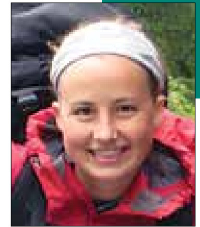

Rural residency programs

My case for a community-based curriculum

Megan Bollinger MD

"Hey, Dr Megan!" he shouted, with a few aisles of vegetables between us. "It's gallstones!" A patient I had seen in the clinic who was suffering from intermittent abdominal pain was now giving me his ultrasound results at the local grocery store. This is rural medicine, and exactly the residency experience I had hoped for.

My reasoning for doing a rural residency is this: I want to learn in the environment in which I want to work. I want to experience working in diverse settings, practising medicine in a small facility, and having my patients also be my neighbours. I was matched to just such a program at the Northern Ontario School of Medicine in Sioux Lookout, Ont. In June 2012, I packed my worldly belongings into my small hatchback, topped it off with a canoe and bike, and drove from Saskatchewan to Sioux Lookout—a place I honestly had not heard of until that spring. My 2-year residency is based in a town of about 5000 people, with a catchment area of 30 000. I live a 5-minute walk away from the hospital, the lake, the grocery store, and the cross-country ski trails. So the hatchback is parked, and I have settled in.

Reactions to my rural residency have been mixed. Many family members and friends picture me becoming a lonesome hermit in the forests of northern Ontario. When speaking with physicians, some are concerned that I will not get adequate training, be exposed to enough patient volume or pathology, or have the evidence-based teaching that is offered at larger academic institutions. However, many physicians are supportive and see huge benefits to rural-based training. During the past 18 months, my experience has confirmed that rural residencies are everything that I hoped they would be: relevant, engaging, self-directed, and responsive, as well as a lot of fun.

Tools of the trade

The rural clinicians I work with are incredible. They know what I need to know. They teach me what is relevant, like learning how to set ventilator settings in the emergency department, as there are no respiratory therapists in the area. I have been taught how to do procedures in the absence of the prelabeled kit .... MacGyver-style medicine. Mind you, I am not doing paracentesis with a straw, some floss, and a few pieces of duct tape; but I am taught what to do with tools found in most remote clinics. I have covered telephone calls from nursing stations in the north, and learned the complexities and frustrations of trying to transfer northern patients to larger centres. These are uniquely rural learning experiences. The physicians I have met are like pocketknives: compact bundles of widely diverse utility, with those little extra tools that often come in handy—and I do not mean the corkscrew. They practise generalist medicine with extra training in areas like obstetrics, anesthesia, orthopedics, and critical care. They have a variety of skill sets and a broad knowledge base. These physicians have taught me that in rural medicine you are the front line, and when you do not know something you figure it out. They also model a collaborative practice. A smaller, close-knit practice facilitates discussion among health care providers, and I find this reassuring. I know that I will not be alone when I step into practice; that in rural sites I can feel well supported.

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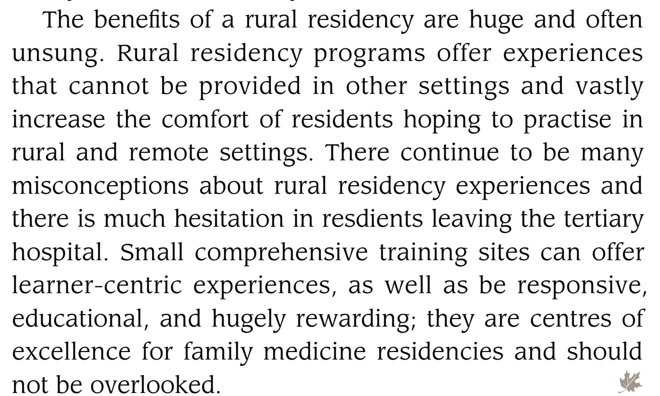
Empowered learning

Rural residencies can be much more responsive to learning goals than larger programs are. There are fewer students to schedule and rotations do not rely on students for service; therefore, scheduling is done to facilitate learning rather than to fill a call schedule. There is freedom to take advantage of learning opportunities where they arise; I have the flexibility to move between surgery clinic and the operating room, depending on the applicability of the case to my objectives. If things are quiet during a hospitalist rotation, I can wander to the emergency department to see a patient with chronic obstructive pulmonary disease. It is never boring. I get to be, and need to be, much more self-directed. As I acquire more responsibility in my training, I learn where my deficiencies lie and try to seek out experiences to improve in those areas. A 2-year residency seems incredibly short; being able to make decisions on how I spend that time is empowering and involves competency-based learning.

Continuity of care happens serendipitously when living in a small community. The patient with gallstones that I mentioned above went for his cholecystectomy while I was on my general surgery rotation. As there were no other learners in line, I assisted with his anesthesia then scrubbed in for the procedure. I go to a family medicine clinic once a month to follow a group of patients and their evolving stories. I enjoy the

connections I have made with patients through this process, and earning their trust over time has been very rewarding. I have even had secret fishing spots shared with me, which I consider a true marker of patient confidence.

The complexity of these patients, especially from remote First Nations communities, creates challenging and interesting medicine. I recently consulted a tertiary centre about a patient with multiple acute medical issues. The specialist sceptically asked if I had heard of Occam's razor and the idea of 1 unifying diagnosis. I had, in fact, heard of this rule but found that it did not always apply in this patient population. An unfortunate combination of poor socioeconomic conditions, rampant addiction issues, and restricted health care access contribute to a high burden of disease and advanced illness among many patients in the north. I do not agree with the perspective that a rural residency cannot provide enough pathology to facilitate sufficient learning in a family medicine residency.



The benefits of a rural residency are huge and often unsung. Rural residency programs offer experiences that cannot be provided in other settings and vastly increase the comfort of residents hoping to practise in rural and remote settings. There continue to be many misconceptions about rural residency experiences and there is much hesitation in resdients leaving the tertiary hospital. Small comprehensive training sites can offer learner-centric experiences, as well as be responsive, educational, and hugely rewarding; they are centres of excellence for family medicine residencies and should not be overlooked.

Dr Bollinger is a second-year resident at the Northern Ontario School of Medicine in Sioux Lookout, Ont.

Competing interests

None declared