# Higher education versus higher learning for rural practice

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It's that time of year again: new medical students in the mill. In the past, rural doctors could have been excused for not noticing; now, it seems that the ivory tower has moved closer to the country. We in "rural" are getting more exposure, particularly to undergraduate students. Perhaps born of necessity, with not enough space on the "main" campus, distributed medical education is in. What an opportunity — both for us and for them.

Now, for some students this opportunity may be nothing more than a tourist trip into cottage country. However, with the reduction in career flexibility among specialists, distributed education may be the only opportunity that the future ophthalmologist will have to experience the rural side of the telephone. Other students are going rural regardless of what the ivory tower could do to them. However, there are some students who had never thought of rural medicine as a career choice whose eyes will be opened. Rural doctors do things. They are something. They can make a difference.

Postgraduate learners present opportunities for higher-quality rural education. Ignore The College of Family Physicians of Canada's "red book" of standards for a moment, and we can do, and should do, so much better. Recently, my general practitioner obstetrician colleague learned that his first-year resident was interested in rural obstetrics. He started teaching her how to cut, and after about 6 weeks (among a few other things that might be taught in a busy general practice) she was the primary surgeon on a cesarean delivery.

Thirty or more years back in the heyday of rotating internships, teaching procedural skills, including cesareans, was not a huge challenge. The challenge in 2011 is not in teaching procedural skills (although this is important for rural practice) but in keeping the "can do" attitude — in both preceptors and learners — warm during the rest of the learner's rotation.

That is the next step. Now that we have the learners among us we are proving that distributed education is as effective as (and, I dare say, in some ways more effective than) conventional medical education. However, the same old training curriculum for family practice that requires just an overall pass is not good enough for us. With the attitudinal agenda that is taught that general practitioners don't do, say, cesareans, that general surgeons don't pin hips (or do cesareans) and that even (cough) emergency medicine requires additional training, we are setting ourselves up over the generations to be able to do less and less with more and more training. It might be fine for the city (I lack the knowledge to make an informed opinion of that setting), but it serves the rural public poorly.

To counter this, we need to define core skills and abilities. There are specific competencies that every rural doctor needs at the outset. We need a rural medicine postgraduate training curriculum that can train to that higher standard and a few family practice programs that can lead by example. Let's demand it and let's do it. We are ready.