Family doctors where they are needed

Integration, not money, required

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Why do some physicians choose a career in rural medicine? In medical school I was told to look down the row of students and contemplate. "Half of you will get divorced, a quarter will fall prey to substance abuse…" They could have added that "one in 10 will choose rural practice," because in those days rural medicine was another type of failure about which you did not speak.

Despite the warnings, I got married, drank beer, and chose to practise rural family medicine. While, thankfully, I am not divorced and not addicted to alcohol or other substances, I have had stressful times in my 12 years of rural practice, and I am not alone.

Who will share the workload?

Thommasen and colleagues have found that high levels of depression (29%) and burnout (55%) exist among generalists in rural areas of British Columbia (page 737). While alarming, it is not surprising. When you are one of a few, there is little "give" in who takes care of the community. Rural doctors have 30% fewer generalist colleagues with whom to share the workload than those in the city.[1]

On the plus side, rural physicians practise all aspects of family medicine because of these needs. This rewarding practice style is increasingly difficult to maintain in other areas. Thommasen and colleagues found that, even among rural doctors working in stressful conditions conducive to burnout, most (83%) scored moderate or high on the personal accomplishment subscale. Rural practice, while challenging, is professionally rewarding. One can "be a real doctor" and "make a difference," but it is not easy.

Many (51%) rural doctors considered relocating, especially those who felt the most depressed or burnt out. This percentage is quite a bit higher than the 15% found for all Canadian general practitioners and family physicians in the 1998 Janus survey.[2] Moving from rural communities back to the city has led to a "revolving door" of 20% to 30% of doctors flowing through rural communities in any given year.[3,4]

Differing rates of actual physician turnover, however, are not explained by differing rates of depression or emotional exhaustion found among physicians in the studied communities. While no doubt these factors could affect someone's decision to move, depression is not what speeds or slows communities' revolving doors; it is not a dominant characteristic of communities that experience high physician turnover. To understand why people leave, we have to understand why people stay in rural practice.

Keeping doctors in rural areas

Cutchin[5] has determined that keeping physicians in rural areas derives from three aspects of integration: physicians themselves, the medical community, and the community at large. Depression would certainly be important in physicians' own health and integration. If doctors are integrated well into the medical community and the community at large, however, they might get the support and nurturing required to remain and recover their own health.

The policy implications of these findings are important. Governments have put little emphasis on integration or the community in their policies and programs for keeping doctors in rural areas. Offering money is almost the only method Canadian governments use to recruit physicians to meet the health needs of rural populations.[6] To an extent, with 20% to 30% of the rural pool being filled annually, money has been extraordinarily successful, and we would quickly have a disaster if it ran out. It seems, however, to be failing to even out the supply of doctors in rural and urban areas in Canada, much less keep existing levels of rural services.[7,8] If the American National Health Service Corps[9] is an example, people recruited primarily with money, such as those with return-of-service scholarships, are less likely to stay once they have met the terms of the bargain than those with other motivations or support. Clearly it is in societies' interest to have physicians integrate

well within their communities. Doctors who stay provide better continuity of care to their patients.

Building support for rural doctors

If we are to slow the revolving door, we need to help with integration. Doctors and spouses need to network in order to reduce levels of depression and stress. The community needs to help integrate practitioners and their families. The local hospital needs to have the nursing staff and equipment for doctors to do what they have been trained to do. Building these supports for physicians, spouses, hospitals, and communities is an important responsibility to which governments need to apply resources.

Pathman et al[10] found that physicians who were prepared for small-town living, especially if they did postgraduate rotations in rural locations, stayed in rural practice. City dwellers preparing for rural practice must be open-minded enough to accept a "foreign" pastoral culture. Many of the so-called challenges of country life are virtues from this cultural perspective. What some call "fishbowl" living, those who integrate into rural culture characterize as a warm bucolic intimacy. Both are valid descriptions, but they derive from the perspective of each individual more than from the nature of the situation.

Those who grew up in small towns are already integrated into rural culture and are more likely to choose rural practice.[11,12] Researchers at Queens University in Kingston, Ont, found that half of their family practice residents with rural origins chose rural medicine as an initial practice option and that they were more likely to make a career of rural practice (odds ratio 2.5).[13] Having a spouse of rural origin was also a significant factor (odds ratio 3.1).[14] Barer and Stoddart[15] have remarked that:

> the importance of recruiting and admitting future physicians who have grown up in rural and remote settings now seem clearly established (everyone agrees that it is better to recruit physicians who want to live in these areas than to have to rely on coercive policies or financial incentives through which one is likely to "attract" physicians who would prefer to be somewhere else). However, the overall impression that one gets both from the existing literature and from speaking with individuals involved in educational strategies is that only a fraction of what could be done in this area is currently being done.

The urban location of all Canadian medical schools, the emphasis on grades to select the "best" candidates, and the escalation of tuition fees all conspire against rural Canadians who usually have rural values, weaker schooling, and parents with less money. Many highly intelligent Canadians find medical school so unattainable they do not even apply. Even a progressive medical school that shelters affirmative action slots for aboriginal candidates with a separate and culturally sensitive application process find it difficult to attract sufficient applicants to fill the positions. If we are to slow the revolving door, we also need to help rural people apply.

Retaining and recruiting rural doctors is a complex issue that needs a comprehensive approach. There is more need for an integrated approach than for a lot of money. Ideas and literature supporting such an approach are not new.[16] The vitality, organization, and vision of rural doctors is new and will ensure progress toward that goal.

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