Supporting future and current rural physicians

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Rural health care systems in Canada are overextended and understaffed. Despite rural generalism thriving in some areas of the country, evidence suggests that, as a whole, rural generalist physicians are poorly supported in their work, particularly by misaligned remuneration models.[1,2] Physicians are increasingly leaving their rural posts seeking more favourable working conditions to avoid the burnout.[3] As the rural physician workforce becomes more unpredictable and dependent on locum coverage, not only do rural communities lose essential access to health care services, but medical students have increasingly limited opportunities to train in rural areas because of a lack of clinical preceptors. Strengthening rural generalism has been a priority area for the College of Family Physicians of Canada and the Society of Rural Physicians of Canada for many years, as outlined in the organizations' 2017 Rural Road Map for Action.[4] Despite the focus on comprehensive rural primary, inpatient, hospital, and emergency care, coupled with in-community specialist services, progress toward a robust rural health system has been slow. We outline ways to inspire and sustain a rural generalist physician workforce for rural Canada.

Key points

- Opportunities for rural training are necessary for students to gain adequate exposure to the field of rural medicine and develop a professional identity as future rural generalist clinicians.
- Appropriate infrastructure, well-structured payment plans, and ample locum access are essential to supporting rural generalist clinicians who are also clinical teachers.
- Rural community members should be engaged in recruitment to ensure physicians feel welcome and connected.
- Rural clinical teachers must ensure learners feel supported through adequate mentorship while helping create a culture that minimizes the risk of burnout and supports clinicians and learners.

Why does creating rural training opportunities for medical learners matter?

Canadian medical schools have embraced the notion that career trajectory can be shaped by early, positive rural clinical experiences.[5] Many medical students want a chance to work with and learn from experienced and satisfied rural clinicians. In rural communities, learners are exposed to a broad scope of practice, develop their procedural skills, and cultivate the resilience and clinical courage needed to manage uncertainty while building knowledge around rural health service delivery.[6,7] These are crucial opportunities, not only to expose students to the breadth of rural practice, but also to allow them to build confidence in their abilities and shape the professional identity that can eventually support independent practice.[5,8] A qualitative study found that learners who trained in low-resource settings adjusted more quickly to residency and full-scope rural practice, leading to a positive influence on professional identity formation, clinical skills, and intention to pursue rural practice.[9]

Rural clinical faculty who can mentor, inspire, and work alongside trainees are essential to the preparation of medical students. In both Ontario and British Columbia, planning is underway for new medical schools and the expansion of admissions. However, to deliver on the promise of social accountability and equitable access to health care in rural communities, more is needed than simply increasing medical student intake. Learners need access to adequate training in and exposure to rural communities to envision a future in rural medicine.[7] Medical schools must commit to training learners who aspire to be rural generalists in their geographic context through a culture that values the role of rural generalists and assures high-quality training.[5]

As the instability of the physician workforce increases, so does the difficulty for students to obtain rural clinical rotations. We have observed that the ability to offer rural placements, including longitudinal integrated clerkships in rural settings, has diminished in our own institutions. A fragile rural workforce directly affects rural training exposure and, by extension, recruitment opportunities.

In Australia, a federally funded National Rural Generalist Pathway has been initiated to specifically attract, retain, and support rural generalist doctors.[10] This pathway coordinates training for rural generalists, provides support for clinicians transitioning between postgraduate training and full-scope practice, and supports rural generalists currently in practice. A qualitative study, which involved interviewing a sample of both Australian and internationally trained physicians, found factors that positively influenced work and training in rural areas, including work–life balance, having a sustainable practice supported by rural community orientation, community integration, and a strong workforce.[10]

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To meet the needs of rural Canada and support the development of comprehensive rural generalists, medical schools and policy-makers must work together to create more opportunities for learners to increase the duration and frequency of rural training, and adopt some of the Australian strategies to strengthen rural generalism.

How can rural practice be made attractive to physicians?

Strengthening the culture of rural generalism in Canada is an essential foundation to attract and retain physicians to work in rural areas and adequately mentor medical students, postgraduate trainees, and internationally trained physicians for rural practice.

Although the Rural Road Map for Action outlines key directions for implementing interventions that align medical education with workforce planning, it addresses only some of the areas in which rural physicians need support to encourage recruitment and retention.[4] These include support for professional development, the creation of health care teams (including optimal funding models), and opportunities to take leave when necessary and transition to practice successfully.

Supporting professional development

Contracts for rural clinicians need to not only ensure capacity for clinical service delivery, but also include time for teaching, scholarly activity, and support for professional development. The volume of clinical information to keep up with is now 3 times what it was 20 years ago.[11] One strategy, identified in a systematic review, is to provide opportunities for professional development through paid sabbaticals, flexible work hours, and manageable call schedules.[5] A reasonable workload for rural physicians — both for practice and clinical teaching — must include time to learn, remain current, and enhance skills.

Development of team-based care

Team-based collaborative practice builds the adaptive capacity to sustain quality health care locally in rural settings.[4,12] Access to skilled teammates (e.g., addictions counsellors, physiotherapists, pharmacists, social workers, home care nurses) supports patient access to valuable services that physicians alone cannot provide. This creates a more attractive environment for physicians to maintain their professional lives and supports better care in rural practice settings. Teams that share the work effectively have all members functioning at top of scope. The benefit of team-based care is not limited to rural practice, but is an important feature of physician retention in rural settings.[12]

Generalist funding models need to reflect the realities of current rural practice. This includes turn-key infrastructure (i.e., no need to buy in to the clinic or fund the clinic capital costs) and funding models that ensure that the physician can focus on clinical care and teaching with reasonable workload expectations. The notion of running the business of the practice is no longer appealing for new graduates, nor is it the best approach for clinical academic settings.[9,13]

Finally, appropriate funding matters. Stable funding models should enable rural clinicians to focus on both clinical practice and teaching. Although BC recently introduced changes for funding for primary care physicians, more initiatives are needed to address understaffing and burnout among physicians in rural areas. Rural generalism is well supported in pockets of the country but, nationally, the payment system does not recognize the challenges of the current environment or the teaching expectations.

Support for taking leave

A 2019 literature review highlighted a common theme among 14 systematic reviews, which is that access to locums is a key element of retention.[5] Being able to take short-term leaves when necessary — such as for vacation, training, illness, parental leave, or elder care — supports physicians to stay in the long term.[5] Every jurisdiction should adopt policies that support physicians to source and fund locums and that enable effective service distribution. In addition, locums play a key role in recruiting physicians as locum work is commonly provided by new graduates looking for a permanent location to practice.[14] Many rural locum support programs have strict requirements for practising physicians to qualify for support, and communities that do not qualify often have trouble retaining doctors. This is particularly glaring with respect to locums for parental leave as young doctors take locum availability into consideration when planning families and choosing a location to permanently practice.[2]

Progressive approaches to locum licensing and privileging would ease the recruitment of locums to rural areas and help retain current rural physicians by providing much needed respite. Pan-Canadian licensure would enable a nimbler locum workforce by allowing physicians to practice nationwide. This is supported by the Rural Roadmap but requires considerable interprovincial government collaboration.[4]

Support at transition to practice

Seasoned practising clinicians need to understand the complexity of entering practice today. Most practising physicians have had a long runway to adapt to the increasing complexity of clinical practice. The average number of patient contacts has been shown to peak at 27–29 years into practice, but this is more a reflection of practice efficiency and stage rather than a result of new graduates working less.[10] Several longitudinal quantitative studies have shown that both new graduates and seasoned clinicians have fewer patient contacts per year now than physicians at the same stage of practice 2 decades ago.[15,16] New-to-practice colleagues are working just as hard as seasoned clinicians, but complexity of care has changed for all clinicians, making the work more time consuming.

New graduates have reasonable expectations of workload and support for succession planning, including overlap of contracts at transition. Work needs to focus on mitigating the potential for burnout at all career stages, ensuring time for meaningful human connection. Sustainability of practice will be built on smaller rosters of patients with longer appointments,

team-based care models, and physician flexibility to work across the spectrum of community and individual needs. To attract physicians, the practice of rural medicine must provide a vision of a sustainable lifestyle through flexible work hours, manageable call schedules, access to locums, work–life balance that prioritizes lifestyle over remuneration, and salaried payment plans.[5,9]

Why is engaging rural communities important?

A qualitative study that explored physician decisions to practise rurally found that clinicians are more likely to be retained when they form relationships within a community, suggesting that physicians should have adequate time for community engagement beyond clinical medicine.[13] Communities that have input into their physician recruitment experience achieve improved health care and physician retention.[9] This includes having community orientations, in addition to having readily available resources for childcare, recreation, and spousal employment.

In the current health care climate, physician shortages are unlikely to be entirely alleviated by Canadian medical graduates. Reliance, especially in rural medicine, on international medical graduates (IMGs) for their return of service is a reality.[17,18] An Australian taskforce for the recruitment of rural physicians identified additional factors that make effective IMG recruitment and retention challenging, including working in locations with a high rate of physician turnover, lengthy physician vacancies, demonstrated need for broad scope of practice with advanced practice skills, a high proportion of Indigenous people in the population, and extreme climate changes.[19]

Community integration and mentorship for IMGs would establish a stable orientation in their early years of practice and are just as important as practice assessment. As the need to recruit and retain IMGs increases, so too does the need for rural communities to learn and show support for IMG physicians of diverse experiences and cultural backgrounds.

Rural municipalities that consider the health workforce as a pillar of economic infrastructure invest in people who can recruit and retain the team.[20] Places such as Marathon, Ontario, have seen success with community members acting as community connectors whose role is not only to recruit physicians, but also to support retention. This model has been further developed in Australia as the "Attract.Connect.Stay" model.[21] International community engagement initiatives and community connector roles should be explored, and the best of these could be adopted in Canadian communities.

Many rural health systems provide services for local municipal populations and neighbouring Indigenous communities. To overcome the legacy of colonialism that has been detrimental to the health of both urban and rural Indigenous people, rural physicians and medical students require time dedicated to Indigenous community engagement.[22,23] By attending community events, physicians and trainees can continue to learn, build trusting relationships, and be a part of continuing reconciliation.

Conclusion

Medical students with rural interest and those in rural-entry streams need to be better supported in their training to have positive rural experiences. Students who currently aspire to be rural generalists are being exposed to numerous challenges in the path ahead and require system-level change to successfully transition into their role as rural care providers. Efforts must be focused on retaining and supporting committed rural clinicians in practice so that rural areas have a stable clinical faculty who can teach, support, and inspire the future of rural generalist family medicine. A shared broad commitment from medical schools, licensing bodies, provincial ministries of health, and local health authorities will be needed to address the prioritization of rural health care. This is the only way that rural and remote communities in Canada will have equitable and sustainable access to quality medical care that serves both patient and provider.

References

1. Ogundeji Y, Clement F, Wellstead D, et al. Primary care physicians' perceptions of the role of alternative payment models in recruitment and retention in rural Alberta: a qualitative study. *CMAJ Open* 2021;9:E788-94.
2. Farkas B, Manns B, Ogundeji Y, et al. Recruitment and retention of rural and remote physicians — the role of alternate payment models. Calgary: University of Calgary, O'Brien Institute for Public Health Technology; 2020. Available: https://obrieniph.ucalgary.ca/sites/default/files/teams/12/Rural%20and%20Remote%20Physicians_role%20of%20APM_Abridged%20stand-alone.pdf (accessed 2023 Sept. 3).
3. Lespérance S, Bradbury-Squires D, Giles S. Physician wellness: burnout among rural and remote physicians is a significant issue we can help with. Ottawa: Canadian Medical Association; 2022. Available: https://www.cma.ca/physician-wellness-hub/content/physician-wellness-burnout-among-rural-and-remote-physicians (accessed 2023 May 15).
4. Advancing rural family medicine: The Canadian Collaborative Taskforce. The rural road map for action – directions. Mississauga (ON): Advancing Rural Family Medicine: The Canadian Collaborative Taskforce; 2017. Available: https://www.cfpc.ca/CFPC/media/Resources/Rural-Practice/Rural-Road-Map-Directions-ENG.pdf (accessed 2024 Jan. 14).
5. Asghari S, Kirkland M, Blackmore J, et al. A systematic review of reviews: recruitment and retention of rural family physicians. *Can J Rural Med* 2020;25:20-30.
6. Orrantia E, Kline T, Nutbrown L. Teams of rural physicians matter: testing a framework of team effectiveness. *Can Fam Physician* 2022;68:280-7.
7. Charter L, Scully R, Laidlaw A. "The word that comes to mind is polymath": medical students' perceptions of rural postgraduate careers. *Rural Remote Health* 2021;21:6750. doi: 10.22605/RRH6750.
8. Rourke J, O'Keefe D, Ravalia M, et al. Pathways to rural family practice at Memorial University of Newfoundland. *Can Fam Physician* 2018;64:e115-25.
9. Snadden D, Kunzli MA. Working hard but working differently: a qualitative study of the impact of generational change on rural health care. *CMAJ Open* 2017;5:E710-6.
10. Young L, Peel R, O'Sullivan B, et al. Building general practice training capacity in rural and remote Australia with underserved primary care services: a qualitative investigation. *BMC Health Serv Res* 2019;19:338. doi: 10.1186/s12913-019-4078-1.
11. Maskalyk J. The future of medicine is here and you are its story. *CMAJ* 2022;194:E1653-4.
12. Canada's health workforce: pathways forward: an assessment by the Canadian Academy of Health Sciences. Ottawa: Canadian Academy of Health Science; 2023. Available: https://cahs-acss.ca/wp-content/uploads/2023/04/CAHS-Health-Workforce-Pathways-Forward-EN_Final_Apr-4.pdf (accessed 2024 Apr. 22).
13. Maclaren AS, Locock L, Skea Z. Valuing place in doctors' decisions to work in remote and rural locations. *Future Healthc J* 2022;9:248-51.
14. Myhre DL, Konkin J, Woloschuk W, et al. Locum practice by recent family medicine graduates. *Can Fam Physician* 2010;56:e183-90.

15. Rudoler D, Peterson S, Stock D, et al. Changes over time in patient visits and continuity of care among graduating cohorts of family physicians in 4 Canadian provinces. *CMAJ* 2022;194:E1639-46.

16. Kralj B, Islam R, Sweetman A. Long-term trends in the work hours of physicians in Canada. *CMAJ* 2024;196:E369-76.

17. Wang Y, Das RLV, Lapa T, et al. Career development of international medical graduates in Canada: status of the unmatched. *Humanit Soc Sci Commun* 2023;10:38. doi: 10.1057/s41599-023-01534-z.

18. Campbell–Page RM, Tepper J, Klei AG, et al. Foreign–trained medical professionals: Wanted or not? A case study of Canada. *J Glob Health* 2013;3:020304. doi: 10.7189/jogh.03.020304.

19. Five-year International Medical Graduates Recruitment scheme. Canberra (AU): Australian Government Department of Health and Aged Care; 2023. Available: https://www.health.gov.au/sites/default/files/2023-04/five-year-international-medical-graduate-img-recruitment-scheme-guidelines-feb-2023_0.pdf (accessed 2024 July 27).

20. Ryser L, Halseth G, Markey S, et al. Tensions between municipal reform and outdated fiscal levers in rural British Columbia. *Can Geogr* 2022;67:150-64.

21. Cosgrove C. Attract Connect Stay [homepage]. Available: https://attractconnectstay.com.au/about-attract-connect-stay/ (accessed 2023 June 13).

22. Turpel-Lafond ME. In plain sight: addressing Indigenous-specific racism and discrimination in B.C. health care. Government of British Columbia; 2020. Available: https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Summary-Report.pdf (accessed 2023 Nov. 8).

23. Kim PJ. Social determinants of health inequities in Indigenous Canadians through a life course approach to colonialism and the residential school system. *Health Equity* 2019;3:378-81.

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