The 'Brokenness' of postgraduate medical education

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There is a disconnection in all Canadian postgraduate programmes, from both the medical school mission and community needs' standpoint. On the one hand, we have Canadian grads not getting matched to a residency programme, and on the other hand, we are training more orthopaedic surgeons than we have OR time to give them. Vacancies in rural practice continue, despite a near doubling of Canadian medical school enrolment to 2836 students.[1] Postgraduate training needs reform. The number of spots needs to better match the number of matriculating students, and the mix needs to better reflect the needs of Canadians. For CaRM ranking, we should stack the deck, and all family medicine programmes should be weighing the undergraduate factors that promote rural careers (especially rural origin which has a prevalence odds ratio of 2.9).[2]

The medical school variable loading for rural practice is well known. In a recent article[3] yet again, rural origin, older age, prior postgraduate training, a rural role model, social orientation, interest in generalism and tolerance for uncertainty were all significantly associated with rural practice. These factors and others have females, francophones and rural and even indigenous students (12% this year at the Northern Ontario School of Medicine [NOSM] yes!)[4] admitted in favourable proportions. At NOSM, all of them are exposed to rural communities early in the curriculum and spend their entire 3rd-year training alongside rural generalist physicians in a longitudinal clerkship.

We need more and expanded access to longitudinal rural postgraduate programmes than already exist. Not surprisingly, a longitudinal residency that takes place entirely, or mostly, in rural generalist settings (typically between 4000 and 30,000 population and 150–1000 km distant from a city of over 100,000) is associated with rural practice at an odds ratio of 3.9.[2]

There is also a need to find new approaches to improve social fairness. Increasing medical school admissions for lower socioeconomic students is important. Innovation such as the proposed rural generalist pathway at NOSM has the potential to increase both the status and rigour of rural training that is 'fit for purpose'.[4]

On his recent tour of Northern Ontario, Dr Denis Lennox, who has been a champion of Rural Generalism in Australia, highlighted the importance of creating a career path that has, as the goal, a rewarding rural generalist and academic career

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'joined up' with other rural generalists in a resilient community of practice. If residents can see an inspiring, supported, rewarding career goal, they will be more likely to enter into rural practice, equipped with the right generalist training.

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La fragmentation de l'éducation médicale de deuxième cycle

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Tous les programmes de deuxième cycle canadiens sont fracturés, tant du point de vue de la mission de l'école de médecine que des besoins communautaires. D'un côté, quelques diplômés canadiens ne sont pas appariés à un programme de résidence et de l'autre, nous formons plus de chirurgiens en orthopédie que le bloc opératoire peut en accepter. Les postes vacants en pratique rurale sont toujours vacants, malgré que deux fois plus d'étudiants, soit 2836, sont inscrits en médecine au Canada.[1] La formation de deuxième cycle doit être réformée. Le nombre de places doit mieux refléter le nombre d'étudiants inscrits, et le mélange doit mieux refléter les besoins des Canadiens et Canadiennes. Pour le classement de CaRMS, nous devons piper les dés, et tous les programmes de médecine familiale doivent tenir compte des facteurs de premier cycle qui encouragent les carrières en milieu rural (surtout l'origine rurale, avec un RC de la prévalence de 2,9).[2]

La distribution variable des écoles de médecine pour la pratique rurale est reconnue. Dans un article récent[3] encore une fois, les facteurs origine rurale, âge avancé, formation antérieure de deuxième cycle, modèle à émuler en région rurale, orientation sociale, intérêt pour le généralisme et tolérance de l'incertitude étaient tous étroitement liés à la pratique rurale. Ces facteurs entre autres permettent aux étudiants de sexe féminin, francophones, ruraux et même autochtones (12 % cette année à l'École de médecine du Nord de l'Ontario hourra!)[4] d'être admis dans des proportions favorables. À l'ÉMNO, tous les étudiants sont exposés aux communautés rurales et passent la troisième année entière de formation avec des généralistes en milieu rural dans le cadre d'un stage clinique longitudinal.

Nous devons élargir et multiplier l'accès aux programmes longitudinaux de deuxième cycle en milieu rural. Il n'est pas surprenant d'apprendre qu'une résidence longitudinale qui prend place entièrement, ou presque, dans un milieu généraliste rural (habituellement entre 4000 et 30 000 habitants et à 150-1000 km d'une agglomération de plus de 100 000) est associée à la pratique rurale avec un rapport de cotes de 3,9.[2]

Il nous faut également trouver de nouvelles approches pour améliorer la justice sociale. Il importe d'augmenter les admissions des étudiants de faible statut socioéconomique à l'école de médecine. L'innovation, tel le cheminement de généraliste rural proposé à l'ÉMNO a le potentiel d'augmenter le statut et la rigueur de la formation rurale pour qu'elle soit « adaptée à l'emploi ».[4]

Dans sa récente tournée du Nord de l'Ontario, le Dr Denis Lennox, qui est un ambassadeur du généralisme rural en Australie, a souligné l'importance de créer un cheminement de carrière qui a pour but de récompenser les généralistes ruraux et les carrières universitaires qui s'associent à d'autres généralistes ruraux pour former une communauté de pratique résiliente.

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Si les résidents ont pour vision une carrière satisfaisante et inspirante, ils auront plus tendance à pratiquer en milieu rural, et seront équipés de la bonne formation de généraliste.

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