

Rural Residency Training: A passing romance or a path for the future?

Randall Longenecker MD



The Ohio State University Rural Program
"A rural practice with a residency"
www.logan.net/users/mrfp

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Objectives

- To frame our discussion of rural residency training from a national and historical perspective
- To present a visual taxonomy of rural graduate medical education across the nation

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Objectives

- To enumerate the ongoing challenges and opportunities these programs face
- To suggest an ecological framework for the understanding and further development of rural health professions education

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Flexner and the 20th Century

- Move away from proprietary self-interest, from apprenticeship-type training toward rigor, standardization, uniformity, regimentation, quality - i.e. the Academic Health Center, often in urban places
- Move away from relevance, community-oriented medical education, training physicians for the place they are needed most (serving the underserved), especially rural places

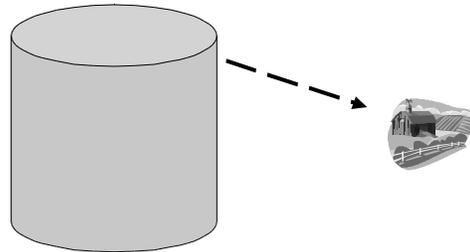
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Evolution of Rural GME

- Rural-focused academic health center
- Rural-located residency program
- Hub and spoke
- Spokane model - "1-2" RTT
- Accelerated programs - "3-3-1"
- Integrated RTT
- Rural Health Professions Campus
- Regional "Medical Education Council"

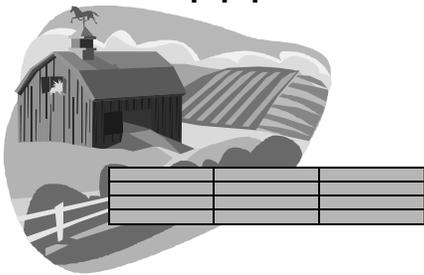
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Rural Focused AHC



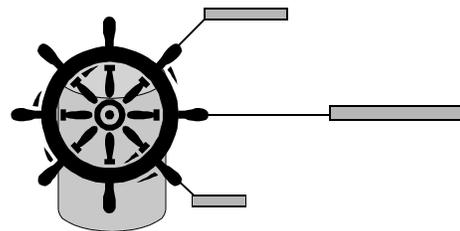
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Traditional Rurally-located "4-4-4"



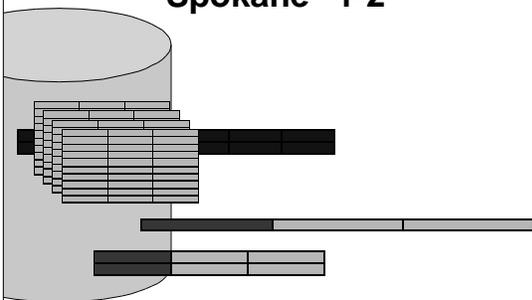
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Hub-and-Spoke



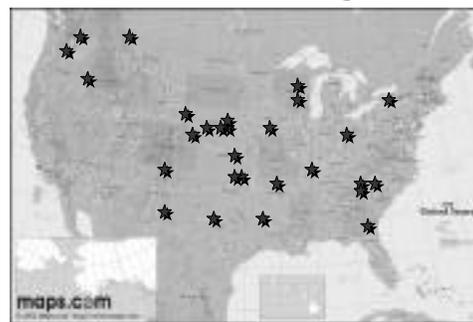
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Spokane "1-2"



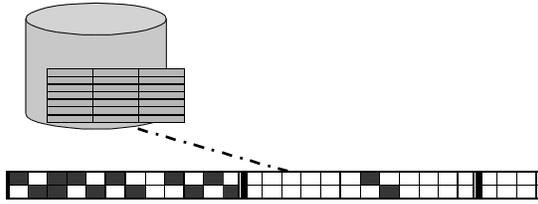
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"1-2" Rural Training Tracks



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Integrated RTT - "2-2-2"



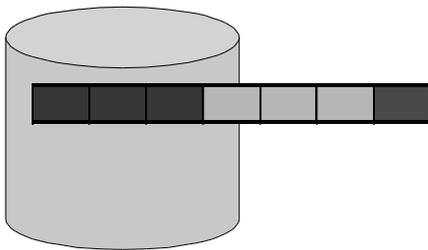
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NRHA - Integrated RTT

- At least 4 rural block months, including public and community health experience
- At least 3 months of OB
- At least 4 months of Pediatrics (ER, Inpatient, Outpatient, NICU)
- At least 2 months of ER

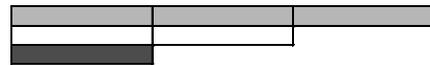
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Accelerated "3-3-1"



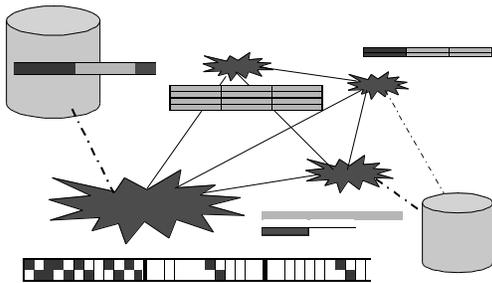
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Rural Health Professions Campus



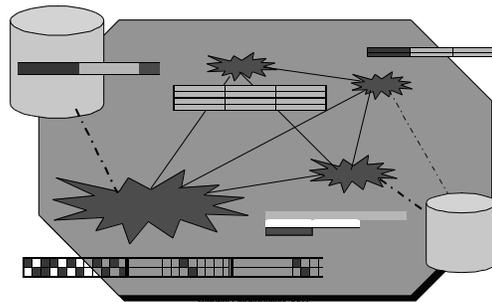
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Rural Campus Network



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Regional Medical Education Council



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Ongoing Challenges

- Recruitment of trainees
- Funding (and financial planning)
- Faculty - recruitment (and retention)
- Community ownership
- Collaboration with other specialties, other health professions (e.g. AHEC)

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Recruitment

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Opportunities

- Reform of GME funding, e.g. an all-payer graduate medical education fund
- State Medical Education Councils (Utah)
- Collaboration with other professionals in rural health professions education, building social capital in community
- Health professions education as an attractor for economic development

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So, where is this taking us?

- A variety of models adapted to local conditions, political realities, available funding leading us to further diversity, forcing innovation
- Rural Medical Educators - a special interest group of the National Rural Health Association, established in 2000

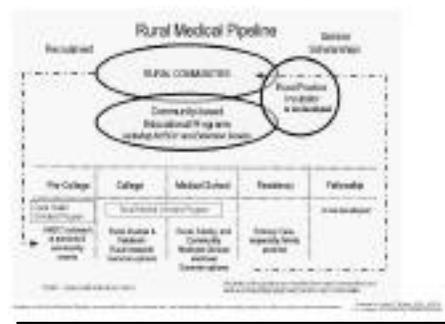
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So, where is this taking us?

- Truly community-based medical education
- Away from the “pipeline” and toward a more organic and ecological model - characterized by such terms as “interdependence (as opposed to dependence),” “collaboration,” “networking,” “sustainability,” “emergence,” and “complexity”

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A Self-Renewing Cycle



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A Self-Renewing Cycle



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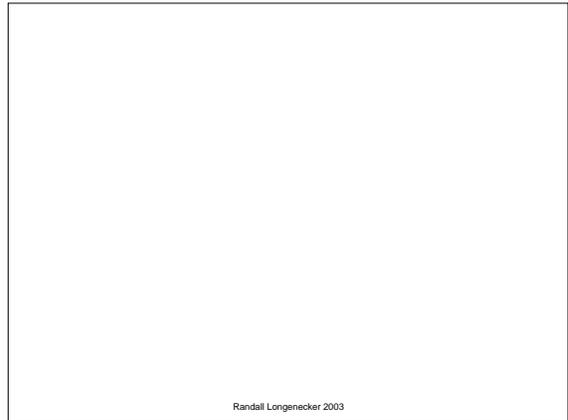
A Change of Metaphor

- > Away from thinking of “rural” as a desert, in need of irrigation only
- > Away from protecting “the vulnerable rural pipeline,” and toward growing our own, tending “the orchard” - planting and growing healthy trees with roots deep in the community, that, with a little attention, can fend for themselves

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“1-2” Rural Training Tracks



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