General practice in remote areas: attractions, expectations, and experiences

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SUMMARY. Interviews with a sample of general practitioners in remote areas of Scotland revealed a strong commitment to a wide family counsellor role as well as a wish to use clinical skills more fully. While many urban doctors express similar orientations we believe that rural practitioners feel better able to implement their preferred style of work which combines personal and professional elements.

Introduction

IF part of the challenge of general practice is to apply one's skills to maximum effect, this appears to imply practising where the bulk of the population and most general practitioners live and work—in towns and cities. However, a significant minority of the population and their doctors live and work in relatively small rural communities often remote from other medical services. It is these doctors, their perceptions of the attractions of practice in such settings, their experiences there, and their decisions on whether or not to remain that are the subject of this paper.

Table 1 illustrates the comparative rarity of this type of practice—that which approximates to the archetypal single-handed country doctor caring for a relatively small and stable panel of patients.

Not all rural general practitioners are single-handed and remote from hospital services, and not all single-handed doctors have small lists. Indeed there was considerable variation within the sample of 28 rural doctors who provided our data. Two were trainees attached to solo practices, 13 were single-handed, ten were in partnership while the other three were in groups of three or more. Fourteen of the practices were more than one hour's journey away from the nearest hospital equipped with at least basic consultant services, and nine were more than two hours' journey away. While they were atypical in terms of their choice of practice, they did not greatly differ from their urban colleagues in terms of sociodemographic or biographical factors such as age, qualifications and length of stay in their present practice.

Aim

Our aim was to illustrate and document the variability of attitudes to general practice among remote, rural general practitioners.

Method

Semi-structured, tape-recorded interviews were conducted with 28 general practitioners all practising in rural Scotland in the North East, the Highlands and the Western Isles. They were broadly representative of the practitioners in these areas. All the interviews were subsequently transcribed for analysis and the respondents allocated pseudonyms.

Attractions of rural practice

What did these practitioners consider to be the satisfying aspects of their practices? Both professional and personal considerations seemed to be involved. One of the most important of the former was the perceived opportunity for adopting a particular style of work, namely the practice of 'family medicine'. In contrast to the scientific approach, which tends to be strictly medical in its content, the orientation towards family medicine has as its distinguishing features: an emphasis on continuity of care; a deep sense of commitment to, and involvement with, patients and the community; a concern to minister to a wide variety of patients' needs;

Table 1. General practitioners: type and size of practice, 1975.

	England	Scotland	Grampian Health Board	Highlands and Islands Health Boards*
Number of unrestricted doctors	20,377	2,797	256	184
Number of unrestricted single-handed doctors	3,570 *(18)*	428 *(16)*	38 *(15)*	80 *(43)*
Average list size	2,365	1,939	1,815	1,349
Patient list <1,600	1,976 *(10)*	636 *(23)*	62 *(24)*	120 *(65)*

*Comprises Highland, Orkney, Shetland and Western Isles Health Boards.
Sources: Scottish Health Department (1977); DHSS, 1977.

and a notion of the responsibility which a practitioner should assume for his patients which extended well beyond the strictly medical to include social and pastoral dimensions. Non-medical problems were not merely *tolerated* as part of the job. Their management was an integral part of the doctors' conceptions of their professional role and there was a positive commitment to dealing with them.

Dr McNeil:

Basically I think we do more things than we did in town. We're part social worker, part minister. I think we're much more involved in the community.

Dr Maxwell:

People come up to talk about their problems and nowadays they may come to a doctor rather than to a minister as in days gone by. People will want to talk about marital problems, every kind of problem. If I minded that, there'd be no point in my being here.

Closely related to this almost paternalistic commitment to total patient care was the emphasis which the doctors placed upon continuity, that is, being able to look after patients and families throughout their lives, and a desire for a more personal relationship with their patients. There is a sense of belonging to a community, which is featured in so many aspects of the work. Here professional and personal features of practice merge.

Dr Dewar:

You've got much more contact with the person, I feel. A lot of your work in general practice is therapeutic listening or social work. It's satisfying and I think you see the patient from the cradle to the grave, literally, which is something I enjoy. This is the thing I think I would miss in a town practice. That's why I like a country practice, you become one of the population and they regard you as a friend rather than as their general practitioner.

Dr Charles:

It is extraordinarily rewarding and I can't visualize myself in general practice anywhere else. I wouldn't do it.

This particular orientation is not, of course, exclusive to practice in the country; indeed, we found that the majority of our sample of urban practitioners also espoused it. It was simply that the scope for implementing it was perceived by our rural practitioners as being more limited in towns. As this would imply, their perceptions of rural practice were considerably influenced by their perceptions or experiences of urban practice, which they felt was more impersonal, more demanding, and offered less continuity of care.

Dr McNeil:

In B. you would deliver one or two babies and then the family would be off. You were just beginning to get to know their problems and they'd begin to know you, you'd be able to discuss things a little more deeply with them if necessary and then they'd be off and another new family would come in.

Dr Maxwell:

In an industrial practice in the South people in general are much more demanding. They tend to be less considerate of doctors than they are here. And that's another thing, down there you are under continual pressure. Your're fighting the clock the whole time.

Trivial illness in particular was seen as being a much smaller problem in country practice than it was in towns.

Dr Brand:

In fact, that is the difficult thing about a practice in a town. You get driven crazy with trivia and you can't concentrate on the important work.

However, this may have had less to do with the relative volumes of minor complaints presented in different contexts than with the fact that the lighter workload in rural practice meant that trivia or other inappropriate presentations could be more easily absorbed.

Two related attractions of rural practice were the greater amount of time available and the smaller number of patients for whom the doctor was responsible. However, it was not, we would argue, the prospect of an easier life which attracted them. One of the doctors (Dr Hamilton) in fact left one small country practice and moved to another with a bigger list largely because he felt that the workload was too light. Only two of the doctors had, on their own admission,

'retired' to a small isolated practice. Rather these two elements combined to allow them scope, as they saw it, to implement their preferred style of work.

Dr Maitland:

You can do both preventive and curative medicine. Here you can do a lot. I think we work as hard despite our low number of patients.

Dr Maxwell:

Here your work tends to be a bit more worthwhile. We're doing a bit more good for any work we do.

Although these doctors would admit that they were not as busy as their urban counterparts, in most cases their time was fully occupied. In a sense it was a case of the work expanding to fill the time available (for example, through a greater amount of social or supervisory visiting). Also, because of the quality of his relationship with his patients, the doctor practising in such areas is both expected, and feels bound, to devote more time to them. Moreover, for many of these doctors the relatively leisurely pace did not continue all year round. Tourists could effectively double or, in some cases, treble the numbers during the summer season. Thus, the crucial difference between rural and urban practice was not so much the amount of time spent at work as the ways in which it was deployed.

However, the professional appeal of rural practice was not confined to the breadth and quality of service which the doctors felt able to provide. Many of them felt strongly that it also afforded greater opportunity for exercising their clinical skills, precisely because they did not have easy access to specialist services.

Dr Leslie:

My trainee had six months in an orthopaedic job, where everything was x-rayed whether it was clinically broken or not. Now here you make jolly sure it's a worthwhile trip (to G., sixty miles away) before sending them, which is nice from a medical point of view.

Dr MacPherson:

I was beginning to find when I was in general practice in an urban area that it was less satisfying. With a hospital next door everything had to be treated at hospital—one was becoming much more of a sorting office. Since I've been up here it's become very satisfying because I can really practise medicine again.

However, as we suggested earlier, personal considerations were also involved. Not least of these was the fact that they could devote more time to themselves and their families.

Dr Maxwell:

Although I do work fairly hard, and maybe work long hours, I have time at home to see my wife and children. They know who I am.

For some the appeal of country life, a feeling of affinity with the people, and a corresponding dislike of urban living were prime considerations. Moreover, some of the doctors were of Highland or rural origin and could be said to have had a predisposition to practise in those areas (Butler *et al.*, 1973).

Dr Farquhar:

I don't think I would be satisfied in the town somehow. Oh no, the frustration of the traffic, you in a bit of a hurry—no' much wonder you get ulcers and heart attacks and things! I like the freedom in the country.

Choice of practice

Our interviews elicited from the rural doctors their accounts of the attractive and satisfying features of country practice *once they were there.* We have no direct evidence that these factors weighed in their decision to opt for country practice in general, or *this* practice in particular in the first instance. Their accounts are retrospective and subject to an unknown degree of unconscious distortion and rationalization.

Despite this caveat, there is evidence to suggest that their choice was at least partly rational based on the factors mentioned above: relatively unhurried work, continuity of care, commitment to family medicine, love of the country, and involvement in community life. But country practice is not a homogeneous category. While we may regard the decision to opt for a country practice as a primary choice, secondary choices were involved in deciding what kind, size, and location of practice to opt for.

The rural general practitioners' practices were, as we said earlier, highly variable. Some of those remote from a district hospital had other facilities at their disposal. For example, a few had access to cottage hospitals while two doctors combined general practice with medical and surgical work respectively in their own small hospital. This variability was, of course, reflected in the reasons they gave for choosing this or that practice.

The most important choice was that between single-handed practice and a partnership or group. The greatest single attraction of solo practice was autonomy. The practitioner could organize his practice in his own way without the constraints of having to accommodate or comply with partners.

Dr Anderson:

I'd sooner be in touch with the patient the whole time rather than sharing the case, knowing that what I wanted to do was being done.

Dr Scott:

The trouble is, if I were in partnership I'd have to *like* my partners. They'd have to be people I'd play bridge with and be pleased to see in the morning. How are you going to know that?

However, this autonomy and the provision of comprehensive care for a whole community had to be weighed against the disadvantages inherent in single-handed practice, in particular the fact that one was continually tied to the practice and had difficulty in getting time off.

Dr Farquhar:

I am not overworked but the tedium is that you're never really off duty—can't even get to the foot of the garden without switching the phone outside. Single-handed is a bit of a tedium, but I have to admit I like it that way.

Family considerations were also important here since a single-handed practice could mean that the doctor's wife was just as much tied as the doctor himself.

Dr Leslie:

Doctors' wives are even more special animals than doctors because at least I have the stimulation of seeing new faces in the job, whereas she is just here, the slave of the door and the bell, and can't get out. It's a pretty terrible job being a doctor's wife here.

The burden of continuous and sole responsibility could also weigh heavily in single-handed practice.

Dr Anderson:

I'd rather not have the responsibility of these people's health. I don't enjoy the responsibility. I don't know whether I take the responsibility unusually seriously; possibly I do. I find it a great mental strain.

For those reasons, a number of doctors, while attracted to rural practice would never have contemplated taking a single-handed one.

Dr Newman (trainee):

I suppose you need to be really dedicated in this day and age to be on call 24 hours a day, seven days a week, throughout the year and I want my time off.

The relative remoteness of a practice also had to be taken into account, especially with regards to referral. There was also the problem of professional isolation: lack of contact with colleagues and the difficulty of getting to meetings or refresher courses, and so on.

Dr Dewar:

We're lucky here, as there are two of us and a trainee we can talk about medicine. In a single-handed practice you can get awfully isolated and you've no one to discuss your problems with and talk to about new techniques and drugs. We can also get to meetings.

Similarly, the social isolation of a remote practice had to be considered. This was partly due to a shortage of eligible friends but there was also a reluctance to forge friendships with people who were also patients.

Dr Leslie:

Very difficult socially. My answer has been not to mix very much. We have a very small circle of friends. It is tricky. Partly because of the age distribution. I don't want to be snobbish, but in theory the banker and the minister and people like this ought to be in the same circle but in fact it doesn't work out because the banker is quite a bit older and, unfortunately, we don't particularly like the minister, because he's too strict.

A small isolated practice could also create difficulties in relation to the schooling of children.

Dr Maitland:

I think it's when it comes to secondary school that this really is a problem. The secondary school is in L. and they'd have to go to a hostel there. You'll find that most doctors in the Highlands have sent their children away (to private schools). Financially, we're finding it very tight; we're spending all our spare money on education.

Finally, the size of the practice was an important consideration for many. If a practice is too large one cannot get to know all the patients well nor can one have the same continuity of care.

Dr McNeil:

I think probably the ideal is two partners, perhaps three, not more. Beyond that it becomes impersonal.

This discussion may have given the impression that the selection of a practice was a highly rational one based upon a conscious and careful weighing of the relative advantages and disadvantages of practice in different contexts.

It is clear, however, that certain contingencies played an important part in many of the doctors' choice of practice with, in some cases, apparent 'drift' into their present practice. Thus, while the decision to practise in a rural context may have been the product of a conscious and rational process, certain contingencies often determined the particular practice entered, the most significant being what was available at the time. Accordingly, some doctors, although they would have preferred to be in partnership, were prepared to practise single-handed in order to have a country practice. The whole exercise of choice is, therefore, a kind of loose cost-benefit analysis, involving the chance factors of what is available at a given time and the long-term ambitions of the person concerned.

Adaptations

Clearly, given the constraints imposed upon their choice, many of the doctors were unable to obtain their ideal practice. In addition, all the doctors entered their practice with some expectations which were not always fulfilled, their present practice being something of a compromise. The most striking examples of this were those solo practitioners who had not really wanted a single-handed practice.

Dr McNeil:

I wanted a country practice. The ideal would be a partnership I think. We're (single-handed practitioners) a complete anachronism, nobody else would do it, you are really lumbered.

Dr Smith was particularly concerned about the isolation and problems of referral associated with his practice. His discontent stemmed largely from the expectations with which he had entered his present practice, which in turn had been based upon his experience in a previous practice.

Dr Smith:

When I came here I didn't know whether they had a hospital nearby. The impression I had was that there would be some hospitals around and I didn't bother to find out because I came from P. and they had an enormous amount of facilities. I thought that there would at least be some hospitals; the nearest place is M., 38 miles from here, which is ridiculous. Here 40 miles is not a small distance. There are lots of circumstances where you need a consulting unit near by.

Moreover, the practice itself could change its character over time and a doctor could find himself in a practice very different from the one which he first

entered. One doctor, who had been in his present practice for 20 years, regretted the way in which it had grown.

Dr Shaw:

When you have more than two doctors you no longer know everything that's going on in the practice. You lose that grip of the whole thing, you're not quite there, it's a most intangible thing to try and describe. Even going from two to three partners means that part of your work involves sitting together at least twice a week. You didn't need to do that with two of you or one of you. Your work was looking after patients. Once you get attached staff then not only have you to set aside a bit of the week to sit with your partners, you also have to set aside a bit of the week with your nurses and some of the week with everybody. This is work just the same but it's not looking after patients, and doesn't come easily to me.

Most practitioners, however, seemed prepared to accept some compromise deciding that, on balance, the advantages of the practice outweighed its disadvantages. However, their reasons for remaining were sometimes different from their reasons for entering it. Moreover, although they had decided to stay not all would necessarily choose the same practice again.

Dr Irvine:

I'd do medicine again gladly. Whether I'd settle for R. again, I don't know. I've lived my whole life here, married a T. girl, I think she was quite miserable for the first few years. There wasn't the coming and going between her and her friends as there would have been if we'd been on the mainland. On the other hand, I have my fishing—it's a poor year I don't have 40 salmon. Life is not quite so fast here as it is on the mainland. We walk fast instead of running.

Other doctors were not prepared to compromise or, for some, the disjunction which they experienced between their expectations and the reality of their practice was too great. One of the problems of course was that they could not tell in advance what a practice was going to be like and how they would react to it.

Dr Hamilton:

When I look back on it now it was a mistake. I shouldn't have gone there at all. But you find these things out later.

Accordingly, while none had become disenchanted with rural practice in itself, some decided to move and looked for alternative country practices which corresponded more closely with what they wanted. Consequently, a number of general practitioners in the sample had done a considerable amount of shopping around before coming across a suitable practice. Dr Hay had cogent reasons for leaving his previous practice and moving to I.

Dr Hay:

One of the main reasons was the children. I have five children. They were nearing secondary school age. Secondary schooling is a problem in H. because children have to leave home. My wife had gone through this and felt it was a very bad thing. Other reasons were that in a place like H. the doctor gets very closely involved with his patients. He is a member of a closely knit community and he gets to know the patients very well and they get to know him very well and I think it's difficult for him to live with this indefinitely. The people you get to know best are those who are seriously ill or those who are dying. And also both my wife and myself were cut off from my own elderly relations. We felt we should be a bit nearer to them—they were getting to the stage where they were likely to need some help.

You have more opportunity here to make friends with people outside your own group of patients and there's more contact with other doctors here through going to meetings and one doesn't seem to get quite so deeply involved here. I suppose partly because we're nearer a hospital. There you were 60 miles from hospital. If anything was wrong, if anyone was ill and something needed to be done about it, then I had to do it. It all came on me. Here it's much easier to call in a specialist for advice or take over the case and one doesn't need to get quite so involved. One felt the responsibility very heavily in H.

Dr Hamilton's reasons for moving were different.

Dr Hamilton:

I wasn't all that happy in W. It wasn't the way I'd expected it to be, primarily socially rather than medically. The medicine was more or less as I expected, but even during the two years that we were there it changed quite a bit. The village became less of a village and more of a holiday centre. It got to the stage where there was myself and the shopkeeper and I think three more houses permanently occupied, two of them by people over 75. So the obvious thing was to get out. I think that was really the sequence. Plus the fact that it was just so difficult to live, to exist. Just to go shopping, just getting groceries. These were the main reasons. But there were professional reasons as well. I just wasn't doing enough work. I'd sometimes go two or three days without seeing anyone. You'd get to the stage where you really were at a loss with really nasty things. The classical one which always frightened me was a bad road accident—60 miles from the nearest hospital with possibly three people needing major surgery. We still wanted to stay in this part of the world but we thought a town of some sort, so I came here. One night on call in five and one weekend in four. We're also covering casualty, so one gets some hospital work as well. With consultants near at hand if needed. Professionally it's ideal.

Some doctors had tried more than one practice before finally settling.

Dr Scott:

I practised for four years in N. in one of the most isolated practices there and then you read the Sunday newspapers and you think 'God, I'm missing out on things. If I were to stay here any longer, I'd just be a savage!" I got a single-handed practice in A., which must be one of the most snobbish places in Britain, it's a thing that I didn't really like very much. We stuck it for five years and then K. turned up. This appealed not just to me but also to my wife, which is one of the most important points about it, working in an isolated place, and we came out here and I can't say that I've ever regretted it.

Conclusion

The main topic in this paper has been the attractions and, to a lesser degree, the disadvantages of rural practice as expressed by a sample of rural practitioners who are by no means representative. Our data, derived from unstructured 'interview-discussions' (Horobin and McIntosh, 1977), also indirectly highlights the factors influencing the choice of rural practice. The latter topic is interesting partly because these practices are increasingly rare and partly because, with their aura of the bygone age of Cronin's Dr Cameron, they are the

subject of many myths. Because most practices are in urban areas (and increasingly in groups and health centres), most recruits to general practice, we believe, do not consciously choose to work in towns; rather it is assumed that they will do so. Rural doctors, in other words, have to choose to be so; urban doctors choose *within* urban practices without seriously considering rural practice as an alternative.

One thing is clear, our rural doctors did not find rural practice a soft option. Indeed, for many of them there was considerable economic stringency involved and the work, especially for the single-handed, was often onerous, arduous, lonely, isolated and, occasionally, hazardous. Nor was it a flight from the rigours of urban practice. On the contrary, given their relative remoteness from back-up services, practitioners in rural practice had perhaps to be specially competent and to shoulder greater responsibility than their urban colleagues. Many of our rural general practitioners argued that they would not have contemplated taking on the responsibility of rural practice without first having gained considerable experience in town practice where advice from colleagues and specialists was more readily available.

What, then, attracted them to country practice? Attractions inherent in rural practice and response to perceived or experienced disadvantages of practice in towns influenced choice. Both professional and personal considerations were important. Rural practices were, of course, highly variable in terms of isolation, access to support systems, facilities available, and the weight of responsibility which they imposed, the latter being diluted in practices with more than one doctor. Nevertheless, our rural general practitioners had some things in common and appealed to the same sources of satisfaction. Their accounts of their motives for selecting rural practice ascribed great importance to their professional orientation to general practice work, specifically a commitment to the practice of 'family medicine'. With the desire for a continuing and personal involvement with patients and their families went a desire to exercise their purely clinical skills to the fullest possible extent and to assume greater responsibility for the strictly medical work which they encountered.

The two most important enabling factors were the small lists and relatively stable populations commonly associated with country practices. Associated with the appeal of a more traditional or 'cottage industry' general practice was a corresponding sense of alienation from urban practice. Their preferred approach to medical practice was, they felt, incapable of adequate expression in urban settings. Thus, in so far as they were fugitives, their flight was not from hard work and responsibility but rather from certain features of urban practice and city life. Specifically, it was a rejection of the tedium, impersonality, lack of continuity, estrangement from patients and their lives, and perceived triviality held to characterize much of urban practice. This conception is, of course, a caricature of practice in towns, where the relationship with patients is far from as impersonal, transient, or attenuated as this portrayal would suggest. Most urban practitioners would also subscribe to the 'family medicine' approach to general practice. Rather, the orientation represents a continuum of approaches, of varying degrees of realization, depending upon the constraints on its implementation imposed by different contexts. The difference between practice in rural and urban environments is therefore one of degree and emphasis rather than kind. Nevertheless, it was this difference in emphasis which attracted the doctors in our sample to rural practice.

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Psychological and social evaluation of deliberate self-poisoning

In a prospective clinical trial 312 cases of self-poisoning (276 patients) consecutively admitted to hospital were randomly allocated to medical teams or to psychiatrists for an initial psychiatric assessment and a decision as to 'disposal'. Junior doctors and nurses received some instruction in this work. Both groups of assessors asked for help from social workers when necessary. Once the medical teams had completed their assessment, psychiatrists provided most of the hospital treatment. Follow-up at one year showed no significant difference between the two groups of patients in the numbers who repeated their self-poisoning or self-injury (or both), or committed suicide.

Provided junior doctors and nurses are taught to assess self-poisoned patients, we think medical teams can evaluate the suicidal risk and identify patients requiring psychiatric treatment or help from social workers, or both. Contrary to the Department of Health's recommendation that all cases of deliberate self-poisoning should be seen by psychiatrists, we have reached the conclusion that physicians should decide for each of their patients if specialist psychiatric advice is necessary.

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