Bridging the divide: rural exposure for urban medical students

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There is no doubt that rural and urban medical practice differ. Rural family physicians are reported to participate in a broader range of clinical activities, including emergency medicine and obstetrical care, and are more likely to have hospital privileges.[1] Rural physicians tend to work a greater number of hours per week and spend less time on each type of activity.[1] They deliver health services to populations with different characteristics than those in cities. Namely, rural populations have comparably higher dependency ratios (i.e. more children and seniors and fewer working age people), lower levels of education, higher unemployment rates and lower incomes, lower immigrant populations, and often a high proportion of Indigenous peoples.[2] At the same time, rural regions struggle to be adequately supported by health professionals. While 17.6% of Canada's population is located outside of population centres, only 8.2% of physicians live in rural areas.[3,4]

The question of how to successfully recruit and retain rural physicians has arisen time and again.[5] Rural upbringing and an existing interest in rural family practice are considered to be strong predictors of future rural practice, altough a multivariate approach will ultimately have an additive impact.[6-8] This includes targeting urban origin medical learners who may not have previously considered rural practice. As two rurally-interested medical students at the University of Toronto, we have taken a personal interest in understanding the value of rural connections and clinical exposure early in medical training to help direct career choices. Not surprisingly, we are not the only ones.

The College of Family Physicians of Canada outlines a "pipeline" approach to improve rural physician recruitment. This pipeline focuses on different stages of development of the rural family physician - from targeted medical student selection to providing rural exposure in undergraduate and postgraduate medical education.[9] The concept of using medical school programs to increase rural physician supply is not new. Programs have existed in North America as early as the 1970's, and countless examples have been successful since then.[10,11] For example, the Rural Physician Associate Program in Minnesota is a 9-month rural clinical training program during medical school, which has graduated a high proportion of rural practitioners relative to other US schools.[1,2] Though longer immersive programs correlate better with rural career choice, even short-term placements (e.g. 3 weeks) delivered by urban medical schools can positively influence intentions and attitudes toward rural careers.[7,10,13,14]

At the University of Toronto, the Rural Medicine Interest Group (RMIG) is putting this very concept into action. Founded in January of 2016, this entirely student-run organization now hosts a diverse lineup of speakers, a community medicine experience day, and a mentorship program for interested students. We know these programs help learners interested in pursuing rural medicine as they provide opportunities to network and gain insight into their future practice. However, what is the influence on students who may not otherwise consider rural careers? Are these short programs enough to persuade students of urban and suburban backgrounds of the benefits of rural practice? We have noticed that the opportunity for hands-on clinical exposure attracts learners to participate in the RMIG programs, irrespective of initial intentions to pursue rural careers. The Rural Medicine Community Experience Day, for example, facilitates a community visit for 40 medical students to practice clinical skills while learning about life in that town. The mentorship program helps students arrange a clinical observership with a rural mentor. Thus, even when students are motivated by clinical exposure, they may inadvertently find a new career interest. While the RMIG is actively evaluating the effectiveness of its formal mentorship program, we believe there is also an important role for the numerous informal connections facilitated via the network of rural physicians that have been invited to speak.

For Tristan, beginning medical school at the University of Toronto provided a wide variety of specialties and subspecialties to experience: cardiology, endocrinology, women's health, orthopedic surgery, HIV clinics, and so forth. He had not considered or been exposed to rural medicine until a chance encounter with a rural physician recruiter landed him in the emergency department of Lindsay Ontario's Ross Memorial Hospital as an elective student in his first summer of medical school. That one elective showed him a side of medicine he had not considered before. He was enamored by the scope of practice, the possibilities for career diversity, the lifestyle, and the sense of community and collegiality found among the physicians he worked with.

It only took one experience and one connection for Tristan to start along the path of rural medicine and catalyze his journey forward. Following that path has provided him with many new opportunities in medical school and we suspect it will take him to many other communities facing resource inequity. Tristan's story is not unique. We like to imagine the possibility of an urban university full of medical students whose perspectives have been broadened

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to include new career considerations as a result of rural exposure. Career exploration is difficult, especially when certain options are not readily available. The RMIG aims to ease these challenges by providing urban medical students with a chance to experience the rural side of medicine early in their careers.

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