

COMMENTARY

Continuing medical education as a map to guide rural physicians

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As with any good article, the recent *Rural and Remote Health* article by White, Willett, Mitchell and Constantine supporting the concept of continuing medical education (CME)¹ raises far more questions than it answers.

How do researchers separate CME from collegiality and vacation time since many return to home or former training locations for CME?

How does CME in sit-down sessions compare with immediate contact CME forms, such as web services or phone or telemedicine, more relevant to immediate patient care and more likely to result in more and better information obtained and retained for future use?

Does the CME involve significant efforts regarding personal and professional management? Rural physicians all have

strengths and weaknesses, but weaknesses in these areas may lead to poor retention.

The types of physicians who benefited most or least may give clues as to whether the information was important or whether other factors such as interpersonal contact were more important.

Any intervention that prolongs rural services is important. What was the relationship of participation in CME, rate of CME, or type of CME to initiation of rural practice or to date of leaving rural practice? What were the responses regarding CME to those who are planning to leave in 1-2 years, 3-5 years, 6-10 years, or not planning to leave?

If nations and states had the choice between spending resources on CME and on improving interactions between



physicians, family, and community, they might spend 90% on interactions and 10% on CME, given studies about integration, relationships, spouse impact²⁻⁶ or practice building²⁻⁷. Since medical training sites do much of the CME, they usually reverse the spending. They also do the research on CME that often guides spending. Retention studies suggest the need for more detailed and prospective studies but simple studies are much easier to do in the course of daily work.

There are also choices that border on CME with a twist. One is the “residency without walls” model in Alaska where exchanges of faculty for practitioners are anticipated in the future to meet the needs of both. Supporting and implementing these exchanges may be a challenging area for local and state support.

A traditional top-down model of CME may also be a problem. In an interactive world, CME has changed and is more interactive, but not all forms have changed. When rural practitioners give the CME, their recognition or remuneration may be support in itself. In initial surveys regarding the design of a faculty development program involving rural preceptors and rural faculty, just as many wanted to give instruction as receive. The best faculty development sessions for the program were interactive. They were also based on projects developed by the “minifellows” and therefore extremely relevant to their lives and careers. CME rarely addresses specific needs so well.

The quality of the CME may also be critical. Repetition of previous information is deadly for experienced practitioners. Ensuring time for interaction means practitioners could query each other and experts regarding their most challenging situations.

For retention in my case, training regarding the informal leadership of rural communities would have been important. Retention would have also meant much better hospital board training and better local decision-making so that the health-care system remained strong. Newer interventions such as office manager monthly exchanges, hospital network

development, and regional organizations of rural physicians can also have impacts on offices, systems and retention.

With physicians growing up in environments with less and less human interaction, with nearly all physicians growing up in the highest status families with less comfort with lower and middle income and rural peoples, with most rural physicians coming from urban origins, the challenges in these areas will mount. Much of retention, really about personal growth, is about becoming a better physician, especially in rural areas. CME can be a factor in this growth, but there may be more efficient and effective methods. Being a rural physician is often a most effective way to grow, especially with some level of support to help overcome the bumps in the road. CME that smoothes the bumps and provides a better map to guide rural physicians to a better experience and around impassible barriers would be welcomed.

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References

1. White CD, Willett K, Mitchell C, Constantine S. Making a difference: education and training retains and supports rural and remote doctors in Queensland. *Rural and Remote Health* 7: 700. (Online) 2007: Available: <http://www.rrh.org.au/> (Accessed 6 June 2007).
2. Cutchin MP. Physician retention in rural communities: The perspective of experiential place integration. *Health Place* 1997; 3: 25-41.
3. Hays R, Wynd S, Veitch C, Crossland L. Getting the balance right? GPs who chose to stay in rural practice. *Australian Journal of Rural Health* 2003; 11: 193-198.



4. Hays RB, Veitch PC, Cheers B, Crossland L. Why doctors leave rural practice. *Australian Journal of Rural Health* 1997; **5**: 198-203.

5. Mayo E, Mathews M. Spousal perspectives on factors influencing recruitment and retention of rural family physicians. *Canadian Journal of Rural Medicine* 2006; **11**: 271-276.

6. Veitch C, Grant M. Community involvement in medical practitioner recruitment and retention: reflections on experience. *Rural Remote Health* **4**: 261. (Online) 2004. Available: <http://www.rrh.org.au/> (Accessed 6 June 2007).

7. Bowman RC, Crabtree BF, Petzel JB, Hadley TS. Meeting the challenges of workload and building a practice: The perspectives of 10 rural physicians. *Journal of Rural Health* 1997; **13**: 71-77.