The price of living rurally

Among the many surprises I faced was the degree of advocacy, the number of back-and-forth phone calls, and the amount of time and effort expended for patients to access the resources they needed.

Cynthia Kong

I had just finished my rural family medicine rotation and, riding on the Greyhound bus back to Vancouver, I was already deeply missing the countryside. I was born and raised as a city girl, so rural medicine was the last thing on my radar when I started medical school. But now I think there are too many people, too many cars, and definitely too few cows in the city landscape.

I have wanted to be a pediatrician for as long as I can remember. I love working with children, navigating family dynamics, and studying pediatric physiology, and I saw medical school as a series of hoops to jump through to reach my ultimate goal. Now that I'm nearly a fourth-year medical student, I'm no longer as sure. Every so often a new rotation steals my heart and makes me wonder. What if I was meant to be a gynecologist? Or an emergency physician? Or even—dare I say it—a family doctor in rural BC? Each path has its pros and cons, but it is rural medicine that is keeping me awake tonight.

Family medicine, particularly in small communities, has a charm that I haven't experienced elsewhere. There is an incredible depth and history to the doctor-patient relationship when all the members of a family can see the same physician throughout their lives. During my time in a small community I, too, had the chance to see patients over a series of follow-ups, and I was drawn by the relationships that transpired: chatting excitedly with the bright but shy teenager—who had barely said a word a few weeks earlier—about her university plans and aspirations; understanding a vulnerable mom's hectic schedule at each weekly prenatal checkup; listening to a gruff elderly man with chronic pain share stories of the beautiful garden he pours his heart into since his wife passed away. At times I was even able to relate to the challenges that their health conditions presented in their school or workplace—after all, there was only one local grocery store, brewery, and pastry shop in this small town of 1000.

Having worked in some of the biggest centres in the province, however, I had to rewire my brain to fit the small town clinical setting. At 5:30 a.m. on my first call shift, a patient presented with classic signs of gallstone disease. But was it biliary colic, choledolithiasis, or gallstone pancreatitis? I presented the case to the attending physician and rattled off investigations. "I would order a CBC with diff, electrolytes, liver enzymes, serum lipase…" My supervisor stopped me in my tracks. First, the lab didn't open until 8 a.m. on Saturdays, unless we wanted stat bloodwork. Second, the clinic couldn't do stat liver enzymes and certainly not lipase. It would take days for them to be sent to Prince George, analyzed, and results reported.

The case was ultimately straightforward—biliary colic, which responded well to symptom control. No bloodwork, no imaging, happily home with return-to-care instructions. I was shocked! When I relayed the story to my preceptors in the morning, they simply laughed. "Welcome to rural medicine!" they said.

However, there are also challenges faced in rural family practice that are no laughing matter. The admiration I hold for my preceptors for their deft clinical skills, knowledge, and dedication can only be rivalled by how astounded I am at the daily battles they fight. I was used to practising in institutions where the CT scanner and surgical suites are just steps away, the trauma team is paged before the CTAS-1 arrives, and the stroke team is on scene when the patient's stretcher is rolled from ambulance to ER. Even though I didn't expect to find state-of-the-art imaging, specialists of every variety, and ERCP equipment for my gallstone patient in this little town, I was surprised by the limited resources available. Another surprise, however, was the degree of advocacy, the number of back-and-forth phone calls, and the amount of time and effort expended for patients to access the resources they needed.

Divisions of Family Practice has

Ms Kong is a UBC medical student in the class of 2016. Her interests include rural medicine and understanding the challenges faced in providing health care in remote areas.

This article has been peer reviewed.

identified the need to move critically ill patients who cannot get the care they need locally as a rural priority.[1] I couldn't agree more. I believe everyone involved is trying their hardest when it comes to saving the lives of those who are ill in a remote area; however, 4 hours is a very long time for a patient with new–onset unstable angina to wait to hear back from the accepting facility, followed by another few hours for transport to be arranged, or for the patient with epistaxis who underwent every tier of management but whose case took ample explaining before it was accepted and sent down for ENT assessment (he was found to have a complex posterior bleed and required 5 hours of surgery). Even longer was the 6-hour wait for confirmation of transport for a patient with severe eye trauma—the patient was shielded, stabilized, and ready to go in the first 10 minutes of ER presentation but ultimately lost his eye due to the delay in reaching a bigger health care centre. Someone in this town once said to me, "This is the price of living rurally." That phrase has stuck with me.

The rural family doctors I have had the honor to meet and work with are amazing, persevering individuals with incredible commitment to their work and community. And while they take great pains to stabilize and best manage the patients they see, sometimes the most difficult parts of a medical emergency are finding support to arrange a hospital transfer and making the transportation happen.

As I pick my upcoming electives and think about my future as a physician, my love for rural practice is rivalled by these logistical, systemic issues that seem to be part of the job description. The problems seem too multifactorial, too difficult to even begin to solve. I asked my preceptor why rural family doctors would choose to work in a job like this. I felt a lump in my throat as my preceptor looked back at me and answered without missing a beat, "Let me flip the question on you. What is so special about rural medicine that you think keeps us all here, despite the challenges? Why do I love my job?"

I can't quite put it into words, but I feel it, and I love it here too.

Reference

1. Divisions of Family Practice. Priorities: Patient transport and transfer. Accessed 20 October 2015. www.divisionsbc.ca/rural-remote/patienttransport.