K.A. Bailey

Family Medicine in Small Communities

SUMMARY

This article is an off-the-cuff commentary on one practice in a city of 40,000 people. This city is in a largely agricultural area. The article stresses the pluses: the continuity of care and the more interesting and variegated nature of family practice here. There are negatives, as well: the more limited social life and the problems relating to employment for one's spouse. Patient confidentiality is more difficult to maintain, as is one's own privacy. Generally it is a busier and more challenging life, which I heartily recommend. (*Can Fam Physician* 1987; 33:1689–1691.)

RÉSUMÉ

Cet article constitue un commentaire impromptu sur une clinique médicale dans une ville de 40,000 de population. Cette ville est située en grande partie dans un environnement agricole. L'article met l'emphase sur les aspects positifs: la continuité des soins et la nature plus intéressante et diversifiée de la pratique familiale dans cette région. Il existe, bien sûr, des aspects négatifs: la vie sociale plus limitée et les problèmes d'emploi pour le conjoint. La confidentialité du patient et la vie privée sont plus difficiles à préserver. Généralement, cependant, la pratique médicale au sein d'une petite municipalité est plus stimulante et plus remplie et je n'hésite pas à la recommander.

Key words: family medicine, small communities

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IN 1979, I was a housewife with two children, living on a farm in Southwestern Ontario. Today, I'm back on the same farm with my husband and three children, and I practise medicine in our nearby city of 40,000 inhabitants. I have a busy practice and do my own obstetrics and some emergency work. It's a busy life, but interesting and challenging.

It was always my intention to return to this community, and I geared my medical school electives and family medicine residency program, as much as I could, to my future responsibilities. My resident project was on health problems in the agricultural community, and I still hope to continue with research in this area if I can ever find the time. This article is my perspective on practice in a smaller community. I hope that it will encourage a few of you to get your feet wet outside of the Golden Horseshoe.

It's always difficult to decide to leave your home town. I'm from Toronto, but several years ago I married an economist who prefers to farm. Smaller communities do have fewer cultural activities, and our social life is different but not necessarily less rewarding. As a doctor, one does tend to be a pillar of the community whether one feels up to that responsibility or not. There is not much that one does that won't be noticed. On the other hand, a small community physician will receive far more respect and consideration than almost anyone deserves. One can really get to know the community, its industries, local trouble spots and trouble makers, social services, police, health professionals, and so on. The patients and their environment are less of an unknown quality.

The practice of medicine in a small community is more interesting and involves more variety. The physician will first confront how little he or she knows or can do. I'm still embarrassed to admit that I assisted at my first ap-

pendectomy and my first cholecystectomy in my first week of practice. However, to defend my reputation and that of my medical school, I did have the diagnosis right. Fortunately, my partner is an older family doctor who is not only a medical jack-of-all-trades, but also a master of several, and he is still teaching me something every day.

It is easier to set up a practice in a smaller centre because you are needed. It costs less and the beginning doctor will make more because he/she is busy—often too busy. We need more doctors out here so that patients may have the luxury of leaving a doctor they hate. It would be nice to have one or two people with an open practice when new folks come to town. There is good office staff available, and a physician can even afford a nurse, which she/he will need, as one is twice as busy as any physician practising in downtown Toronto.

Real continuity of care is offered here. I can admit my patients to hospital and ask for a consultant if one is needed. I still must see my patients daily or arrange for a colleague to do so. If my patients require surgery, I am the assistant. I must set up home care or rehabilitation or nursing-home care. If my patient enters a chronic-care facility, I continue to provide care there. This hospital practice requires services on the various hospital committees and participation in educational rounds. This service, although occasionally onerous, keeps one up to date with changes in the hospital facilities and capabilities.

Family practitioners in a small community tend, if they have one family member, to have them all. One may have so many patients with the same name that filing is a problem. I'm still learning who is related to whom in my practice. This knowledge really helps me know where patients are coming from. If I see a woman with an assortment of minor complaints, it helps me to know that her husband is the obvious alcohol abuser I treated for a scalp laceration on Saturday night. One problem is being called upon to treat relatives and friends. I discourage close friends and relatives from seeing me unless absolutely necessary.

We see all age groups here, although one's practice does tend to age with one's self. We also see the full gamut of problems, as our consultants are so busy that they only consult. This requires that one keep up with one's education, and I attend local rounds, educational days in our local 'big' city and read, read, read. Twice monthly the consultants and family practitioners get together for educational rounds in our own hospitals. Interesting and problem cases are discussed.

Not every small centre has the advantage of a good consultant staff. We do here, and not only do these staff members provide first-class care, but they are also kind to me and teach me. It is my decision whether to involve a consultant, and I still remain involved in the patient's care. This arrangement provides me with continuity of the problem and the patients with continuity of care. Many patients returned from a tertiary-care centre unsure of who looked after them, often naming the last intern they saw. We still encounter people who insist on going to a larger centre or who must do so because of their particular problem. I believe that we can offer better care here.

I have no statistics to indicate how our patient profiles differ from those of dwellers in the bigger cities. It is my impression that we do much more of well-baby and child-care practice. We see the usual large numbers of respiratory complaints, and our environment here causes all sorts of allergies. In my practice here I see a greater variety of age groups and more complete families than I saw in the city. I find myself investigating new problems rather than inheriting a well-investigated patient from an internist. We follow our chronic problems and ask for help when needed. There doesn't seem to be the same loss of patients to a specialist that occurred in the city. Every day seems to bring at least one challenge.

A brief word about obstetrics: I do it—with a lot of worry and great thanksgiving when all goes well. I am not adequately trained, not because of my teachers or my effort; there is just not enough obstetrical practice to go around in the teaching centres. I feel strongly that we family doctors should be delivering babies, particularly in smaller centres. Our consultants are overworked as it is. We can offer a more relaxed type of care. We can get the kind of changes like birthing rooms and rooming-in that are just not a priority of specialists. This is important, and so I worry but continue cautiously to deliver.

In small communities the local family doctors staff the emergency departments. Our two emergency departments are fairly busy. I do about five shifts a month in the emergency departments. Essentially, I am responsible over 24 hours for eight doctors' patients. During the day, ambulatory patients come to my office or to that of their own doctor. Occasionally, I have to run over to the hospital. This is a distinct disadvantage, but there is really not enough business to keep a casualty officer busy during the day. It is not mandatory that the physician on emergency duty be in the hospital, but as I live out of town, I do stay in. Much of the emergency is very routine: colds, minor injuries, and so forth. Our consultant staff is quickly available when real trouble appears. Again, there is a certain continuity of care, as one gets to know the frequent visitors in one's own group. There is always a report on all of one's patients who were seen in the emergency department available to one the following day. Problem patients, such as drug abusers and child abusers, tend to be known. Nursing staff and the local police are good sources of information about people. Again, working in the emergency department requires that one maintain skills and knowledge.

What makes up a typical day here? It begins with hospital rounds at two hospitals. Two or three times a week one will also have minor surgery in the emergency department, such as removal of a cyst, sigmoidoscopy or X-ray and check. Occasionally one has a surgical assist and hopes that it does not conflict with office hours. There is then a morning office where 10 or 15 people are seen. Lunchtime is spent on paperwork, meetings or surgical assists. The afternoon office load consists of 30 or 40 people. It is a very full day! The problem is scheduling time for people who need to talk. It is necessary to bring them in early or to stay even later than usual. There are the same social problems here, but we have less time to deal with them. Someday, I hope, we can change this.

Social problems bring me to one major problem in smaller centres: patient confidentiality. It is impossible to make a real fool of yourself without almost everyone in the community hearing about it. It is consequently difficult

for someone to recover from a problem as he or she tends to have a label. There is always the risk that information about incidents such as an abortion, wife-beating, case of STD, or arrest for drunkenness will leak out. I currently have the only AIDS patient in the county, and I have told him already that he must accept the fact that people are going to find out. This is a real problem, balanced only by the tremendous kindness and help that can come from a community that not only knows, but also cares.

What about facilities? There is no question that no small centre has the technological wizardry available in the teaching centres. On the other hand, I can get someone into a hospital bed a great deal more easily than a physician can in Toronto. Nursing staff, lab technicians, X-ray technicians, and other medical personnel are generally good. Our ICU nurses are almost all quite capable of telling me gently and politely how to run an arrest when my ACLS gets a bit rusty. Most patients don't need high technology, and those who do, usually only briefly. Care is often better in a smaller centre because the doctor knows the patient, and the patient's family and friends are nearby.

I hope as I near the end of this article that I have persuaded a few of you to leave the big city and accept the challenge of a smaller community. Such a community will offer a different social life for you and your spouse, and I appreciate that not all of you can be fortunate enough to marry a farmer. But a smaller community does offer you the only real chance you can have to practise old-fashioned family medicine. Here you can deliver babies, care for people in your office, in their homes and in hospital, and provide care for the dying. There is no need to relinquish your role when your patients enter hospital or a chronic-care facility. Here you can become part of the community and work for advancement in health-care facilities and social services. You have a voice that can be heard.