Introduction

Dedicated Issue on Rural Health: Inspiration, Celebration, and a Challenge for the Future

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The question is, then, not merely to define the ideal training of the physician; it is just as much, at this particular juncture, to strike the solution that…will distribute [them] as widely as possible.

The Flexner Report, 1910

Everyone deserves access to health care.

Howard Rabinowitz, 2004
Caring for the Country: Family Doctors in Small Towns

Rural America needs family doctors. Not only does it need more doctors, it needs family doctors that are well trained, enthusiastic, and committed to rural careers—careers that present both challenges and joys distinct from those of their urban colleagues. As the vast majority of physicians in small towns are family physicians, America depends on family medicine educators to identify, recruit, and prepare these rural doctors.

The Flexner Report, commissioned by the Carnegie Foundation in 1910 and quoted above, revolutionized medical education by calling for standardization of quality and centralization of medical training to university centers. With this urban shift of medical education, the distribution of physicians to rural America suffered. What Flexner once described as an overabundance of physicians in rural areas has evolved over the subsequent century into a severe and disproportionate shortage of rural physicians. Currently, about 10% of America’s physicians are practicing in rural areas, serving more than 20% of the nation’s population.

What is often overlooked in this conversation about the inequality of workforce distribution is that currently 22% of America’s family physicians practice rurally, making ours the only specialty that distributes to rural areas based on population expectations. Throughout the history of our specialty, family medicine programs have graduated physicians that are capable and willing to provide health care to this underserved population. This issue of Family Medicine, dedicated to rural health education, celebrates that accomplishment by showcasing family medicine programs and educational strategies designed to produce high-quality rural family physicians.

What has family medicine learned about identifying, recruiting, and preparing rural physicians? First, both student characteristics and mentoring are important. Students raised in rural areas and students that have rural experiences during medical school are more likely to practice in rural underserved areas. Medical schools have addressed this in various ways, including special admissions programs that target students from rural or underserved areas and educational programs that focus training in rural areas or embed rural experiences into mainstream programs. A brief meta-analysis in this edition, written by Eron Manusov, MD, and colleagues, works toward developing a common definition of rural background to standardize these discussions. Also, two articles in this edition address programs designed to attract and retain rural interest. James Kallail, PhD, and his colleagues describe a successful admissions program from the University of Kansas that targets and supports undergraduate students interested in rural or underserved primary care. William Crump, MD, and colleagues describe the problem of retaining students’ initial interest in rural health during the preclinical training years in an urban setting. Dr Crump presents 10 years of experience and outcomes of a Rural Medical Elective at the University of Louisville.

Graduates of residency programs that are located in rural areas are also more likely to establish rural practices. To increase rural physician supply and better prepare rural physicians, rural training tracks that combine residency education at urban tertiary care centers and distant rural communities have been developed. One such program is the Family Medicine Spokane Rural Training Track, the oldest rural residency training program in the country. The Family Medicine Spokane...
Rural Training Track’s success in training family medicine graduates for rural areas—as well as challenges faced over the past 25 years—are presented in this issue by Robert Maudlin, PharmD, and Gary Newkirk, MD.

Family medicine programs have also developed fellowships for training in additional skills that enhance the ability of rural physicians to provide care in geographically isolated areas. Wm MacMillan Rodney, MD, and colleagues present one such fellowship in advanced surgical obstetrics, describing 18 years of data on the post-graduate careers of fellows. Possibly even more importantly, Dr Rodney explores the reasons why many of these well-trained fellowship graduates eventually stop doing surgical obstetrics.

One of Flexner’s major criticisms of medical education at the turn of the last century was that medical schools were “frequently set up regardless of opportunity or need.” In 2010, the Carnegie Foundation has once again identified new challenges for medical educators, including a call to “participate in the management and improvement of the health care systems within which (physicians) learn and work,” with a recommendation that clinical education be located in settings where quality patient care is delivered, not just in university teaching hospitals. In that spirit, Mariana Garretson, MPH, and colleagues have written an excellent article on their deliberate and extensive research into the health care needs of the rural communities in Northeastern Pennsylvania that the recently established Commonwealth Medical College was designed to serve. Not surprisingly, Dr Garretson’s research uncovered a pervasive shortage of rural mental health services in these communities—a theme expressed by every focus group in this study. Indeed, residents of rural counties in America are less likely to have access to mental health or substance abuse services, less likely to receive psychotherapy, and are more likely to be treated for mental illness by primary care physicians than residents of urban areas. This has implications for family medicine educators who need to ensure that rural family physicians are both capable of providing necessary mental health services and are informed enough to provide the leadership to face these challenges. Dr Garretson’s article is published in this issue with a commentary by William Wadland, MD, MS, on the challenge of balancing the often-contrasting social missions and financial expectations of emerging medical schools.

Another major theme of both Flexner’s original report and the Carnegie Foundation’s 2010 update is that the quality of medical education needs to be standardized to high levels regardless of where that education occurs. This issue includes two articles that explore this subject, written by Therese Zink, MD, MPH, and colleagues at the University of Minnesota’s Rural Physician Associate Program (RPAP). Dr Zink first shows that students trained in RPAP’s longitudinal rural preceptorship program perform similarly on standardized educational testing when compared to students trained at the University of Minnesota’s urban-based academic health center. Following this, she shows through a qualitative evaluation of OSCE scenarios that students trained in the longitudinal rural program also demonstrate specific interpersonal skills and content knowledge not seen in their traditionally trained colleagues.

Finally, we need to look toward our future. A new model of patient care is evolving. This care model assumes technological systems with the ability to manage patient populations, support personnel with advanced care management skills, the technological infrastructure to facilitate the exchange of information (even to remote areas), and efficient utilization of care resources within communities. Will our 21st century rural physician workforce be prepared to manage the new challenges these expectations will create? Marie Dent, PhD, EdS, and colleagues explore some of these issues while describing a curriculum designed to teach chronic disease management with an emphasis on community-based health. Further research needs to explore the outcome-based effects of such interventions as well as the feasibility, cost, and implications of patient-centered and community-based health care in rural areas.

This special issue came about through the assistance of many dedicated educators, several of whom, like myself, are currently or have been rural family doctors. Each article submitted for this edition underwent peer review by two to three reviewers, which resulted in revision and acceptance of some papers and a decision not to publish others. I’d like to thank the reviewer team, including Kelley Withy, MD, PhD; Cathleen Morrow, MD; Rebecca Malouin, PhD, MPH; Richelle Koopman, MD, MS; Ian Bennett, MD, PhD; Diane Harper, MD, MPH; William Wadland, MD, MS; Steve Roskos, MD; Raza Haque, MD; Vince WinklerPrins, MD; Julie Phillips, MD, MPH; and Lee Radosh, MD. I’d also like to thank John Saultz, MD, and Barry Weiss, MD, for their support and editorial wisdom as well as the STFM Group on Rural Health for its enthusiasm for this project.

As family medicine educators, we should be proud of what we’ve done to advance the care of rural America; we should also be striving for ways to continue to meet this need with high-quality, well-trained primary care physicians. The dilemma of creating a physician workforce that meets the needs of this country is well known. The solution—which would encompass an acceptance of the social responsibility of medical schools to produce graduates that serve the needs of the public, a change in the economic forces that have historically undervalued a commitment to primary care, and a shift
from the cultural bias toward technology and specialty-
dominant care—will be complex, but it is our solution
to create. Let this dedicated issue be a celebration of our
successes as well as inspiration for the future.

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