2026, Volume 58, Issue 5, 370-371, e-ISSN 1938-3800

Family Medicine

NARRATIVE ESSAY

Beyond the Shortage: What Rural Medicine Still Gets Right

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HOW TO CITE: Burmeister JR, Rubino IJ. Beyond the Shortage: What Rural Medicine Still Gets Right. *Fam Med.* 2026;58(5):370-371. doi: 10.22454/FamMed.2026.516413

FIRST PUBLISHED: May 15, 2026

I learned the meaning of family medicine in a place far from where I grew up. I was raised in one of the busiest and wealthiest corridors of the country, where hospitals rise like glass cities and health care moves with the speed of traffic on a good day. Medicine there felt enormous, intricate, and always in motion.

So when I signed up, somewhat naively, for a rural health outreach trip to southwest Virginia, I assumed the lessons would be about scarcity—fewer clinicians, fewer specialists, fewer resources. Rural communities, I knew, faced significant health challenges, including higher rates of chronic illness and preventable mortality compared with urban areas.[1] Still, what stayed with me was not what rural medicine lacked, but what it held onto with remarkable strength.

The work we did there was simple. We supported screenings, shared educational materials, and helped connect patients to community resources. But standing beside nurses and community health workers who had known their patients for decades, I began to understand continuity not as a curriculum topic but as a lived practice. I watched patients walk into the clinic and greet staff by name, sharing family updates before symptoms. Illness was never separate from identity; stories were never separate from care. Several clinicians spoke of caring for multiple generations of the same family—grandparents, their children, and now grandchildren—carrying forward not just medical histories but an understanding of family dynamics that shaped care.

One patient, whom I'll call Clara, came in for a routine blood pressure check. She had long struggled with medication adherence, and during the visit she quietly admitted that side effects frightened her and that getting to the pharmacy meant choosing between gas money and groceries. Because the nurse had known her for years, Clara spoke freely, trusting she would be heard without judgment. The visit shifted from managing hypertension to managing life. As she left, she touched my arm and thanked me for listening, yet in truth, I had barely spoken. What she needed was not another instruction but a relationship steady enough to hold her worries.

That experience taught me that continuity is more than a best practice; it is embedded in care. In rural communities, where hospitals have closed at alarming rates over the past two decades, leaving some regions without nearby emergency care or reliable access to specialty services,[2] continuity remains an essential part of infrastructure. When systems struggle, relationships often hold them together.

Yet even in those strong communities, I could sense that continuity was becoming harder to sustain. Many rural clinics now rely on temporary or rotating clinicians to keep their doors open. Patients told me they sometimes met a new doctor every visit, and they worried that their stories—and thus their identities—were being lost in the shuffle. I saw how much resilience continuity instilled across patients, clinicians, and communities—and how fragile it could feel when staffing was in constant flux. Rural medicine's strengths, and its vulnerabilities, coexisted side by side.

What surprised me most, however, was not the fragility but the creativity I saw everywhere. Rural clinicians adapted constantly, not out of desperation but out of commitment. Much of this adaptability was possible because these clinics retained a degree of local autonomy, allowing clinicians to shape care around their communities rather than conforming to distant system priorities. One clinic I visited had redesigned its intake forms with simpler language after realizing patients were silently skipping questions they couldn't understand. A nurse practitioner held group diabetes visits in a

church basement because patients felt more comfortable there than in an exam room. These solutions weren't innovations in the formal sense; they were acts of community sense-making, rooted in knowing what people truly needed.

Hope, resilience, and respect were woven into that work in ways I didn't expect. These actions were not naïve optimism, they were something quieter and more durable. I recall a clinician explaining colon cancer screening options to a man who had never heard of them. She didn't hide the barriers: the wait times, the transportation limits, the cost concerns. But she also didn't stop there. Instead, she offered a plan that was possible for him today, not someday. Hope, I realized, is not an emotion in medicine. It is a direction.

As my training continued in a large metropolitan health system, I often reflected on that rural community. In the city, feels fragmented—multiple specialists, brief encounters, stories told and retold because systems are too large to remember them. In contrast, I kept returning to what I had seen: continuity not as convenience, but as connection. Evidence supports what I observed, that continuity of care is associated with better outcomes and greater patient trust.[3] Yet in rural communities, the power of continuity felt even more deeply lived than measured.

Of course, rural practice carries burdens that aren't romantic. Broad scope can stretch clinicians thin. Community embeddedness can blur personal boundaries. Trainees today worry, rightfully, about balancing purpose with sustainability. Those concerns deserve honest attention and structural solutions, not calls to heroism. Still, the values I saw in rural practice—presence, trust, and adaptability—felt indispensable to the very heart of family medicine, no matter the setting.

I used to think rural medicine was a niche path, something chosen by a few with a particular calling. But now I see it differently. Rural communities helped me understand what it means to care for patients not as collections of problems but as people living in contexts that shape every decision. They showed me what medicine looks like when relationships drive care rather than revolve around it. They revealed that strength emerges when clinicians are allowed, and expected, to know their patients well.

What I learned in that rural town became a compass for my own training. It reminded me that medicine, at its best, is neither fast nor fragmented. It is steady. It is attentive. It grows in the space between familiarity and trust.

I do not know yet where I will ultimately practice. But I do know this: the lessons of rural medicine are not rural at all. They are universal. They remind us that even in a strained health care landscape, the most enduring solutions may not come from new technologies or complex systems but from the simple, difficult work of being present with people over time.

The communities I met did not teach me what family medicine lacks. They taught me what it still gets right.

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