Occasional musings

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Is it irresponsible to publish procedural how-to's for rural doctors? Take the occasional epidural or caudal epidural steroid injection in this issue.[1,2] Don't you need (insert the time the expert took to learn his or her entire specialty) years of training to be able to do it safely? Don't you need to perform (use a number here that doesn't exist in rural practice) procedures annually to keep up your skills? How can a mere rural general practitioner do this work?

And yet, take David Howe, author of the paper on caudal steroid injections, who practises in rural Nova Scotia. He was taught the technique on a model at an orthopedics course in Colorado, and he tells me that over the subsequent 20 years he has practised the technique perhaps monthly. It's not a huge series, but it is a large number of patients who have had meaningful reduction in pain. Don't try to tell me that they would have all gone to Halifax to see a specialist for similar results.

Another example is rural obstetrics, as detailed in the updated joint position paper on rural obstetric care, also in this issue.[3] Rural obstetrics in this country is sustained by doctors who do occasional deliveries. Unless we are doing referral work, even those of us with large practices attend fewer than a dozen deliveries annually. There is evidence that, for obstetrics anyway, numbers do not matter, and that when patients with low-risk pregnancies have to travel for delivery, obstetric outcomes are actually worse.[3]

This does not necessarily mean that all procedures are for all doctors, rural or otherwise. It is my contention that you do need training and experience in broad-based general practice to perform these procedures. Doctors particularly suited to rural medicine are intelligent people who have had 5 or 6 years of training supplemented by country experience that, among other things, informs them of the needs of their communities.

That country experience provides many opportunities for cross-training. For example, the technique I use to insert intrauterine contraceptive devices (which I learned in residency), is the same technique I taught myself to do hysterosalpingograms and endometrial biopsies. The discretion in patient selection I use for a patient with a stenotic cervix (who is best seen by a specialist) is the same discretion I use to decide which patients with acute myocardial infarction I keep and which I send to a specialist (we are too far from the bright lights of the city to divert patients for primary percutaneous transluminal coronary angioplasty). The same ultrasound findings that I look for in the rare abdominal trauma patient with internal bleeding, I see in my patients with ascites before I tap them. The echocardiograms I read in the emergency department help me to interpret tracings of patients undergoing a treadmill stress test.

No, publishing procedural how-to's is not irresponsible. If anything, not publishing them would be a disservice to the rural doctors who are our readership and, by extension, to the patients they care for in this country and others.

REFERENCES

1. Minty R, Kelly L. The occasional epidural steroid injection. *Can J Rural Med* 2012;17:148-50.
2. Howe D. Caudal epidural injection. *Can J Rural Med* 2012;17:145-7.
3. Joint Position Paper Working Group. Joint position paper on rural maternity care. *Can J Rural Med* 2012;17:135-41.

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