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How do we train rural generalists?

A scoping review on postgraduate training

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Rural general practitioners practise across broader clinical and procedural scopes
How are they trained post-graduation?

METHODS

- ✓ Scoping review
- ✓ Following PRISMA-ScR guidance and JBI methodology
- ✓ 3 databases searched (PubMed, Cochrane, OpenAlex
- ✓ Search strategy PRESS'ed
- ✓ Two independent reviewers, conflicts solved by discussion
- ✓ Protocol pre-registered

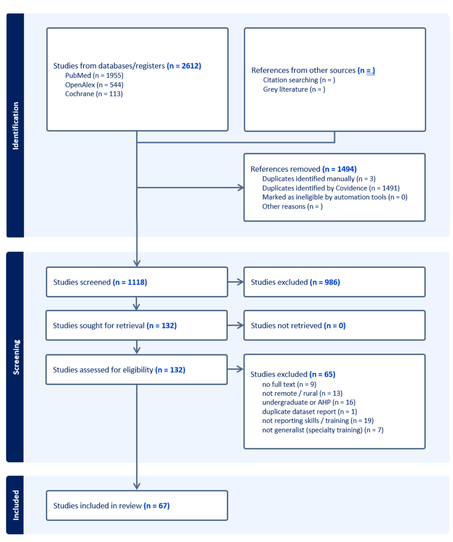

Fig. 1. PRISMA Flow-chart

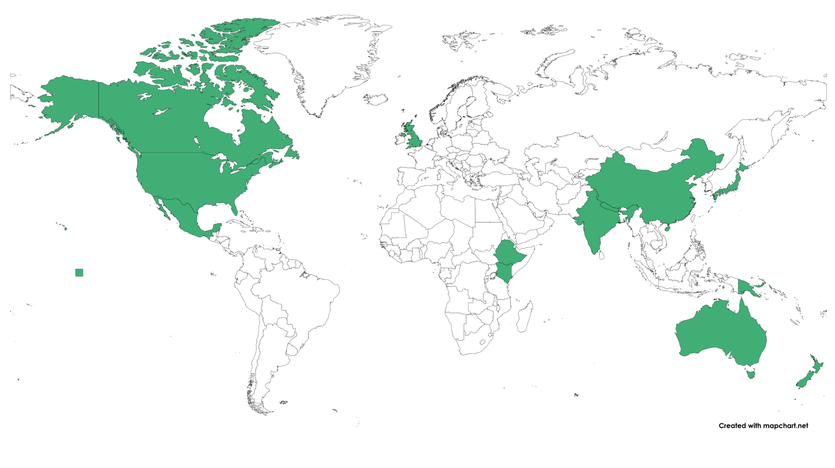

Fig. 2. World map showing countries with published studies highlighted in green

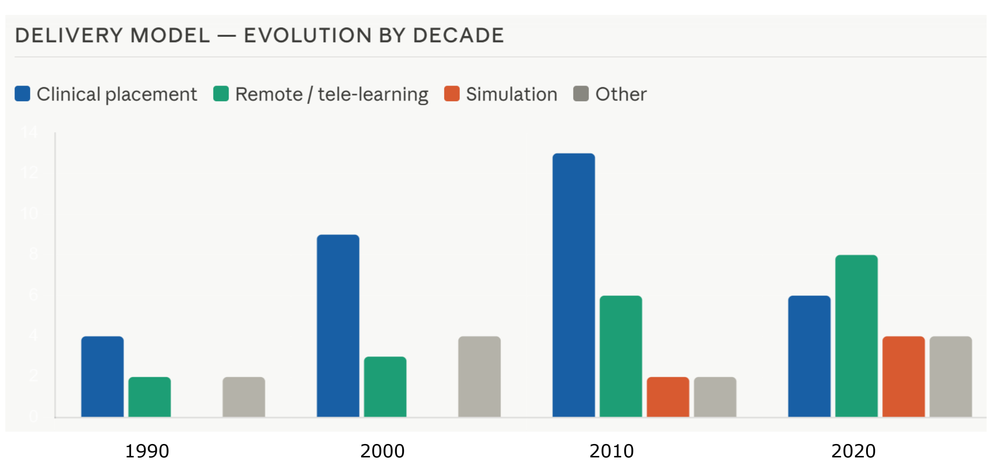

Fig. 3. . Changes in the type of programme delivery method over time

Postgraduate training for rural generalist practice

Scoping review · n = 67 · 1990–2025

~50/50	38 / 20 / 5	1 day – 4 yr	≤ 10%
Generalist vs extended specialty skills focus	Specialist / resident / intern stage	Training duration range	Report follow-up beyond 1 year

Clinical scope
Integrated generalism vs discrete upskilling — surgery and obstetrics dominate the specialty corpus; POCUS and emergency medicine are expanding.

Study design
Curriculum descriptions, service evaluations, needs assessments and commentaries predominate; comparative evaluations are rare.

Delivery modalities
Clinical placement near-universal; remote learning in ≈ 1/3; simulation clusters around emergency, anaesthesia and procedural skills; mentorship under-specified.

Duration heterogeneity
Three orders of magnitude; many pathways remain "variable" or unspecified, indexing self-regulated and non-accredited structures.

Outcome assessment
Self-reported confidence dominates; objective metrics (OSCE, logs, tests) in a minority; longitudinal skill-maintenance data scarce.

Geographic stratification
HIC: formalisation, credentialing, scope benchmarking. LMIC: task-shifting under workforce scarcity, with supervision as the rate-limiting factor.

Take-home
The evidence base is broad but fragmented: descriptive design, short or unspecified training durations, self-reported outcomes, and minimal follow-up limit causal inference on competence, skill retention and rural workforce impact.

FORMAL RURAL CREDENTIAL PATHWAYS
Australia (ACRRM), China,
New Zealand (Rural Hospital Medicine),
Scotland*

WITHIN FAMILY PHYSICIAN training with rural sub-theme
US, Canada, Japan,
Sweden*, Norway*, Republic of South Africa*

HAVE YOUR SAY!

Should there be an internationally consistent list of extended skills for rural generalists?

https://forms.gle/XdrSHDZoZydHrLi96

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