A warm place to practise: meeting the challenges of medicine in the North

Editorial

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Opportunity, diversity, challenge, lifestyle and practice satisfaction. Does this read like a classified ad extolling the virtues of a rural or remote practice? The ads are true, but they are often unsuccessful: few physicians come, and even fewer stay. A shortage of physicians in areas considered remote is still an important problem that besets the Canadian health care system.

I moved to Whitehorse in 1974 after training in Ontario. My adventure in the North was to have lasted 3 months. More than 2 decades later I am still here, with no intention of leaving. Whitehorse is remote, but it is not really rural, given its role as the capital of the Yukon and its population of 23 000. When I arrived, no physician here was over the age of 50, but many of my colleagues who came to the Yukon when I did are still practising here. Typically, it was young graduates who found positions in isolated areas. Some of them discovered an affinity for the place and its people, and stayed.

What makes practice in the North different from practice in the city? The locums who have filled in for me over the years may be in the best position to compare practice settings. Most comment, when they leave, that the patients they saw really were ill and appreciated a doctor's advice. They did not view physicians as a commodity to be made use of because health care is "free." Inappropriate visits and unreasonable patient demands were uncommon.

Unfortunately, many of the medical students and family practice residents who spend time with us feel that their training has not equipped them with the skills and knowledge they need to work outside a tertiary care setting. They have done few deliveries, and they haven't inserted chest tubes, set fractures, performed a manual removal of a placenta or been on a medevac. Even when, in urban settings, they did push for extra experience they were usually told that specialty residents needed the practice. "Besides," they were told, "you should always call a consultant to do that."

In light of my new responsibilities with the CMA, I have handed over my family practice to a locum for 2 years. It's a challenging job. In a typical day I would do rounds twice at the hospital. This is quite feasible, as the hospital is less than a 5-minute drive and an easy walk or bike ride from my home or office. In my office I might do a few allergy or dermatology consultations for my colleagues in addition to seeing my own patients. My practice is quite varied, and might involve treating someone with AIDS, adjusting insulin doses for a patient with diabetes who was awaiting kidney transplantation, monitoring someone with severe valvular heart disease, diagnosing porphyria cutanea tarda in a patient with hepatitis C, helping a family deal with grief after the suicide of a young man, dealing with routine prenatal visits, and seeing patients with hypertension and children with otitis media. On the way home I might make a house call to review the palliative care of a patient with cancer, or visit a long-term care facility to see a patient with Huntington's disease. In such a small community many of your patients are also your friends; this makes for close rapport and empathy during difficult times but is also stressful for the physician. Whenever possible I attend the funeral of any patient who has died; many families have said that this has been a great support to them.

I am not implying that urban physicians do not or cannot have a stimulating work environment. Still, across the country I hear physicians complaining that

they do not feel appreciated and that they are bored. Morale seems to be low.

Physicians offer society and their patients 3 things: skills, knowledge and time. In rural and remote areas all 3 must be optimized. Communication skills in particular may be challenged. For example, many First Nations elders speak neither English nor French. Body language can be difficult for the outsider to interpret: eye contact is not common, the presence of pain is not always expressed, and patients can appear to be withdrawn or shy until a rapport has been established. Many of my patients live hundreds of kilometres away; it is important that all their questions are answered and that arrangements for self-monitoring are made in one visit so unnecessary trips can be avoided. Last year at Christmas, temperatures hovered around –52°C. I considered cancelling my office hours, but every patient who had an appointment showed up, including those from Haines Junction, Mayo, Burwash Landing and Atlin — all more than 100 km away. This reinforced my belief that my patients value their visits.

In remote and rural practice it is vital for physicians to maintain their technical skills. The Yukon has only 2 general surgeons, who alternate calls. They provide general surgical care as well as cesarean sections, emergency orthopedic services, and emergency neurologic, plastic, urologic and vascular surgery. The training needs and the shortage of general surgeons in remote and rural practice settings could and should be the subject of another article.

We are lucky to have an obstetrician–gynecologist, a pediatrician who also does general practice, a psychiatrist and, more recently, a specialist in anesthesia. We have no internist or radiologist. As a result, the family physicians here have expanded their skills to serve the community. One physician provides ophthalmologic care, another does ultrasonography, another provides abortion services, another concentrates on chronic pain, counselling and acupuncture, 5 others provide anesthesia, and others concentrate on cardiology or emergency medicine. I provide allergy and dermatology consultations and work in occupational medicine. By developing specialized expertise in this way we are able to provide service without the expense of transporting patients by air almost 1500 km to Vancouver, our closest referral centre. It also makes for a very stimulating career.

Working in a rural or remote area is really a type of specialty practice. Medical schools are beginning to acknowledge this by including experience in rural settings in family practice rotations. This trend should be encouraged, but I would also urge that residents in specialties other than family practice also do a rotation in a rural setting. It is frustrating to have to explain to a neurology resident on call who criticizes you for not getting a CT scan before contacting him that there is no CT scan because there is no CT scanner. In my experience, the most helpful consultants are aware of the limited investigations available to us and emphasize clinical diagnostic skills.

Doing a rotation in a rural practice also exposes students and residents to some of the pleasures of rural life: cross-country skiing from one's front door, never having to wear a tie (except to CMA meetings), saying hello to people on the street, and being able to enjoy magnificent scenery and great fishing spots (which we keep secret).

Forcing physicians to go somewhere against their will won't encourage them to stay. Exposure to rural practice, appropriate training, reasonable remuneration and holiday time, opportunities for postgraduate training and employment opportunities for spouses will help to entice physicians to work and stay in rural and remote areas. To urban family physicians I would say: Try a stint in a rural or remote setting. The people are different, and you might enjoy yourself. You might even stay.

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