Credential creep and rural generalist practice

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Do you need a CCFP(EM) to work in a rural emergency department? Yes, you do, is the unwritten curriculum that our undergraduates and family medicine residents receive at the foot of ivory towers.

No wonder, as, over the last 30 years, most Canadian urban emergency departments have become staffed entirely with CCFP(EM)s or Royal College Fellows. And yet neither of those 2 classes of specialist are the predominant provider seen in rural and remote parts.

The vast majority of physicians working in rural and remote emergency departments have always been rural generalist physicians. In Canada, that represents thousands of doctors. Even if most emergency medicine graduates locate in rural areas for the next 30 years, it is unlikely that the majority provider for rural emergency medicine will be anything other than the generalist physician. That's a good thing. The predominant rural provider needs to be a generalist.

There is nothing quite like generalism to support continuity of care, with known outcome benefits to patients, physicians and the system (with attendant reduced costs). We need more people trained in this mode, and preferably in rural settings.

Whatever the strengths CCFP(EM)s may offer for an urban emergency department, they may not be confident in the resource-poor rural emergency department (what, no magnetic resonance imaging machine?) or be able to deal with other aspects of rural generalist practice. This would include looking after the patient they admitted, after the patient has been sent to an inpatient bed (what, no internist to take over care?). These might be some of the reasons why the vast majority of emergency medicine graduates work urban and near urban.

Yet there is the fact that new family practice graduates, and particularly urban ones, may have limited training or confidence to work in a rural practice of any type. Are they safe? Probably, although without having a family practice curriculum that specifies and tests for rural competencies, it's hard to know. We need that curriculum, and soon, to support our assertion that rurally trained generalists are qualified to undertake the scope of practice that our communities need.

I suspect that the challenge of entering practice has always been a challenge for new graduates, regardless of credentials; that when you became a new rural doctor (unless you lacked insight), you were unsure, you were slow, and you frequently asked for help from more experienced colleagues and allied health care professionals. It's that support, that mentorship, that has been informally present that allows for safe practice until the new doctor gets up to speed.

My experience is that credentials are, regrettably, poor proxy for competency. Mentorship and the ability to work with a supportive team is what makes you safe in rural practice.