Medical Education and Training for Rural Practice

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What is “Rural”

“Rural” is:

- outside big cities
- outside regional centres
- state of mind
- rural vs remote

Rural Health
Around the World

access is the rural health issue

- resources concentrated in cities
- communication
  and transport difficulties
- rural health workforce shortages

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Rural Health Care Delivery

- different from cities
- local services preferred
- not assume patients will travel
- specialists' support role
- partnership not putdown
- consultant support local service

Rural Practitioners

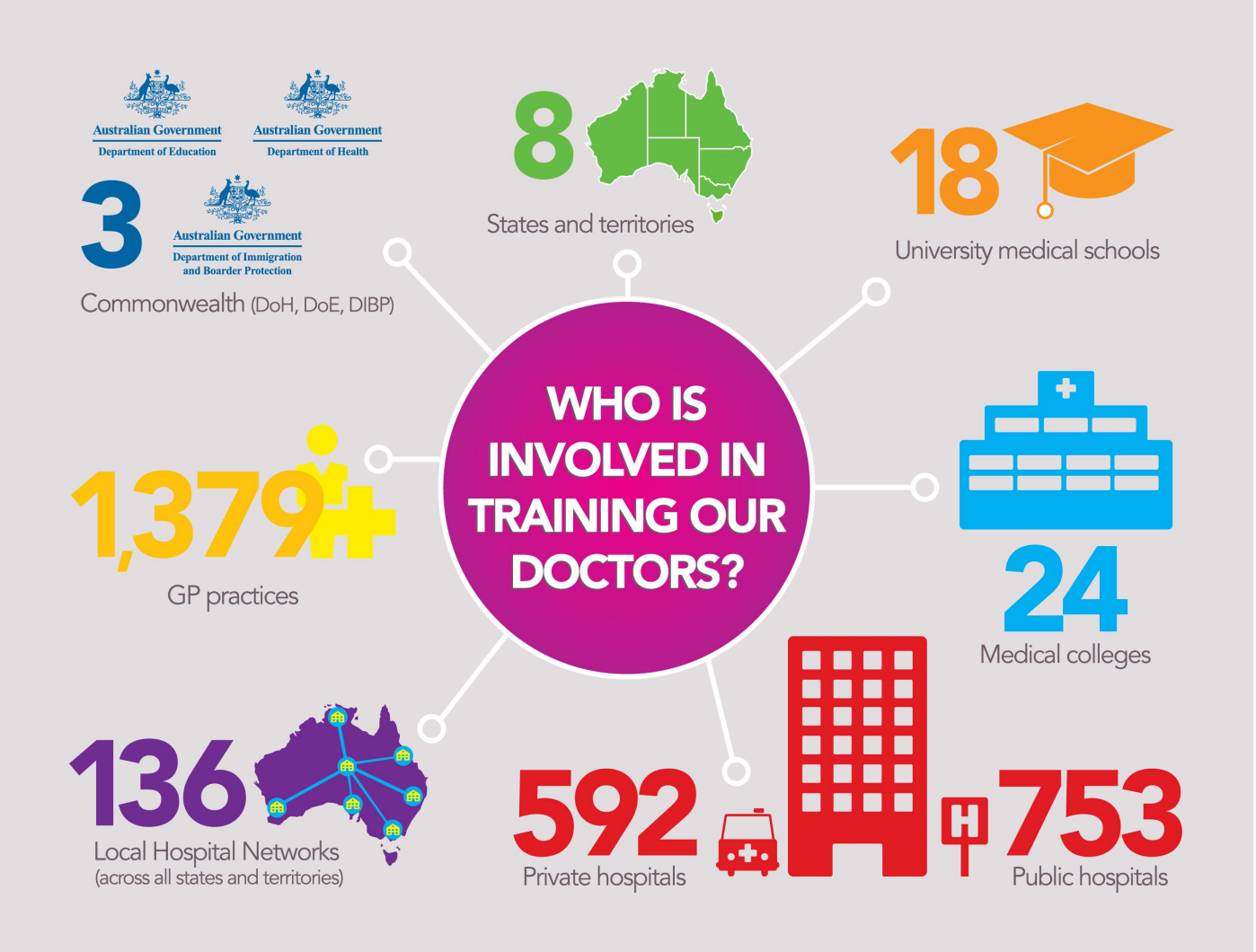
"Extended Generalists"

- wide range of services
- high level of clinical responsibility
- relative professional isolation
- specific community health role

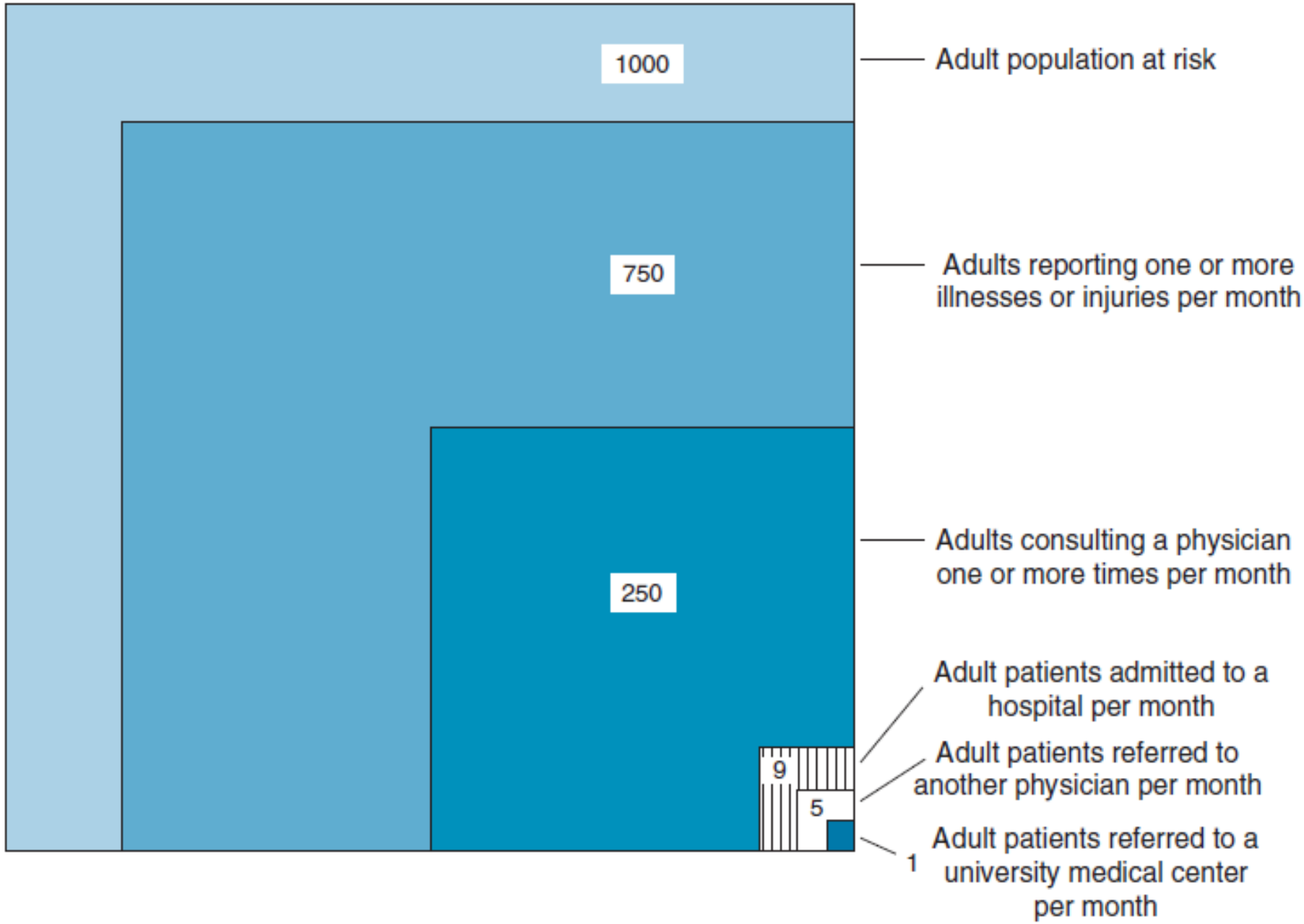
Health System Challenges

- machine-like - driven by deliverables / indicators
- risk of “hitting the target and missing the point”
- human dimension lost - patients feel alienated
  - health worker compassion fatigue / burn out
- fragmentation / disconnects of care / silos
  - from “hat tipping syndrome” to “black holes”
- healthcare is really about people and relationships
- policies designed in cities with negative rural impact

Medical Training Complexity



Australia's Future Health Workforce – Doctors 2014



Green LA, et al. The ecology of medical care revisited. *New England Journal of Medicine.* 2001. 344: 20212025.

“Hidden Curriculum” Assumptions

- sub-specialties are the pinnacle of health professions
- hospital care = health care
- community practice (GP/FM) is less complicated
  - the career if you are not good enough to be a specialist
- “rural” = second class or a lesser standard
  - city “geographical narcissism” - rural inferiority complex
- becoming a rural practitioner is the ultimate failure

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EDUCATION OF HEALTH PROFESSIONALS FOR THE 21ST CENTURY: A GLOBAL INDEPENDENT COMMISSION

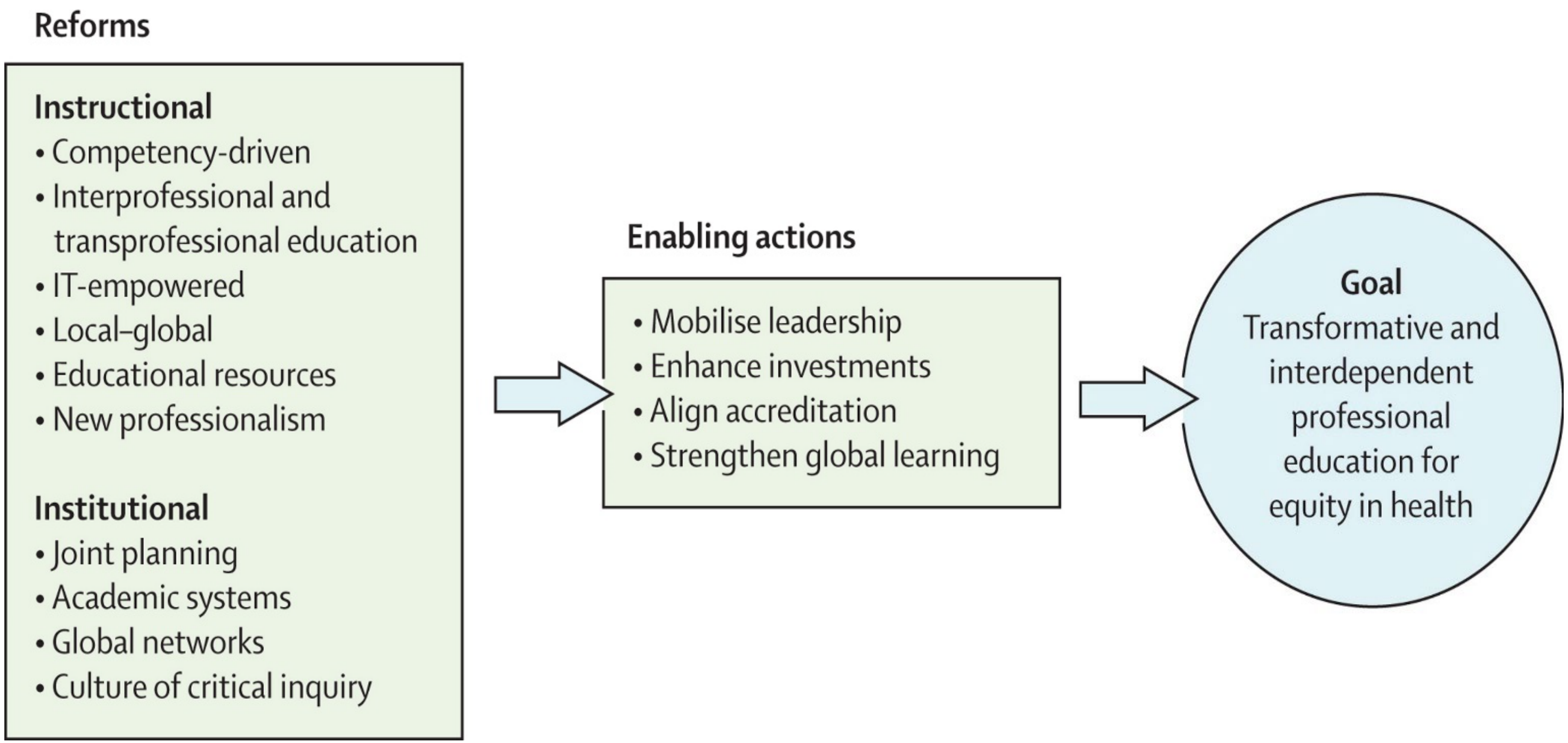
THE LANCET

Health professionals for a new century: transforming education to strengthen health systems in an interdependent world

Julio Frenk, Lincoln Chen*, Zulfiqar A Bhutta, Jordan Cohen, Nigel Crisp, Timothy Evans, Harvey Fineberg, Patricia Garcia, Yang Ke, Patrick Kelley, Barry Kistnasamy, Afaf Meleis, David Naylor, Ariel Pablos-Mendez, Srinath Reddy, Susan Scrimshaw, Jaime Sepulveda, David Serwadda, Huda Zurayk*

Frenk J, et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *Lancet* 2010; 376: 1923-1958

Recommended Reforms and Enabling Actions



Social Accountability

"Social Accountability of medical schools is the obligation to direct education, research and service activities towards addressing the priority health concerns of the community, region and/or nation they have a mandate to serve" WHO, 1995

"building accountability that relies on civic engagement, in which citizens participate directly or indirectly in demanding accountability from service providers and public officials"

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World Bank, 2009

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Fit-For-Purpose Health Workforce

- right skills, right care, right place, right time
- leadership, communications, team work
- addresses population health needs
- right mix and distribution
  - within and between medical disciplines
  - full scope of practice, top of licence
  - generalists and specialists in discipline
  - primary care and other levels of care
  - geographic mix and distribution

Valuing Generalism

- generalism is foundational for all doctors
- undergraduate education must focus on broadly based generalist content including comprehensive family medicine
- family physicians...must be integral participants in all stages of undergraduate education

Future of Medical Education in Canada, 2010

"a philosophy of care that is distinguished by a commitment to the breadth of practice within each discipline and collaboration with the larger health care team in order to respond to patient and community needs"

Royal College of Physicians and Surgeons of Canada, 2011

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Immersive Community Engaged Education

- students immersed in community and clinical settings
- generalist health care providers
  as the principal clinical teachers and role models
- socially accountable education
  grounded in community engagement
- authentic relationships focused on
  improving the health of local population
- successful production of skilled health workforce

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Longitudinal Integrated Clerkships

- breadth of exposure to clinical problems over time
- continuity of relationships with patients and clinical teachers
- simultaneously meet core clinical competencies across multiple disciplines
- graded responsibility supports growing autonomy and counters learned helplessness

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Rural Generalist Career Pathway

- rural high school health careers promotion
- rural community-led selection process
- prolonged immersive rural community undergraduate educational and clinical learning
- immersive community-based postgraduate training
- enhanced skills training for rural practice
- continuing professional development
- other career pathways while staying in rural community

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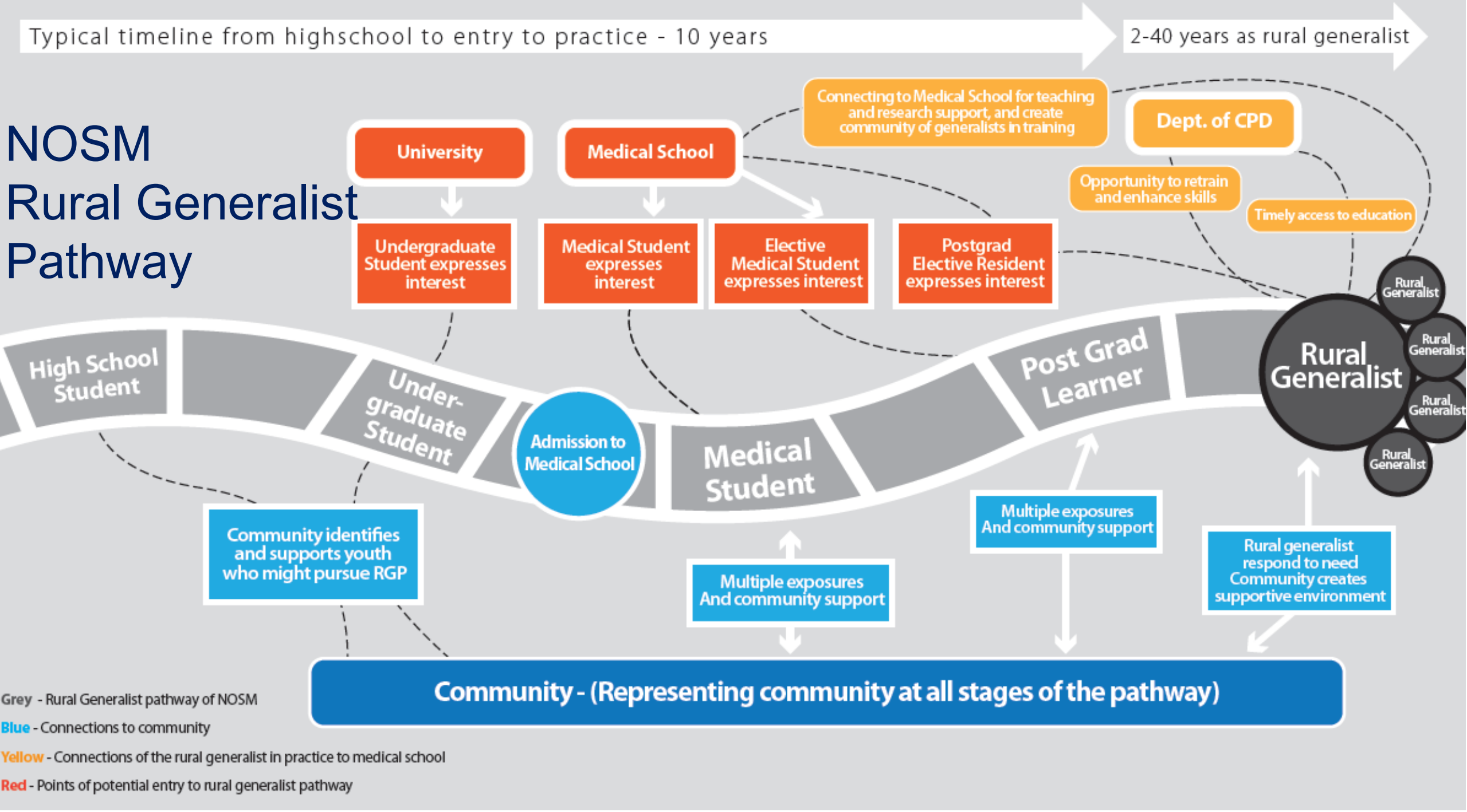
NOSM Rural Generalist Pathway



NOSM Career Directions after 10 Years

- 77% general practice / family medicine
- 14% general specialties
- 9% sub-specialties

- 63% of trainees stay in Northern Ontario
- 92% of FPs who completed NOSM undergraduate and postgraduate practise in Northern Ontario

NOSM Generalism in Rural Practice

- Rural Generalist Medicine is

- not an alternative to city-based specialist care
- explicit provision of quality healthcare within geographic, demographic and cultural context, and human and material resource constraints of rural communities

- NOSM experience shapes career choices
  - speciality, scope and location of practice

Rural Medical Education

- initially a response to rural workforce shortages
- rural practice requires specific knowledge and skills
- rural settings = high quality learning environments
  - more hands-on experience
  - more common conditions
  - greater procedural competence
- following a rural LIC, students have higher level clinical knowledge and skills / competence and confidence
- rural postgraduate training = more rural practitioners

Foundational Principles for Building a Sustainable Rural Physician Workforce

1. Grow your own "connected to" place
2. Select trainees invested in rural practice
3. Ground training in community need
4. Rural immersion - not exposure
5. Optimise and invest in general medicine
6. Include service and academic learning
7. Join up the steps in rural training
8. Plan sustainable specialist roles

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Socially Accountable Medical Education

- genuine interdependent partnerships - common goals
- respect and value all forms of expertise
  - community members and practitioners
  - generalists and specialists
- education and training where services needed
- “flipped training” - training based where future career
- prolonged immersive clinical placements
- visible pathways with support and encouragement

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