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Personal View

The heart of community care: becoming a family doctor in rural Portugal

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Abstract

This perspective article, based on personal experience, reflects on a family medicine residency in rural Portugal, across a small town and two villages characterized by aging populations, high dependency rates, low health literacy, and social isolation. Family medicine residency training in resource-limited rural settings offers unique learning opportunities, demonstrating that effective primary care extends beyond clinical decision-making and requires continuity of care, community engagement, and adaptability to local contexts. Daily practice involved addressing not only medical conditions but also the social, emotional, and logistical factors influencing health, while building trusting relationships with patients, families, healthcare teams, and the wider community. This experience highlights the essence of family medicine and underscores the importance of rural residency training in cultivating adaptable, community-oriented, and person-centered family physicians.

Keywords

community engagement, continuity of care, family medicine residency, Portugal, primary health care, rural health.

Organizational context

The National Health Service (*Serviço Nacional de Saúde*, SNS) is Portugal's publicly funded healthcare system, established in 1979, with the aim of guaranteeing universal and equitable access to health care for the entire population, regardless of socioeconomic status. It was founded on the principles of universality, comprehensiveness, and the tendency towards free provision of care, and it operates under its own legal framework[1].

Primary health care (PHC) is the first point of contact between individuals and the healthcare system. As defined by the Declaration of Alma-Ata (1978), PHC comprises essential

healthcare that is universally accessible, scientifically socially acceptable, and delivered at a cost that communities and countries can afford[2].

In Portugal, PHC has evolved over more than 50 years since the establishment of the first healthcare centers in 1970. Two major milestones have shaped its development: the creation of the general practice medical career in 1982 and the PHC reform launched in 2005, which introduced the Family Health Units (*Unidades de Saúde Familiar*, USF) and transformed the organization of primary care[3]. In 1990, the specialty was renamed general and family medicine (*Medicina Geral e Familiar*), reflecting its broader scope and person-centered approach. According to WONCA, family medicine is an academic and scientific discipline and a clinical specialty oriented towards PHC, providing comprehensive, continuous, coordinated, and person-centered care[4].

Currently, PHC in Portugal is organized within the Local Health Units (*Unidades Locais de Saúde*, ULS), healthcare organizations responsible for ensuring the integrated provision of primary and hospital care[5]. Within the SNS, family physicians can deliver care through two types of primary care units: USFs and Personalized Health Care Units (*Unidade de Cuidados de Saúde Personalizados*, UCSP). USFs are autonomous multidisciplinary teams composed of family physicians, family nurses, and clinical secretaries, with organizational and technical autonomy and a performance-based model. UCSPs, in contrast, follow a more traditional organizational structure while providing the same comprehensive range of PHC[6].

These PHC units provide healthcare services across both urban and rural settings, as there are currently no specific types of PHC units exclusively designated for either context in Portugal. According to the Portuguese National Statistics Institute (*Instituto Nacional de Estatística*, INE), 12.3% of the Portuguese population live in predominantly rural areas, a classification based on criteria such as population density and the number of inhabitants per civil parish[7]. The concept of rural health has been defined in different ways in the literature, with population size, population density, cultural barriers, and distance from specialist or advanced referral healthcare services being among the characteristics commonly used to describe rurality in relation to health care[8].

Formation context

Regarding undergraduate medical education, the Medicine degree in Portugal consists of a six-year integrated Master's program. Family medicine is a mandatory curricular unit in Portuguese medical schools, although its weight in the curriculum varies between universities. As part of the undergraduate medical curriculum, students undertake supervised clinical training in PHC settings with family physicians. The University of Beira Interior has one of the highest curricular commitments to family medicine, with 30 European Credit Transfer and Accumulation System credits allocated across the medical curriculum[9-11].

Following this, graduates complete a 1-year general internship, predominantly in hospital settings, with only a 3-month rotation in PHC. At the end of this internship, a national ranking examination determines access to and selection of, specialty training. The duration of residency programs varies by specialty. In the case of general and family medicine, the residency spans 4 years, the majority of which is undertaken within PHC settings, gradually assuming responsibility for a patient list under supervision[12].

A residency at the 'end of the line'

When I chose family medicine, I knew I wanted to become a physician of proximity – the kind who knows patients by their names, who knows where and with whom they live. What I did not know was that being assigned to the last position available in a UCSP in Guarda – the 'position nobody wanted' – would become the best thing that could have happened to me. I found myself in what was then a single PHC unit, later divided into two USFs and one UCSP, leaving me with a residency carried out almost entirely in rural health settings: one small town and two villages. It was far from the headquarters, far from what was usually considered more attractive. Yet it was there, at the so-called 'end of the line', that I discovered the true meaning of family medicine.

It was within this framework that I carried out my residency in family medicine, not in a large urban healthcare setting, but in three small rural communities in Portugal's interior: two villages and one small town near Guarda. The district of Guarda is a large district in terms of territorial area, while having a low population density compared with other Portuguese districts[13]. The city of Guarda, its administrative capital, is home to a district hospital providing a range of medical and surgical specialties. However, despite being geographically close to Guarda, these rural communities are, in many ways, far away.

The populations of these three rural communities were markedly older and more vulnerable than both the populations served by urban healthcare settings in the city of Guarda and the national average. Among the patients I followed, 44.6% were aged 65 years or older, compared with 32.5% in the city of Guarda and 24.2% nationally. Dependency ratios were also particularly high: the overall dependency ratio exceeded 100% (compared with 73.6% in Guarda and 57.6% nationally), while the dependency ratio among older adults approached 91% (compared with 56.5% in Guarda and 38.2% nationally)[14].

Education levels also reflected longstanding inequalities. While nearly 20% of Portugal's general population have a university degree, in these villages the proportion was less than half of that. The proportion of residents completing secondary education was also lower, while illiteracy rates in the communities where we provided care ranged from 5.5% to 14.3%, compared with 3.1% nationwide[15].

Many patients had no reliable means of transportation, either because they did not own a car or were no longer able to drive. Public transportation was severely limited, with, in most communities, only one bus early in the morning and another late in the afternoon, while taxis were often prohibitively expensive. These transportation barriers were compounded by social isolation: between 19.8% and 25.4% of households in these communities consisted of adults aged 65 years or older living alone, many with children living far away or with no children at all[16]. As a result, many lacked the informal support needed not only to attend medical appointments but also to manage their chronic conditions.

Learning adaptation

Being a family doctor in rural healthcare settings was, above all, an exercise in adaptation. I did not have the same technical resources, the same logistical comfort, or the immediate support that larger centers could offer. Yet it was precisely in this more demanding

environment that I came to understand the depth of human relationships that words can scarcely capture. At the end of each day, as I drove away from the healthcare settings, along the main street of the village, neighbors would come out onto their balconies or doorsteps, waiting to wave goodbye with a gesture of quiet closeness. In those moments of shared recognition, the essence of my role became clear: I was not only a family doctor trainee, I was a living part of the community I cared for – and which, in turn, quietly cared for me.

What had the greatest impact on me, however, was not the numbers, but the realities I encountered in everyday practice within those communities. Each consultation was an immersion in a context that far exceeded disease or health care. Often, what I addressed were not only medical complaints, but social deprivation, emotional isolation, functional illiteracy, lack of transport, or even religious beliefs that influenced health decisions. I learned to listen differently, to communicate with different words, and to care with different tools.

In rural healthcare settings, care delivery extended far beyond the usual doctor–patient dyad. What truly developed was a triad: health team–patient–community. I worked side by side with parish councils, churches, cultural associations, schools, and neighbors. Health promotion here was inseparable from knowing people's daily lives, routines, and values, and adapting each interaction to their reality. Many patients came to the healthcare setting not only for clinical care, but also for a reassuring word, a conversation, or simply to be seen. I knew because I asked, but also because I was there, and because I allowed myself to become involved.

The challenges were many. Hospital appointments were difficult or even impossible to attend, health literacy was often limited, and supporting patients at the end of life demanded an emotional and logistical involvement that was only possible thanks to a fully dedicated team. But it was precisely there that family medicine revealed its strength: the ability to do much with little, to reach everyone, even at the end of bumpy roads.

Looking back

Today, looking back, I realize that I had the privilege of learning to be a doctor where doctors are most needed; where listening is both clinical and attentive to the community context; where every medical decision is guided by empathy; where every home visit is also an act of presence and dignity.

If asked whether I would choose this path again, I would answer without hesitation: yes. Because being a family doctor in rural healthcare settings is to live the essence of what our specialty has most nobly: proximity, continuity, and commitment.

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