

Keeping Doctors North: Recruiting and Retaining Physicians in Underserved Areas

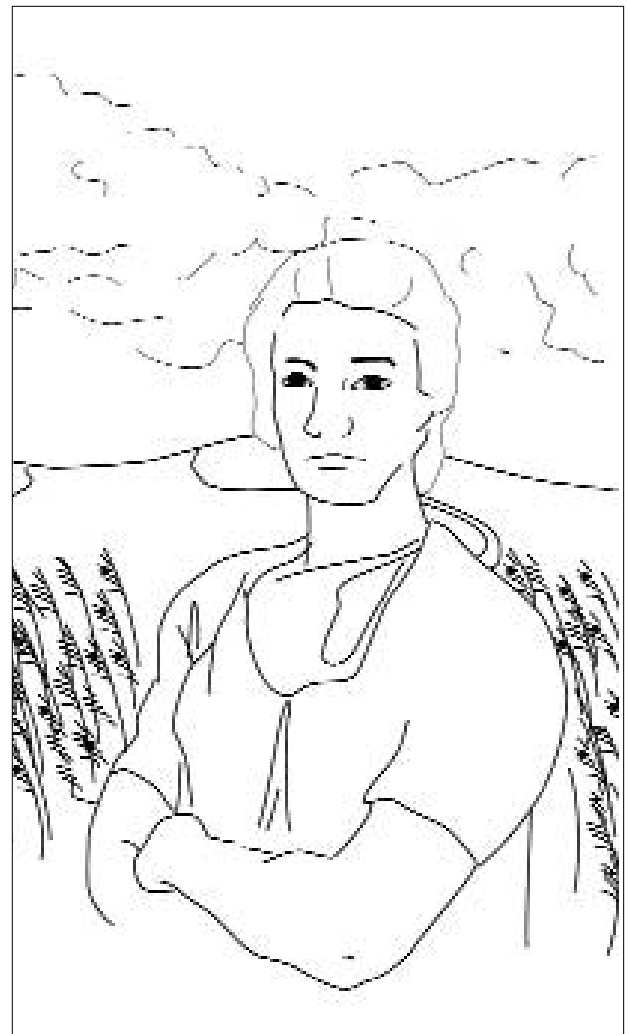
Jason A. Shack, Bsc. (OT0), and Alison D. Baker, MSc. (OT1)

Abstract

The issue of recruitment and retention of rural physicians is a long-standing problem in Canada. Recent attempts at trying to solve the problem of underserved areas have resulted in much hostility and little achievement. While the Canadian rural population has continued to grow, the number of physicians in these areas has steadily declined. This problem is not exclusive to Canada and work in other parts of the world, such as Australia, has been successful in increasing the numbers of rural physicians. An effective solution is complex and must encompass all aspects of a physician's training and career, including interventions prior to medical school, during medical school and post-graduate training, and continuing throughout medical practice. This paper outlines a comprehensive and integrated solution that is needed in order to solve Canada's problem of physician recruitment and retention in rural and underserved areas.

Introduction

Few would argue that Canada has a health care system with many enviable attributes, nor would many argue that this system has failed in a few key areas. One of these areas is the provision of medical care in rural and underserved communities. Population need has continuously exceeded physician supply in rural and remote Canadian communities. While 23.5% of Canada's population lives in rural areas (communities of less than 10,000 people), only 17% of the country's family physicians and 3% of the specialists practice in these areas.¹ Within the last decade, the population of rural and small-town Ontario has increased by over 10%; in contrast, the number of physicians practicing in



Zacharo Roula Drossis

these communities has decreased by 12% between 1994 and 1998.² In 1995, 63 designated underserved communities in Ontario were trying to recruit 88 physicians; in 1997, the need increased to 68 communities seeking 116 physicians.³ Provincial governments have tried to alleviate this discrepancy, but their 'solutions' have usually been met with hostility among medical students, residents, and practicing physicians. What follows is an outline of the problems that exist in providing health care in rural and underserved areas and an integrated solution to the complex problem of recruiting and retaining rural physicians.

Defining the Problem

In 1995, Graham Scott, QC, a retired bureaucrat from the Ministry of Health published "The Scott Report."⁴ This report was initiated on the observation that many small communities were unable to maintain adequate hospital-based emergency services. In a 1991 survey of Ontario small-hospital medical services, 44% reported a shortage of physicians willing to staff the emergency department and 71% predicted a shortage within 5 years.⁵ The initial intent of the report was meant to focus on emergency care in rural areas; however, it uncovered many facts about rural practice as a whole.

The simplest and most easily overlooked finding of The Scott Report is that rural practice is different from urban or suburban practice. Rural doctors feel that others in the medical community do not recognize this difference and that rural medicine is not appreciated nor encouraged in most academic settings. The medical profession often views a rural physician as someone who is unable to succeed in larger centres such as Toronto. In reality, rural physicians perform three times as many procedures and work much harder for the same financial rewards as urban physicians.⁶ Many recent graduates are neither prepared nor oriented for rural practice, and family physicians coming out of a traditional residency often feel inadequately prepared for the specific demands of rural practice.

The added pressures and responsibilities of practicing in a rural area require a trade-off between income and lifestyle. Many young graduates are finding that working in an urban walk-in clinic can provide more satisfying earnings and a better lifestyle than can be achieved in a rural practice.⁷ The small number of patients in rural areas often does not allow for high earnings, especially in the case of fee-for-service in low-volume rural emergency rooms. The frequency of unpaid on-call time, which may involve more than one night in five in a 24-hour emergency room, can cause problems with family and social life. A shortage of rural surgeons, as well as family physicians with additional training in anesthesia, emergency, obstetrics, and psychiatry, results in a more onerous on-call schedule for those with this training. For physicians who decide to settle in rural areas, a feeling of professional isola-

tion, especially if in a solo practice, and a sense of abandonment by their medical associations, governments, and hospitals are major deterrents to their retention.⁸

The problem of physician recruitment and retention in rural areas is complex and requires examination of the three main areas of physician needs – professional satisfaction, financial remuneration, and lifestyle.⁹ One reason that new graduates enter rural practice is the opportunity for a variety of medical experiences. This type of practice is limited in an urban centre with many specialists and frequent referrals. Also, most physicians in rural practice obtain a significant proportion of their incomes from hospital service. Cutbacks to the services provided by rural hospitals may result in physician attrition due to a lack of variety and challenges, as well as insufficient income.

Lifestyle issues as a whole are the major reason why physicians leave rural practice. A heavy workload resulting from too few doctors to share responsibilities often results in early physician burnout. In addition, the lack of anonymity in a small town may lead to physicians feeling that they have little personal time and no privacy. Single physicians may be faced with few social opportunities, and married physicians may have to deal with spousal discontent over lack of employment, along with the isolation. Only one of the factors of professional satisfaction, financial remuneration, or lifestyle has to be detrimentally affected to cause compromise of physician-based resources. Any solution to the problem of recruitment and retention of physicians in rural and underserved areas must address all of these needs. A useful approach in defining the solution is to examine it at all levels of a rural physician's training and career.

Solving the Problem

The problem of recruiting and retaining rural physicians is complex and the interventions that have been implemented in Canada are proving to be only ineffective short-term measures. Australia has been a leader in rural health research and in solving the problem of their lack of rural physicians. They have had success with an integrated and multifaceted solution that starts early in the lives of potential rural physicians and follows through to supporting them in their rural practice.¹⁰ Many Canadian medical groups understand that this type of approach is needed, as evidenced by a document recently released by the Ontario Regional Committee of the Society of Rural Physicians of Canada (SRPC) and the Professional Association of Internes and Residents of Ontario (PAIRO), which put the integrated solution into an Ontario context.²

Pre-Medical School Interventions

Individuals who come from a rural area are likely to return; thus, increasing the number of students in medical schools from rural areas would be a good place to start in address-

ing the problem of rural recruitment.^{11,12} One approach is to introduce rural physicians and medical students into rural high schools to create an interest in rural medicine as a career and then support those students who express an interest. This type of program in Western Missouri has resulted in an increase in rural applicants and entrants to an urban medical school.¹³ A program in Manitoba in which medical students and rural family physicians visit high schools has caused an eight-fold increase in the number of rural applicants to medical school.¹⁴ Memorial University in Newfoundland provides opportunities for rural high school students to spend time at the medical school during their regular breaks.¹⁵ Promotion of medicine as a career choice to rural high school students is something that is being done at the University of Toronto as part of the Outreach Program of the student-developed and student-led Rural Health Initiative. With support given to these types of programs, it is possible to increase the number of rural students in medical school; however, it is necessary to provide a means of maintaining that interest throughout their education in an urban area.

Medical School Interventions

While coming from a rural area increases one's likelihood of returning to a rural area, not every rural doctor originally comes from a rural area. For this reason, programs at the level of the medical school can be used to maintain the interest of those from rural areas and also provide exposure for those who might never have considered rural medicine.

Interest in, and enthusiasm for, rural medicine can be sustained on-site at an urban medical school by supporting the efforts of student rural health interest groups. These groups, such as those that have existed in Australia for years, and that are now appearing in Canada, have been shown to encourage and maintain student interest in rural medicine.¹⁶ This type of focus is needed to provide collegial support for students interested in practicing medicine in a vastly different way from that which is taught in the referral-based tertiary care practice of most teaching hospitals.

The key change needed in medical school is to make time available early and throughout the curriculum for opportunities in rural medicine.¹⁷ Like all things in medicine, the old adage "exposure, exposure, exposure" is also true for rural experiences. Medical students' participation in rural medicine has been shown to improve their perception of this specialty and to increase the likelihood of their choosing a rural career.¹⁸ At present, this type of experience is limited and difficult to obtain. Medical schools need to facilitate access to rural electives, and resources are needed for students to access rural preceptors. Financial resources are also required to make these experiences viable. It is not helpful for medical schools to create a restricted database of rural physicians who are only able to act as preceptors for stu-

dents from one school. Resources are limited already and this type of approach will only worsen the problem. Medical schools need to work together and support a single program to link interested medical students with interested preceptors. An example of such a program has just been started by the Society of Rural Physicians of Canada.¹⁹

Each school, however, does need a central resource where students and faculty can access available rural medicine opportunities. This resource can be instituted by creating a Rural Medicine Office at each medical school.⁸ Ideally this office would arrange rural electives and provide access to financial support, as well as providing a focus for research in rural medicine. It would also play an advocacy role in making necessary changes to the medical curriculum to foster positive rural ideals and sensitize the entire faculty to rural issues. In order to be meaningful, such an office needs to have connections with, and participation of, rural physicians.

For students interested in practicing urban medicine, finding mentors and role models in an urban medical school is not difficult; however, easy access to such role models is lacking for students who have an interest in rural medicine. Changes in the organization of the university need to be made to include faculty members who are not geographically located on campus.

Medical schools should, of course, strive to create competent clinicians. They should also endeavor to train physicians who can function effectively in a community setting. In order to prepare students for community practice, community exposure is needed as part of medical school training. Medical schools have to diversify and move into both urban and rural communities.²⁰ To some, this decentralization is a very radical and feared change; it is, however, similar to what has happened in the postgraduate training of family physicians in rural areas. In this way, medical schools will educate competent physicians who are willing and prepared to practice in rural and underserved communities.

Postgraduate Program Interventions

Much like the undergraduate medical curriculum, postgraduate training in tertiary and quaternary care settings does not foster attitudes and practice patterns conducive to rural practice. Those who train in a rural area, however, are more accustomed to practicing in a rural area and more likely to stay practicing there.²¹ For this reason, postgraduate medical training, as well as undergraduate training, should be decentralized. To varying degrees, the opportunity to do some or all of their training in a rural area should be available to residents in every specialty.

In regards to postgraduate training of family physicians, much positive change has been made. Programs such as the Family Medicine North program in Thunder Bay, Ontario

and the Northeastern Family Medicine Program in Sudbury, Ontario provide for an intense and independent environment to train rural family physicians in hope that they will stay and practice in these communities. Programs of this nature are not just limited to Ontario but are available to some degree in all Canadian provinces. It is appropriate that there be regional differences between the programs, but there should also be a core skill set that every rurally trained physician obtains. Standardizing a subset of skills necessary for licensure in rural practice could be accomplished by developing a national agreement outlining what these programs should offer.

Due to their limited population base, most rural areas are not conducive to a specialist's practice. The rural 'generalist' family physician must provide a wide variety of services, including those that are provided by specialists in larger urban areas. Presently, there are limited guidelines in place for the training, certification, and continuing medical education of rural family physicians with these advanced skill sets (e.g., anesthesia, obstetrics, and emergency medicine). Thus, there is a need for rural training programs that provide advanced skills training.¹⁷ The ability to acquire, practice, and maintain a specialized skill set will require an integrated approach by the government, educational institutions, and the various licensing bodies. If this approach is taken, rural physicians can provide an increased number of services to their communities to avoid inconvenience of patient referral to a larger centre and relieve pressure on existing rural specialists.

Interventions for the Practicing Rural Physician

While the previously mentioned programs are very important to a comprehensive package in addressing the recruitment and retention of physicians to rural areas, probably the most important area of support and change is in regards to the practicing rural physician. Rural medicine is substantially different from that practiced by its urban and suburban counterparts. As a result, rural physicians need an organization that will give them a substantive voice to advocate for change and gain a feeling of empowerment over their professional lives.

Communities in underserved areas can also implement changes to help address physician shortage and retention. The demographics and opportunities of a prospective community must first complement the practice and lifestyle interests of the physician to increase the chance of retention.²² The funding of a community resource officer, whose job it is to recruit physicians to the area and match the interested physician with a suitable town, has been effective in Northwestern Ontario for a number of years.²³ A community resource officer has most recently been assigned to

Northeastern Ontario, but there is still a need for officers in Southwestern, Southeastern, and Central Ontario.

The community itself can also become part of the solution. Underserved areas can help by playing an active role in physician recruitment, providing a community-sponsored medical clinic, and supporting regional hospitals and their programs. The community should also assist in providing opportunities for the physician's spouse. Willing local governments could create a vibrant and dynamic environment to attract and enhance the lives of physicians and their families.

Every physician needs to maintain competence through continuing medical education (CME). CME is difficult to obtain in rural areas due to long travel distances, inability to obtain locum coverage, and a paucity of rurally relevant programs. The application of computers, the Internet, and the ability to teleconference will help solve the issue of distance for a subset of the CME that is required. These methods are not cheap, however, and financial support will be needed.¹⁷ A novel and integrated solution to "hands-on" CME and locum coverage is found in a program provided by the Society of Rural Physicians of Canada. This CME program is provided by rural physicians for rural physicians, and the session facilitators both teach and provide locum coverage for those that participate.

The issue of financial support has always been contentious. Giving rural physicians more money is not a solution to the problem. The underserved area financial incentives that have been tried have been reasonably good at recruitment but not at retention.²⁴ The traditional fee-for-service (FFS) payment scheme is not conducive to an effective rural practice.⁶ Numerous plans have been initiated that all rely on some form of yearly salary based on services provided and special skill sets obtained. Given that each rural area is different though, no one plan is going to be a solution for all, and the government must have the courage to recognize this fact and allow for numerous flexible payment plans.

One of the most important issues that needs to be addressed when considering lifestyle is the frequency of on-call. It is generally accepted that call of more than 1 in 5 is not reasonable.⁴⁸ There are many communities, however, in which on-call of 1 in 2 is the average. While this type of schedule can be maintained for a short period of time, physicians become burned out and long-term relationships, both professional and personal, suffer. As well, the FFS method of payment is not an effective means of remuneration in rural areas where there is low volume of patients. An hourly rate for time on-call is one possible solution in attempting to make rural on-call compensation consistent

with that in urban areas. In addition, efforts to reduce call frequency, effective nurse triaging, and the possible use of nurse practitioners need to be explored.

Conclusion

The complexity of the problem of recruitment and retention of rural physicians requires a solution that is implemented at all stages of a rural physician's training and career. An integrated approach to problem solving requires not only interventions at the high school, university, medical school, and residency levels, but also the active participation and co-operation of the physicians, the communities in which they practice, and the regional and provincial governments.⁸ If a coordinated effort is not taken, what will result is analogous to many horses trying to pull one cart in different directions. The outcome is much effort, but a broken cart. In Canada, this uncoordinated approach exists on the national, provincial, regional, and academic levels. The solution to addressing the needs of the increasing number of underserved areas will be more effective and more expedient if a unified and national approach is taken to create comparable and effective programs and standardized curricula. Australia has successfully led the way in forming a national governing body on rural health and in the training of rural practitioners and can be an effective role model to Canada.¹⁵ Graham Scott said it best: "it is time for everyone involved to show some courage and leadership and take some risks."⁶

Acknowledgment

Special thanks to Kim A. Ferguson, BSc. (OT1).

References

1. SRPC. (1998) <http://www.srpc.ca/numbers.html>.
2. SRPC and PAIRO. (1998) From education to sustainability: a blueprint for addressing physician recruitment and retention in rural and remote Ontario.
3. Sibbald B. (1998) Desperately seeking doctors. *CMAJ*. 158(3):377-8.
4. Scott, GWS. (1995) *Report of the fact finder on small/rural hospital emergency department physician service*. Toronto: Ontario Ministry of Health.
5. Drummond A. (1998) A critique of the Scott Report. *Canadian Journal of Rural Medicine* 3(1):27-30.
6. O'Reilly M. (1997) "Take some action, take some risk," conference on rural recruiting told. *Canadian Medical Association Journal*. 157(7):936-7.
7. SRPC. (1998) A doctor's review. <http://www.srpc.ca/librarydocs/review.html>.
8. SRPC. (1997) Recruitment and retention: consensus of the conference participants, Banff 1996. *Canadian Journal of Rural Medicine*. 2(1):28-31.
9. Irvine H, Rowntree C, and Thompson J. (1994) Needs of rural physicians. <http://www.srpc.ca/needs.html>.
10. Brooks J. (1994) Australia develops national strategy for bringing physicians to rural areas. *CMAJ*. 150(4):576-8.
11. Cullison S, Reid C and Colwill JM. (1976) Medical school admissions, specialty selection, and distribution of physicians. *JAMA*. 235:502-5.
12. Boulger JG. (1991) Family medicine education and rural health: a response to present and future needs. *Journal of Rural Health*. 7:105-15.

13. Calkins EV, Johnson A and Mares KR. (1978) Identification of rural-background applicants by the talent identification program of WMA-HEC. *J. Med. Ed.* 53:764-5.
14. Carter R. (1995) Training for rural practice: what's needed? *Canadian Family Physician*. 33:1713-5.
15. Rourke JTB. (1996) Education for rural practice in Canada and Australia. *Academic Medicine*. 70(5):464-9.
16. Kamien, M. (1995) Undergraduate rural incentives program: assisting medical schools to help solve the shortage of rural doctors. *The Medical Journal of Australia*. 162:228-9.
17. Wilson DR, Woodhead-Lyons SC and Moores DG. (1998) Alberta's Rural Physician Action Plan: an integrated approach to education, recruitment and retention. *CMAJ*. 158(3):351-5.
18. McAllister L, McEwen E, Williams V and Frost N. (1998) Rural attachments for students in the health professions: are they worthwhile? *Australian Journal of Rural Health*. 6(4):194-201.
19. <http://www.srpc.ca/elective.html>.
20. *WONCA Working Party on Training for Rural Practice* (1995) WONCA policy on training for rural practice.
21. Magnus JH and Tollan A. (1993) Rural doctor recruitment: does medical education in rural districts recruit doctors to rural areas? *Medical Education*. 27:250-3.
22. Cullen TJ, Hart, LG, Whitcomb ME and Rosenblatt RA. (1997) The National Health Service Corps: rural physician service and retention. *Journal of the American Board of Family Practice*. 10(4):272-9.
23. *PAIRO*. (1996) Answering the call: towards an effective recruitment and retention program for communities and physicians in Ontario's underserved areas.
24. Copeman WJ. (1987) The underserved area program of the Ministry of Health of Ontario. *Canadian Family Physician*. 33:1683-5.