Dr. Kirk McCarroll
Rural Family Practice Anesthesia

Overview

1. **Profile**: Family Practice Anesthetist (Revelstoke), Rural Coordination Centre of BC Family Practice Anesthesia Network Lead; Family PGY3 Anesthesia (UBC), Rural Family Medicine Residency (UBC), MD (Dalhousie)
2. **Pitch**: Incredibly broad practice, allowing you to work as a GP, Emergency Doctor and OR Anesthetist, providing important pain control to patients and needed services to small communities
3. **Path**: Initially wanting pediatrics, an elective in Rural Family Medicine shifted interest. It wasn't until working as a staff in Iqaluit that Dr. McCarroll learned about and decided on becoming a Family Practice Anesthetist
4. **Personal**: Dr. McCarroll allowed his life to fall into place around his core lifestyle values. He was open to new experiences and places a huge emphasis on feeling that the care he provides is rewarding and helpful.

Elevator Pitch (2:00)

- The scope of rural family practice anesthetists is incredibly broad, making family medicine even more interesting and rewarding.
- Diverse skill set allowing for **symptom control** and lends itself well to family practice and taking care of long-term patients with **chronic illness**, as well as definitive management of many community medical situations.
- Incredibly useful and needed in **rural emergency departments**, allowing the team to achieve comfort, hemodynamic support, airway management and symptom control.
- **Diverse** career:
    - May focus solely on anesthesia in medium-sized centres
    - Some mix family and anesthesia services in smaller communities, providing basic obstetrical care, pain management and other services and procedures that wouldn't otherwise be possible in those settings
    - May focus on ICU if interested in critical care.

Maintaining Skills: It is sometimes a challenge to maintain skills given smaller patient volume, so there is frequent traveling and coaching in larger centres, about 2-3 times/year.

Personality (6:58)

- Enjoys the outdoors, smaller community, does not mind being approached by patients outside of the office.
- Have to be okay with uncertainty and providing care without full diagnosis because of limitations in rural diagnostic ability.
- Have to be comfortable with, and even enjoy, dealing with stressful situations in trauma or emergencies, with the ability to sometimes accept poor outcomes.

Stereotypes (8:31)

- Canadian family medicine residents associate Rural FM with a broad practice, but a less lifestyle-friendly practice because of practical realities.
- Australian residents identified increased feelings of loneliness because of isolation.
- Response:
    - You have to like the job - call burden, seeing your patients, no anonymity
    - Dr. McCarroll still gets excited every time he is called in - “you are the town doctor”
    - Isolation exists - smaller community and colleagues, but there are close relationships and tightly knit communities
- There is a stereotype that some enter Family Practice Anesthesia (FPA) in order to become anesthetists more easily than the 5-year program.
    - The job is entirely different - FPAs brings fundamental anesthesia skills to provide their small community with a greater ability to perform basic procedures and enact effective symptom control.

Referenced Material:

- *Feldman et al. The difference between medical students interested in rural family medicine versus urban family or specialty medicine. Can J Rural Med 2009; 13 (2).*
- *Isaac et al. Self-efficacy reduces the impact of social isolation on medical student’s rural career intent. BMC Medical Education 2018, 18 (42).*

Path (14:18)

Medical School

- First instinct was pediatrics, because he always enjoyed working with kids, doing most electives in pediatrics - still remains a favourite part of his FPA practice!
- Rural Family Elective in New Brunswick, which showed him the scope of practice - palliative care, emergency, etc...
- No interest whatsoever in anesthesia

Residency and Fellowship

- Began to be interested in emergent care, especially obstetrical care
- Still no interest in anesthesia, only taking a few electives in order to learn basic intubation and emergency skills

Staff

- First job was in Iqaluit, along with several locums in BC
- Knew he wanted to add a PGY3 eventually but unsure of which area
    - During a 3-hour Med-Evac flight to evacuate a patient in Nunavut, Dr. McCarroll met an FPA who was part of the team.
    - The FPA described his proposed management of the patient and illuminated the value of an FPA to provide airway support and sedation, a major barrier to allowing the safe evacuation of this patient.
    - Decided right there that he would do a PGY3 in anesthesia, further confirmed on subsequent elective experiences.
- The PGY3 program for FPA consists of joining the PGY2 Anesthesia residents - difficult because of significant time away from typical medical education. Huge learning curve regarding the machines and medications to catch up to those who had spent the prior year familiarizing themselves with these tools.
    - Still recommends working for a couple years before returning because he appreciates that he was able to see the scope of being an FPA in practice
    - Allowed him to tailor and focus his training to the specific skills he would need.

Day-to-Day Life (21:04)

- Huge Variety
- Anesthesia (1-1.5 days/week)
    - Start early, leave around 2-2:30, usually on call after you leave.

    - Small community - 4 FPAs, 4 OR days/week, divided evenly over the month - so each FPA gets 4 OR days/month.
    - Usually general services - general surgery, OB/GYN, orthopedics and dental. Some ENT and endoscopy.
    - 1 in 4 call, with a small burden. Called in every other day for emergencies, with specifically many fractures in Revelstoke because of skiing. Usually do 5-6 days in a row so that you have more time not on-call.
    - **Interesting and challenging OR cases are the most exciting part of Dr. McCarroll's job.**
- Emergency (1.5-2 days/week)
    - 7:00 AM - 7:00 PM call, coming in when there is a patient
    - 1 weekend per month on call
    - Not overly busy, with 20-25 patients in a 12-hour shift, although difficult to predict
    - Huge variety - geriatrics, pediatrics, trauma
- Family Practice (1-1.5 days/week)
    - 9:00 - 4:30
    - Barrier to providing traditional family medicine is that he is not always available to patients like full time family doctors

Personal Takeaways (28:26)

End-of-Life Care: Palliative experiences stick with you forever. This type of care means the world to both the patient and their family.

Personal Story 1: (28:50)

"One lady with intractable pain... had an intra-abdominal malignancy that was quite aggressive... We had tried all sorts of interventions to get her pain under control, and in the middle of the night she had this pain crisis, and the pain got way out of control. She was at the end of her life, and ***the only thing that helped this lady was [placing] an epidural****. It was so effective. To be able to provide that service made such a difference for that lady. She died a couple days later, but* ***taking somebody that was in so much suffering and having that skill set to relieve that suffering in such an effective way was probably one of the most rewarding experiences of my career.****"*

Note: While we tried to keep these transcriptions as true to the speaker as possible, some dialogue is paraphrased and/or edited for easier reading.

Final Comments (30:40)

1. Relieving pain, anxiety and suffering is a privilege and the most rewarding part of rural family medicine anesthesia.
2. Take your time and explore all your options. Look at the lifestyle you want, and then figure out what interests you most. You can tailor things as you go. Things will slowly fall into place.