifications and recognition of what we're doing. The GMC rural and remote healthcare credential is designed for doctors who are operating out of what they were trained in – I'm a general practitioner.

Voiceover: This new credential has been developed to recognise the unique skills required to work in remote and rural environments. Dr Wilson has been helping with the development of the credential, and Dr shepherd has undergone the review process. Here they talk about why it's important.

Neil: The credential has been launched to recognise these doctors who have these extra skills in remote and rural urgent care.

Pauline: We've talked a little bit about the credential already. So, it might just be nice to give a bit more detail on that.

In about 2019, the GMC looked at the process of credentials, and remote and rural medicine was chosen as one of those areas to look at whether it would be worth developing a credential in remote and rural medicine.

And that's actually quite a big ask because it's quite a big topic. The focus of the credential was on the unscheduled and urgent care aspect of rural medicine. Looking at the individual skillset for looking after patients that come into unscheduled and urgent care.

And then we actually thought, well who would do who would do the credential? Who does this apply to?

We look at doctors coming from a range of backgrounds. The majority of those have come through general practice. But we do have other individuals who have come from an emergency medicine background but then spent some time overseas and then come back to the UK.

It's a wide range of doctors that can apply to come into the credential. What it's allowed us to do is have a framework.

We've also tried to make it flexible and proportionate. So, there are two routes into the credential. One is the recognition route. That is when doctors who are working already within the capabilities of what is described in the credential curriculum can collect some evidence, put that in a portfolio.

If it seems that the individual doctor has met all the capabilities and procedural skills, we'll then recommend that individual to the GMC for recognition.

The second route is what we call the learner route. It's a workplace, experiential-based learning programme where an individual doctor working in remote and rural will look to get the credential.

Maybe that individual doctor will spend anything from six months to two years gaining the skills. There's a lot of collecting of evidence. But it's also tailored, so it's tailored to that person.

Neil's undertaken it. Neil, I suppose asking you, you went through the recognition route, so you had to collect evidence. And I suppose when we start off with that we can think, oh gosh, this could be an awful lot of work. It's going to be really hard to do. How did you find doing that?

Neil: It wasn't too onerous. I think the recognition was quite sensible and pragmatic in that you need to show your learning and your evidence of the skills in the various areas.

Several of us who work in Caithness and elsewhere have been awarded it. The new doctors coming through who are training in rural areas are encouraged to apply for the credential once they've gained appropriate competencies to help reassure the employer and the local population that the doctors have the right skills.

But also, to build a network of doctors with this professional identity, which will enable us to move jobs if we need to or if someone's off sick. We know the skills are there to provide cover in another site.

One of the things that inspired me about this was having worked in Australia for a couple of years before I came to the UK, which is more advanced in their setting up of the rural GP role.

And I think Scotland has certainly caught up with that with the credential. I think over the next few years we'll see a lot of doctors coming through with awarded it and really strengthening the rural clinical workforce.

Pauline: The reason I got involved with the GMC credential was primarily around the fact that we are, as you said Neil, generalists. And I've been asked quite often to work at the edge of my area of comfort.

When this opportunity arose to look at what would be the capabilities in practice and the procedural skills that you would expect a doctor to have, I was really interested because I thought this was an opportunity to kind of articulate what is expected and maybe just shed a bit of light on the general nature of our job.

But also, beyond that, as you say Neil, I think the important bit was that empowering the doctors that our communities feel safe in our hands because we then know that we've matched the skillset, that actually we've agreed across the four nations that you need to have a rural specialist team.

I think the other really important thing for me within this was our specialist colleagues' understanding was better as well. You pick up the phone and maybe speak to neurology and, you know, sometimes a specialist is not understanding the context that we're working in. And I think that we can raise the profile of rural so our specialist colleagues can network with us.

Voiceover: Being a successful rural doctor requires a different mindset than those in more suburban settings; Dr Wilson and Dr Shepherd discuss the qualities that make a good rural physician and the personalities that might thrive in this area.

Pauline: I think being a doctor who works in rural medicine, you have to be fairly, resilient. You have to be able to get over yourself in the fact that you are a generalist. I don't think generalism is that well understood. I think there is still a certain aspect of snobbery around specialism.

When I came back to Shetland 20 years ago, one of the comments made to me was 'why on earth would you want to work In Shetland and not stay in a kind of university hospital?'

So I think you have to be pretty assured of yourself that actually, you know, rural areas are not filled with failing doctors that have not made it in a big urban centre. Rural doctors are really diverse, really interesting people who've come to medicine and really like the challenge of every day being very different.

I think you need to be a problem solver. I think you need to be solution focused as well to find ways of doing things.

The most important part is that we still want high-quality medicine. We strive to keep up to date across lots of areas of our practice. Kind of resilience, problem solving, being an innovator, but also like a bit of a challenge.

Neil: Yeah, and to be honest, most people in medicine I think you could sum up with that description. The vast majority of doctors could thrive in a rural setting. You know, you don't have to be particularly gung-ho and renegade or whatever.

You just have to be comfortable with having a bit less resources available. Tolerating uncertainty is the real thing. And being comfortable picking up the phone and asking for help or speaking to specialists, you know, as you say, not having that pride.

Especially with modern medical training, I think that the vast majority of residents, consultants and GPs would thrive a in a rural setting. The challenge is getting the people here and getting people to experience it because it's very much an unknown for most people.

The more people we can get through the door, through fellowships or rotational training or students, the more doctors we'll be able to recruit in the future because they'll have had positive experiences of it and realised that it's actually a really good place to work.

Pauline: The other cohort of doctors that were attracted at the moment is doctors who will work hybridly. We do understand that maybe living on an island isn't for everybody full time, but actually they like the challenge of being a generalist.

What we found in Shetland over the last wee while is that we've recruited people that also have a real interest in doing humanitarian work. They'll be completely part of our team for a round about a month.

And then, they'll go sometimes overseas or to different parts of the world to do humanitarian work, and that keeps them kind of upskilled in that area you said Neil –that uncertainty. And what they bring back is knowledge, experience, a wealth of generalism, but they are also invested in being part of a hospital and being part of a team.

And that's been really good for us. These people are invested in rural healthcare but couldn't maybe see themselves being here full time. And we find this kind of natural niche.

So, I think it's that part – innovating, having different types of contracts, seeing who is interested and seeing if you can fit it a little bit around them as well.

Can you make it work for everybody? And I think we've got some fantastic doctors who give us so much back by us recruiting in that way, rather than trying to fill that 12-month, full-time post.

Neil: Yeah, absolutely. We just need to be creative for the job planning and recognise that permanently living in a rural area isn't for everyone but having the opportunity to do medicine in a rural area, combined with living in an urban area – it really appeals to a lot of clinicians.

It's not all about living somewhere where there's a nice beach and you can go hill walking. You don't want people to move to your hospital to do that. You want them to move to be excellent clinicians and develop services and build relationships and teach and train and innovate.

Pauline: And then they do still get the nice walks and the beaches because we do have a spectacular outdoor lifestyle. But you're right, often we come at it by selling the outdoor part of the lifestyle in rural areas and maybe not actually the job.

It's about coming and being part of a really small, close-knit team who's really passionate about providing high-quality medicine.

Neil: Having the credential, I would be tempted to do a secondment in rural Australia for six months just to see what it's like. I promise I'd come back. The credential itself, I think officially it's not recognised but it would certainly bring credibility to your clinical skills.

And I would be pretty comfortable working in a in a rural Australian hospital having worked in a Scottish rural hospital for several years. Of course, there would be things I would need to learn about local policies and the transfer of patients.

And there'd probably be some clinical skills that I'd have to improve and some things that were done differently. But I think that there'd be a lot of common themes. I imagine rural Australia is probably more out there. You know, the distances are much bigger. The inequalities are much bigger in some areas.

I think our credential here, from my understanding of the Australian one, stands up pretty well in comparison to it.

Pauline: We are a specialty. I think the difficulty with the word specialty is you tend to think of the fact that you come through a certain path to get to that endpoint. And I think in remote and rural what we have shown is actually that what you need is a set of skills.

And so, I think that's why it's hard to badge this as a specialty. Specialties are often run through, you know, colleges and it's one type of individual. So, it's either a physician that will do that role or a surgeon.

But actually, if you look at myself and Neil's backgrounds, I've come at rural medicine from being a hospital-trained registrar. And Neil's come to the same job from a general practice background. But each of us have felt at the end of that that we needed to upskill in certain areas to continue to provide care.

Neil: The danger of having a specialty mid-badge is that you may make your recruitment harder. You know, the vast majority of doctors who work in the rural hospitals have come through a standard training pathway and then done a little bit extra or just got the job in the rural hospital and picked up the skills they needed while they were doing it.

I think most doctors who have the personality where they can tolerate uncertainty and they can enjoy a wide variety of clinical presentations, can do it. And it doesn't really matter what their individual qualification is, as long as they've got experience and they're good.

Pauline: I would just say to anybody, if you're interested in remote and rural, go and find out about it. We've got an awful lot to offer. Whether that's in Caithness, Shetland, Wick, Dumfries and Galloway and throughout rural England as well.

Go and find somebody to speak about it, because actually, if you've been interested – take that next step.

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If you'd like to find out more about the remote and rural accreditation, read up on the article Special job, special people, linked in this episode's show notes.

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