Residencies Revolve Around Rural Care

—By Elissa Fuchs

While the old song says country roads may take you home, they may not lead you to better health care.

Rural Americans face massive health care obstacles. Only about 10 percent of physicians practice in the countryside, although nearly one-fourth of the population lives there, according to the National Rural Health Association (NRHA). The NRHA also reports that 2,157 geographic regions designated as health professional shortage areas are in rural and frontier areas, compared with 910 in urban settings. With this demonstrated need for more rural providers in mind, new family medicine graduate medical education (GME) programs have sprouted up to turn out more doctors who are both willing and able to perform countryside care.

Rural family medicine has a unique set of challenges. Unlike physicians based in metropolitan areas, rural doctors practice in remote places with few nearby specialists; thus, these doctors need to provide a wide range of services, from delivering babies to handling traumas to treating older patients. When rural physicians do collaborate with specialists, they may have to do so remotely. They may also have to provide effective care without all the latest diagnostic and therapeutic tools at their fingertips.

The residency programs may be uniquely positioned to reach the two-pronged goal of training doctors who both want to practice in rural areas and are equipped to meet the specific health needs of these regions. Because they have a stated rural medicine focus, these programs will most likely attract young physicians already interested in this type of care. By offering extra support, resources, and training, the programs can better prepare residents for the challenges of rural medicine.

The West Virginia Family Medicine Rural Scholars Program was developed in 2004. Perhaps its most innovative component is that it starts early—trainees apply to the program as third-year medical students. This selection process helps identify those who are interested early in their medical training. Students from West Virginia University School of Medicine and West Virginia School of Osteopathic Medicine may apply.

"A lot of women and men start medical school saying that they want to practice family medicine in smaller towns, but these numbers go down as people advance in their training," said Konrad C. Nau, M.D., chair of West Virginia University School of Medicine Department of Family Medicine-Eastern Division. "We realized we were missing a golden opportunity to get these people engaged in rural care."

By offering direct community experiences via training in small hospitals or small-group practices, the program tries to instill skills necessary for rural family medicine. Trainees gain exposure to the full scope of rural medicine. Because it can be difficult for patients in rural areas to get to the doctor, the program emphasizes interacting with patients by phone, e-mail, or even through house calls. At most training sites, an MRI machine is brought in only once or twice a week; residents learn to decide whether patients can wait a few days, or if they should travel elsewhere for immediate MRI access.

Because residents often collaborate with specialists who are not in-house, program administrators make resources available for remotely consulting with these professionals. A Medical Access and Referral System telephone line helps connect residents to West Virginia University faculty.

"We can dial in and say, 'I need to talk to somebody in pediatrics infectious diseases,'" said Justin Glassford, M.D., a rising second-year resident. "Often we are looking for guidelines or treatment alternatives, and talking to a specialist can open these avenues."

Good decision-making skills are necessary when communicating with specialists remotely.

"Ultimately, you have to decide whether to follow these specialists' recommendations," Glassford said. "They are still your patients, you are the one examining them, and you are in charge of their care."

Accepted students receive a $10,000 scholarship. There is no obligation for program graduates to practice in rural America, but Nau said that the program's first three alumni have pledged to stay in small West Virginia towns.

"If we are selecting the right people and rewarding them with a stipend and a quality training experience, that is going to work out on its own," Nau said.

The Hanford Family Practice Residency Program in California's Central Valley opened its doors to residents in 2006. Hanford is the rural track of the Loma Linda University Medical Center (LLUMC) Family Medicine Residency Program, headquartered about 60 miles east of Los Angeles.

After spending their first year at Loma Linda, residents move to Hanford's rural environment, where they train in a longitudinal model. This means that residents alternate between half-day blocks of learning specific aspects of family medicine. In a single day, residents may work in an intensive care unit, treat diabetic patients, and assist on a chest surgery, said Program Director Daniel L. Engeberg, M.D.

By continually switching gears, residents become better accustomed to the many medical roles they are expected to play as rural care providers.

"A rural family physician must immediately be ready to do something different," said Jamie Osborn, M.D., program director of the LLUMC Family Medicine Residency Program. "If we can train residents for something different every few hours, we can simulate real-world rural family medicine."

Residents learn to rely on their clinical judgment so they can be effective practitioners in areas with limited resources.

"Outside the patient's room, we constantly ask residents, 'If you didn't have this test available, what would you do?'" Engeberg said. "Residents are surprised about how accurate they are."

Like West Virginia, Hanford's program is contributing to improved rural health access: Its first two graduates will stay in rural California to practice family medicine doctors.