FREQUENTLY ASKED QUESTIONS (Distributed Sites) – 2016

Specialty/Field Questions:

1. **What are some strengths about your specialty? What draws and keeps people in your specialty?**
   A career in Rural Family Medicine demands a wide breadth of knowledge and clinical and procedural skills. In the answers below I outline what is the draw for our specialty and how our distributed sites, Red Deer, Fort McMurray and Grande Prairie allow for Family Medicine residency training meeting generalist principles.

2. **What are some common complaints of your specialty?**
   It can be hard for some rural doctors to set boundaries regarding their time available for their patients versus personal/family time. The fee schedule is getting better but given the huge responsibility one carries as one of the handful of docs in a small community providing comprehensive cradle to grave care we are perhaps not remunerated as well as some of our subspecialty colleagues.

3. **Why did you choose your specialty?**
   Physicians who choose Rural Family Medicine come to the field for a variety of personal reasons but on the whole I believe they are passionate about all aspects of patient care. As they went through med school they were the type who fell in love with every rotation they were on and found it hard to choose among them to come up with a favorite. They cannot imagine a professional life that doesn’t incorporate every aspect of medicine they were exposed to during med school. They want to be the one who is there to help their patient deliver their first baby, to survive their first heart attack and finally to help him or her ease their pain in leaving this planet. We have a rare privilege of being involved in every facet of our patient’s lives over an extended period of time. As rural doctors we truly do “see it all and do it all”. Rural Family Medicine allows for evaluating and treating undifferentiated patients from a truly generalist point of view.

4. **What types of clinical cases do you commonly see?**
   This is the beauty of our specialty. We truly see it all. We do minor procedures, set broken bones, manage acute MI’s and stabilize traumas. We also deliver babies, do psychotherapy and grief counseling, wipe runny noses and comfort fears. We are masters at preventative care and are often “life coaches” in the education we provide on a daily basis. We see “clinical cases” before they are defined... we see patients with early, ill-defined symptoms and bring then to the point that we can define their illnesses as “clinical cases”.

5. **Briefly describe a typical day.**
   Start at the hospital to round on your in-patients, run over to your office clinic and see a wide variety of clinical issues, sip out to deliver a baby or two then back to the office. Then zip home to drive your daughter to piano practice and back again to perhaps do an afternoon of lumps and bumps, or maybe over to the ER to take an evening shift on call. It really varies with how you and your colleagues set up your days. The key feature is that you are ultimately in charge of how your schedule works. If your daughter announces she is eloping this weekend and wants you to be present to sign the register you can easily rearrange your schedule to make this happen by trading your ER shift with your colleague or asking the locum program to send relief. If you get called midday from the school because your son is puking in the principal’s office you can get your receptionist to rebook your afternoon as you have to go home right now. It is usually that simple.
6. What are the varieties of lifestyles within your field?
Lifestyle is a huge factor in helping rural doctors choose the community they want to practice in. If you have a passion for hiking and skiing you will likely choose a small town close to the Rockies and if you prefer fishing and hunting you might gravitate to lake country. If you are into horses you will choose ranch lands. In the end the key feature of being a rural doctor is that you can choose to set your schedule to take advantage of everything your community has to offer. Most rural doctors tend to be very active members of their communities.

7. Specifically how able is your specialty to accommodate family life?
As stated above, the beauty of being a rural family doctor is that you and your colleagues set your own schedules depending on your interests and family obligations. In more recent times the availability of sponsored locum programs also makes it much easier for rural doctors in very small communities to get away when they need to for vacation time without over burdening their colleagues.

8. Range of Incomes?
The Alberta fee schedule is getting more equitable in the way that family doctors are remunerated. We are for the most part fee-for-service so our personal income really varies as to how many hours you choose to put in to your professional life. It is very easy for rural family doctors to make a generously comfortable income and still be home for important family events. If you really are in it just for the $$ you simply offer to work a bit more.

9. How do you see you discipline changing over the next decade?
I believe that our discipline is in a period of exciting growth. 20 years ago when I stared my career there weren’t the number of training programs available to give me the skill set I needed to feel really comfortable handling all the things a rural doctor must be able to face on a daily basis. One often heard horror stories of being left as the only doctor in town... over worked with not a moment to spare to enjoy other parts of family and leisure life. The picture I see now is very different. There are more and more advances in technology, remuneration and locum coverage to make rural medical life exciting and enticing. I anticipate in the next decade to see rural medicine becoming the sought after profession for those out there who want to be full spectrum practitioners.

Residency Program Questions:

1. What are you looking for specifically in an impressive candidate?
Confident, self-directed learners who are not afraid to get their hands dirty with first call and procedures in a wide variety of clinical settings.

2. What can a potential candidate do now in order to be an appealing applicant to your program?
Show us that you have spent clinical time in rural settings so you know what you are getting into. There are 5 months (minimum) in our program spent essentially on your own (i.e. without a fellow resident/learner colleague) in a rural setting. Of course you will have great preceptor guidance and back up but you might be the only learner your age in the community. You have to be certain that you are comfortable in this type of setting before signing on with us.

3. How is your residency program organized? (i.e. year by year breakdown and schedule of rotations.)
There is a good outline of our curriculum on the U of A Family Medicine website. The Red Deer and Grande Prairie programs are a two year program with the first year rotating through the general specialties such as
peds, obs/gyn, gen surg, anesthesiology, and orthopedics with 5 months of family medicine as well (4 of which are rural locations). In the second year 6 months is rural family medicine split into 4 mo. and 2 mo. block rotations with 6 weeks of elective time as well as 2 mo. ER, 2 mo. Internal Medicine, and 1 mo. psychiatry with 2 weeks palliative care. In the Fort McMurray program the first year is a totally integrated rotation through a 6 month rotation of the general specialties (peds and obs/gyn) then a 6 month rotation of gen surg, anes, and ortho with family medicine integrated through the year. In the second year there is 2 months ER, 2 months Internal Medicine/ICU and 1 month psychiatry with 2 weeks palliative care and a 5 month rural Family Medicine rotation. While in the regional setting, Family Medicine is integrated within all general specialty rotations. All 3 distributed sites are very hands on and interactive from a clinical perspective and “formal academics” are provided on a monthly basis as well as several workshops and courses throughout the 2 years to give you the enhanced procedural skills you will need to become competent rural doctors.

4. What is your residency program’s orientation and focus?
The U of A distributed sites for Fort McMurray, Grande Prairie and Red Deer are skill oriented, non-service; preceptor based educational experience focused on producing competent and confident rural family doctors.

5. What is the availability of experiences in subspecialty areas during training?
As we are a rural training program our specialty areas are kept to the general specialties listed above.

6. Are there sufficient elective opportunities during training to explore your special interests?
As stated above there is elective time available for our residents to fill in learning gaps or explore areas of special interest that they want to incorporate into their rural practice. As our residents are involved in scheduling their second year rotations our elective time can also be grouped to allow for international experiences.

7. What is the on-call schedule during each year of residency?
We hear from most of our residents that a selling feature of our program is that we are a “non-service”, learner focused program so our residents set their own call schedule within the bounds of the PARA 1 in 4 call parameters. We also do not “block time” your vacation. You will be given 4 weeks/year of vacation time and it is up to you to schedule it when you need the breaks. We have certain vacation guidelines to assure that our residents all get enough time in each specialty block to ensure competency of course, but for the most part the timing of the scheduling is up to you.

8. What distinguishes the U of A program from other programs?
In addition to the above mentioned on call and holiday differences, we have separate funding to make sure that joining the U of A Distributed site training programs doesn’t disadvantage you financially from your urban counterparts in family medicine. We also have managed to maintain control of our numbers which keeps us a preceptor based learning program. Throughout the two years our residents are often the only residents assigned to their preceptor. We feel we provide more one on one experiences for our learners than some other programs are able to provide. Because we are small we also get to know our residents very well which helps us tailor their educational experience to fit their personal learning needs better than some larger programs.

9. Who can we contact for more information or set up electives?
The distributed Site Directors are Dr. Jack Bromley and Dr Jordan LaRue in Red Deer, Dr. Edward Deng a (Fort
McMurray) and Dr. Vali Duta and Dr. Brad Martin in Grande Prairie and their respective administrative program co-coordinators are Charlene Carver, Leslie LeFebvre and Jane Schotz. Contact information for these individuals can be obtained on the CaRMS website.

10. **Specifically is there a list of residents whom we can call or email?**
    Our chief residents are Red Deer: Keely Abercrombie (R2), Kate Overbo (R2), Amy Cockburn (R1) and Greg Sawisky (R1). In Grande Prairie: Kim Allan (R2) and Lauren Galbraith (R1). In Fort McMurray: Brennan Arduini(R2).

11. **How competitive is it to get in, and then to succeed in your field?**
    Rural family physicians are still in short supply country wide so to get work in our field is very easy to do. To succeed in our field is dependent of course on your personal definition of success. As far as the competition to get into the U of A Family Medicine program I feel this has increased with every passing year as word gets out about the rewards of becoming a rural doctor and the ability of our program to give you the skill set to be competent in the field.

12. **Is there active and/or required research in your residency program?**
    Yes, as with most residency programs, U of A Department of Family Medicine requires that the residents learn to participate in research to enhance their future practices and their fields of study. In our program in the first year we ask our residents to do four short literature search type projects which are meant to answer specific clinical questions and find evidence for clinical practices they see in their preceptor’s offices. These are called BEARS which stand for Brief Evidence Based Assessment of Research. In a second year we ask for a more in depth project in the form of a practice audit.

13. **What role does research play in your career?**
    In keeping with the personal flexibility that I have outlined in the description of our career path, rural doctors can choose to participate in larger formal academic research projects or keep their “research” limited to helping find current up to date evidence for clinical questions they come across in their daily patient lives.

14. **What local, national or international conferences would be of benefit to candidate interested in your residency program?**
    Locally the ASA (Annual Scientific Assembly) conference is a favorite, and nationally the FMF (Family Medicine Forum) as well as the SRPC (Society of Rural Physicians of Canada) annual conference.