Telemedicine and rural care

Telemedicine can be a marvellous bridge between rural hospitals and tertiary centres, but the spectacular case recounted by Bruce Campana and colleagues[1] may not illustrate this point well. Telemedicine works best when it does not degrade local care. The article seems to imply that the rural hospitals involved would deny patients proper care without the video presence of an urban specialist. This implication insults the staff of rural hospitals without access to telemedicine, who competently handle a variety of serious conditions with outcomes equal to or better than those achieved by their tertiary care counterparts.

Drilling a burr hole, although a rare procedure, is not a skill requiring advanced neurosurgical expertise. Rural doctors have sometimes had to do craniotomies themselves, the skill being swiftly acquired.[2] Perhaps the local hospital described by Campana and colleagues lacked training and equipment, given that many rural facilities are becoming triage centres that also offer geriatric and palliative care. More likely, however, the telemedicine — while providing a measure of reassurance for what is probably a superb rural hospital — reinforced the authors' notion that burr holes, trauma or any advanced care cannot be handled competently without an urban specialist.

No one knows the financial cost of making telemedicine widely available in rural Canada, but enhancing local skills and equipment (through provision of CT scanners and operating rooms along with well-trained generalists) could probably be achieved at a fraction of that expense. The latter option would improve morale and outcomes more than images on a video screen. Telemedicine could then be used in a more selective, effective manner than the authors' "protean" hopes.

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A life in the country

James Rourke[1] suggests numerous strategies for increasing the enrolment of students of rural origin, in the hope of increasing the supply of rural physicians. Yet these proposals fail to address the fact that many rural students will not return to small communities after training; furthermore, many nonrural students with the type of outdoor interests suggesting a likelihood to take up more isolated practices never leave the city where they trained. Even smaller cities are in a chronic human resource crisis.

One has only to look at the training of physicians to see why. To be accepted into medical school, candidates must already have completed a 4-year honours course, and they have often made 2 or 3 applications to med school before they are accepted. With a minimum of 6 years at medical school before they are free to decide where they will practise, these new doctors have already spent at least 10 years at school, often in the same large city. Given that many of them will have taken extra time in high school to ensure top grades for their initial university admission, the "young doctor" is, at 30 years of age, no longer young. Most will be married or in a committed relationship, with the other partner established in his or her own career. Some will have children and mortgages. Their friends and social activities will be centred close to where they trained. Is it any wonder that they don't up and move even 50 miles from a major city?

The answer is not going to be a medical school in every community, because that would dilute the enormously important "centre of excellence" function of these institutions. Rather, the solution must include reducing the length of training. Making a 2-year premedical program the prerequisite for medical school, instead of a 4-year honours degree in an often unrelated subject, would go a long way to producing the kind of younger and more adventurous physicians we require.

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Reference

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Readers concerned about the issue of increasing enrolment of rural students in medical school, as addressed by James Rourke,[1] may be interested in a new initiative at Queen's University that is intended to better prepare students for the realities of rural life. "Professionals in Rural Practice: An Interdisciplinary Approach" is an elective course for undergraduate students in education and health sciences (medicine, nursing and rehabilitation therapy) and for graduate students in theology, which will be offered for the first time in fall 2005. Many issues of rural life are similar for people in all these professions. A research component will assess whether