Residents

Training Issues in Rural Psychiatry

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Abstract: This article examines training issues associated with rotations in rural psychiatric practice. It also discusses how community and rural psychiatry differ. Further, the idea of how to promote and to support rural rotations is examined.

Résumé : Questions de formation en psychiatrie en milieu rural
Cet article examine les questions de formation liées aux stages de pratique psychiatrique en milieu rural. Il présente également en quoi la psychiatrie communautaire diffère de la psychiatrie rurale. En outre, il aborde la manière de promouvoir et de soutenir les stages en milieu rural.

Key Words: rural, community psychiatry, residency, training issues

Here are not enough specialists serving rural communities, and most government officials and health-care providers agree on this point. What to do about this, however, is another matter. In Quebec, the government has proposed a solution that would allow it to control the number of specialists licensed to practise in a given area. Needless to say, this has been met with opposition and resistance in the form of pressure tactics and "study days." As residents in psychiatry, we have been watching this battle unfold with much interest. Is there another solution, other than legislated work in a rural setting? Are there training measures that we could implement that would promote rather than oblige practice in rural or underserviced regions? Having just completed my three-month mandatory rural rotation, I have learned much in this regard. Residents accustomed to an academic environment face numerous challenges in making the transition to even a brief period of rural practice. At the same time, the experience should be maximized; it is often the only time that psychiatry residents are exposed to alternative practice settings during residency. The discussion that follows considers some of the training issues that are implicit in the rural rotation experience.

Community Versus Rural Rotation
The Royal College of Physicians and Surgeons defines a community experience as "a learning opportunity occurring outside the conventional teaching service in a teaching hospital. This experience may occur in an environment associated with the teaching hospital . . . or may be remote from the parent teaching hospital in a community hospital and/or offices and clinics associated with such an institution. It should be emphasized that ‘community’ does not necessarily equate to ‘ambulatory’ but may include a variety of environments where an educational experience can be obtained that would otherwise be provided to the resident in a teaching hospital. This would include rural or remote sites with adequate qualified supervision"(1). Clearly, a community experience is a broad category. In a recent CPA Bulletin, Dr. Warren Steiner quotes the American Association of Community Psychiatry definition of community psychiatry: "a branch of psychiatry which emphasizes the integration of social and environmental factors with the biological and psychological components of mental health and mental illness"(2). The practice settings wherein one could achieve such experience are varied and could include urban community clinics or home consultations, to name a few. Therefore, although a rural rotation may be considered a community experience, in essence community training does not require a remote location. In the June 1996 issue of The British Columbia Medical Journal, a practising rural physician describes several qualities that a psychiatrist should possess to succeed in rural practice. Competencies such as having consultation liaison experience, being able to share responsibility for patient management, protecting personal boundaries and relying on other health professionals could be achieved easily in a community setting, regardless of location (3). Limited evidence exists at this point with respect to the factors that encourage a physician to choose a rural practice. Whether exposure to a rural setting in residency promotes this choice is also unclear. What seems likely, however, is that a successful rural physician could obtain necessary competencies in both rural and urban community settings.

Encouraging the Choice of the Rural Experience
Despite achieving competencies in rural psychiatry without a remote location, some residents may opt to take this route, while others may find their choice of community rotations limited to rural areas. By supporting residents through this experience, the difficulties that may arise can be turned into positive learning events. With residents facing increasing stress and commitments to divided interests (that is, research, psychotherapy patients and teaching opportunities), three months away from the academic setting can increase that burden. Measures such as reimbursing residents for travel costs and allowing some mandatory academic work, such as teaching, to be
deferred or to be accomplished via e-mail may go a long way in making the experience a positive one. Further, didactic teaching in community or rural psychiatry prior to embarking on this type of rotation would educate residents about what knowledge they should obtain from the rotation itself. Another essential element is that supervisors at the rural site become familiar with resident education and with the objectives of a community experience. There should be a close liaison with the base academic institution to ensure that supervisors continue to meet these requirements. With adequate support, many residents describe their rural rotation as an important and well-received component of their training.

A Unique Opportunity

There are aspects about being taken out of your milieu that are invaluable to training in psychiatry. Apart from the opportunity to acquire the skills necessary to be a rural practitioner, a rural community experience offers something different—a chance to experience a cultural or social milieu different from that seen daily at one’s academic institution. In describing training objectives for a community rotation, Dr. Warren Steiner wrote, “Residents must display appropriate respect for and sensitivity to ethnic and cultural values of patients, families and community members. Beyond that, they should appreciate the richness of the patient’s life and community and express a willingness to learn from the encounter” (2). In my experience, that meant not only learning to work exclusively in French (as opposed to the bilingual setting in which my academic institution operates) but also to understand cultural references and social nuances that were completely foreign to me. Although this was undoubtedly difficult, it was also valuable—an experience that I could not have achieved had I remained closer to home.

Conclusion

There are many ways to support community-based and rural practice for those residents in psychiatry who are considering this route. Implementing more didactic teaching and broadening rotation options and locations to suit resident needs provide a good start. In addition, ensuring standards for resident education at remote sites remains an important objective. The factors promoting the choice of a career in rural medicine are complex. Ensuring positive training experiences in this area may go a long way to encouraging residents at least to consider alternative practice settings. Although this may not alleviate the shortage we now face, for those residents who choose rural practice, it will most certainly provide the basis for a more informed choice.

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national action plan for Canada. Governments will find it increasingly difficult to ignore our recommendations,” he added.

CAMIMH founding members include the Canadian Psychiatric Association, the Canadian Mental Health Association, the Schizophrenia Society of Canada, the Mood Disorders Society of Canada and the National Network on Mental Health. The group was founded during the 1998 Mental Illness Awareness week and has since established itself, with a substantial level of credibility, as the “consensus” voice of national stakeholder groups in Ottawa. Its anchor document, A Call to Action: Building Consensus for a National Action Plan on Mental Illness and Mental Health, is now a widely referenced discussion paper.

Canadian Researchers Begin Framing a National Research Agenda for Suicide

On February 7–8, the National Workshop on Suicide-Related Research was held in Montreal. The workshop, co-organized by Health Canada and the Institute of Neurosciences, Mental Health and Addiction (INMHA), gathered over 45 of Canada’s top suicide researchers to take the first steps toward establishing a national, collaborative agenda on research related to suicide. Several leading psychiatrists in the field attended, including Dr. Roger Bland, Dr. Jean-Jacques Breton, Dr. Simon Davidson, Dr. Elliot Goldner, Dr. Laurence J. Kirkmayer, Dr. Alain Lesage, Dr. Paul Links, Dr. Isaac Sakinofsky and Dr. Cornelia Wieman.

Workshop participants identified six initial themes: suicide in social and cultural contexts, evidenced-based standards, mental health promotion, multidimensional models explaining suicide, the spectrum of suicidal behaviours and a national database for suicide-related research. INMHA Scientific Director, Dr. Remi Quirion, in a statement following the meeting, stated that identifying and recognizing the cultural and demographic realities that underline suicide will help researchers in their work, especially research focused on social and neurological approaches. “The CPA sees the reduction of suicide as an important measure of how successfully Canada is addressing mental health needs,” says CPA President, Dr. Blake Woodside. The CPA is currently developing a clinical practice guideline on suicide assessment and risk management through a working group led by Dr. Isaac Sakinofsky. Suicide was also the theme of the 2002 Mental Illness Awareness campaign. ● HC/FK