An Introduction to Remote and Rural Placements

Kirsty Griffiths
I would like to thank the following people for their contributions to this learning guide:

Current and former University of Aberdeen medical students:

Dr. Ross Hendry, Dr. Gemma McKay, Dr. Clare Morgan, Dr. Patricia Wells, Emma Brown, Laura Burns, Michelle Clarkson, Holly Stewart and Graham Walker

Clinical teaching staff in the Highland Medical Education Centre:

Mr. Michael Gale, Dr. Helen Ford, Dr. Ross Manson and Dr. Luke Regan

Dr. Luke Regan, Dr. Alison Searl, Laura Burns, Michelle Clarkson and Luke Griffiths for contributing photographs.

And a special thank you to the University of Aberdeen GP tutors who responded to a survey covering a number of aspects of remote and rural medicine as well as remote and rural placements.

Finally, I’d like to acknowledge my supervisor Mr. Michael Gale, and the guidance and support from Dr. Sue Tracey, Professor Jennifer Cleland and everyone in the Highland Medical Education Centre (HMEC)

Front cover photographs, clockwise from top right: Laura Burns, Luke Griffiths, Kirsty Griffiths
Contents

Introduction 1
Remote and Rural Placements – A Survival Guide 2
Defining Remote and Rural 3
University of Aberdeen Placements 13
What to Expect on a Remote and Rural Placement 16
Differences as a Student on a Remote and Rural Placement 22
The Differences Between Rural and Urban health 27
The Differences in How the Healthcare Professionals Work 39
Accessing Learning and Support 46
Getting the Best Out of a Remote and Rural Placement 49
All Students Can Gain From a Remote and Rural Placement 52
What problems might I have and how can I resolve them? A quick overview 54
Introduction

This learning guide has been produced to compliment peripheral clinical placements in both primary and secondary care. Although initially designed for University of Aberdeen Medical Students, we believe that is entirely applicable and adaptable for any undergraduate health care peripheral placements. The guide, written by Kirsty Griffiths a fourth year student from the University of Aberdeen, has been designed to give a student perspective on the opportunities and challenges that peripheral attachments offer.

Depending on their background and previous experience, some students will consider anywhere outside of a city as rural, whereas others consider towns as still urban and think of small villages and hamlets as rural. A discussion of what remote and rural is and what it means to health and healthcare will follow in this learning guide. This guide also aims to support students on their placements and help them make the most of their time on attachment. It is designed to stimulate students to be able make the most of remote and rural placements, where they may be distant from some of the support and resources they have been used to at their base University. Although it covers many of the specific issues in remote and rural practice it does not claim to be comprehensive. It is however a great place to start for all interested students who may wish to find out more about working in a remote and rural environment in addition to the specific clinical learning outcomes associated with their attachment.

An understanding of remote and rural health and remote and rural health care is useful on all on peripheral placements not only those going to very rural or very remote places. There may be parts of the population the GP practice or hospital serves that are remote and rural, or rural influences on the community.

In addition, some of the advice given in this guide may be applicable to other placements.

Professor Rona Patey
Head of Division of Medical and Dental Education
School of Medicine & Dentistry
University of Aberdeen
Remote and Rural Placements – A Survival Guide

What do the terms “Remote” and “Rural” mean?
In most cases the definition of remote and rural is linked to distances and population density. The precise definition varies depending on the context, person and place. Remote might mean being 30 minutes drive from a hospital in Scotland, or hours of walking to a healthcare facility elsewhere in the world.

What should I expect on a remote and rural placement?
This depends on where your placement is based. Perhaps the romantic image of rolling countryside and majestic mountains we might associate with rural is not necessarily the reality you should expect. There are some challenges, for example access to some services and facilities, including supermarkets, banks and petrol stations as well as schools, leisure centres and cinemas may be limited. In addition the cost of living is often higher, with greater fuel costs and basic goods coming at a higher price. That said, there may be beautiful landscapes, other activities going on in the area you can be involved with and new places to explore, so it isn’t all negative! If you research your area in advance you will be more prepared for what to expect when you arrive.

What differences will I experience as a student on a remote and rural placement?
Studying in a rural location will offer different experiences to those at an urban centre. Compared to in an urban centre you may be more noticeable as “the” student on the ward or at the GP practice. Students find this advantageous in offering learning opportunities and becoming involved in the healthcare team. In addition it means you may be a recognisable face in the community, which comes with its own positives and negatives. As a medical student it is important you uphold the values of the profession you are entering into, and behave in an appropriate manner.

How will I access learning and support?
Learning will take place across a range of contexts and while on placement you should still have access to learning materials. Plan ahead and take only core textbooks you use with you, this means that limited internet access won’t affect your studying. There is wealth of people who you can contact should you need support, see “What problems might I have and how can I resolve them? A quick overview” at the end of this guide and “Learning and Support”.

How can I get the best from a placement?
To get the most from your placement approach it with an open mind, a willingness to learn and motivation to be involved in both the life of the hospital or medical practice and the life of the community. It is a good idea to come prepared with a list of what you would like to learn, which you can discuss with your tutor and use to guide your learning so you can get the best out of a placement.

But I don’t want to work somewhere like this...
See this as an opportunity to experience a different learning environment and a new place. The wide range of patient interactions available offer valuable learning experiences. In addition, as the receiving doctor in a hospital you need to understand the stresses and pressures on the referring doctor, who could be in a remote or rural location. Also, when discharging a patient you need to know what services are available to them in the community and think about the realities of getting a patient home.

Read on to find out more including the differences in remote and rural health and healthcare and the differences in how the healthcare professionals work in remote and rural places.
There are many different ways of defining “remote” and “rural”, in many cases depending on the context in which it is being discussed. This section will explore both terms and consider what they mean in the context of healthcare.

Before you read on, reflect on what the terms remote and rural mean to you:

i) What is key to your own idea of what is remote and rural?

ii) What are the factors which you would think make somewhere remote and rural?

iii) Does this vary depending where you are in the world?

iv) Why is it important to differentiate between what is urban and what is remote and rural?

The dictionary definition

The dictionary definitions of rural are about countryside, while definitions of remote are about distance from other places.1,2,3

“Rurality is like beauty, which is in the eye of the beholder”1
Scottish Government definitions

- “Rural” is a settlement with a population of fewer than 3000 people.
- Urban, as in “Other Urban” and “Large Urban” areas, have a population of 10,000 or more.
- “Remote” settlements are defined as having a drive time of over 30 min from a settlement of 10,000 or more.
- A “Very Remote” settlement has a drive time over 60 min from a settlement of 10,000 or more.
- An area fulfilling the definition of rural but under 30 min drive away from a larger settlement is “Accessible Rural”.

In its 8 fold classification Remote Small Towns are also included, a settlement with a population of 3000-10,000 people with a drive time between 30 and 60 minutes to a settlement of 10,000 or more. Very Remote Small Towns are settlements with a population of 3000-10,000 people over 60 min drive time to a settlement of 10,000 or more. On this map it is not possible to see the small towns owing to the scale, however a full sized map can be accessed here: http://www.scotland.gov.uk/Topics/Statistics/About/Methodology/UrbanRuralClassification/Urban-Rural-Classification-2011-12/8-Fold-Urban-Rural-2011-2012

Figure 1 Modified from the Scottish Government 8-fold Urban-Rural Classification, 2011-2012 Map
The University of Aberdeen and the University of the Highlands and Islands Centre for Rural Health created a clinical peripherality index\(^5\) as a measure of remoteness and rurality of general practices communities in Scotland. This used 4 factors:

- Practice list size,
- Population density,
- Travel time to the nearest hospital with specialist led facilities,
- Travel time to the Health Board headquarters.

**What do Clinicians think?**

A study of health care professional and health care undergraduate students in seven western countries\(^6\) asked participants what they felt was rural. The study found that 80% of the participants viewed communities with populations smaller than 5,000 as rural, and for 76% of the participants urban communities were those with populations of 10,000 or greater. The recognition of urban areas as being populations of over 10,000, matches the Scottish Government definition.\(^4\)

**What the tutors think: Defining remote and rural**

“Remote would be not having 24hr access to a DGH. Rural would be in a village not a town/city.”

“Remote= far away from where I am e.g. London, Paris, Rigel 7 etc.”

“Where there is the potential of having to provide services out with the normal remit of primary care because of distance from secondary care facilities.”

“Distant from hospitals and public services, distant from telecommunications, low population or scattered population, single track roads!”
Remote and Rural in Scotland

The Scottish Government\(^7\) found 94% of the landmass of Scotland to be classified as rural, and that 18% of the Scottish population lived across this area.

Remote and Rural Healthcare in Scotland

Remote and rural healthcare in Scotland can be organised into primary and secondary care.

**Primary Care**

Primary care consists of extended primary care teams (EPCT), in the context of extended community care teams.\(^9\) An EPCT includes:

- General Practitioner(s),
- Community Health Nurse,
- Midwife,
- Care Manager,
- Social Workers,
- Support Workers,
- Education.

Primary care includes medical practices and community hospitals as GP run hospitals.

A remote and rural GP practice may be defined by a number of factors, such as those used in the previously mentioned clinical peripherality index\(^5\) (population density, size of practice list, travel time to nearest specialist led facilities and travel time to Health Board administrative headquarters).

Some large communities distant from rural and district general hospitals have community hospitals with extended services to enable them to provide a first line response in emergencies. In emergency situations these community hospitals will either diagnose and manage the patients, or stabilise the patients prior to transfer. Examples of such rural community hospitals offering extended services include Campbeltown community hospital and the Mackinnon Memorial Hospital, Broadford, the Isle of Skye.\(^9\)
Secondary care

Secondary care for rural areas is provided by the distant District General Hospitals (DGHs) and Rural General Hospitals (RGHs) (where they exist). A RGH acts as an emergency centre for a community and has the ability to manage acute medical and surgical emergencies and act as place of safety in mental health emergencies. It provides out-patient, day-case, inpatient and rehabilitation services. Compared with a community hospital it has a greater number of diagnostic services available. A RGH is able to provide high dependency care and some surgical services.

The six Rural General Hospitals are:
- Gilbert Bain Hospital, Lerwick;
- Balfour Hospital, Kirkwall;
- Western Isles Hospital, Stornoway;
- Caithness General Hospital, Wick;
- Belford Hospital, Fort William;
- Lorn and the Isles Hospital, Oban.

Other hospitals in Scotland will serve remote and rural population. For example, Raigmore Hospital in Inverness is the only acute DGH for the Highlands, a largely rural population. Dr Gray’s Hospital (Elgin), Dumfries and Galloway Royal Infirmary, and Perth Royal Infirmary are all examples of hospitals in councils area with a low population density, suggesting a rural population base.

The Highlands and Island Medical Service - An early model for the NHS?

Provision of healthcare to the rural communities of the Highlands and Islands has long been a recognised problem.

The Dewar report was a report made by the Highlands and Islands Medical Service Committee in 1912. The committee had been tasked with assessing the current medical services in the highlands and islands and to then give recommendations on how this could be improved. The committee met in various places to investigate this and found a number of challenges including travel, poverty, beliefs around traditional cures and doctors having difficulties making an income. They also reported on the fact the new National Health Insurance Act was irrelevant to crofters either as they did not contribute at all or not enough to receive the benefits.

The recommendations of the committee lead to the formation of the state funded Highlands and Islands Medical Service in 1913 which initially provided primary care to the rural areas and the service extended to hospitals in the 1930s. Medical services had a minimal fee attached and an inability to pay did not prevent patients from receiving treatment. Doctors were allowed to do private work as well as their public work, and the scheme insured doctors earned a reasonable income and were not reliant on the little work they got from wealthier patients.

It was not until 1948 that the NHS was born and a state provided healthcare service was available across the UK, by which time the Highlands and Islands Medical Service was 35 years old.

Remote and Rural Worldwide

47% of the total world population lives rurally, in countries classed as least developed by the UN this rises to 71%. 

Around the world definitions of rural and remote will differ depending on factors such as country size and population distribution.

The World Bank website has interesting data on rural areas: 

Australia

For example in Australia remote and rural are defined separately. There are three main classifications in use to define remoteness. These are the Rural, Remote and Metropolitan Areas (RRMA), the Accessibility/Remoteness Index of Australia (ARIA) and Australian Standard Geographical Classification (ASGC) Remoteness Areas.

- Rural, Remote and Metropolitan Areas (RRMA) was developed in 1994 and uses population densities from the Australian 1991 census and distances to urban centres.
- Accessibility/Remoteness Index of Australia (ARIA) was developed in 1997 using the ARIA index score, based on road distances from 4 different categories of service centre.
- Australian Standard Geographical Classification (ASGC) Remoteness Areas is a classification developed in 2001 and is similar to ARIA, however uses 5 different categories of service centres and uses a different island weighting for Tasmania.

In all 3 classifications the proportion of the Australian population living in remote areas is ~2-3%, however this population is spread across a huge part of the Australian landmass.

In Australia, as in Scotland the distinction between urban and rural is made on population size, however different boundaries are used. The Australian Statistics Bureau uses the term “Major Urban” to refer to populations of over 100,000 people, “Other Urban” for populations between 1000 to 100,000 people. Populations smaller than this are rural and divided into “Bounded Localities” between 200 and 1000 people, with the remaining areas being classed as “Rural Balance”.

Figure 4 Rural population (% of total population), the World Bank

Figure 5 ASGC Remoteness Areas (2006), Rural and Regional Health Australia
1% of the Australian population is rural using this definition. The population size used to differentiate between urban and rural is smaller than that used in Scotland, so using the Scottish Government definition a greater proportion of the Australian population might be rural.

New Zealand
In New Zealand a different approach is taken, with rural areas being split into rural centres and other rural areas. A rural centre provides centres for the surrounding rural population and has a population of between 300 and 999 people in a localised area. Rural areas are then divided up according to the level of urban influence, as decided by workplace of the residents, leading to the categories of: “Rural - high urban influence”, “Rural - moderate urban influence”, “Rural - low urban influence” and “Highly rural/remote areas”.

4% of the New Zealand population is rural. Again the population size used to differentiate between urban and rural is smaller than that used in Scotland, so using the Scottish Government definition a greater proportion of the New Zealand population might be rural.

Least Developed Countries
Looking at an example of what the UN calls least developed countries (LDCs), Malawi defines urban on the basis of administrative criteria and not on the basis of access to services. There are no clear cut criteria for the classification of an area as urban, the classification of an urban area is decided by the Office of the President and Cabinet. Rural is then defined as that which is not urban. 84% of Malawi’s population is rural.

Remote and Rural Healthcare Worldwide
As the definitions of remote and rural differ around the world, so do remote and rural healthcare systems.

In Australia, the difference in remote and rural practice compared with urban practice is recognised by the fact there are 2 colleges for general practice. Australian College of Rural and Remote Medicine provides specific education and training for rural general practice.

In New Zealand, within The Royal New Zealand College of General Practitioners there is a Division of Rural Hospital Medicine, which supports rural hospital doctors, who may or may not be GPs and whose work will generally be out with the range of normal general practice.

In LDCs there are issues with healthcare provision for rural populations. Malawi, the example of a LDC used above, has roughly one doctor to every 52,630 people. This means access to healthcare is likely to be very difficult for most of population, and probably exacerbated for rural areas. For example, in terms of obstetric care (where there is the potential for rapid deterioration in wellbeing in the case of emergency), in rural areas mothers are more likely to have home births and less likely to have a healthcare professional present when compared to urban areas. The high maternal and neonatal mortality rates in Malawi reflect this.

What the tutors think: What is their experience of remote and rural healthcare abroad?

“In an Australian remote island settlement, hospital facilities were available for a population of 200 with nursing staff, air evacuation was available, ‘flying doctors’”

“In rural India, [there was a] greater population density, extreme poverty, less expectation from health care and no social services”

Countries working together to improve rural healthcare:
“Recruit and Retain”, a Northern Peripheries Programme project (2007-13)
Across Northern Europe there are issues in recruiting and retaining staff to the public sector in rural areas. “Recruit and Retain” aimed to find some answers to how this could be improved. The two Scottish partners in the project were the NHS Western Isles and the Centre for Rural Health, the University of Aberdeen. The other six partners were based in Greenland, Iceland, Norway, Sweden, Canada, Ireland and Northern Ireland.
Conclusion
In most cases the definition of remote and rural is linked to distances and population density. However, from country to country, from person to person, what is considered as remote and rural can be very different. Remote might mean being 30 minutes drive from a hospital in Scotland, or hours of walking to a healthcare facility elsewhere in the world.

While you are on placement, you may wish to take time to reflect on what the terms remote and rural (R&R) mean to you:

i. Consider your own idea of what is R&R?
ii. What are the factors which you would think make somewhere is R&R?
iii. Why are the definitions so different around the world?
iv. Why is it important to differentiate between what is urban and what is R&R?
References


University of Aberdeen Placements

A brief overview of the placements available at the University of Aberdeen will follow.

Placement Types

Not all of these placements would be classed as rural according to official definitions; however a reasonable proportion of the population served by the practice or hospital may be rural. Therefore having an awareness of remote and rural issues will still be useful.

Year 4 Placements

In Year 4 peripheral hospital placements take place at Raigmore hospital in Inverness, which is the only DGH providing acute medical services for the Highlands. While a small group of students are able to spend the whole year in Inverness on the Remote and Rural programme, most students will spend between 5 and 15 weeks there.

General practice placements in Year 4 are offered in 89 general practices, 52 of which are outside of cities. Students spend roughly 4 weeks of a 5 week block attached to their general practice. If you do not have a car, unfortunately it will be limited which peripheral practices you can be attached to. This is because some areas do not have good public transport links. Links or information sheets to help you find out more about the general practices can be found here: http://www.abdn.ac.uk/iahs/research/primary-care/practice-placements.php.

Year 5 Placements

In Year 5 outwith Aberdeen, the university offers hospital placements in Inverness, Elgin, Wick, Fort William, Western Isles and Shetland. The latter four are Rural General Hospitals, which were introduced in the “Defining Remote and Rural” section. From the NHS health board webpages it is possible to find out more information about the hospitals:

- www.nhsgrampian.org/ (Dr Gray’s Hospital, Elgin),
- www.nhshighland.scot.nhs.uk/ (Belford Hospital, Fort William; Caithness General Hospital, Wick),
- www.shb.scot.nhs.uk/ (Gilbert Bain Hospital, Lerwick, Shetland),
- www.wihb.scot.nhs.uk/ (Western Isles Hospital, Stornoway, Isle of Lewis).

There is also a section within the Year 5 Handbook with further information on each location.

The majority of Year 5 general practice placements are outside the city - 68 out of the 73 general practices, are outwith the city. As with Year 4 attachments if you do not have a car, unfortunately it will be limited which peripheral practices you can be attached to. Links or information sheets about general practices can be found here: http://www.abdn.ac.uk/iahs/research/primary-care/practice-placements.php.

The placement is a total of 8 weeks. 7 weeks are spent attached to a general practice after an initial week of teaching in Aberdeen. The geographical areas are organised to cells including:

- Aberdeen City
- Buchan
- Kincardine and Deeside
- Gordon
- Moray
- Dumfries and Galloway
- Shetland
- Western Isles
- Inner Moray Firth
- Skye and Lochaber
- North Highland
- Argyll
- Orkney
- Fife

During 5 of those 7 weeks there are meetings with other students in the same cell, where students can discuss different topics, problems and experiences.
Accommodation

For students on remote and rural placements accommodation is provided\(^{6,7}\). This may be at the local community hospital, in a self-catering flat or a bed and breakfast. It varies between B&Bs if they offer evening meals, so consider it a bonus if they are offered. Not all the B&Bs will have internet access; if this is the case then you will have access to the internet in your practice, although it will be limited to office hours.

“Make sure you phone ahead, when I arrived at my accommodation they didn’t think I was going to arrive for another 3 days. They were able to sort it out but I wished I’d followed the advice in my letter to phone and confirm”

While staying in a B&B, you may find you become part of the family over the course of the time you stay with them. As many students will have lived independently for some time, and do not wish to impinge on the B&B owners, this can be an uncomfortable experience. Some B&B families will offer to do your laundry or join in with other activities with them; this is their way of making you feel at home as their guest. Remember that you are an ambassador of the university while on placement, and therefore it is important that you behave appropriately and professionally. There is an accommodation behaviour agreement which you will be asked to sign at some point prior to your placement.

“I was a bit embarrassed to come home and find my washing done for me - I was expecting to take it back to Inverness to do it”

“Some evenings I sat and watched TV with the couple who owned the B&B, the first time I felt a bit uncomfortable as they invited me up into their own home to watch it - but they were good company and made me feel at home”

Food solutions:

As previously mentioned, an evening meal is not necessarily included with your accommodation at a B&B on GP placements, which can make it hard to get a cooked meal in the evening. This is one of the reasons why calling ahead to both your accommodation and medical practice can be so helpful, in terms of finding out what is available and what other students have done in the past. Here are some ideas if you are struggling to work out how you will eat in the evenings:

- Depending on access to the kitchen in your accommodation, it may be possible for you to cook large batches of food at the weekend or prior to leaving on your placement. The food can then be microwaved as you need it.
- The medical practice may have a kitchen you can use to cook meals.
- You may be near to a community hospital with a canteen (for example at Broadford, it is possible to get food from the Mackinnon Memorial Hospital)
- There may be a takeaway of some description nearby, or stores selling bakery items, sandwiches etc.
References


What to Expect on a Remote and Rural Placement

“What to expect is very dependent on the placement, the location and its degree of remoteness and rurality. It is easy to stereotype remote and rural areas with romantic ideas of the rural idyll. The alternative is to worry about the distance from colleagues and that there will be nothing to do while you are away.

“I was quite anxious before I went; I thought I could hate it being so far away in such a rural area. I was worried I would not fit in with the people there... When I got there, everyone was incredibly friendly and welcoming.”

In the previous section the range of definitions of remote and rural was discussed, depending on their background and previous experience, some students will consider being outside of a city as rural, whereas others consider towns as still urban and think of small villages and hamlets as rural.

This section will cover some of what placements are available, what to expect in terms of your accommodation and what it can be like to live in a rural community - other sections will cover in more detail what it is like as a student, learning and support, what is expected of you and a quick guide to the problems you may encounter.
Living in the Community

As well as preparing for the medical side of the placement, have an awareness of the location that this placement will occur in, and what this might mean for living and working there.

Culture

Language
Something that may be a concern is language, however Gaelic is unlikely to be an issue. The main Gaelic speaking areas are across the Highlands and Islands. Although among smaller children there may be children with limited English, for most consultations a lack of Gaelic is not likely to be an issue. It may take a while to get used to the nuances of the local dialect however.

Gaelic speakers in Eilean Siar (the Western Isles)
This is the council area with greatest percentage of Gaelic speakers in Scotland, however almost a 1/3rd do not speak Gaelic.

Sabbath observance
What was once a Scotland wide affair, in the Highlands and Islands there are still areas of strict Sabbath observance. This is the belief that Sundays are for rest and not a time for work, and so shops, services and leisure facilities are not necessarily open. Whilst much of Scotland is very liberal on Sundays compared to the rest of Scotland and Europe, it is possible to be caught out by Sabbath observance as someone who is used to indifference in an urban environment. In recent years controversy has still arisen in relation to Sabbath observance in the western isles, such as the outcry in response to a Sunday ferry crossing and resistance to opening leisure centres on Sundays. Planning ahead means that it won’t be a problem, for example if you are not sure if you can get petrol on a Sunday then top up the previous day.

“I also made use of my weekends to explore, which I had not anticipated before going. I think I probably just expected to be sat in my bedroom with my books and feeling lonely (this was definitely not the case).”

“While I was away it was Fireworks Night, so the whole community came down for a huge bonfire and fireworks, then looked across the water and watched the neighbouring town’s fireworks too”
“I was able to borrow the tutor’s bicycle which was great”

“It was everyone else’s cars that made it simpler. If you don’t have one get someone to tell you the bus timetables!”

The provision of public transport in rural areas is often limited. For example, students sent to Gairloch will need to be aware that there is one bus every evening from Inverness to Gairloch (except from Sundays), and one bus in the opposite direction every morning (except from Sundays) however no other buses in the in-between hours that would allow them to travel back and forth. This means it is important to take the time to plan in advance and look at other transport arrangements. Within the area you are staying in if you do not have a car you might consider hiring or borrowing bicycles, coordinating with other people in the community, or coordinating with other students in the area to share lifts.

Another thing to bear in mind is that across Scotland there are still areas with poor mobile phone signal, while some networks are better than others you may find that you have limited or no phone signal in the area you are living and working in. This is something some networks will allow you to check before you go, by looking on their website for coverage maps (The Ofcom website offers links to these http://ask.ofcom.org.uk/help/telephone/mobilecoverage). There may be a landline you can ask to use in your accommodation, general practice or in the hospital to allow you to keep in contact with your friends and family.

To help plan transport, Traveline Scotland has information on public transport for the whole of Scotland: http://www.travelinescotland.com/welcome.do

While you are living in a rural community, consider what it would be like to there permanently:

i) What facilities you normally use would you not have easily access to?

ii) What activities could you be involved in, in the community?

iii) What would it be like as a young person?

iv) What would it be like as an elderly person or vulnerable adult?

v) Are there any official schemes or informal activities which aim to help young people, elderly or the more vulnerable in the community?
Rural Deprivation and the Cost of Living

“The scale of deprivation in an area we visited on a house call shocked me. The experience will probably never leave me. I knew that not everyone in the country was well off, but that someone could be living in housing in that state... It felt like I was in an inner city area of Glasgow.”

In contrast to the picture of the rural idyll, the reality is that deprivation can be found outside of urban areas. While urban areas have areas of greater deprivation, deprivation can still be found in rural areas. Deprivation is a more general term for a lack of resources, whereas poverty refers more specifically to financial resources.3

When thinking about deprivation in rural areas it is useful to remember that although studies show it is lower than in urban areas this may be in part due to the way it is measured. Deprivation tends to be measured according to areas rather than individuals; this means there is the potential to miss pockets of deprivation or deprived individuals living in otherwise affluent areas, so looking at deprived areas alone does not show the whole picture. The indicators chosen to measure deprivation are also important. For example, if you use car ownership as a measure of income, the necessities of rural living means car ownership is likely to be high, with owners sacrificing other goods in favour of a car which is unlike in an urban area.3

Deprivation comes in many forms such as in accommodation, opportunities, mobility, health and education. Some of these types of deprivation will be common across urban and rural areas, but some are more specific to rural areas. In rural areas for example, mobility deprivation is likely to be greater and it is likely there will be fewer opportunities for people living there.3

In terms of rural poverty specifically, there are a number of reasons that rural poverty may be less obvious. In rural areas people may be embarrassed about their poverty and avoid letting the rest of their communities see it. People may also be unaware of their poverty or being unwilling to declare themselves as poor.15

The experience of rural poverty is likely to be different from that of living in an urban area. Living in a rural area means higher fuel, energy and food costs. So for someone living in poverty, the higher costs of basic items this means a low income doesn’t stretch as far.15

**Shopping solutions**

Some students may find in their communities they are some distance from a reasonable sized shop. Here are some ideas which may help you:

- Supermarkets will deliver using “shop and drop” to surprisingly remote areas so it is worth researching this option.
- There may be local solutions within the community, such as mobile shop units or local deliveries from smaller stores. For example on Hoy (Orkney) it is possible to order your shopping from the Cooperative on the Mainland and they send your shopping across on the boat for you to collect.
- Find out if there are any students nearby who do have a car and who could take you to a supermarket

While this may be an inconvenience for you, it is worth remembering that elderly members of a community may still be reliant on other members of the community to help them get their groceries.
Occupations
The occupations of those living in a rural environment are likely to be different to those living in an urban environment. In rural areas activities such as agriculture and fishing are far more common\textsuperscript{16,17}, due to the closeness to natural resources. Scottish Government statistics\textsuperscript{17} also show people living in rural areas are more likely to have a 2\textsuperscript{nd} job. For example someone may do a mix of crofting and fishing, or have employment as a postman and a handyman. This may lead to different issues around health and accessing healthcare which will be discussed in the section “Differences between rural and urban health”.

Conclusion
What to expect will depend very much on the type of placement you are going on and where the placement is. Perhaps the romantic image of rolling countryside and majestic mountains we might associate with rural is not necessarily the reality you should expect. Living in a rural community comes with its own issues, this section starts to address this and it will be explored further during this guide. If you have any specific worries, contact your practice or tutor, the GP or Block coordinator, secretaries or accommodation providers as appropriate.

Before you leave to go on your placement:

i) Find out about the hospital or medical practice you are going to.

ii) Think about the surrounding area and consider issues such as transport and entertainment.

iii) If you are aware of a colleague who has been on a similar placement take the opportunity to ask them about what to expect.
References


Being a student on a remote and rural placement is different from being a student in an urban centre. There are benefits, but also what could be considered to be negative aspects and challenges you may need to overcome as a student - this section will go through some of these.

Benefits of a remote and rural placement as a student

As a student on a remote and rural placement there are many advantages when it comes to teaching. Research in Australia\(^1\,^2\) has found that students find the following to be valuable assets to their placements:

- The multiple learning opportunities afforded by the small doctor to student ratio,
- One to one time with healthcare professionals,
- Support from inclusive staff,
- Differences in teaching owing to a smaller environment,
- An exposure to a range of patients, with less competition with other students for patient exposure.

Back in the UK, research\(^3\) looking at the University of Aberdeen remote and rural programme found that students who chose to do the extended remote and rural placement partly due to advice from older students. The older students had a positive experience of their placements; this was thought to be due to:

- Students being made to feel a part of a team,
- Tutors get to know the students well,
- This allows more meaningful individual feedback,
- A desire not to let down “their” teaching staff produces motivation.

“The goldfish bowl” and “supermarket aisle consultation” situations

“The goldfish bowl scenario”\(^4\) describes a common situation in remote and rural practise which can be a negative aspect to living and working in a remote and rural environment which you may come across as a student. Whereas in an urban environment you may occasionally bump into a face you think might be a patient, in a small community it is an inevitable part of life. As a student visiting for a short time you may be viewed as a newcomer and therefore be put under even more scrutiny. This makes it even more important you uphold professional values and behave in an appropriate manner.

Doctors working in these locations may find patients trying to consult with them as they go about their daily life, for example in the supermarket aisle.\(^5\) This is probably less likely to occur as a student but still important to be aware of while you are out in the community.
Thomas’s experiences in the community - what would you do?

Thomas is a student placed at a small medical practice in the far north of Scotland. The practice covers quite a large area and has a list of around 900 patients. Thomas has been enjoying his placement so far and has seen lots of patients from the community. While buying his lunch in the small grocery store near the practice, someone taps him on the shoulder. Thomas doesn’t recognise the man, after introducing himself as the brother of a patient, the man asks “Did you see my brother John McLeod the other day? Is he going to be okay?”.

What would you do if you were Thomas?

a) Politely tell the man that his brother was quite unwell but the treatment he has been put on should make him better
b) Politely say that you are not at liberty to disclose which patients have attended the practice and any information about a consultation
c) Explain that yes you did see his brother and got on quite well with him, but don’t give any more information

Later on Thomas is in the pub, enjoying a drink with one of the GP trainees. As he looks around he sees a number of people he has met in the practice. The GP trainee has gone to the toilet and Thomas is left on his own in the pub, he decides to go and speak to some of the others at the bar - he recognises Lorna and a few of the others as patients.

What would you do if you were Thomas?

a) Approach the group, greet Lorna “Hello Lorna, are you feeling better now since I saw you on Thursday?”
b) Approach the group and say “Hello, do you mind if I join you?” and introduces yourself to the group
c) When you recognise the patients decide to go back and sit down to wait for the GP trainee to return

The next day in the morning clinic a number of patients Thomas has never met before ask him “Did you enjoy your pint?”. 
Answers part 1:

a) This option is breaking the patient’s confidentiality, you don’t know what information John has told his brother and cannot give information about John to a relative without John’s permission.
b) This option avoids breaking confidentiality, it may feel uncomfortable as you want to be friendly and helpful to community members, however patients will want to know that you can be trusted and will not break their confidentiality.
c) This option is breaking the patient’s confidentiality, the brother may not know the John had attended the medical practice but be speculating in the hope you will enlighten him.

Answers part 2:

a) This option is breaking Lorna’s confidentiality. The other people will probably recognise you as the medical student even if you do not introduce yourself, your greeting Lorna suggests she has been a patient, however she may not have told anyone else there she had been unwell or gone to the medical practice.
b) This option is a possible answer, it means you are able to meet and chat to members of the community but avoid mentioning that you have met them before as patients. By speaking to community members you will gain knowledge of how the community works which will be both interesting and helpful to you as someone involved in improving the health of the community.
c) This option is a possible answer; however imagine living in this community full time. If you did not speak to any of your patients outside of clinical settings there would be no one for you to speak to. It is possible to speak to then socially and by giving a general greeting you are not breaking anyone’s confidentiality by singling them out as someone you have met as a patient.

When forming relationships with community members remember that there should be no improper relationships with patients. Personal relationships with former patients can also be inappropriate depending on a number of factors such as the nature of the professional relationship. This does however highlight that it can be easy to become isolated as a healthcare professional in a small community.

The scenarios were produced using the following GMC standards and guidance\textsuperscript{6,7}, which you may find useful to read:


Challenges as a student

Compared to when working in an urban hospital or GP practice you may find that there are different expectations of you in terms of your professionalism, behaviour and learning.

Whilst the above studies\(^1\-^3\) show that students draw many positives from being on a remote and rural placement this does come with added responsibility, which you should be aware of. In one of the studies\(^2\), students found it required commitment and hard work to have the positive experiences and opportunities, for example, effort needed to be put in to set up good relationships to allow the experiences to occur. In addition, unlike in a city where students are more anonymous, the students thought that if they chose not to go in to their placement this was likely to be noticed. They were also aware that they may give the wrong impression if other staff or patients saw them out with the clinical environment when they were supposed to be at their placement. **If you do not attend this may result in disciplinary action from the university.**

As identified by students in the above study\(^2\), whilst on these placements it is important students manage their time well and avoid exhaustion so that clinical commitments and personal study can be maintained. There is often a requirement to take a self-directed learning approach on a remote and rural placement.\(^2,^8\) In the section on “Learning and Support” what this means to you as a learner will be discussed.

As previously mentioned, you will be conspicuous in the community and so a high level of professionalism and behaviour is expected.

Anxiety

If you are on a GP placement you will be the only student for much of your placement. Research looking at students on rural placements\(^2\) found that more anxiety might be experienced as a single student working totally separate from colleagues compared to when working with other students who are focussing on the same topics. There are things that you can do which may help reduce anxiety about studying, such as maximising use of any time spent together in tutorials, and using modern technology to allow you to study with others or find out what other students in your group or block are doing. Remember that the university also produces learning outcomes which can help guide your studying.

“Think about what you want to gain from it before hand - practical experience, feedback on communication skills, teaching sessions, ask to visit patients in their homes, go out with the nurses, physio, whoever is prepared to take you so that you can get the best picture of how the service knits together”

Conclusion

Studying at a peripheral hospital or a rural GP practice will offer different experiences to those at an urban centre. Compared to in an urban centre you may be more noticeable as “the” student on the ward or at the GP practice. This can be advantageous in offering learning opportunities, however does mean that you need to be aware of your prominence in the rest of the community. As a medical student it is important you uphold the values of the profession you are entering into, and behave in an appropriate manner. Failure to do so may lead to your fitness to practise being called into question.


The Differences Between Rural and Urban health

“There are many differences in rural health as compared to urban areas, in terms of healthcare, challenges to healthcare and patterns of disease.1-3 This section will go through some of these, however you may become aware of others, or factors specific to your community, while on placement.

Differences in population

There are differences between and urban and rural populations, in terms of age, deprivation and occupations, all of which influence health.

What do you think the differences in urban and rural populations are in terms of:

i) Age - will there be more young or old people?

ii) Deprivation - is deprivation an exclusively urban phenomenon?

iii) Occupation - what differences might there be?

How might this impact on health?

An ageing population is one of the challenges to rural health.1-3 This situation is worsened due to migration patterns of people between rural and urban areas. Rural-Urban migration is predominately of younger people and Urban-Rural migration is predominately by older people.4 In other words young people are moving into cities while older people are moving into rural areas. Rural-Urban migration by young people is due to a myriad of factors including employment and career development, access to services and social pressure.5 Urban-Rural migration later in life is also due to a range of reasons including people being attracted by the natural environment, a perceived better quality of life, the tranquillity of rural life and the sense of community in rural environments.5

As elderly people are more likely to suffer ill health and chronic disease the age structure of a population is important, in terms of the burden of disease and the health needs of a population. However, as healthcare services are generally located in regional centres ill people may move out of rural areas to seek healthcare, decreasing the burden of illness in the population.

Figure 6 Age Distribution of Population by Geographic Area, 2010. Taken from Rural Scotland Key Facts 20126

“Research is beginning to show that there are rural-urban differences in health outcomes, and challenges the belief that rural patients have a health advantage over their urban counterparts.”1
As mentioned in the “what to expect” section, deprivation is a general term for a lack of resources, and not exclusive to urban populations. Indeed in rural populations some types of deprivation will be greater than deprivation present in urban populations. Deprivation and poverty are known to be important determinants of health, and so may influence health within a community.¹⁸⁹

Additionally, a rural situation means there are likely to be differences in the occupation of the population. For example agriculture, fishing, manufacturing and construction are commoner areas to work in compared to urban.⁶¹⁰ Arguably these are occupations with a higher risk of accidents: health and safety statistics show that these are occupations with high injury rates.¹¹ This contrasts with the expectation that rural life is likely lead to better health due to the pleasant environment. As well as the difference in sort of employment people undertake, in rural areas there are higher percentages of people who are self-employed and who have more than one job⁶. This means they may have less free time, be less willing to take time off work as it means loss of income or find it more difficult to find time in which they can attend healthcare services.

The life expectancy is higher for rural areas than urban areas⁷, which would suggest the population in rural areas is healthier.
The effect of rural living on health is complex.

Factors which are positive to health may include:

- Feeling part of a community,
- An active lifestyle and/or occupation,
- Less pollution.

Negative factors include:

- The alcohol culture,
- Rural poverty,
- Different hazards to living in a urban environment.

Some of the topics considered in more detail under other headings, such as access to healthcare, will also impact on the health of the population.

**Social Inclusion**

Generally rural areas are associated with a sense of community and community support$,^13,14$, people living in rural areas of Scotland have cited this as one of the aspects they particular like in their neighbourhood.$^6$ Research into rural poverty in Scotland$^13$ found that despite young people and families moving away, elderly people still received good informal community support in smaller rural areas. This community feeling and community support may mean a healthier community, with healthier members.

**Active Lifestyle**

With the attraction of outdoor activities and more physical sounding occupations it is a reasonable preposition that people living rurally would be more active and have a lower weight than their city counterparts. This may not be the case. In America for example, research in children$^15$ has found obesity is actually more common in rural areas however the levels of physical activity are also higher for rural areas. The authors suggest a number of reasons for what seems like a contradiction. One of these is that even if the lifestyle they lead is more active, if their diet contains more energy than they need then this leads to weight gain.

Although there are differences between American and Scottish lifestyle and attitudes, both are considered to be western countries which have an associated western lifestyle - in terms of the foods that make up our diet and more sedentary past times and occupations - so this research may be relevant to the UK. Although increased physical activity is likely to contribute to better health compared with urban counterparts, increased obesity will have an overall negative effect on health.

**Mental health**

Focusing on mental health, the effects of living in a rural area are complex. Rural inhabitants report a greater stigma related to mental illness and that living in a rural area brings physical isolation from others.$^13$ However to counter this, green space may help some people with mental illness$,^13$, and they may feel better supported by the stronger community spirit.

From your experience and knowledge so far:

i) Do you think living rurally is positive or negative for your health?

ii) What is different about living rurally which could have a positive effect?

iii) What is different which could have a negative effect?
It could also be suggested the increased obesity may be due to rural poverty, as adult obesity is associated with poverty.\textsuperscript{16}

**Pollution**

In terms of more directly environmental influences on health, it would not be unreasonable to expect cleaner air away from urban smog. In Scotland, there is less air pollution in rural areas, away from the central belt and urban centres on the east coast.\textsuperscript{17}

The issues affecting water quality are different in rural and urban environments. Whilst in urban areas the manufacturing industry, sewage and urban development all impact on water quality, in rural areas activities such as agriculture, forestry and mining will impact on water quality.\textsuperscript{18}

**Alcohol**

Alcohol is ingrained into Highland culture, with economic activity such as breweries and distilleries being important to local economies. Counteracting the positive effects of the employment opportunities alcohol offers, the alcohol consumption is higher than the national average and there is a higher rate of harm owing to excess. Alcohol is a risk factor for many different diseases and therefore this is likely to have a negative impact on the health of this Scottish rural population.\textsuperscript{19}

**Hazards**

There are a number of examples of different hazards to health in rural areas, the ones mentioned here occur in Scotland but will be different according to the environment the rural areas are in. Certain types of accidents may be more common in a rural area, for example work related accidents related to farm machinery or trauma from outdoor sports such as climbing, mountain biking and skiing (Students on placement in Fort William in particular may see mountain trauma).\textsuperscript{20} Due to the animals that patients may be in contact with through work and the general environment they live in, zoonosis occurs more commonly than in urban environments.

**Zoonosis**

Lyme disease is a tick-borne disease that is commoner in rural people, also more common in those living closer to woodland, which is probably more likely in a rural setting as compared to an urban setting.\textsuperscript{21}

Another example of this is Tuberculosis, which may be a source of infection for farmers or in estate workers.

**Summary to Pros and Cons to lifestyle and environment when living rurally**

It is difficult to say whether living in a rural environment is positive or negative for health. While some of the factors here will affect the whole population living in an area, such as pollution, others will only affect specific groups of people, such as rural poverty. Evidence\textsuperscript{7} shows that the life expectancy of people living in rural areas in Scotland is better than that for urban areas. However the number of confounding factors such as population related factors discussed in the previous section means that it is not simply the environment in which the people are living in that is affecting their life expectancy.
Attitudes to health

There is evidence\textsuperscript{14,23,24} that the attitude to health in a rural area is different to that of those in urban areas. The attitudes you may come cross may lead to challenges with providing healthcare.\textsuperscript{14,23,24}

People tend to present later, this may be because they keep going until they can go no longer and an illness affects their function before they seek help.\textsuperscript{24} This may be linked to a culture of self-reliance\textsuperscript{14,23} or stoicism\textsuperscript{14}.

The fact that a greater proportion of the population is self-employed\textsuperscript{6} may mean that they keep going without seeking help out of necessity, because they cannot afford the time off to attend medical appointments. This may make them reluctant to attend follow-up appointments or appointments in the outpatients departments of hospitals as well, unless they really feel it is necessary.

In addition, because seeking healthcare may mean travelling away from home, this can lead to concerns to isolation from their community which could alter their likelihood to attend medical services.\textsuperscript{24}

Doctors (and potentially you as a student) coming into a community may be seen as newcomers, and so people may have reluctance to speak about private health matters with them.\textsuperscript{24} However you might also argue that as a newcomer, you do not know the community members socially which may make it easier for them to open up to you.
Access to and availability of health services

The Healthcare Quality Strategy for Scotland\(^2\) states that NHS Scotland should aim for equality in terms of the healthcare experienced and the outcome achieved by this. This is not only the basis of gender, age, disability and race but also in terms of geographical location. This can be challenging to achieve in remote or rural locations, where one of the main trials to overcome for health and healthcare is the distance from mainland or specialist centres.\(^2\) In some rural areas this extends to access to any health services, worldwide rural areas are particularly underserved by healthcare providers\(^26\) and resources are focussed at urban populations\(^14\). The effects of attitude on access to healthcare and access to emergency care is discussed in more detail elsewhere.

Work\(^27\) reviewing the Scottish medical workforce in 2002 found that 11% of the population lived a drive time of 30 minutes or over to reach an acute hospital able to accept acute admissions, with 16% living out with a 30 minute drive time to a major A and E department. In addition, taking into account the weather and other factors which may affect traffic flow such as road works and road traffic collisions, it is possible the time it takes to drive to the hospital from rural areas may be greatly increased at times.

The availability of certain health services is less in rural areas than in urban areas.\(^1\) For example, not all the Rural General Hospitals have CT scanners, and some of the Rural Community Hospitals will be providing care to people whose treatment may depend on CT scan results (such as in stroke patients). The availability of specialist facilities such as cardiac catheterisation laboratories may be reduced, in NHS Highland this service is available only in Raigmore and even then not over 24 hours. Some of the allied health professional groups are too small to be able to offer a sustainable service located in rural areas\(^3\), this means either patients have to travel, or visiting services are needed.

Rural General Hospitals and Rural Community Hospitals offer a range of visiting outpatient services however not every specialty, and these hospitals may still be a distance from where a patient lives. If a patient has to go in to the District General Hospital or tertiary centre, this may cause additional distress as it means they are a long way from their community, friends and relatives. For those who are self-employed, for example on a croft, any hospital stay can be disastrous to their livelihood.

As previously mentioned under the “Living in the Community” subheading of “What to expect”, transport is more expensive due to fuel costs\(^13\), and there is also limited public transport\(^28\). Poor transport links can make accessing healthcare difficult, as well as potentially limiting access to education and employment, which will also influence health.

“One practice in remote Scotland has 5,000 patients who live an average of 130 miles away from the nearest district general hospital.”\(^1\)

Students on General Practice placements
From your Medical Practice how long do you think it would take people in the practice population to get to an outpatient appointment or visit a patient:
1) In the nearest community hospital (if there is one serving your area)
   a) By car
   b) By public transport
2) In the nearest rural general hospital (if there is one serving your area)
   a) By car
   b) By public transport
3) In the nearest district general hospital
   a) By car
   b) By public transport

Students on peripheral hospital placements
If you needed to refer a patient to access services at the nearest district general hospital how long would it take them to get there:
   a) By car
   b) By public transport
To increase local access to services the use of telehealth is being explored. Video-conferencing has enabled learning and networking for professionals in Orkney and on the Western Isles and reduced their travel times for these activities, but as well as a facility for professional development they can also be used to allow support for clinic decision making and to run clinics by video-conferencing consultations.¹³

A number of studies have shown poorer outcomes for patients presenting with illness in rural areas²³. Whether distance and access underlies this or other factors such as attitudes are responsible, is difficult to say. Studies into the uptake of breast screening have found it to be reduced with distance, suggesting this may be an access issue.²³ In terms of access to treatment, there is evidence for poorer access for rural patients with acute myocardial infarctions, diabetic retinopathy, asthma and cancer.²³

Some research has found evidence that in rural areas the hours, appointment times, lack of anonymity and stigma lead to reduced access to healthcare²⁴. In the case of stigma this also influenced doctors’ decision making about whether to treat patients in the community or in hospital²³. However anecdotal evidence from students suggests appointments are readily available with some medical practices holding open surgeries (meaning no appointments are needed). Surgery opening times were also reported to be more flexible than is typically the case in urban areas.

Video-conference Clinics
In NHS Highland there is a video-conference (VC) consultation service linking Thurso hospital, Belford Hospital (Fort William) and Portree Hospital (Skye) with Raigmore for clinics. There are also VC consultation clinics in NHS Orkney.²⁹

More information about this and some of the other telemedicine projects that were implemented as part of a multi-country collaboration as part of the Northern Periphery Programme³⁰ can be found at:

http://www.transnational-telemedicine.eu/countries/scotland/

Some of the other VC links that have been created include emergency psychiatry services and remote exercises classes for rehabilitation. Other technological solutions which are already in use or soon to be implemented include smart phone and internet support for chronic disease.³¹

A List of other technology enabled health and care projects that you may wish to research can be found on the database maintained by the Scottish Centre for Telehealth and Telecare³²:

http://sctt.co.uk/
“You may be the only doctor on the island, you are always on call. The onus is on you when it comes to decision making, you have to decide when to evacuate a patient earlier than if you were on the mainland. For air transport what is the weather like, you have to allow maybe 5 hours for transport to occur, if the patient is fine now do you still want to call them as something could go wrong in the future?”

The Scottish Ambulance Service (SAS) has a huge task in providing a service to rural areas. In the North Division of the service they are responsible for many remote islands, with varying population sizes from 10s up to 1000s. The limits of ferry services combined with limited or no cover by ambulance teams, doctors or nurses makes responding to the islands a challenge. On the mainland there are still areas which are hard to reach. When a local crew is called out and required to travel to a distant main hospital, this means the community left behind is covered by crews which might be based in other communities a long way from the patient requiring emergency care.³³

The Emergency Medical Retrieval Service (EMRS) is the pre-hospital service that uses helicopters or planes to respond within minutes to requests for help. This allows remote and rural areas access to acute care from an emergency or intensive care medicine consultant, in situations where patients have life-threatening conditions.³⁴

In addition to the SAS and EMRS there are voluntary responder organisations. British Association for Immediate Care (BASICS) Scotland Responders are rural doctors, nurses and paramedics who have received additional training and who work with SAS, EMRS and hospital based pre-hospital care teams.³⁵ A community may also or instead have a first responder, someone who is trained in basic life-support and how to use a defibrillator who can be alerted to attend potentially life threatening emergencies.³⁶

There is a tradition of voluntary emergency services such as Mountain Rescue Teams, the Lifeboat Service, Auxiliary Coastguard Teams and Fire Teams.¹ This may be something doctors and other people you are in contact with are involved in, so there may be opportunities to see how they work while you are on placement.
Challenges to the future of Remote and Rural Healthcare

There are a number of challenges to the future of remote and rural healthcare; some of these have already been touched upon. There are issues such as an ageing population and the increasing mismatch between cost of healthcare provision and the budget. While these will also affect urban areas, there are also other issues which are more rural specific.

One of the big challenges to the future of remote and rural healthcare is the ongoing recruitment and retention of healthcare workers. There are challenges in attracting people to work in rural areas and in providing training opportunities to support professionals. There are a number of organisations working to change this; these include NHS Education for Scotland (NES) and the Remote and Rural Healthcare Educational Alliance (RRHEAL).

Current NES\(^2\) training initiatives for graduates include the Rural Track Foundation programme option, the rural-track GP specialty training programme, post-CCT (certificate of completion of training) rural GP fellowships and peri-CCT (as in peri- certificate of completion of training, i.e. soon to be consultant) surgical and anaesthetic fellowships. NES also aims to improve recruitment by supporting the various undergraduate schemes developed by the universities that provide remote and rural exposure for potential rural practitioners, such as the Year 4 Remote and Rural Programme developed by the University of Aberdeen.

RRHEAL\(^3\) provides learning support to healthcare professionals working in remote and rural areas. Its mandate is to co-ordinate remote and rural education development.

Conclusion

There are many ways in which urban and rural health and healthcare differs, reasons range from the lifestyle and attitudes of the areas people to the topography of the land.

Reflect on the differences you have read about here and while on placement look for them in real life. Try to learn from the community and the medical practice what challenges there are to people’s health and healthcare.

During and after your placement consider:

i) Do you think living rurally is positive or negative for your health?

ii) What is different about living rurally which could have a positive effect?

iii) What is different about rural life that could have a negative effect?
References


A previous section has discussed the differences to being a student in a rural community, this section will think about what it is like to work in this environment.

**General Practice**

There are clear differences between urban and rural general practice.

There are differences in practice size:

- The number of patients on the practice list is usually smaller,
- The geographic area covered is larger. ³, ⁴

There are differences in workload and services provided:

- More emergency care and minor casualty work,
- Different illnesses, for example zoonoses,
- There may be more obstetric care in general practice,
- Community hospital work,
- Dispensing practices - when there is no nearby pharmacy. ⁴, ⁵

“The practice itself was pretty much as I expected, small, with a dispensing pharmacy within it. The practice had roughly 850 patients and one main GP, although there was a locum GP who covered the occasional shift, holidays etc., she also worked on the islands and in Inverness so I only saw her a handful of times.”

“The geography is huge, the population thinly spread and the weather changeable. We are two hours from Inverness or Fort William. Hence we are an essential stabilisation service for any acutely unwell or injured patient in our region.”

Jonathon Hanson, a rural practitioner, talking about the importance of the rural practitioner role in the Mackinnon Memorial hospital, Broadford, Skye²

“Extended skills in all domains of general practice are useful – such as minor surgery, palliative care, emergency medicine, dermatology and general medicine. You may also find yourself attending a road accident, doing a ward round or applying a plaster cast.”

David Hogg, a rural GP in Arran, talking about the special skills needed as a rural GP¹
There are differences in technology:

- Access to fewer diagnostic services,
- There is a role for telemedicine.

And there are personal and professional challenges:

- Social and professional isolation,
- The challenges of being the only doctor for a community,
- Lack of anonymity in the community (for the healthcare professional and for the patient),
- The challenges in maintaining skills and knowledge,
- A greater amount of on-call time may be required with difficulties obtaining locum cover and cover for out-of-hours services,
- It may be difficult for spouses to find employment.

The challenges listed above may make seem working in a rural environment negative; however there are also advantages to working in a rural environment:

- Prestige and status within the community,
- A good environment for families and those with outdoor interests,
- Less crime,
- The workload offers variety,
- It can be associated with more personal relationships with patients allowing more holistic and personal care.

What the tutors think: What differences do they find in their workload compared an urban practice

“[We] need to be self-sufficient at dealing with emergencies and not reliant on the ambulance services.”

“The fact that we are part of the emergency first responders unlike suburban or urban practices.”

“[We are] initiating secondary care procedures in a primary care centre.”

“Dual response 999 calls / pre hospital care.”

What the tutors think: What downsides are there to working where they do?

“Lack of privacy for my family at times.”

“Everyone knows everyone so if you upset one patient the whole village knows.”

“Remote from various cultural amenities such as theatre/cinema, museums, art galleries etc.”

“Professional isolation. Lack of public services like buses, leisure centres, shops.”

“Being "on call" can be tiring at times. Dealing with complex patients as one is essentially "single handed".”

“Working times, difficult to completely 'switch off', nearly impossible to get locums, the cost of living and reduced opportunities for culture.”

“Living in a "goldfish bowl" environment. The constant need to protect patient confidentiality which is hard in a small community.”

What the tutors think: What do they enjoy most about their jobs?

Many commented on the doctor-patient relationship:

“Continuity of care for patients.”

“Patient contact / ongoing patient doctor relationship.”

“Getting to know my patients and their lives. The old adage of care from the cradle to the grave is partially possible.”

Other reasons included:

“Work/life balance perfect.”

“The wide scope of services you can provide, integration with the community.”

“Variety”

“Place, people, pace of life and work, tutoring students, plenty of clinical opportunities.”
Find out more about life as a rural GP:


David Hogg’s rural GP blog can be found at: [http://www.ruralgp.com/wp/](http://www.ruralgp.com/wp/)

Books: There are a number of books written about life as a country doctor. For example “A Seaside Practice: Tales of a Scottish Country Doctor” by Dr Tom Smith is an enjoyable account of his days as a young doctor in a rural area.

What the tutors think: Why did they choose to work where they do?

“Perfect combination of being quite small but not too small & possible to commute from my home.”

“Geography and culture.”

“Wonderful place and wonderful people. And scope to get involved in practice that is beyond traditional primary care.”

“I love the beauty that surrounds us plus I like practicing skills that I wouldn’t have an opportunity to do close to hospitals.”

“Previous elective experience and also family ties with the island.”

“Lifestyle and nice people.”

“I wanted a challenge.”
The demands of hospital medicine in a rural general or rural community hospital can be different to those in urban centres. For example, surgeons are likely to perform a wider range of surgery, more clinical autonomy and similar to GPs, offer a more personal and holistic approach to care.\(^3\)

An interview with Jonathon Hanson, a Rural Practitioner at the Mackinnon Memorial Hospital on Skye as part of an NHS Highland project: [www.nhshighland.scot.nhs.uk/News/Events/Documents/What%27s%20our%20role%20-%20JH.doc](http://www.nhshighland.scot.nhs.uk/News/Events/Documents/What%27s%20our%20role%20-%20JH.doc)

Tweets he made as part of the project: [http://www.nhshighland.scot.nhs.uk/News/Events/Documents/Rural%20practitioner%20tweets.doc](http://www.nhshighland.scot.nhs.uk/News/Events/Documents/Rural%20practitioner%20tweets.doc)

The Mackinnon Memorial is a rural community hospital offering extended services, although the Rural Practitioners are accredited as GPs they work full time in the hospital and not in GP practices.

Dr Leo Murray’s website also offers his perspective on the Mackinnon Memorial Hospital: [http://www.drmurray.co.uk/mmhquickguide.htm](http://www.drmurray.co.uk/mmhquickguide.htm)

This news article looks at the life of David Sedgwick, a general surgeon at the Belford Hospital in Fort William who has since retired. It highlights the number of hours some doctors work to maintain a good service for their communities: [http://www.independent.co.uk/life-style/when-did-you-last-see-your-father-1351596.html](http://www.independent.co.uk/life-style/when-did-you-last-see-your-father-1351596.html)


<table>
<thead>
<tr>
<th>Emergency Surgical Workload</th>
<th>Planned Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appendicectomy;</td>
<td>Biopsy of lesions;</td>
</tr>
<tr>
<td>Caesarean Section;</td>
<td>Cholecystectomy and/or exploration of common bile duct;</td>
</tr>
<tr>
<td>Endoscopy (including injection of varices);</td>
<td>Circumcision;</td>
</tr>
<tr>
<td>Evacuation of retained products of conception;</td>
<td>Endoscopy;</td>
</tr>
<tr>
<td>Lacerations;</td>
<td>Nail bed procedures;</td>
</tr>
<tr>
<td>Initial fracture management and joint dislocations;</td>
<td>Peri-anal procedures;</td>
</tr>
<tr>
<td>Repair of perforated ulcer;</td>
<td>Resection and anastomosis of bowel;</td>
</tr>
<tr>
<td>Control of haemorrhage (including splenectomy);</td>
<td>Simple undescended testes repair;</td>
</tr>
<tr>
<td>Resection and anastomosis of bowel;</td>
<td>Scrotal surgery including vasectomy;</td>
</tr>
<tr>
<td>Ruptured ectopic pregnancy surgery;</td>
<td>Varicose veins surgery.</td>
</tr>
<tr>
<td>Chest drain;</td>
<td></td>
</tr>
<tr>
<td>Drainage of pericardium injury (for cardiac tamponade) plus suturing of penetrating injury.</td>
<td></td>
</tr>
</tbody>
</table>
The junior doctor experience

Junior doctors’ experiences of rural training in Scotland have been studied, as some remote and rural hospital rotations are offered during the foundation programme. From an educational viewpoint, in rural hospitals junior doctors found there were more opportunities as there was less competition for clinical experience compared to in the bigger hospitals. They had more responsibility as part of their job and were encouraged to take more responsibility for clinical decision making, but this came with more support compared to what they received in urban centres. In addition, the support and feedback tended to be from consultants as there were fewer senior trainees and the consultants were seen to be approachable by the junior doctors.

As the healthcare team was smaller this meant junior doctors could form relationships with the different team members and were able to feel like they had a role within the team. This was seen to aid communication and teamwork within the team and therefore positively influence patient care.

While the junior doctors found it a positive learning environment they did find some aspects of the experience negative:

- In the rural general hospitals, rotas were strained by vacancies and absences due to the difficulties recruiting healthcare professionals to remote and rural locations, this impacted on the junior doctors working on the rota;
- Trainees’ participation in professional or social events in urban centres was sometimes affected by the distances involved and availability of transport from remote and rural locations;
- Trainees were also discouraged from doing more remote and rural rotations, as a feature of these was frequent moves and prolonged periods away from where they considered to be their home;
- Another disadvantage was the expense of travel from their rural location to other activities and the expenditure involved in maintaining a flat in a population centre whilst on placement.

Student perceptions

An Australian study found that students perceived rural doctors as having a different way of thinking and taking a more holistic approach to patients. They thought doctors planned more in advance when making referrals or requesting investigations to avoid the patient making multiple trips. They saw rural doctors as showing more leadership and having a higher social standing as compared to an urban doctor, however this was connected to a need to be more accountable for both the skills and outcomes in patient management.
Inter-professional teams and extended roles

In a rural medical practice, the team members may find themselves fulfilling extended roles to meet the desires of the community. Professionals may need to work outside of their traditionally defined roles, inter-professional education is therefore important to aid the formation good professional relationships allowing teams to work together to meet the community’s need.

There are also opportunities to get involved in the community voluntary emergency organisations in rural areas as previously mentioned.

Conclusion

There are differences to working in remote and rural environments when compared to working in urban areas. This section has predominately focussed on doctors; however the differences affect all healthcare workers. On placement it is likely you will be in contact with other health professionals and will be able to see how the whole healthcare team works. At times the needs of patients in their community can mean this can involve the team and team members taking on different activities and roles to a similar team in an urban area.

Whilst on placement reflect on what you have read here and your own experiences with regards to working in a rural environment as a:

i) GP

ii) Doctor in a rural Community Hospital or Rural General Hospital

iii) Another member of the healthcare team
References


Accessing Learning and Support

Learning
Some students are concerned about accessing materials for learning on remote and rural placements.

In your senior years at medical school it is expected that you already have the core knowledge from didactic teaching and that learning will occur in a different setting. As part of this section there is a subheading on self-directed learning which will explain what this term means and involves.

During your placement learning may take a different style to in an urban environment, students are likely to have closer relationship with teaching staff, with more opportunities to learn from them. The numerous advantages for students are discussed in the “what is it like as a student” section, such as the fact students find that being known by their tutor leads to more meaningful individual feedback which students find helpful. Other advantages include the fact that the diversity of patient problems and encounters may be greater than what you are in contact with in other placements. On General Practice placements, this variety of patient interactions can occur in different environments, such as patients’ homes as well as clinics - all different contexts for learning.

As well as healthcare itself, it is also a good setting in which to learn about the local culture, life/work balance and professionalism, such as relationships with patients and patient confidentiality.

If you are going on a hospital placement there may be a library or small study space you can utilise for personal study, if this is not evident when you arrive then ask the tutor if there is a space you can use. All students will have internet access at the GP practice they are attached to; internet for personal use is available in most but not all accommodation. Loans on library books from the University of Aberdeen libraries, or University of Stirling library in the centre for Health Sciences in Inverness may not last long enough for you to take them on your placement, so check this before taking them away.

Plan ahead and consider what texts may be useful to you while you are away, ensure you pack what you consider to be core learning materials in case there is limited access for internet for personal use.

In terms of formal teaching during your placement, this is achieved by a mix of group tutorials all can attend and some tutorials which are video-conferenced to allow you to join them from a peripheral placement. The tutorials given in the Year 4 General Practice teaching block are given at the start and end of the block in Inverness and Aberdeen. In Year 5 general practice formal teaching occurs in the first week, there is also formal teaching in the general practice cell groups on five of the seven weeks that the students are attached to a general practice (as described earlier in this guide). Some tutorials are video-conferenced to Inverness in Year 4 and for students on peripheral hospital placements in Year 5.

If you have internet in your accommodation, or using the internet in your practice you can access e-books and e-resources the university owns. You can do this using the platforms Ebrary and Dawsonera:
http://site.ebrary.com/lib/aberdeenuniv/home.action
https://www.dawsonera.com/
**Self-directed learning**

Self-directed learning is a term that is used a lot by tutors and lecturers however it is worth taking a moment to consider what it means.

In the context of medical education, self-directed learning is taken to mean that learners take an active responsibility for their own learning. It aims to encourage learners to take a deep approach to learning and understand the context of the knowledge they are acquiring. 5,6

Firstly, as a learner you need to identify your learning needs, this means identifying gaps in your knowledge. To aid you with this, the university produces learning objectives, and you yourself may have specific aims for what you would like to know at the end of the block. Once you have identified your learning needs you can then map these to what resources you have available. The resources may be textbooks, patients, podcasts, clinicians, e-learning or peers. 5,6

Self-directed learning definitely does not mean that others have no role in your learning. On a peripheral hospital placement or in a general practice environment there are many different healthcare professionals who you may be able to learn from, however it is up to you how you make use of those around you. You may also find it valuable to spend time studying together in small groups, taking turns to be a teacher and a student.

It is thought that self-directed learning is the best approach for continuing lifelong education as a doctor5, so by practising this learning strategy at medical school you will be well equipped for this.

Support

Depending on what support you are looking for, there is a wealth of people you can contact or speak to. This includes your tutor, hospital or practice staff and other university staff. Useful contacts are:

- **Block Coordinators** - see your learning guide – Year Lead Coordinators or Year Secretaries
- **Inverness support team** (this consists of the Director of Teaching, Director of Medical Education, the Year Coordinators, the Clinical Teaching Fellows and the Clinical Teaching FY2 in Inverness). If you speak to anyone in the HMEC office they will be able to either help you yourselves, or direct you to someone who can help. HMEC office, tel: 01463 255073
- **Penny Linemann** (Student Welfare Officer)
- **Your Regent** (Students on the Year 4 remote and rural programme will have an Inverness based Regent)
- **Aberdeen University Counselling Service** ([http://www.abdn.ac.uk/counselling/](http://www.abdn.ac.uk/counselling/); tel:01224 272139, email: counselling@abdn.ac.uk)
- **Aberdeen University Chaplaincy Centre** (tel: 01224 272137. Email: chaplaincy@abdn.ac.uk)
- **Aberdeen Counselling and Information Service** (tel: 01224 573892)
- **Infohub** has pages with advice on financial support [http://www.abdn.ac.uk/infohub/finance/](http://www.abdn.ac.uk/infohub/finance/) Student Advice & Support Office can be contacted at student.advice@abdn.ac.uk

**Conclusion**

Learning will take place across a range of contexts and while on placement you should still have access to learning materials. There are a wide range of support mechanisms in place, should you need them then do not hesitate to make use of them.

“We had lots of fun as a group in Fort William doing our own teaching sessions on things that interested or worried us; we went over insulin and pain relief etc”

“It might be good to ask if you can run through the common GP problems with your GP”
References


3. Graham W. Rural Areas: Valuable Learning Contexts for Medical Students, Chapter 2.2. Rural Medical Education Guidebook: World Organization of Family Doctors (WONCA); 2014.


Reflection

Students find reflection a valuable part of their education when on rural attachments. As well as using the activities boxes within this guide to aid reflection you may find it useful to reflect on particular patients you interact with, or particular experiences which highlight differences between urban and remote and rural practice.

Suggested Areas for Reflection

Learning from patient interactions:
  i) What remote and rural issues were present in this case?
  ii) What have you learned from this case?
  iii) Can you identify any new learning need this raises?

Learning from the experience of e-health (eg. tele-medicine, tele-conference, email consultation) in remote areas:
  i) What was your opinion of the e-health modality prior to seeing it in use?
  ii) How do you feel about it now?
  iii) Does it raise any particular issues?
  iv) How does this fit into the health needs of the population?

Learning from the experience of emergency service in remote areas:
  i) What was different about the experience compared to experiences you have had in the past?
  ii) Does it raise any particular issues?
  iii) How does this fit into the health needs of the population?

(Modified from the reflection points suggested in the reflective learning log for Remote and Rural students on the Year 4 programme at University of Aberdeen)

Be involved in the community

Going on a remote and rural placement is more than simply attending the practice or ward every day. Students are likely to gain more by being engaged in the community. Engaging in the community allows you to improve your understanding of the community providing insight into the social influences on health.

“Have fun, explore the surrounding location - you get a much better sense of the challenges facing the community by exploring the place.”

What the tutors think: What common pitfalls have other students have made?

“Being too shy to ask.”

“[Making] incorrect assumptions regarding amenities and distances.”

“Many try to read ‘blocks’ of subjects like cardiology or paediatrics while here. Their learning would be enhanced by being led by what they experience rather than trying to learn all of general practice in 4 weeks.”

“Unfavourably comparing rural practice with urban practice.”
Take opportunities

One of the ways to make the most of your block is to be aware of the differences in what it is like as a student on remote and rural placement, there is a separate section dedicated to this which covers areas such as the need to take a self-directed learning approach. Unlike on city placements, as there are fewer students attached to the hospital students can be less tied to one specialty. If a colleague tells you about an interesting patient or you wish to see what goes on in other parts of the hospital then take the opportunity to do so. You may find patient interactions more meaningful while on remote and rural placements, and it may be easier to follow a patient through their healthcare journey allowing longitudinal learning.5

“If it is quiet on your ward see what else is going on. For example, have you had a look round A and E?”

Conclusion

To get the most from your placement approach it with an open mind, a willingness to learn and motivation to be involved in both the life of the hospital or medical practice and the life of the community.

What the tutors think: How should students get the best out of their placements?

“Look forward to it and be enthusiastic, throw themselves[sic] in to being part of the community.”

“Research the area/amenities. Join in with local interests of theirs e.g., hillwalking, running etc.”

“Find out what makes the practice different and immerse yourself in the things you have not previously experienced.”

“Be open minded, stay consistent in reading around what you see and treat every patient as a learning opportunity. “

“Being available, trying to look at the patient’s situation. Engaging with local events.”

“Bring an open mind and clothing for any type of weather situation.”


There are a number of ways in which you will gain from this experience:

- It is an opportunity to experience a different learning environment and a new place.
- The placement will give you a chance to have a wide range of patient interactions, all of which can be learning experiences.
- As the receiving doctor in a hospital you need to understand the stresses and pressures on the referring doctor, who could be in a remote or rural location. Their environment may be what is leading them to make the decisions they have, and you also need to be aware that issues which may arise—for example with patient transfer.
- As a hospital doctor, patients’ access to services from home needs to be taken into account; this may change your opinion on when it is safe to discharge a patient. This may include medical and surgical services, and access to services run by the allied health professionals.
- Understanding the challenges of remote and rural environments will allow more informed decisions if you become involved in service planning in the future. There needs to be recognition of the differences between remote and rural health and urban health to create a health service that will meet rural populations’ health needs.¹

**The Positive Influence of Remote and Rural Placements**

After going on a remote and rural placement some students will find that they may consider working in such an environment later.

The role of rural placements in changing students’ opinions of remote and rural health is not fully understood. This is partly due to confounding factors such as the fact that if a rural placement is optional, or a highlighted part of a particular course, those who are interested in rural health are more likely to apply.

A study² in Australia showed rural placements can increase the number of students considering working in a rural environment for part of their career. In New Zealand, a study³ showed rural placements can change students’ attitudes to remote and rural medical practice, however it also showed students did not alter their intentions on whether they would work in a remote and rural environment.

---

¹ Hospital clinicians discuss why they need an understanding of remote and rural issues, and what challenges can be involved in managing a patient from a remote and rural location:

**The Surgical Registrar:** “Multiple episodes [when this has impacted on care and decision making]... Helicopters not able to fly due to poor weather. One patient with hepato-renal syndrome had to travel by different transport method, he had to come in by lifeboat... Transport is a massive issue.”

“A lot of rural communities don’t have community hospitals and limited allied health professionals available. This gives us a problem of through-flow with elective cases.”

**The FY2:** “If someone has been seen by their GP who has referred them to hospital with sepsis, it can take 3 hours to get to hospital and they can arrive very ill.”

“Discharging patients to a remote and rural location is a nightmare. If there is no public transport and they are not safe to drive it’s very difficult.”

“[In Raigmore] you meet so many patients who have been thrombolysed. The cath lab is only open 9-5 Monday to Friday and GPs thrombolysed in the community. It’s a lot of pressure on GPs to expect them to thrombolys.”

“GPs are in a tricky situation making big calls”

**The Renal Physician:** “In clinic it is harder, in terms of fluid balance you might normally see them back next week but this isn’t possible and it’s a lot to ask GPs to do.”

“I can’t see people in clinic as often as I would like”

² The Positive Influence of Remote and Rural Placements

After going on a remote and rural placement some students will find that they may consider working in such an environment later.

The role of rural placements in changing students’ opinions of remote and rural health is not fully understood. This is partly due to confounding factors such as the fact that if a rural placement is optional, or a highlighted part of a particular course, those who are interested in rural health are more likely to apply.

A study² in Australia showed rural placements can increase the number of students considering working in a rural environment for part of their career. In New Zealand, a study³ showed rural placements can change students’ attitudes to remote and rural medical practice, however it also showed students did not alter their intentions on whether they would work in a remote and rural environment.


What problems might I have and how can I resolve them? A quick overview

Where should I go for support?

- Block Co-ordinators - see your learning guide - or Year Co-ordinators
- Inverness support team (this consists of the Director of Teaching, Director of Medical Education, Year Co-ordinators, the Clinical Teaching Fellows and the Clinical Teaching FY2 in Inverness). If you speak to anyone in the HMEC office they will be able to either help you yourselves, or direct you to someone who can help. HMEC office, tel: 01463 255073
- Penny Linemann (Student Welfare Officer)
- Your Regent (Students on the Year 4 remote and rural programme will have a Inverness based Regent)
- Aberdeen University Counselling Service (http://www.abdn.ac.uk/counselling/ tel:01224 272139, email: counselling@abdn.ac.uk)
- Aberdeen University Chaplaincy Centre (tel: 01224 272137. Email: chaplaincy@abdn.ac.uk)
- Aberdeen Counselling and Information Service (tel: 01224 573892)
- Infohub has pages with advice on financial support http://www.abdn.ac.uk/infohub/finance/ Student Advice & Support Office can be contacted at student.advice@abdn.ac.uk

Internet access

Some of the B&Bs used by students on GP placements have poor or no internet connections, however the internet will be available in the practice so you will be able to access it there. It is best to take the core textbooks and learning materials you use with you, so you know that poor internet access won’t affect limit your studying.

Fewer Students in the Area

Students generally have a very positive experience on their remote and rural placements, and enjoy living and working in a rural community. Sometimes the experience of being on remote and rural placement can be isolating as a student but there are things you can do to help this. For example you could ask the people you are working with and the accommodation providers if there are any community events or activities you could join in with.

On peripheral hospital placements students enjoy being able to socialise together in their groups of 2-5. On GP placements you may be the only student in the immediate vicinity however you will have timetabled contact with other students in your block. Students on Year 4 attachments will have time with other students
on the block at the start and end of the 5 week rotation. Final year students will have cell tutorials on 5 of the 7 weeks they are attached to a practice, which will be an opportunity to spend time with peers. On top of these timetabled interactions, you may be able to meet up with other students socially, for example on day trips at the weekend. Living in a rural community is an opportunity to explore a new area and do different things.

**Accommodation Issues**

- For students staying in a B&B, it varies from place to place whether evening meals are included. Depending on access to the kitchen, one option may be to cook large batches of food at the weekend or prior to leaving on your placement, and then store it for when you need it.
- There may be limited options for where to shop, however supermarkets will offer shop and drop to quite remote areas. You can also ask about local delivery systems or solutions.
- In the past some students have found their rooms to be quite noisy due to their location, for example above a bar. Ear plugs can help with this.

**Tutor Issues**

On remote and rural placements you will have a lot of one on one time with tutors. This is something which most students find very positive to their learning, and students enjoy feeling involved as part of the healthcare team. Very occasionally students may have difficulties with their tutor. Rather than letting this ruin your placement, consider whether this is something you could discuss with them. This is usually the best initial course of action. If you don’t feel confident enough to approach them directly then contact the university support systems (see above) - in the first instance it may be most appropriate to contact the block co-ordinator or Inverness support team.

**Travel Expenses**

It is possible to claim travel expenses - see MyMBChB to review this policy, as it is regularly updated.

“*My family also sent me some packages from home for me to enjoy while I was away*”

---

[Image of a Search and Rescue Dog - www.sarda.org.uk]
Find Out More...

Before, during and after your placement talk to remote and rural healthcare professionals; find out about their roles, ask them about training and job opportunities in that area, and take the opportunity to discuss other remote and rural topics you are interested in.

Some other resources you might find useful include:


NES North of Scotland GP training blog http://www.northscotgptraining.org

Rural GP blog by David Hogg: http://www.ruralgp.com/

Educational resources for rural healthcare providers provided by the Remote and Rural Healthcare Educational Alliance (RRHEAL), as part of NHS Education for Scotland: http://www.rrheal.scot.nhs.uk/Default.aspx

The Centre for Rural Health is a research institute supported by the University of Aberdeen and the University of the Highlands and Islands, its webpage will give you an idea of past, present and future rural health research in the Highlands and Islands: http://www.abdn.ac.uk/crh/