CME

Marathon works

How to thrive in rural practice

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ABSTRACT

PROBLEM BEING ADDRESSED Medical care in rural Canada has long been hampered by insufficient numbers of physicians. How can a rural community's physicians change the local medical culture and create a new approach to sustaining their practice?

OBJECTIVE OF PROGRAM To create a sustainable, collegial family practice group and address one rural community's chronically underserviced health care needs.

PROGRAM DESCRIPTION Elements important to physicians' well-being were incorporated into the health care group's functioning to enhance retention and recruitment. The intentional development of a consensus-based approach to decision making has created a supportive team of physicians. Ongoing communication is kept up through regular meetings, retreats, and a Web-based discussion board. Individual physicians retain control of their hours worked each year and their schedules. A novel obstetric call system was introduced to help make schedules more predictable. An internal governance agreement on an alternative payment plan supports varied work schedules, recognizes and funds non-clinical medical work, and pays group members for undertaking health-related projects.

CONCLUSION This approach has helped maintain a stable number of physicians in Marathon, Ont, and has increased the number of health care services delivered to the community.

RÉSUMÉ

QUESTION À L'ÉTUDE Au Canada, les soins en milieu rural ont longtemps souffert d'un pénurie de médecins. Comment les médecins des communautés rurales peuvent-ils modifier la culture médicale locale et instaurer de nouvelles mesures pour soutenir leur pratique?

OBJECTIF DU PROGRAMME Créer un groupe de pratique familiale collégiale viable et répondre aux besoins de santé d'une collectivité rurale souffrant d'une pénurie chronique de services.

DESCRIPTION DU PROGRAMME Afin d'améliorer le recrutement et la rétention, on a incorporé dans le fonctionnement de l'équipe sanitaire des éléments importants au bien-être des médecins. Le développement d'un mode de fonctionnement où les décisions sont prises au consensus a permis d'obtenir le support de toute l'équipe médicale. Des réunions, des retraites et un groupe de discussion sur Internet favorisent la communication. Chaque médecin demeure maître de son horaire et de ses heures de travail annuelles. Un nouveau système d'appel en obstétrique assure maintenant des horaires plus prévisibles. Les médecins ont convenu d'un plan de paiement alternatif qui facilite des horaires variables, reconnaît et subventionne des travaux médicaux non cliniques, et soutient financièrement les membres du groupe dans des projets sanitaires.

CONCLUSION Cette approche a aidé à stabiliser le nombre des médecins à Marathon (Ont.) tout en augmentant le nombre des services sanitaires à la population.

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Marathon Family Practice (MFP) is located in the town of Marathon, Ont, about halfway between Sault Ste Marie and Thunder Bay. This community of about 4700 sits on the stunning rocks of the Canadian Shield where it dips into the cold waters of Lake Superior. The economic engines of the area are a pulp mill and the three nearby mines of the Hemlo gold field.

The local hospital has nine acute care beds and a catchment of 6500 population. The catchment area includes two aboriginal reserves. Consistent, comprehensive primary care is provided in Marathon by the nine family doctors of MFP. This community has not always had enough physicians.

In the 10 years before establishment of MFP, the community of Marathon was served by more than 87 transient physicians. During that period, the local hospital closed its obstetric service and at times was forced to consider closing the emergency department due to a lack of physicians. A scarcity of human resources continues to plague the profession of medicine, particularly in rural Canada.[1]

Attempts to improve recruitment and retention of physicians in rural areas have addressed some pertinent factors: financial incentives,[2] rural community experience during medical training,[3] medical school admission policies favouring rural origins,[4] and professional and lifestyle issues.[1] In Ontario, financial incentives are provided by the Underserviced Area Program to attract physicians and by the Northern Physician Retention Initiative to keep them practising in the north.

Up to now, the Underserviced Area Program's approach has not affected the distribution of physicians in the province.[5] Though there is little evidence of its effectiveness,[6] the Underserviced Area Program also has a Free Tuition Program with a return-of-service commitment. The Northern Physician Retention Initiative has yet to have rigorous evaluation. Exposure to rural practice during medical school and residency through programs such as the Northwestern Ontario Medical Program is associated with a higher likelihood of recruitment to,[7] and retention in,[3] rural communities. Even in northwestern Ontario, where such educational opportunities have been offered for many years, there is still an insufficient number of physicians.[8]

Professional issues are important. Issues that might influence physicians to stay in rural practice include having enough colleagues, having locum tenens available, having opportunities for group practice, having alternative compensation to fee-for-service payment, and having continuing medical education available.[2] A common reason for considering leaving rural practice is dissatisfaction with long hours of work,[9] which is associated with burnout, a condition brought on by excessive workload, lack of control over practice environment, and problems with work-life balance.[10] Though initiatives such as the Ontario Medical Association's Locum Program for Rural Physicians and its Rural Continuing Medical Education Program are already working to address professional issues, local interventions can further enhance rural recruitment and retention. This is what we attempted in Marathon.

Objective of the program

In 1996, MFP was developed to address the chronically underserviced state of medical care in this rural northern Ontario community. Physicians in Marathon envisioned providing excellent health care by creating a sustainable, satisfying, and collegial family practice group[11,12] that intentionally addressed physicians' professional issues and well-being.

Program

Marathon Family Practice has adopted guiding principles to facilitate recruitment and retention of doctors by encouraging physicians to take excellent care of themselves. This is a cornerstone of our practice philosophy. Elements that contribute to physician well-being include relationships (professional and personal), limits on work, and attention to personal needs (eg, exercise, special interests).[10] In addressing

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such issues, we have applied consensus-based decision making and integrated elements that facilitate an attractive balance of work and personal life. Along with an alternative payment plan, these components contribute critically to the experience of engaging in medicine as part of MFP.

For physicians to thrive in rural medicine, they must cooperate. The strength of our group is directly related to the people in it and the relationships we share. A fundamental element of our professional dynamic is consensus-based decision making, an inclusive approach that permits all the physicians to help shape and support decisions. Though occasionally a slow process, it produces innovative, respected solutions that allow us all to proceed with confidence. If, as has happened on occasion, consensus is not reached, then change does not occur. If we cannot agree on a critical issue, we have agreed to seek mediation to facilitate achieving consensus. To date we have not had to do this. Achieving consensus on issues has provided an opportunity for personal and relationship growth and has helped create a cohesive, functioning group of physicians.

Recognizing that group functioning has an important effect on our own individual health, we have been diligent about addressing this on an ongoing basis. All the physicians meet at least once a month to discuss group and practice issues. A private, Web-based discussion board facilitates ongoing dialogue on issues and tasks. Regular group retreats provide opportunities to reflect on the important, but not urgent, issues that often get overlooked during the daily demands of medical practice. Working together, we have developed expertise in holding meetings, enhanced our practice, and fostered a sense of connectedness.

Our group's health depends on the effective integration and balance that each of its members has in his or her own personal and professional life. To this end, we support individual preferences in total clinical hours worked as well as flexibility in scheduling. As there are no minimum or maximum hours defined by the group, there is a range of clinical involvement among our members. Emergency room on-call duties are usually proportionate to clinical hours worked, although there are exceptions. In obstetrics, we have implemented a system in which physicians who do obstetrics each take a month of the year in rotation and care for all patients due that month through their pregnancies for prenatal care and delivery. This supports continuity of care for patients and more predictable work hours for physicians. Managing schedules has been very important to our members' satisfaction.

At MFP we keep each other individually accountable for our commitments with regard to professional practice and health. We are responsible to our MFP colleagues for the group-related tasks and medical responsibilities we take on, and we receive constructive feedback from our colleagues on them. We have committed to monitoring and discussing how we are coping regularly, so that we avoid getting lured into professional schedules beyond our personal preferences, tolerances, or abilities.

Our principle of having no financial investment to join MFP facilitates arrivals and departures of physicians. We attempt to minimize financial commitments and long-term contractual obligations. Office space is rented on a monthly basis. Capital purchases are shared by all group members. If someone leaves, most of the undepreciated portion of his or her capital purchases is bought out by the remaining members. The practice is easy to come to and easy to leave, which enhances its appeal for potential recruits.

Payment

After spending years in the fee-for-service scheme, MFP's physicians signed on to a Northern Group Funded Program (NGFP). We have finished our fifth year under this plan and have found it to be effective in supporting the medical life to which we aspire. The NGFP pays our group a fixed monthly rate based on the six-physician complement that the Ontario Ministry of Health and Long Term Care (OMHLTC) has assigned our community. We find it liberating that the OMHLTC relies on the physicians in the group to devise their own governance agreement for the NGFP. Instead of having six physicians work similarly and then share equally

in the earnings, our governance agreement focuses on clinical hours worked. Near the beginning of every contract year, physicians indicate how many clinic hours they intend to work over the next 12 months. They are then paid on an hourly basis. If there is a forecasted shortfall of hours compared with contract requirements, we then know that we need to recruit some new physicians. We also calculate the vacation and continuing medical education coverage needed by our group and try to maintain the number of physicians that allows for internal locum tenens (group physicians covering for group physicians) and decreases our reliance on scarce locum tenens physicians. For these reasons, MFP has nine physicians instead of the OMHLTC complement of six.

We budget our NGFP finances so that a substantial pool of money remains after paying physicians for their clinic hours. This allows us to pay physicians for time on hospital committees and for acute, chronic, and obstetric inpatient care. As well, physicians can propose special health-related projects and, upon group acceptance, be paid for the time involved in bringing those ideas to fruition. This has helped group members to explore interests and enhance skills as well as launch a variety of public health initiatives in our community. Recent projects include developing a community non-smoking bylaw, research into local rural obstetrics, and community talks on teen suicide.

Discussion

Marathon Family Practice has created one type of rural medical model that works in its particular sociomedical environment. The medical staff situation has greatly improved; 16 physicians have participated in our group since its inception 9 years ago. Currently, nine of those 16 continue to work at MFP. During the last 5 years, Marathon has been the only community of the 16 rural communities enrolled in the NGFP that has consistently maintained physician numbers of at least its government-assigned complement. Our approach has enhanced recruitment and, perhaps more importantly, improved retention.

A reflection of the health of the MFP group is the energy that it has put into enhancing medical services. Obstetrics has reopened; chemotherapy and stress testing are now provided locally; a successful telemedicine program has been launched; and regular satellite clinics are held on local aboriginal reserves. The group is now consistently involved in teaching family medicine residents and medical students. Members have also been involved in developing the Northern Ontario School of Medicine. Improvements are being realized in provision of local health care and education.

In analyzing the success of MFP, we must recognize the substantial contributions of the many government initiatives in creating a rural environment more conducive to sustainable care in Ontario. We believe, however, that physicians themselves creating a medical community with an intentional focus on both patient and physician wellness is what distinguishes ours from most approaches to rural recruitment and retention. It is what has allowed us to thrive.

As a group, we attempt to anticipate, create, and manage change, but our future is tied to many unknowns. For instance, the projected closure of the Hemlo gold mines within the next decade could affect Marathon greatly. Primary care reform mandates and fiscal issues might greatly influence future iterations of our NGFP contract. Within our group, individual changes in professional or personal priorities, as well as unexpected illnesses, could affect our precious human resources. Uncertainty is currently widespread in medicine everywhere in Canada, and our experience is no exception. We consider that a given and persist.

We continue to evolve. We are now trying to position our clinic to ride the information technology wave and benefit as much as possible from developments such as electronic medical records. In exploring the possibility of opening a satellite dialysis clinic, we continue to work at expanding local medical services. In striving to further support good quality of life, we are building a system that supports sabbaticals for rest, adventure, and education. Making a priority of keeping a balance in our lives has provided the creative energy to continue investing in our profession.

Conclusion

Creating a supportive group of physicians through application of a consensus-based principled approach with a focus on personal and professional well-being is helping us succeed in the practice of rural medicine. We hope some of our ideas will interest others looking to further enhance their lives in medicine. For now, change, challenge, and opportunity continue to nourish a community of physicians who love where they are and what they are doing.

Author's note: After this article was submitted, MFP was selected as one of four sites in northern Ontario to implement Ontario's new Family Health Teams. The group looks forward to integrating this new collaborative approach.

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EDITOR'S KEY POINTS

- Rural communities across Canada have been chronically understaffed, despite many efforts to encourage rural recruitment.
- A group of physicians in Marathon, Ont, created a unique model of practice that has stabilized the number of physicians and allowed expansion of services in the community.
- Marathon Family Practice uses a consensus-based approach to decision making and focuses on the well-being of its physicians. Factors considered include hours of work; time for other interests; physical and mental wellness; and opportunities to participate in non-clinical medical work, such as community projects.
- Other aspects of the practice include an alternative payment plan, an in-house governance agreement, and regular communication among the group. The group is funded for six full-time physicians, but nine share the funding, allowing time for the other activities. Marathon works!

POINTS DE REPÈRE DU RÉDACTEUR

- Au Canada, les collectivités rurales ont toujours souffert d'une pénurie d'effectifs médicaux, en dépit de nombreuses mesures pour favoriser le recrutement.
- À Marathon (Ont.), un groupe de médecins s'est donné un modèle de pratique qui a permis de stabiliser les effectifs et d'accroître les services dispensés à la communauté.
- Dans le modèle de pratique familiale de Marathon, l'objectif visé est le bien-être des médecins, et les décisions sont prises au consensus. Les facteurs considérés incluent les heures de travail, le temps consacré aux autres activités, le bien-être physique et mental, et la possibilité de participer à des activités médicales non cliniques, comme des projets communautaires.
- Ce modèle de pratique prévoit aussi un plan de paiement alternatif, une entente interne de gestion et des communications régulières entre les membres du groupe. La rémunération du groupe est prévue pour six médecins à plein temps, mais neuf médecins se la partagent, ce qui laisse du temps pour d'autres activités. Le modèle de Marathon fonctionne!

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