Reflections on the Rural Northern Initiative

Christopher J. Dainton MD

When I finished my medical training in downtown Toronto, Ont, the rural north was the last place I saw myself practising. If anyone had suggested it to me at the end of medical school, I probably would have scoffed.

But somehow I spent a substantial portion of my second-year family medicine rotation away from my familiar downtown Toronto teaching site, managing to secure 2 weeks of rural medicine north of Thunder Bay, Ont. It was the second time that I had exiled myself from the urban medicine that accounted for most of my medical training and residency. A staff physician from my home clinic supervised the trip. The locum position fell under the auspices of the Rural Northern Initiative, a new provincial program that brings academic family physicians (and their residents) to underserviced areas in designated towns across Ontario.

Unlike many towns of its size, our small community was surprisingly well-served by 4 family physicians and locums. It had not yet reached that vortex of demand that so badly outstrips supply that recruitment becomes an exponentially increasing challenge. Naturally, it was a resident's playground—an endless bounty of minor procedures, which would be done locally or simply not done at all. On weekends, the ultrasound machine sat idly in a darkened room in the x-ray department; it was not long before we were wheeling it out routinely in our assessments of urinary retention, abdominal pain, minor trauma, and even congestive heart failure.

Urban versus rural

Our small-town hospital paid lip service to the trappings of its bigger brothers; the beds, the drapes, and the charts were all the same, but the atmosphere was inexplicably different. In the emergency departments in downtown Toronto, doctor-patient confidentiality meant a conversation behind nothing more than a blue curtain, yet sensitive disclosures were wholly disregarded by the dozens of anonymous passers-by, nurses, and orderlies. In the small-town emergency department, the blue curtain possessed none of these magical properties. We wondered out loud whether a sexual history could be fully trusted when the same passers-by could easily be neighbours, colleagues, or even relatives.

In the short time that I was in town, I encountered patients in restaurants and stores who wanted to discuss their recently sutured fingers. In downtown Toronto, a curt nod would suffice in the unlikely happenstance of encountering a patient outside the clinic. Here, playing a round of golf with one's physician was not only obligatory but in all likelihood unavoidable.

The rural on-call experience usually meant a few patients added to the end of our clinic schedule; however, a few trickled into the emergency department until the late evening. There was an implicitly neighbourly quality to the emergency department visits: just as one would never knock on a neighbour's door at 2:00 AM to borrow a cup of sugar, conjunctivitis and coughs came reliably around midday, while hockey injuries, acute abdominal pain, and other items of necessity emerged unpredictably at night. The emergency department was the last line of defence. Failure meant calling the specialist in Thunder Bay—a far cry from calling the specialist upstairs, as was possible in the urban setting. Rural care was immediate and efficient, without a doubt, but whether it was definitive was entirely at the mercy of the physicians and nurses. There was no upstairs. Only Thunder Bay, located many kilometres across the empty wilderness of the Canadian Shield.

Ultimately, this led to a deliciously skewed view of the capabilities of the single regional tertiary care centre, based in a city that was an order of magnitude smaller than Toronto. Thunder Bay Regional Hospital—sight unseen—was the new ivory tower. It was not long before we wondered openly about referring our patients to its presumed pulmonary hypertension clinics. In an urban setting, the patient would be duly processed by the triage nurse, then by several medical students and residents. The wait could be long, the care uneven, and the demeanor aloof, but in the end, anything was possible if you waited long enough in the hallway gurney. The complicated, difficult patient would be shunted upstairs or discharged home to follow up with the histoplasmosis clinic several weeks later.

Undecided

The change from corporate medicine to a reliance on the comprehensive care model was refreshing. I had never considered the challenge and scope of rural practice. When I did, I found it compelling. For my adventurous side, it offered the opportunity to see a part of the country that I would otherwise never have visited. I remain undecided on whether I would permanently settle in a small town, but as a residency experience, rural practice is not to be missed.

Dr Dainton is a second-year family practice resident at St Michael's Hospital in Toronto, Ont.

Competing interests
None declared

La traduction en français de cet article se trouve à **www.cfp.ca** dans la table des matières du numéro de mai 2010 à la **page e201**.