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Rural health care

Dr. James T.B. Rourke is to be commended for his article "Politics of rural health care: recruitment and retention of physicians" (*Can Med Assoc J* 1993; 148: 1281–1284). Statistics indicate that the recruitment and retention of physicians for rural practice is a growing problem. There is an urgency not only to meet increasing demands for accessibility of care but also to recognize that the responsibility of nurses for primary care in rural and remote areas becomes part of their professional experience and competence. Inevitably territorial conflict will arise as these professionals move to urban areas. Communities that feel neglected by traditional medical practice may adopt "alternative" medical care.

Meanwhile, other changes to be faced are the de-emphasis on hospital care in favour of community services, as was undertaken by the Ontario Ministry of Health, and the postwar development and maturation of health care professionals such as those who deal with prevention (public health nurses), family problems (social workers), rehabilitation (physiotherapists and occupational therapists) and psychotherapy (psychologists), all in the context of the general societal move from rural to urban areas.

I emphasize some of Rourke's conclusions, add a few pointers and recount some personal experiences.

I moved with my family to Kelowna, BC, in 1962, to develop psychiatric services there. I worked 35 full-time hours a week at the government mental health centre and 35 or more full-time hours a week in private practice. The mental health centre team included a social worker, a psychologist and a nurse. A travelling clinic from the mental health centre in Burnaby, BC, had provided preparatory work for over a year. The Canadian Mental Health Association had rallied strong community support, and the travelling clinic's staff and the physicians who provided office space and gave up hospital beds for a psychiatric ward extended a hearty welcome to me and my family.

The government appointment allowed time for the development of an infrastructure through liaison with personnel from schools and social service and probation departments, as well as police, pharmacists and clergy. Volunteer services such as day cares, group homes, a crisis line and a social planning council had to be enlarged or begun. For several years the centre team spent 1 week each month travelling to towns within 2-hours' drive of Kelowna for consultations, and some continuing care was offered at the centre or hospital in Kelowna.

My family was fully involved in the community (the local church, the service club, recreation activities and hospital committees). We lived in downtown Kelowna, near schools and services, and had a summer camp by Okanagan Lake, 24 km from the hospital. Our camp phone was unlisted. A family physician took calls and supervised the hospital ward during my summer vacation. I still had time for continuing education, teaching and writing the occasional article. If we hadn't known it before, we soon learned that there were satisfactions in life other than making a lot of money.

Both government flexibility and community interest are needed to decentralize health care. Internships and residencies away from the main centres broaden the options of new practitioners. It must be recognized that most graduating specialists are married before they complete their studies, so their plans are tied to not only their spouses' interests but also mortgages, children's schooling and companionship. As well, the trend toward subspecialization works against the rural areas that need internists, surgeons and psychiatrists, not just for breadth of coverage but to maintain a humane not a technologic emphasis in medical practice.

It's been a rewarding lifestyle.

Frank McNair, MD, FRCPC
Kelowna, BC

Dr. Rourke neglected to describe what, in 1993, is an acceptable program for recruiting physicians to and retaining them in rural areas.

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