Recruiting rural doctors: ending a Sisyphean task

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The problem of physician supply in rural Canada is a growing concern at both the national and provincial levels. As Mark Easterbrook and colleagues report in this issue (page 1159),[1] there is increasing evidence not only of a current crisis but also an exacerbation of the problem in the foreseeable future.

The problem is multifactorial and can be seen throughout the life cycle of the medical trainee and practising physician. Despite some changes in approach, medical school training is still conducted primarily in urban centres and offers only limited, optional, exposure to rural medicine and lifestyles. Residency training programs, particularly for specialists, remain oriented toward urban training and practice.

The current dilemma also stems from interrelated issues surrounding general licensure, early career decision-making and a lack of re-entry positions. Until recently, the career path of many physicians included acquisition of a general licence after a rotating internship, several years of general practice in a rural setting and then a return for specialty training (without a return-of-service commitment). For example, in Easterbrook and colleagues' study, which surveyed physicians who had graduated before the recent changes, 23.5% of the respondents had pursued additional specialty training.

By contrast, today's trainees are forced into a specialty training stream immediately upon medical school graduation with the knowledge that opportunities to switch tracks either during residency or after entering practice will be limited. Moreover, in many regions of the country new graduates select their practice setting influenced by the fear that billing-number restrictions or other changes in policy may make future migration very limited.

Clearly, a variety of solutions is needed. The recently released *From Education to Sustainability*[2] delineates over 150 recommendations spanning the career path of physicians. This publication was a joint effort of the Ontario section of the Society of Rural Physicians of Canada (SRPC) and the Professional Association of Internes and Residents of Ontario (PAIRO). The document also draws on individual and organizational expertise at both the national and provincial levels. Easterbrook and colleagues evaluate recommendations in 3 specific areas: the importance of recruitment of future physicians from rural settings, the need for exposure to rural medicine in medical school, and the role of exposure in residency training. These areas are also given a strong emphasis by the Ontario Task Force on Rural/Northern/Community Medical Education, which is designing a series of recommendations for the Ontario Ministry of Health.

In keeping with similar research in other countries, including the United States, Easterbrook and colleagues' survey shows that the physicians from rural communities were more likely than their nonrural colleagues to choose these settings for practice location. This was a statistically significant finding with respect to both the time of first practice and the time of the survey (up to 16 years after graduation) and suggests that there is a need to improve recruitment into medical schools from rural areas.

For many reasons, recruitment of medical students has traditionally favoured more urban areas. The recent astronomic and unprecedented increases in tuition at many of Canada's medical schools will only add to the problem. Increased participation in medical schools from rural areas, particularly from aboriginal and other minority groups, requires the dismantling of many barriers, some of which exert an influence even earlier than high school.

There is increasing recognition that an aging cohort of practising physicians combined with reductions to medical school enrolment also contributes to the problem of physician supply in rural areas. If governments begin to address the issue by increasing medical school admissions, there should be initiatives to help fill these new positions with qualified students from rural communities.

Easterbrook and colleagues' findings also underline the importance of exposure to rural practice in training, particularly during medical school. Although their sample was too small to support statistical significance, the results of their survey is congruent with existing evidence and with recommendations of the SRPC and PAIRO consensus document.[2] Programs to facilitate electives in rural areas must be well funded to support student expenses (which are generally higher than those for electives in urban areas) as well as preceptor time and costs. Evidence that exposure to rural practice in the course of training can change perceptions is also needed. There may be a preselection bias with regard to which students and residents participate in rural electives.

Studies such as this one, which look at constructive means to address the problem, are important. A failure to

investigate, validate and promote long-term solutions leaves a vacuum that risks being filled by coercive measures. Billing-number restrictions and fee differentials are just 2 examples of coercive measures that have been discussed (indeed, fee differentials have been at least transiently implemented in some provinces). Legislation was recently introduced in Toronto that, if enacted, would demand mandatory return of service from *all* medical students.

Coercive measures are not real answers but, rather, unproven short-term interventions that victimize both the communities in question and young physicians. Easterbrook and colleagues' study is timely in providing Canadian evidence about recommended solutions regarding the selection and education of future physicians. More data are needed about recommended changes that span the gamut of the medical career and address the specific professional and personal challenges unique to rural practice.

Implementation of most of these solutions will require additional financial and nonfinancial support from physicians, government and communities. However, the benefit is the development of sustainable health care in Canadian communities and an end to the Sisyphean task of recruiting, training and retaining rural doctors.

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