

. Letter

Rural Medicine: Its Own Specialty?

Dear Editor:

The specialty of family medicine was organized in response to the specialist-heavy medical world of the 1950s.¹ Times have changed. In some urban areas, there is no shortage of primary care physicians and mid-levels to serve the needs of most patients. However, despite one fifth of the US population living in nonmetropolitan areas, only 10% of physicians practice there.² Family physicians are the specialists most likely to work in rural areas, but two thirds work in metropolitan areas with populations more than 250,000.³ Over the last decade, the overall trend has been downward in family medicine residency matches.⁴ The American Medical Association estimates that 16,000 more physicians are needed right now to alleviate medical needs in underserved areas.⁵

Rural medical care is in trouble, and it is time for rural medicine to become its own specialty. Rural medicine requires a unique skill set, both broader and deeper than that required by physicians in urban or suburban areas with quick access to specialty colleagues. Primary care practitioners consult sub-specialists easily in most urban settings, and transport to tertiary care is usually fast and efficient. In contrast, rural physicians must be trained to deal with a wide variety of serious medical problems in the absence of specialist colleagues and often hours away from advanced care.⁶⁻⁹ The different medical skills required in the rural setting justifies a unique type of training.

How would the board-certified rural medicine physician differ from today's family physician?

First, the residency program would be longer. Three years is insufficient to become proficient in the wide and deep knowledge base required for competent rural practice. A 4-year residency would be necessary.

Second, the curriculum would change. Rural medicine residencies would preserve much of the current curriculum of family medicine. However, unlike many family medicine residencies, rural medicine programs would emphasize the following areas:

- Procedural learning (eg, endoscopy, operative obstetrics);
- Emergency medicine (particularly orthopedics, trauma stabilization, and critical care fundamentals);
- Psychiatry (given the lack of mental health resources in most rural settings); and

- Radiology (since most rural physicians depend on distant radiologists).

Ideally, rural medicine residencies would be based in hospitals with no specialty residency programs, allowing maximal participation in hands-on procedural and surgical learning with emphasis on individual competence. Frequent experience in rural settings would be required. Courses on small-town dynamics, dealing with solo- and small-group practice, agricultural medicine, hospital board interactions, medical direction of volunteer emergency services, and coroner training would be included.

In rural medicine residencies, residents would be explicitly training to leave the area and to serve in settings in which sub-specialists cannot. A rural physician performing endoscopy in a rural setting is not competing with a gastroenterologist in an urban area. Many rural patients are not able or willing to travel the hours it takes to see a specialist for a consultation, then have the procedure, then go to a follow-up visit. Rural patients often will simply not undergo the inconvenient procedure. A well-trained rural physician would fill this gap.

This new specialty would also be in an advantageous position to receive funding from small towns or counties looking for physicians, towns that have sponsored local students through medical school, and grants from philanthropic and government programs to support rural causes. Physician recruitment and retention efforts by rural communities could be easily directed toward rural medicine residencies.

A rural medicine specialty would recognize the unique challenges of these settings. Urban areas enjoy multiple overlapping primary care and non-primary care physicians, but rural communities require specially trained physicians with the experience to perform many procedures and competently handle most common and critical illnesses.

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. Erratum

In the Spring 2009 issue of *The Journal of Rural Health*, in the article titled "High Self-Reported Prevalence of Diabetes Mellitus, Heart Disease, and Stroke in 11 Counties of Rural Appalachian Ohio," Schwartz, MD, FACE; et al., Vol. 25, No. 2, pp. 226, the name of a coauthor was misspelled. Anirudh V.S. Ruhil was incorrectly listed as Anirundth Ruhil. The authors apologize for this error.