PLATFORM

Rural medicine needs help

ROBERT MARTEL, MD, PHC

A national strategy to bring physicians to rural areas is long overdue in this country. Many provinces have identified a problem: without a stable rural manpower base delivering primary care, delivering home care will be impossible. In Nova Scotia we have a serious shortage of doctors in rural areas. Last year Dr Reg Perkin, Executive Director of the College of Family Physicians of Canada (CFPC), outlined succinctly the circumstances that face those of us who need help in the periphery.[1]

There was a time when the enthusiasm for practising away from academic centres could be compared to the zeal of the homesteaders of yesteryear, and it was espoused as a vocation. In less than 50 years, we have evolved along a continuum whereby technology has been embraced at the expense of basic clinical skills, robbing general practitioners of that much needed modicum of confidence essential to practising medicine in the periphery. Somewhere along the way the CFPC failed to notice the metamorphosis that resulted in graduates who now (by their own admission) possess neither the skills nor the desire to practise the type of medicine required in rural areas.

Dr Perkin says the following points are critical to the discussion at hand: more than 30% of family physicians believe that their training was inadequate for rural practice; and more than 30% of family physicians think that access to both continuing medical education (CME) and locum tenens relief is inadequate. It should not surprise anyone that residents in family practice in 1995 feel unprepared to hang out shingles in small towns across Canada when practising family physicians responded the same way to a CFPC survey in 1990.

In Nova Scotia the rural population is small, and perhaps it is unreasonable to expect the CFPC to tailor programs to meet everyone's needs. The Australians recognized a decade ago that their training program for physicians destined to practise in the periphery had to be packaged differently if Australian rural medicine was to survive. In this country, training and support for family physicians who practise in small communities are not yet adequately provided by organized medicine.

Crisis in rural medicine

At the risk of being accused of using superlatives to make a point, I say there is a crisis in rural medicine. For years family physicians in rural Canada have worked long hours under conditions that would be unacceptable in many other professions. It is difficult to identify a government decision, a change in medical curricula, an adjusted fee structure, or a legal decision that can be blamed for the crisis in rural health care. Suffice it to say that rural physicians are tired of trying to be everything to everyone without recognition for past or present efforts. Moreover, rural family physicians are acutely aware that downsizing health care will affect people living in rural Canada more than those in urban centres.

It would be myopic to believe that the crisis is all a result of manpower deficiencies. Significant to this discussion is the realization that universality as a pillar of Canadian medicine has never reached rural Nova Scotians. Low marginal incomes and great distances from specialists and investigational techniques have worked against rural people. Rural Canada is undergoing depopulation as Canada evolves onto the world stage. The media have painstakingly portrayed rural Canada as a dying sector of the Canadian mosaic, lacking infrastructure, people with ambition, and hope for the future. This negative stereotype, coupled with a longstanding urban selection bias for medical school candidates, has incorporated a definite value bias against practising rural medicine.

Reform of the Canadian health care system seems at the moment to be driven more by happenstance than by forethought. Absolutely pivotal to constructive reform is the participation of well informed and

committed family physicians. Circumstances, such as lack of locum tenens services, increasing expenses, and decreasing net incomes, have resulted in the departure of physicians from rural practices, leaving fewer and fewer doctors to manage the many new problems that have come with home care, alternative care, and the increased specialization of medicine. As the health care dollar shrinks, more demand will be placed on physicians to look to a parallel, private health care system. Despite the musings of politicians, it is rural physicians who will be caring for patients who need unfettered access to universal medical care.

Issues

Dr Perkin identified two critical factors that came out of the CFPC survey of rural physicians: 19 out of 20 respondents experienced some level of personal stress, and one in two said being on call was a problem. No aspect of rural practice further sets apart rural physicians from their urban counterparts than the responsibility for being on call.

There are 168 hours to be covered in a week; it therefore stands to reason that the more people sharing those hours, the less stressed each one will be. Many of us have experienced extreme levels of personal anguish over the years, not only because of grueling one-in-two call schedules spanning many years, but also because of being constantly aware that patients, families, colleagues, and ever-present lawyers expect sterling performances at all times in all aspects of care. As a Canadian Medical Protective Association official recently said with striking clarity, "fatigue is no defence."

The concept of relative value was raised by Dr Patricia Mark[2] when she attempted to compare workloads, responsibilities, and lifestyles of urban-based general practitioners with those of rural practitioners. The problem, she concluded, is the fact that the latter group is at such a disadvantage by virtue of small numbers that the concept is moot.

A reality check, however, indicates that the inequity is real. Despite the fact that urban physicians claim more than 70% of medical service insurance funds, they do less than 10% of the on-call duties. Add to this the observation that rural physicians are likely to manage more complex cases, assume responsibility for most in-patients, have much less time off, have less time to consult with colleagues, and are less able to access CME. Vacation time and good quality time with family for most rural physicians is rare.

The reality faced by rural physicians is best seen when unexpected events require time away from the practice. Unless the group has sufficient resources, time off is always complicated by the knowledge that one's colleagues must cover not only the on-call schedule but also daily practice responsibilities, to say nothing of ongoing expenses. In the last 6 months, three of my colleagues have been forced to continue working while ill: two with pneumonia doing hospital rounds with intravenous poles trailing them and another with a fractured limb. Apocryphal as it might sound, these rural physicians felt they could not abandon their patients. Attempts to arrange for relief from outside colleagues fell on deaf ears.

It is difficult for physicians who practise in areas with lots of colleagues and ancillary equipment to understand the stress a rural physician can experience in an emergency room faced with a multiple trauma, a cardiac arrest, an injured child, or an overdosed patient, knowing he or she will have only a single nurse to assist. And while doctors try desperately to cope, family members hover around asking when their loved ones are going to be transferred. Their questions imply their lack of confidence in the physician's judgment.

Rural physicians are also faced with the added burden of often having to treat friends and neighbours in the community. This does not happen every day, but neither is it rare.

At whose feet should we place the blame for this remarkable failure? This type of problem usually evolves insidiously, arising from a breakdown in communication between graduates and medical schools. But the CFPC should have seen it coming. Graduates in family medicine have been expressing anxieties that are symptomatic of the problems stated above and have manifested those concerns by not choosing rural practice locations.

Some say that lifestyle issues are the real issues. Perhaps we should explore the paradox unveiled in the CFPC survey cited by Dr Perkin.[1] Four out of five respondents expressed satisfaction with rural life, and nine out of 10 respondents were satisfied in their work.

Could it be deduced that, if rural Nova Scotia could attract physicians and their families, these physicians would find professional solace? If we accept this as a first premise, then we have to accept that the problem lies not only in preparation but in presentation, given that the perception among residents is that they are better off starving in big cities than risking life and limb in the boonies.

Responses

The Australians recognized very early in their evaluation of rural practice training that its intrinsic

value was lost on students.[3] Prospective candidates chose not to do general practice in rural areas because other disciplines over the years had gained more respect. Medical schools tend (albeit ever so slowly) to evolve curricula to meet the needs of consumers who were, in this case, urban general practitioners.

Unfortunately for rural people, medical training in Canada has contributed to the reluctance of recent family practice graduates to meet the manpower shortfall. Lack of support from medical training institutions and colleagues is probably the greatest stressor faced by rural physicians after the lack of good quality time spent with their families.

The Australian government, faced with the same structural problems some years ago, decided to revamp their whole training program. Starting with admission of candidates to the Rural Practice of Medicine Training Program and ranging to the recognition that practitioners of rural medicine are subspecialists in their own right, the Australians have developed a program to be emulated by Canadians.

The recent accord signed by the Nova Scotia Medical Society and the Government of Nova Scotia recognizes, for the first time, that a problem exists. The deal opens the door for a comprehensive review of rural family practice.

Action

Many factors that make rural practice difficult and unappealing to medical school graduates can be modified,[4] but modifications in training and support absolutely require better communication with the CFPC, medical societies, medical schools, and provincial governments. Limiting practice opportunities for physicians gives the impression that the powers that be are addressing problems, but a closer look confirms that a piecemeal approach will only damage the cause of rural medicine.

In Nova Scotia, medical education has been organized, until recently, around a conservative model evolving slowly over time to meet consumer needs. Somewhere along the way the needs of medical students and urban specialists took precedence over the needs of rural family physicians. Perhaps rural physicians failed to articulate the need for improved curriculum and working conditions.

In a recent study sponsored by the Ontario Ministry of Health (MOH), the Ontario Hospital Association (OHA), and the Ontario Medical Association (OHA),[5] Graham Scott identified the urgent need for principal parties to find constructive ways to work together. Scott identified rural practice as distinct from general practice, as requiring special attention regarding training and recognition as a discipline crucial to the well-being of community hospitals and rural health care. Central to his thesis is the strong sense of abandonment felt by rural physicians who believe they are not supported by the MOH, the OMA, the OHA, and medical academic leadership.

Many other jurisdictions have sought counsel from rural practitioners through rural medicine societies. In Nova Scotia a move is under way to organize a similar body. The Medical Society of Nova Scotia's Section of General Practice has traditionally been spokesperson for all general practitioners. I want to put forth the concept that rural medicine is a distinct discipline with specific needs in training, CME, manpower, and lifestyle.

While the Society of Rural Physicians of Canada was developed as a support group for rural physicians and has identified areas for improvement in training, it lacks the official clout of the CFPC. Only the CFPC can become directly involved in making changes in education that will provide adequate training for rural physicians. I suggest that the CFPC form a Section of Rural Medicine to take leadership at the national level to help the cause of rural medicine. The CFPC should fill the void in speaking out when rural medical training is discussed. I see the CFPC leading a national forum and bringing stakeholders to the table to discuss and promote change, taking a leaf from the Australian experience.

The issues intrinsic to the continuation of stable rural general practice are complex and are best articulated, defended, and developed by those individuals who are faced with the issues daily. I hope that, when the boundaries between disciplines cross, a strong spirit of professional commitment to the ideals that make general practice what it is will continue to exist. Family physicians must continue to advocate for patients in a health care system under tremendous internal and external stress. ■

Dr Martel *practises family medicine in Arichat, NS.*

Correspondence to: *Dr R.F. Martel, 1255 Main St, Arichat, NS B0E 1A0*

References

1. Perkin R. Rural practice [Progress notes]. *Can Fam Physician* 1994;40:632 (Eng), 630-1 (Fr).
2. Mark P. RVG rewards *Fam Pract* 1994;6:9.
3. Brooks J. Australia develops national strategy for bringing physicians to rural areas. *Can Med Assoc J* 1994;150(4):576-8.
4. Rourke J. Politics of rural health care: recruitment and retention of physicians. *Can Med Assoc J* 1993;148:1281-4.
5. Scott GWS. *Small/rural hospital emergency department physician service* [report]. Toronto: Ontario Ministry of Health, Ontario Hospital Association, Ontario Medical Association, 1995.