City mouse, country mouse
Different but the same

Tony Reid, MD, CCFP, FCFP

Are we all different? Most family doctors in Canada practise in urban environments, reflecting the distribution of the population. But many others practise either in smaller communities or more remote rural settings.

There is a stereotypical image that urban and rural doctors are two different breeds, characterized by different aspirations, scopes of practice, and professional satisfaction. The stereotype has urban family physicians practising mostly in offices, often with high-volume practices, and punting everything the least bit complicated to emergency rooms or specialists. Few do inpatient care or intrapartum obstetrics, and at 5 PM, they sign out to an emergency or entrepreneurial call group. In doing so, they are meant to enjoy a better lifestyle but give up some professional satisfaction.

In contrast, the stereotype has rural doctors practising a wider range of care in their offices as well as in hospitals with inpatients, emergency, or obstetrics. This is meant to lead to greater professional satisfaction although it results in a heavier workload. At times they feel overloaded and burned out. Such are the stereotypes, but how close are they to reality?

Urban family physicians

The articles in this issue reveal an interesting picture. The study by Bates and Andrew (page 337) shows that recent family medicine graduates in British Columbia who locate in urban centres are involved in a surprisingly wide range of practice, including inpatient care and obstetrics, although this might not reflect most urban physicians' scope of practice. What is striking, however, is that, while urban physicians might have given up some medical care to specialists, they have found other important areas that need attention. Many have developed special interests in inner-city health problems and care for mentally ill patients, people living with HIV, troubled adolescents, aboriginals, and street people. They truly reflect the principle of family physicians as a resource to the community. They appear to have taken up the challenges of their unique environments and are providing essential services in the health care system that are almost invisible and underappreciated, but so important.

With tertiary care hospitals and specialists so prominent in urban centres, the true role of family physicians is often lost, forgotten, or never registers with the medical community or the public. But we know that without them, the system would soon implode. Urban family physicians usually have more nonmedical activities to choose from, and they usually become involved in cultural, sporting, or local community events outside practice. Whether fundraising for the city's symphony or volunteering to clean up a hiking trail, urban family doctors are an integral part of their communities.

Melnitzer (page 293) captures, beautifully, the commitment of an urban family physician who really cares, and she shows how to connect with people who have severe medical and social problems. Here is an example of family medicine at its best: adapting to the environment and working through a mix of social and medical problems to improve, even if only a little, the lives of marginal people. After reading her story, no one could accuse her of having an "easy living" urban family practice. And her scope of practice is definitely far beyond usual office-based care.

Rural family physicians

Although less numerous, country family doctors seem to have made a greater impact on our consciousness with their wider range of care and well developed sense of purpose. In the past, as a group, they felt marginalized by urban medicine to such an extent that they organized themselves into a rural support group, and created a new publication, the *Canadian Journal of Rural Medicine*, to address their issues. It captures the unique positive aspects of rural practice and offers a sense of community and continuing medical education for family doctors in rural and remote areas.

The study by Incitti et al (page 320) confirms most of our preconceived ideas: rural family physicians do have a wider scope of practice but pay for that with longer work hours and a diminished sense of balance between work and personal life. It is worrying when rural women physicians find the balance unsatisfactory, given the increased

number of women graduating from family medicine programs. Some of the authors' suggestions for improving rural environments for women need urgent attention if we are to avoid more shortages of physicians.

Similar to their urban cousins, rural family doctors adapt to their environments by learning new skills to match their settings. Whether it is with skills in the intensive care unit, anesthesia, extra obstetrics, or surgery, rural doctors identify and fill the needs of their communities. As an example, the study by Iglesias et al (page 328) confirms that family physician surgeons perform appendectomies safely and seem to be able to triage the more difficult cases to specialist surgeons. These family physicians provide a valuable service to remote communities that could not support a specialist surgeon. They also become involved in nonmedical aspects of community life: coaching hockey teams, playing in musical groups, and supporting art galleries. This is easy in small communities. Volunteers are always needed. And rather than just attend an event, rural people usually participate. They will be the actors in a play instead of just the audience. Does this pattern begin to sound familiar?

Escape from the city

I believe the difference between urban and rural family doctors is less than imagined, something I can confirm from personal experience. I trained at the University of Toronto in Ontario, but could not wait to get away from the ennui of the big city. The scope and challenge of family medicine appealed, but it was seriously underrated by the tertiary care environment where I trained. I wanted to be a "real doctor" and headed to South Porcupine, Ont, which was certainly rural enough. That first practice was wonderfully satisfying, and I appreciated the increased scope of practice, the greater sense of knowing patients in their own context, and the easier access to the outdoors. I did miss some of the city's amenities, but I would not have traded my place for an urban practice.

Following a stint overseas, I returned to a practice in St John's, Nfld. Although it was located in a city, it was much more like a semirural practice, at a community health centre in an impoverished suburb of the capital. There, the feeling of rural practice was strong even though it was within sight of the city itself. At the same time, I also had a part-time "urban" practice in downtown St John's. Although the patients were different, and the settings quite different, I did not feel that patient concerns or how I reacted to them were all that different in each setting. There were certainly cultural differences in how illness presented and how a physician would manage problems, but the basic concerns of patients were remarkably similar. In both practices, people had similar anxieties about their health, wanted reassurance or guidance, and to a greater or lesser degree, took my advice. Basic human nature shone through in both settings.

And back again

Following another tour overseas, my wife (who is also a family doctor) and I returned to Toronto to be close to family and tried urban medicine again. We both developed very satisfying practices downtown in the biggest city in the country, where we adapted our practice again to fill new needs. We were able to continue with obstetrics but gave up inpatient care. Instead we developed skills in working on inner-city health problems related to poverty and women's issues. Were we less satisfied with our practices? Not really. At the coal face, the interactions with patients and colleagues were just as rewarding.

During our years in Toronto, however, the balance between advantages and disadvantages of city and country living were slowly tipping in favour of the country. After 7 years we moved to small-town Orillia (of Stephen Leacock fame) where family doctors were doing most of the primary care and where consultants consulted. We slipped comfortably back into the wider scope of practice and the greater interconnectedness that a small medical community offers.

Are we really that different?

Are city and country family doctors really that different? Yes and no. Although the settings and skill sets are different, the adaptation and commitment of family physicians is impressive wherever they go. Family doctors are the WD-40 of the medical world—the lubrication that makes the system work. Family physicians see gaps in care or needs in communities and move to fill those needs. In their daily work, family doctors in every location deal with similar problems, emotions, traumas, and human "cussedness." They address patient and community issues with unmatched dedication and resourcefulness. At the same time, they struggle to find personal and family balance, not always to their own satisfaction.

I suggest that city and country doctors are the same at their core: very caring, committed people. We should recognize our shared values and celebrate our common achievements. City mouse or country mouse, we are made of the same stuff.

Dr Reid *practises family medicine in Orillia, Ont, and is Scientific Editor of Canadian Family Physician.*