

## The four-legged kitchen stool

### *Recruitment and retention of rural family physicians*

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**C**anada is the second-largest country in the world, covering 10 million square kilometres. Our population density is sparse by international standards. Canada is one of the most urbanized nations in the world, however, with one third of the population living in Montreal, Toronto, and Vancouver and 90% living within several hundred kilometres of the American border.<sup>1</sup>

Approximately 20% of Canadians live in communities of less than 10 000 people. Providing equitable and sustainable health care services to rural Canada is challenging; our extreme weather conditions and diverse geography prove obstacles to traveling over the vast distances and difficult terrain between our scattered communities. For small remote communities, it is hard to provide required technology and adequate numbers of health professionals. This dilemma is shared by all regions in Canada and by most countries around the world. Rural communities suffer from a chronic shortage of family physicians who are challenged to provide primary and secondary medical care to patients who are older, poorer, less healthy, less well educated, and more likely to be obese and to smoke than Canadian patients in urban areas.<sup>2-4</sup>

#### **Looking for a simple solution**

A succession of governments at all levels, along with many medical organizations, have hoped to find a single solution to a complex problem. A lack of specific comprehensive initiatives has left many rural communities reliant on human resource policies based on the theory of trickle-down economics: if a sufficient number of physicians are trained and urban centres are adequately serviced, the remaining physicians will trickle into less urban areas, and the health care needs of rural communities will be met. Until recently, most Canadian medical schools have not seen training and providing rural physicians as part of their mission or social contract. Thus, most graduates have been trained in

cities where rural medicine was undervalued and students were discouraged from pursuing careers in rural areas. I hope that the Northern Ontario School of Medicine, with a mandate to train physicians for rural and remote Ontario, will act as a catalyst for other medical schools in Canada.

The factors affecting the provision of an adequate number of physicians for rural Canada are multidimensional. Specific factors have a cumulative effect on increasing the likelihood of physicians choosing to practise in non-urban communities. In some ways, recruitment and retention of family physicians in rural practice can be illustrated by the four-legged kitchen stool. One leg represents the personal interests and background of physicians and their families; the second encompasses appropriate training for rural practice; the third leg includes the community and all its attributes; the final leg takes into account working conditions and remuneration for rural physicians.

#### **Personal interests and background**

Evidence supports the notion that the background experiences and characteristics (eg, rural origin, interest in and attitude toward rural practice) of medical students and their spouses influence the choice of career location.<sup>5</sup> It is important for medical schools to take these characteristics into consideration, because students of rural origin with an interest in rural medicine are more likely than students from urban or suburban areas to enter rural practice. Hutton-Czapski, Pitblado, and Rourke (page 1240) provide current evidence that medical students of rural origin are underrepresented in Ontario medical schools.

It is only recently that many communities have begun to realize the importance of physicians' spouses in determining the likelihood of their remaining in a specific setting.<sup>6</sup> The career of a physician can be seen as a life cycle, with personal priorities changing to accommodate important life

changes, such as the birth of children, a spouse's career aspirations, or family educational goals. As personal or family goals change, physicians strive to find a medical practice and community that provides the best fit. Despite fond memories of country doctors who worked their entire careers in one community, the reality is that most physicians, like other Canadian professionals, do not spend their whole careers in one community. Thus, a family physician who leaves a rural community after 5 years of service should not be seen as a disappointment, but rather as someone who has made a positive contribution to that community.

## Appropriate training

Training physicians, including the need for life-long learning, encompasses experiences at the high school, premedicine, medicine, residency, and continuing education levels. Rural experiences during undergraduate and postgraduate medical training can influence decisions to practise in a rural community.<sup>5</sup> For rural rotations to have an impact, learners must move from being medical tourists to truly living the joys and challenges of small-town practice.<sup>7</sup> These experiences appear to be additive in providing physicians with the necessary skills to live and practise in communities where on-site specialists are usually unavailable. Medical learners are more likely to practise in settings that parallel their educational experiences, which highlights the need for training specific to rural practice at the residency level. As medicine is a rapidly changing field, the availability of appropriate continuing medical education is a prerequisite for retention of rural practitioners as well.

## Community attributes

Rural and northern communities have environmental assets that are considered by most Canadians only when planning a vacation. Where else can you ski to work, fish on your lunch hour, paddle in the evening, or be charmed by graceful wildlife? Ask any rural physicians why they practise without the bright lights of a city; they will often describe specific attributes of their setting that are available within 5 minutes of seeing the last patient of the day. Cahill's community profile ([page 1193](#))

illustrates this well. Retention of physicians is profoundly influenced by the recreational, cultural, educational, and social opportunities available to them, their spouses, and their children.

## Working conditions

Working conditions, including scope of practices, on-call requirements, support from colleagues, medical group dynamics, available diagnostic services, and financial remuneration, also shape physicians' satisfaction with their careers. Rural settings require family physicians with a range of skills to handle patients in multiple locations, including offices, emergency departments, hospital wards, operating rooms, delivery rooms, and chronic care facilities. An insufficient complement of physicians has been the cause of burnout or departure for many rural physicians. Innovative funding arrangements that take into consideration the unique challenges of specific rural communities within the framework of nurturing working conditions have the potential to transform a revolving locum service into a stable medical group. *Orrantia* ([page 1217](#)) describes a vibrant practice model that has been successfully developed in Marathon, Ont.

## Achieving balance

Stools are most stable with all four legs firmly planted on the ground and braced to make a strong foundation that can withstand the inevitable changes going on around it. No one leg can be seen as the most important: the stool's strength is derived from the presence of all four legs. Three-legged stools are a compromise that will provide adequate support under some conditions. Recruitment and retention of a physician complement where only one or two legs are present or functional will likely result in a rural community that unsteadily swings from crisis to crisis. One-legged stools belong in the circus for our amusement and astonishment and should not be the basis for providing medical services to our rural communities.

Rural practice can be one of the most satisfying experiences for family physicians. McWhinney has suggested that, when we share the same habitat as our patients, our potential for meaningful careers

as physicians is strengthened.<sup>8</sup> Effective rural physicians are aware of this principle. In addition they have learned to balance personal goals with those of their patients and their shared community.

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