

Clothing the emperor: rural training challenges and opportunities

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There is a new fashion in town for training in family medicine. It's just a bit drafty right now for the real world of rural practice.

Oh yes, the Triple C Competency-based Curriculum sounds good. "Comprehensive." I have no idea how to measure that, and neither does The College of Family Physicians of Canada. "Focused on continuity of education and patient care." Can we really teach continuity? Please don't think it's taught and measured by putting in half a day a week at an academic clinic. "Centred in family medicine." Yeah, go measure that too.

If the concept is too diffuse to objectively define, measure or evaluate, how do we know when we have succeeded?

To this cynical scribe, the only concept worthy of the ink is the competency-based curriculum. This is exactly what rural generalist doctors have been requesting.

In practice, what Triple C has meant so far is dropping mandatory rural rotations and downloading responsibility from the university to the rural preceptor to sign off on competency. Whereas the first bit really does raise the hairs (what were they thinking?), the second bit shouldn't.

We rural medical generalists, of all people, have always worked shoulder-to-shoulder with other doctors. It's how we ourselves learned many new techniques that were not taught in residency. We know which learners need to be shown, which could do with us leaning over the table and which could work on their own with us sleeping by the phone. Signing off on competency

just formalizes this training, and the question of competency is much more relevant than the questions involved in the previous fashion of evaluations.

The real question is, what is the competency being evaluated? That is the crux that needs to be pursued, and whereas the college can provide the framework, it's rural doctors who need to define our rural curriculum and convince residency programs to enact it.

Are residents competent in the diagnosis, investigation and management of more complex, chronic and advanced conditions that would normally be referred to a specialist in an urban setting? Are they capable of working at the primary, secondary and tertiary care level for complex conditions in consultation with regional specialists, based on community needs and geographic locations? Do they know when to refer? Are they competent working within a multidisciplinary and cross-cultural team, in which other team members also work in an advanced and extended role, often with different values and priorities? Can they handle common farm injuries, hypothermia, burns, fractures, attempted suicide, drowning, car crashes, and wilderness and disaster medicine?

And yes, can they attend low-risk and developing high-risk deliveries without local obstetric and pediatric support?

The fact that we can offer this training in rural areas has often been despite the training we ourselves have received. In the future, it should be because of the training we have received. Let's clothe the emperor with a rural curriculum. Ask your local residency program for it, and accept no substitutes.