Making useful links between inner-city and remote physicians

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Are there useful links to make between physicians in the inner city and remote Canada?

As friends with similar backgrounds and interests, one of us chose remote medicine while the other chose the inner city for residency. Our divergent educations made us think: what do remote and inner-city medicine have in common, and what links could be made between inner-city and remote physicians to create a more socially responsive health care workforce?

Though seemingly occupying virtual extremes, inner-city and remote medicine share striking similarities. Patients in both populations are often marginalized. Poverty, inadequate living conditions, uneven access to nutritious food, addiction and mental health issues are more common in both environments than in the mainstream of Canadian society. For geographical, financial or sociopolitical reasons, inner-city and remote populations also share restricted access to care from physicians and allied health care professionals.[1,2]

Given these challenges, both inner-city and remote communities require family physicians to push the boundaries of advocacy, creativity and breadth of skills. This allows physicians to be true generalists while also developing special skills in areas like addiction, primary care for HIV, palliative care and mental health.

It is likely these unique aspects of the work that draw physicians to underserviced settings. The resilience and resourcefulness of patients and families, along with the appealing sense of community that inner-city and remote environments often foster, make the work rewarding. In both places, we share a sense of being on the front lines of health, as advocates for patients, facilitating access to care. It is this shared enthusiasm and set of values that draws us closer as friends and colleagues, but finds us farther apart geographically.

We believe there are others who share our fascination with and desire to work in both inner-city and remote medicine. This shared aspiration raises interesting questions. Can we do both effectively? Does city-based training adequately prepare physicians for remote medicine? Is there a way to practise in both environments while providing continuity and quality of care?

Despite some logistical challenges, longitudinal relationships between inner-city and remote physicians might increase the breadth and depth of collegial networks for physicians in underserved communities. This could be achieved through any number of creative ways, for example, northern continuity rotations for a stream of inner-city residents, or a network of inner-city physicians who serve intermittently in the same northern communities, creating continuity and ensuring skills are maintained. "Practice sharing" with communities in the north could perhaps convince some inner-city doctors, many committed to serving the underserved, to be recruited to remote communities for longer periods.

Although dedicated, long-term physicians in remote areas are optimal, increasingly linking inner-city doctors

to northern communities may provide support in areas requiring more physicians. It might also start important conversations about commonalities in serving vulnerable populations among geographically diverse physicians who share the value of access to health for all.

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