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**“As they trickle in, they trickle out”: Recruiting Physicians in Rural Ontario**

**Jennifer Ann Perzow**

**A Thesis**

**in**

**The Department**

**of**

**Sociology and Anthropology**

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**for the Degree of Master of Arts**

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## ABSTRACT

“As they trickle in, they trickle out”: Recruiting Physicians in Rural Ontario

Jennifer Ann Perzow

This exploratory study examines the recruitment of rural physicians in Ontario, Canada. Emphasis is on the social context in which practice location decisions are made, with four Spheres of Consideration playing a dominant role: financial, personal and social, professional, and educational. Eleven physicians and medical students were interviewed regarding the basis for their decisions to practice in rural areas. Their responses were compared to the major issues regarding recruitment found in the research literature. From a financial point of view, respondents mentioned the importance of student debt loads and government incentive programs for rural placement. Personal and social considerations include the special relations between physicians, their rural clients and neighbours, as well as their partners/spouse and children. Professional concerns included the legitimization of rural practice and more specifically, making rural medicine a specialty. Educational concerns referred to the need for exposure to rural issues and conditions in medical school. The thesis underscores the special characteristics of rural practice and the importance of specific training directed to its support. Recommendations for rural communities, governments, and the medical community are included.

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## **Chapter One: Introduction**

### **1.1 Contextualization of the area of inquiry**

Health care in rural Canada is in crisis. Physicians working in rural and remote parts of the country often are overworked and feel underappreciated. As a result, many rural communities are unable to attract and keep physicians and health care in these areas is not sustainable (O'Reilly, 1994).

A great deal of Canadian research and literature exists on almost every aspect of health: biological, social, emotional, and spiritual. However, until recently, rural health care has occupied a peripheral position in Canadian medical sociology that mirrors the marginalization of rural health care within Canada's medical community. Despite the fact that Canada's geography is 90% rural and one-third of Canadians live in rural areas, very little is known outside of the medical community about the struggles and challenges of Canadian rural health care. Furthermore, only 11% of Canadian physicians practice outside of urban centres (Rourke, 1993) and there are less than half the proportion of physicians in rural areas as there are in urban areas (per 1000 population) (Statistics Canada, 1999). According to the *Canadian Medical Association* two problems relating to the lack of physicians are: 1) there simply are not enough doctors working in Canada right now with physician shortages in both rural and urban areas 2) there is a maldistribution of doctors who are working here (CMA Task Force, 1999).

As with urban health care, a thorough introduction to rural health care is time consuming. The realities of Canadian health care reflect the “interlocking set of ten provincial and two territorial<sup>1</sup> health insurance plans” (Health Canada, 1997) that form what Canadians know as Medicare. This thesis seeks to introduce rural Canadian health in broad strokes by focusing on one of the largest problems in rural health care: recruiting physicians. While the physician is one part of a health care system, she undoubtedly is the central force in a Western medical model.

Recruiting physicians can be challenging for numerous reasons. However, the struggle to obtain sustainable health care does not end when communities recruit physicians. The next problem with which they are often confronted is that physicians do not stay in rural areas. For this reason, I had initially intended to focus my attention on the retention of rural physicians. I was unable to do so due to difficulties in finding practicing rural physicians who were willing and able to participate in this study. In part, I was subject to the end result of the trend that I endeavoured to investigate: rural physicians are overworked. Retention is an important issue, worthy of study of its own accord.

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<sup>1</sup>The creation of an additional territory called Nunavut, in 1999, has increased the total number of territorial health insurance plans to three.

Physicians practicing in rural communities feel frustrated and powerless. They see a decline in the quality of rural health care and have little control over its fate. Rural communities have trouble recruiting and retaining doctors because of the heavy workload, long hours on-call, professional isolation, general lifestyle choices, and because of the lack of appropriate recognition that rural practice gets from mainstream, urban medicine. These problems lead to a high rate of burnout among rural doctors and consequently high turnover rates in rural communities (SRPC, 1997; O'Reilly, 1994).

In consideration of the professional and personal isolation, the demanding workload and the lack of teaching about rural medicine in medical schools, it is easy to see why rural communities often have such difficulty recruiting and retaining physicians. But what is being done about it? Federal and provincial governments have responded to rural communities in different ways, but it is the communities themselves and non-partisan medical associations that have generated the most positive movement towards an end to this crisis.

In an effort to combat the problem of rural recruitment and retention, both the federal and provincial governments have designed programs and invested a substantial amount of money in rural health care. The 1999 Federal Budget allocated \$50million towards rural and community health<sup>2</sup> (Health Canada, 1999). The Ontario Ministry of

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<sup>2</sup>The Budget did not indicate how the money would be divided between 'rural' and 'community'.

Health has invested more than \$83 million in rural and Northern health in the province, close to 80% of which is directed to the recruitment and retention of physicians (Ontario Ministry of Health, 1997: 2). In 1998, Canada's Health Minister Allan Rock announced the creation of a new branch of Health Canada whose primary interest is rural health. In creating this position, Mr. Rock stated that he wants "to ensure that the views and concerns of rural Canadians are better reflected in health policy and in the health system" (Health Canada, 1998). Before then, rural health issues had been absent from many National debates on health care. The National Forum on Health, released in 1996 by Health Canada, fails even to acknowledge the struggles of rural health care.

Because specific health care policies vary between provinces and territories, there are thirteen distinct sets of policies governing rural health in this country. In Quebec, recent medical graduates are paid only 70% of the standard fee-for-service rate if they practice in Montreal but are paid up to 115% of that same standard rate if they practice in a Northern community (Armstrong, 1994: 27). Additional bonuses also are paid to physicians who practice in designated areas. Restricting billing privileges is proving to be successful in Nova Scotia, but the Ministry of Health in British Columbia was sued for their "Physician Supply Measure" which reduced billing rates for doctors in urban areas (The House, 1998).

Forcing physicians to work in rural Canada does not address the real problems in rural health care. Moreover, it jeopardizes the health of rural communities and places

barriers between the rural doctor and the community. Often, both the doctor and the community may know that the doctors are there against their will. The implications of this forced labour on the quality of care that patients receive are not yet known.

Medical associations also provide support and services to rural doctors and rural communities. The Ontario Medical Association (OMA) organizes rural locums, or relief staff, for physicians wanting to take some time off, whether for a vacation or to attend a conference. Similarly, the OMA sponsors Continuing Medical Education programs that are specifically designed for rural practitioners. Other programmes, designed to attract recent medical graduates to rural practice often employ the use of limited term contracts. Physicians sign a contract for a 1 to 5 year period. In that time they will receive substantial cash and in-kind bonuses. When these contracts end, however, there is no guarantee that the physician will stay in the community. Even communities that are able to recruit physicians can have difficulty retaining them.

The World Organization of Family Doctors (WONCA) has been instrumental in detailing the troubles of rural medicine and offering practical solutions. The Organization recommends that undergraduate medical training expose students to rural medicine in order to attract them to rural practice. In their publication *Policy on Training for Rural Practice* (1995), the Organization discusses the key misperceptions of rural practice. They state that:



A number of attitudinal and perceptual barriers have been identified as discouraging medical graduates from entering rural practice....The key misperception is that rural practice is somehow 'second class medicine' (4).

In Canada, the recently formed Society of Rural Physicians of Canada (SRPC) has, among other things, integrated the WONCA guidelines into the Canadian health care system. Like the WONCA, the Society's members feel that "...education is the key to solving the problems of recruitment and retention of rural physicians" (1997: 29)

Medical schools have started to acknowledge rural medicine. Presently, most Canadian medical schools provide some exposure to rural medicine for students who are interested, and evaluations of those programs have been positive. The Department of Family Practice at the University of British Columbia (UBC) initiated a rural training program in 1982 (Whiteside and Mathias, 1996: 1114). An evaluation of the program indicated that "graduates of the UBC rural training program consider themselves better prepared for rural practice than non-program-trained rural physicians" (Whiteside and Mathias, 1996: 1113). Moreover, the evaluation suggested that specific, structured training was indeed helpful in preparing physicians for rural practice and by extension also increased the number of new graduates practicing in rural areas (1120).

## 1.2 Theoretical Framework

It is important to know what draws physicians to rural practice. Without that information, it is difficult to find solutions that are meaningful, appropriate and sustainable. For a sociologist, it is also important to know the social context in which those decisions are being made because individual choice is always affected by external conditions. Each physician has his or her own reasons for choosing rural practice. While each choice is indeed personal, physicians approach that choice from perspectives that are influenced by their social experiences. For example, a recent study by Easterbrook et al. (1999) suggests that doctors who grow up in rural areas are more likely than doctors who grow up in urban areas to choose and stay in rural practice. This suggests that the person who grows up in a rural area is used to the social context of rural life. A person of rural origin is used to knowing many people in town, and having many people know him; is accustomed to having limited access to shopping facilities and driving long distances to reach the nearest urban centre. This familiarity prepares physicians of rural origin for the personal and social aspects of being a rural doctor. That preparedness, in turn, means that they are likely to choose rural practice. Physicians who grew up in an urban centre are, at best, less familiar with the day to day experience of living and working in a rural area and are therefore less prepared. Lack of experience or preparation also will influence a physician's choice of practice location. This is one example of how social context can influence physician recruitment.

I propose, in Chapter Two, a theoretical framework that accounts for the influence of social context. I call that framework the Spheres of Consideration and I suggest that practice location decisions are being made within those spheres of consideration. The four spheres of consideration that I use in this thesis are: financial, social-emotional, professional, and educational.

### **1.3 Statement of Research Questions**

Physicians decide whether to practice in an urban or rural location. Logic dictates that asking physicians about their decision will help us identify solutions to the problem of physician recruitment. Asking rural doctors about recruitment is the first step to solving the health care crisis in rural Canada. My inquiry is two-pronged. On the one hand, I will be examining the reasons that physicians and medical students claim are the determining factors in their choice of practice location. While this is a good start, there is no way to verify or confirm that the factors that physicians report as being important are variables when the time to make the decision arrives. Often, in social science research, we see a discrepancy between people's perceptions and what they actually do. In order to glean more information from this study, I propose the second prong in my approach to the problem. I will identify the social and personal conditions in which those responses are given. In conclusion, my research questions are: What issues are cited in the literature regarding rural physician recruitment and retention? What issues are cited regarding rural recruitment and retention by physicians and medical students? To what extent are these

issues congruent and comprehensive? What is a useful framework for research into rural recruitment and retention? What is a useful framework for policy suggestions to improve the present situation of rural recruitment and retention?

#### **1.4 Expectations**

Prior research in the field of rural physician recruitment suggests a number of structural factors that encourage physicians to locate in rural areas. The following factors are highlighted in the literature and I expect to find similar factors identified by my respondents. The respondent:

- feels adequately trained for rural practice
- has adequate professional support
- foresees that he or she will be able to integrate into the community
- is able to address his or her spouse or partner's happiness
- feels opportunities for children (education, cultural, extra-curricular, etc.)  
are adequate
- receives financial compensation beyond standard remuneration
- has interest in and aptitude for rural life
- has professional aspirations that are adequately met

## 1.5 Statement of Purpose

Rural medicine, largely marginalized by both sociology and medicine, has been in the spotlight recently, due in large part to the efforts and dedication of rural people. Issues concerning rural communities are slowly moving from the margin to the centre. With some exceptions, the sociological community in Canada has been slow to respond to this area of inquiry, which is ripe for sociological analysis. More is published about rural medicine in medical journals than in sociological journals. However, rural medicine also has been marginalized within the medical community and the literature suggests it is often not taken seriously within the urban-based medical community. In this instance, the urban biases of both sociology and medicine have negated the validity and importance of rural life.

I begin to fill that void in order to benefit the sociological and medical communities, as well as the rural communities that struggle to keep doctors among them. My hope is that this work will contribute to the social activist nature of sociology, will suggest that sociology should not remove itself from the subjects under its investigation and will inspire a different sense of social responsibility in social scientists in general. I also hope that the medical community will take from this research some indications concerning its role in the marginalization of rural communities and peoples, and seek to change. Finally, I hope this work will inform rural communities and policy makers about potential solutions to the problem of physician recruitment in rural health care.

## **1.6 How and why I decided to investigate this subject**

The need for patients to advocate for themselves has always interested me and in thinking of how to apply that advocacy concept to communities, I developed an interest in community health care. While working for a national research initiative organized by the Canadian Rural Revitalization Foundation (CRRF) entitled The New Rural Economy: Options and Choices (NRE), I became more conscious of rural struggles and triumphs. Over time I saw a clear link between my interest in community health care and the struggles rural residents were having getting and keeping doctors in their communities. The NRE has designated thirty-two sites across Canada to participate in a comparative study about the economic and social realities in rural Canada. My work with the NRE has been a superb academic and personal learning experience, and has sustained my interest in and desire to assist rural communities in the creation of sustainable health care in their communities. Through my work with CRRF and the NRE, community health care moved from being an abstract, academic construct to a tangible social quandary affecting the lives of real people.

## **1.7 Defining 'Rural'**

Defining *rural* for the purposes of this study has been a complex task. Finding definitions of the word has not been the problem. The OECD indicates that a community is considered 'rural communities' if it has a population density of less than 150 per square

kilometre (OECD, 1994). I have felt unable to use such specific definitions for two reasons. First, to do so would be incongruous with the small but growing body of literature studying rural medicine. This literature does not define *rural* in a specific fashion, referring not only to *rural* but to *remote*. The exact distinction between the two is rarely made although some distinctions are implied. The second, and more consequential reason for not defining *rural* in a specific way stems from a methodological concern, that doing so would potentially limit the pool of respondents who were willing to participate in this study. I decided to allow people to self-define *rural*. The implications of this decision are further discussed in Chapter Three.<sup>3</sup>

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<sup>3</sup>For a more comprehensive discussion of defining rural for the purposes of health, and other, research, see Leduc 1997

## **Chapter Two: Theoretical Framework**

### **2.1 Introduction**

What issues are cited in the literature regarding rural physician recruitment and retention? What issues are cited regarding rural recruitment and retention by physicians and medical students? To what extent are these issues congruent and comprehensive? What is a useful framework for research into rural recruitment and retention? What is a useful framework for policy suggestions to improve the present situation of rural recruitment and retention? In this chapter, I explore the answers to these questions commonly found in the literature, and develop and employ a theoretical model to assist with this task.

Much of the literature on and discussion around rural physician recruitment exists within the medical community. While this is changing, as researchers in the social sciences and policy makers become increasingly aware and interested in the various aspects of rural health care, there are several implications of the origins of this research that must be addressed.

I consider it a positive thing that the research and discussion in this field were instigated and for the most part developed by the research subjects. Rural physicians have been speaking out (formally - in academic research and publications, and informally - on



internet listserves) for many years. It is essential that physicians' voices be an integral part of identifying the problems and suggesting some solutions.

There are several caveats of which we must beware. The first and perhaps most obvious is that physicians are not the only cohort involved in this problem; rural community members are the ones who are not getting the medical care that they need. It is ultimately on their behalf that one undertakes research in this field -- with a hope and intention to improve the lives of rural Canadians. Likewise, nurses and other medical personnel are involved. Advances can and do come from realizing that ultimately medical personnel (physicians, nurses, and others) and other community members share common goals.

Research conducted by the medical community is rarely grounded within a theoretical framework. Its full potential remains unexplored until it is placed within a theoretical framework that can help us better understand why things are the way they are. My hope is that employing a sociological lens in exploring questions of physician retention will contextualize the problem in a new and helpful way.

Sociology can help us overcome a third caveat. To conduct a thorough and rigorous examination of this topic, we cannot rely solely on the explanations described in the medical literature. Sociologists examine what is *not* said as well as what *is* said and ask questions that have not been asked.

Although the scope of this thesis is primarily limited to recruitment issues, the value of addressing retention issues should not be overlooked. Recruiting physicians requires different strategies and involves different variables than retaining them. While the two issues are not mutually exclusive, there are enough differences between them that they necessitate individual attention. Many strategies employed by governments favour recruitment issues over retention. That is why, despite substantial energy and money invested, so many communities remain without physicians. It is not enough to ask “How do we *get* a physician?”, we also must ask “How do we *keep* a physician.” The tendency to conflate the recruitment and retention, in both theory and practice, hinders efforts to find manageable and appropriate solutions. Retention recently started to be investigated independently of recruitment, although Cutchin reports that the two are often conflated (1997). He indicates that:

...the best explanation for why we have been slow to develop theories to explain retention is the ongoing assumption that the same factors involved in locational behavior are at work in retention. It must be realized, however, that the decision to locate in a place is not the same as the decision to remain there. The decision to locate in a rural practice setting occurs largely from outside that setting. The decision to remain takes place from within the practice setting and arises from the stream of experience there. (1662)

## 2.2 Spheres of Consideration

Although Cutchin's (1997) work focuses on retention, it is likewise helpful in developing a theoretical framework to determine what factors influence physicians to choose rural practice and is the work from which I take my theoretical cue. From his research involving rural physicians, Cutchin concludes that the key to physician retention is in community integration. He posits that physicians are more likely to stay in rural practice when they feel integrated within the community. He adds that:

...retention research to date has tended to focus on quantitative methods and 'factors' of satisfaction determined from the context of the initial locational decision, we must recognize that complex and dynamic social relations affect rural physicians and their decision-making process within the particular rural setting (1672).

In other words, it is not sufficient to identify factors that influence retention, we must also understand the social context within which those decisions are being made. To do so, Cutchin identifies three domains that influence integration: the physician, the medical community, and the community-at-large.<sup>4</sup>

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<sup>4</sup> An elaboration on Cutchin's domains is beyond the scope of this thesis.

The use of theoretical tools in additional works (Pope et al, 1998; Crandall et al., 1990) marks the increased presence of the social scientific community in informing this dialogue. Pope et al. (1998) offer categories that describe the decision making process, but do not explain the context of those decisions. They inform us that physicians balance lifestyle with three conceptual categories in making their decision: community commitment, medical confidence, compensation (broadly defined). They acknowledge that “[f]or every factor judged positive by one physician there is another who sees the same situation in a different light” (210-11) but do not suggest why that might be so. The spheres that I explore in this thesis attempt to speak to that issue.

Crandall et al. (1990) provide conceptual models with which they describe various efforts at recruitment and retention. The models are: affinity models, economic incentive models, practice characteristics models, and indenture models. Affinity Models, they suggest, are most commonly used and are “...premised on the idea that physicians choose rural practice because they find it desirable” (26). Economic Incentive Models suggest that physicians act “as rational economic beings” (29) and will work in rural areas providing that it is cost-effective to do so. Practice Characteristic Models (30) address non-economic aspects of rural medicine, such as professional support. Finally, Indenture models (31) refer to forced service in rural areas.

Crandall et al.’s work benefits literature in this field in two ways. First, it does a good job of summarizing recruitment models. Second, in doing so, the work highlights a

number of important factors that influence rural recruitment such as: professional support and rural origin. However, the Models that Crandall et al. employ are of limited use in this thesis. The authors fail to provide a critical analysis of the factors that they identify as being important. For example, when discussing Affinity Models they state that “...recruitment to rural practice occurs...because the physician is from a rural background” (26). Rural origin is an important factor in both recruitment *and* retention, as I discuss in Section 2.4.1, but the authors do not explain *why* it is an important factor. The goal of this thesis is to explore the underlying social conditions that explain why, in this case, rural origin is important.

Recruitment literature indicates that there are many reasons why rural communities have difficulty getting and keeping doctors. However, what also becomes clear is that the reasons one doctor cites as disadvantages of rural practice are the precise reasons another doctor finds rural practice appealing. As Cutchin (1997) suggests, it is not enough to simply list the reasons why doctors do or do not choose rural practice. Literature in the field of rural medicine suggests that people have similar reasons for both decisions.

Many reasons are cited as being responsible for the difficulty of recruiting and retaining physicians in rural areas. Numerous authors (Conte et al., 1992; Rourke, 1993; O'Reilly, 1994; MacLellan, 1996; CMA, 1997b; OMH, 1997; Wilson, 1999) have identified the following factors as the main challenges in rural medicine: formal training,

professional support, social integration, spouse or partner's happiness, opportunities for children, financial compensation, interest in and aptitude for rural life, and professional aspirations.

Take professional support as an example. There are fewer doctors, specialists, and diagnostic tools in rural areas. This means that physicians who are working in a rural community probably are doing so with less professional support than they might have had in an urban centre. Some physicians identify this aspect of rural medicine as a disadvantage. They do not want to work in an environment with so little professional support, and refer to themselves as 'isolated' from the larger medical community. Other physicians see minimal professional support as an advantage of rural practice, enjoy being challenged, and express appreciation for the 'independent' nature of their practice. What accounts for the difference between these two perceptions of the same variable? I suspect that the answer lies within the social context and experiences of the physician in question. While this hypothesis has not yet been explored, I suspect that, in this case, medical education is related to perception. Physicians trained to work independently are likely to see this variable as an advantage while physicians trained to depend on other medical professionals see this variable as a disadvantage. In this example, the context of medical education influences the perception of rural medicine.

In conclusion, most literature in the field of rural physician recruitment identifies variables that influence recruitment. I submit that it is insufficient to simply list those

variables. In a simple list there is no mechanism to help us understand why these variables influence recruitment or how they interact with one another. While each person's life experiences are unique, there are similarities in the context in which these decisions are made. We need to develop a mechanism or theoretical framework that will enable us to understand why and how those variables are important. Drawing on Cutchin's work, as noted above, I propose that we must identify the social context in which those variables exist. His domains form the basis of how I identify and understand social context, namely through the examination of spheres of consideration.

Spheres of consideration are interrelated groupings of variables that recur in both the literature and in my own research. These spheres represent the space where decisions are made about choosing rural or urban practice. They also represent the variety of social factors that influence those decisions. I have identified four spheres of consideration: financial, personal/social, professional, and educational.<sup>5</sup> Financial compensation is the main variable in the financial sphere. Comprised of more than salary and incentive packages, the financial sphere also houses questions of debt and professional aspirations. Family considerations, such as a spouse or partner's and/or children's happiness, are subsumed within the personal and social sphere. Social integration is similarly included.

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<sup>5</sup>The spheres are not meant to be mutually exclusive. Variables, such as financial compensation, often reappear in more than one sphere. Nor is this an exhaustive list, but a recommended starting point. It is expected that the spheres will change and grow as we come to understand more clearly questions of rural retention.

Questions of professional support and aspirations are the main elements in the professional sphere, although it does often overlap quite heavily with the financial sphere. Finally, the educational sphere refers to the training and preparation for rural practice that physicians receive during their formal medical training. As we will see, each of these spheres is influenced by several different sources. Government programs and policies influence the amount of money a physician receives and the kind of support available to him or her. Communities vary greatly in what they can offer to a physician, both in terms of formal and informal support. The medical community plays an important role in training and supporting rural physicians. I will examine the role of the government, community, and medical community in each of the four spheres.

As indicated, this model affords the investigator an opportunity to understand how and why decisions are made. This discovery is important for two reasons. First, it allows us to see that recruitment is more than simply a factor of individual choice that is beyond the influence of government or community. Ultimately, it is the doctor who decides where he or she will practice medicine, but we now can see how social context influences the decision. We may not have much control over the psychological determinations of an individual doctor but through public policy we can influence the spheres in which that doctor makes decisions about his or her practice location that may in turn influence personal decision-making.



## **2.3 Financial Sphere of Consideration**

Financial discussions account for a substantial amount of the dialogue surrounding rural recruitment. Four issues continue to emerge as important: professional remuneration, incentive packages, debt load, and education costs. Remuneration refers to the income that a physician receives (excluding any income acquired through financial incentives) for his or her work and are discussed in Section 2.3.1. Incentive packages, discussed in Section 2.3.2, refer to the financial bonuses that governments offer physicians who are willing to work in specific rural communities that have been designated (by the government) as underserved. Section 2.3.3 addresses the impact that student debt has on physician recruitment. Finally, the rising cost of medical education, which relates directly to student debt, is examined in Section 2.3.4.

### **2.3.1 Remuneration**

The current structure for remuneration has been constructed to be beneficial to a doctor practicing in an urban context. The fee-for-service payment method compensates physicians for each patient visit (for physical examinations) or for specified services (sutures, burn treatments, etcetera). Income, therefore, is dependent upon the number of patients that a physician sees in practice. Additionally, physicians are compensated for on-call hours irrespective of whether or not they see a patient while on call. Currently, physicians in rural areas are paid on the same basis as their urban counterparts. There are

some claims that using similar payment methods for rural and urban areas is unjust because a rural physician has a smaller population base which results in fewer billable visits for physicians.

Salary negotiations are on-going between rural physicians and the provincial government. Instead of recognizing the needs and practical experiences of rural physicians, and developing and implementing a remuneration system which would better reflect the different work-load of a rural doctor (ie. that they may see fewer patients but spend more time with each one because they cannot refer the patient elsewhere as easily as an urban physician can), rural doctors are forced to operate under a system not constructed with their needs in mind.

### **2.3.2 Incentive packages**

Financial incentives are the preferred “solution” employed by the provincial government to encourage physicians to go to rural areas. Not all rural areas are eligible for incentive packages. The provincial government first identifies those communities which it feels are underserved. Only physicians working in those areas are eligible for financial incentives. Most incentives programs in Ontario and the rest of Canada work on a contractual basis. Physicians are offered money in addition to the standard fee-for-service and on-call remuneration. The Ontario government employs this technique frequently, as do other provinces. Crandall’s (1990) report on international recruitment

and retention practices notes that the economic incentive model is also popular in other countries.

While the financial incentive model is a popular one, it does not seem to be effective in keeping physicians in rural areas. There is little empirical data available to identify the effect of incentive programs on recruitment rates, but financial bonuses have not solved the problem of rural physician shortages (Hardy, 1998: 8). Furthermore, incentives packages are not recommended by most physicians, who see them as being “out of step” with what is needed to attract and keep physicians in rural areas (Hardy, 1998: 8). Incentive models are not widely supported for three reasons.

First, incentive packages do not *keep* physicians in rural areas. Their focus is recruiting, not retaining, physicians. As discussed in Chapter One, bringing a physician to a rural area is not enough if that physician leaves after a couple of years of service because the community is then in the same position that it was in initially - doctorless. Communities that have more than one doctor are likewise affected by high turnover rates. Building professional ties and support can be difficult when your colleagues change on a regular basis. The breakdown of those professional connections can lead to a breakdown

in professional support.<sup>6</sup> Professional support is often indicated as being a variable which affects both physician recruitment and retention.

Second, there is a great deal of concern about money being the primary factor that brings a physician into a rural area. Few rural residents, no matter how desperate to have access to a physician, want a doctor who is in their community only for the money. The motivation to provide quality care to patients does not stem from financial considerations.

Finally, incentive packages give a false sense that the problem is being adequately addressed and dealt with. They mask other issues that need to be addressed such as student debt and rising tuition costs. Sections 2.3.3 and 2.3.4 demonstrate how all of these issues are interrelated.

### **2.3.3 Student Debt**

Student debt has only recently been acknowledged as a factor involved in recruitment. Hardy (1998) suggests that student debts make people wary of investing in a

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<sup>6</sup>Ultimately, whether or not a physician feels that she is professionally supported in her work may be as much perception as reality. The concept of professional support is, to some extent, socially constructed. A physician can work with other doctors and still not feel professionally supported. Likewise, a physician working alone may feel adequately supported. While deserving of further attention, an in-depth discussion of this process is beyond the scope of this thesis.

rural practice. The concern, he explains, is that physicians graduate from medical school with substantial debt loads and are primarily concerned with paying back their loans. Student debts have increased substantially in recent years, due in large part to the rising tuition costs of medical schools.

Because Ontario employs a fee-for-service payment scheme, physicians who see more patients per day make more money. Rural areas have a smaller population base and consequently a smaller patient base than do urban areas. Physicians with large debts are not always certain that they will be able to see enough patients to repay their loans promptly. An additional concern when the money is guaranteed (as is the case with incentive packages) is that the physician will leave the community as soon as the debt is repaid. Increased debt loads and incentive packages together make recruitment unlikely.

#### **2.3.4 Tuition Fees**

“Tuition costs may help place docs where needed” was the title of a recent article that appeared in *The Medical Post*. - a weekly medical newspaper (Quinn, 1998). The article explained that the Ontario government was considering offering financial aid to medical students who agreed to practice in rural locations in response to “skyrocketing” tuition fees. Eminent deregulation of tuition fees for Ontario medical schools could mean that fees double in one year, placing students in unprecedented fiscal crisis.

Tepper and Rourke express concern in their recent article that “[t]he recent and unprecedented increases in tuition at most of Canada’s medical schools will only add to the problem [of recruiting medical students from urban areas and not having enough rural students]” (1999: 1173). Tepper and Rourke’s concern touches on the question of who can afford to go to medical school. Data suggests that students from rural areas are more likely to choose and stay in rural practice than their urban counterparts (Easterbrook et al., 1999).<sup>7</sup> However, it is not clear that rural students have the same access to medical school as urban students, finances and school grades being among the concerns. The importance of rural origin in physician retention is discussed in Section 2.4.

In conclusion, factors within the financial sphere that are suggested to influence physician recruitment are: remuneration, financial compensation, student debt, and medical school tuition fees. In Chapter Four I compare these factors with those identified as important by my respondents.

## **2.4 Personal and Social Sphere of Consideration**

The decision to choose rural practice involves considerations of a personal and social nature. While I have combined both considerations within one sphere, I discuss them separately below, in Sections 2.4.1 and 2.4.2. The personal considerations that

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<sup>7</sup>The impact of rural origin on retention is further discussed in Section 2.6

affect rural retention are: interest in and aptitude for rural life, rural origin, spousal contentment, and opportunities for children. Social integration, and the social role of the rural physician are included as social considerations that affect rural recruitment.

#### **2.4.1 Personal Considerations**

What do physicians like about rural practice? A landmark report published in 1995 by the World Association of Family Doctors (WONCA), reported that the

...great attraction of rural practice is the country environment and lifestyle which is associated with a better family life in a good place to raise children....Social satisfactions of rural practice identified by rural doctors include community standing and respect, coupled with a sense of belonging to a stable community, and enjoyment of outdoor living with many recreational opportunities (WONCA, 1995: 9).

The personality and background of a physician also is a factor in recruitment. According to a 1999 inter-disciplinary study published by Easterbrook et al. in the *Canadian Medical Association Journal*, physicians who were raised in rural communities

were 2.3 times more likely to choose a rural practice than those from non-rural origins and 2.5 times more likely to stay.

An overworked doctor, whether urban or rural, has little time or energy for home life.<sup>8</sup> The physician contemplating rural practice may envision a relaxed lifestyle and good quality of life but be too busy to take advantage of rural life. There also is the consideration of educational opportunities for children, and, often, there are no job opportunities for the physician's spouse or partner. This is no small consideration as two incomes often are essential for financial survival. Feelings of social isolation often are reported (OMH, 1997; Cutchin, 1997; Pope et al., 1998; Wilson, 1999), especially by the physician's spouse or partner. Social isolation can be explained partially by the confusion of social roles that physicians confront in rural practice.

#### **2.4.2 Social Considerations**

Physicians generally occupy well defined social roles. However, the rural physician occupies a somewhat different social role than the urban doctor. Western

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<sup>8</sup> The exact distinctions between the life of a rural and urban doctor cannot be generalized. Certainly, there are urban doctors who are highly overworked just as there are rural doctors who enjoy a relaxed work environment. Presumably, there are both similarities and differences between rural and urban medicine and research is required to determine their impact. The concepts raised in this work reflect the literature in the field of rural physician recruitment.



medical practice is predicated upon substantial social distance being placed between a doctor and his or her patient. The doctor-patient relationship is socially constructed to discourage social interaction between physician and patient. This distance allows the physician to retain objectivity about the patient and not get emotionally involved, which might affect his or her treatment decisions. Additionally, this distance serves a mechanism of social control. There is a hierarchy in the traditional doctor-patient relationship that places the physician in power. In an urban setting, the interactions between doctors and patients are confined to the physical space of the office. Moreover, the patients under an individual doctor's care are unlikely to know one another. Such rigid divisions do not exist in rural communities. In a rural community, maintaining social distance between physicians and their patients is more difficult because your patients are also your neighbours and friends. Mediating the spaces between doctor, neighbour, and friend is a constant struggle for rural practitioners.<sup>9</sup>

The factors in the personal and social sphere of consideration that affect rural physician recruitment are: interest in and aptitude for rural life, rural origin, spousal contentment, opportunities for children, and the social role of the rural physician.

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<sup>9</sup> The extent to which a physician is able to integrate within the community in which he or she works is important. Cutchin's work on physician satisfaction and retention indicates that socio-cultural integration is a primary factor in both recruitment and retention (1994, 1996). Although important, Cutchin's emphasis on retention, as opposed to recruitment, places his work outside the scope of this thesis. The extent to which physicians make practice location decisions based on a perception that they will be able to integrate is a question worthy of consideration and research.

## **2.5 Professional Sphere of Consideration**

The profession of medicine differs between rural and urban areas. These differences, as discussed below and in Chapter Four, make an important contribution to our understanding of physician recruitment. The doctor-patient relationship, an integral part of the medical profession, seems to be less rigid in rural areas than it is in urban areas. This is so partly because of the breadth and scope of rural practice. For both of these reasons, rural physicians often work with less professional support and more responsibility than their urban counterparts.

Rural practice is quite distinct from urban practice. In fact, many rural health care professionals argue that it should be a specialty unto itself, like cardiology or pediatrics. The rural practitioner relies on a greater variety of skills than does the urban physician. As we have seen, this develops out of necessity - the common urban response of referring patients elsewhere is not possible for rural doctors. For this reason, rural doctors need to be proficient in many dialects of the language of medicine. They must be pediatricians, cardiologists, dermatologists, emergency medicine specialists and many others. The variety of cases that the rural doctor sees is far greater than her urban counterpart (MacLellan, 1996; Kingsmill, 1997; Pope et al, 1998).

Hospital admission privileges mark another distinction between rural and urban medicine. Generally, urban family doctors do not admit their patients to a hospital.

Specialists, to whom the patient has been referred by the family physician, determine whether or not the case warrants hospitalization. In contrast, the low numbers of specialists in rural areas necessitates that family doctors interact directly with nearby hospitals. Obtaining hospital privileges often is easier for rural family physicians than urban ones (Henderson, 1996). Because of this expanded role, rural family physicians generally follow patients through a wider range of their health care experiences.

Family physicians are “front-line” medical personnel. They are generally the first medical professional with whom a patient consults with a health-related concern. When a family physician can no longer help the patient with their particular health concern, the patient is referred to a specialist who then assumes care of the patient. Rural doctors often are professionally isolated and support services in communities vary. In some cases there may be full laboratory services or even a hospital. In other communities, there may be new, state-of-the-art equipment but no trained personnel to operate it. While in another community there may be no support staff at all. Rural physicians cannot refer patients to specialists as easily as urban physicians because there are few specialists in rural areas (OReilly, 1994; CMA, 1997b; Pope et al., 1998). Consequently, rural physicians often need to be specialists as well as family physicians.

The professional life of a rural doctor is demanding in content and in hours. Rural doctors by necessity offer a wider range of services than their urban colleagues (WONCA, 1995: 13). The heavy workload and on-call hours of professional life in rural

communities can have negative consequences for personal as well as professional endeavours. Isolation, long hours, and lifestyle choices deter some physicians from considering rural practice. For others, however, these are not deterrents, but incentives to establish a rural practice:

Rural doctors identify a series of key attractions of rural practice. First is the greater variety of practice that often includes obstetrics, surgery, anaesthetics and emergency medicine together with hospital access and care of the acutely ill. Rural practitioners are much more likely to be looking after individual patients for all of their medical problems on a continuing basis... (WONCA, 1995: 9).

What is it that makes these factors an advantage to some physicians and a disadvantage to others? I address that question in Chapter Four.

Barer and Stoddart, in a report entitled *Improving Access to Needed Medical Services in Rural and Remote Canadian Communities* (1999), suggest that sustainable health care in rural areas may be achieved by integrating non-physician health care professionals into the rural health care model:

The expanded deployment of personnel such as nurse practitioners, with training sufficient to provide a considerable range of primary care services, enabled by appropriate adjustments on the regulatory

front to allow expanded scopes of practice (e.g. prescribing) offers, in our view, significant untapped potential to address the problems of access to primary care (33).

The Society of Rural Physicians of Ontario hosted, at their annual conference in 1998, a discussion on nurse practitioners and rural doctors. While little exists in the literature about this topic, the Society seems to be open to the suggestion (SRPC, 1998).

## **2.6 Educational Sphere of Consideration**

Generally speaking, rural communities have trouble recruiting and retaining physicians because medical students have not been adequately exposed to and prepared for the realities of rural practice. Nor will they be, says Society of Rural Physicians of Canada president Dr. Keith MacLellan, "...until rural medicine is recognized as a discipline" and given the recognition that it deserves in the broader medical community (Kingsmill, 1997: 141).

Canadian medical schools, traditionally, teach urban students (O'Reilly, 1994; Tepper and Rourke, 1999; Wilson, 1999) urban medicine. Most medical students are from urban areas due in part to the structural and political disadvantages that rural students face in access to educational services and other determinants of career choice (Tepper and Rourke, 1999). For this reason, some argue that more rural students should be admitted to medical school no matter what it takes to get them there (WONCA, 1995;

Easterbrook). While there is no guarantee that a student will choose and stay in a rural practice simply because she is from a rural community, rural origin is positively correlated to both recruitment and retention (Easterbrook, 1999).

Another important factor to consider is the medical school and its faculty. Traditional medical curricula are urbanly biased and most doctors teaching medicine, whether in the classroom or in the hospital, are urban doctors: "Most of this training [undergraduate medical education] takes place in city hospitals where the emphasis is technology, the benefits of the city and of specialization...It is a very urban-centred approach and many graduates are blinkered when it comes to appreciating what happens outside the doors of those university hospitals." (John Wootton in Wilson, 1999) Rural medicine has not been visible in Canadian medical schools. This is of great consequence in view of what we know about processes of socialization and professionalization. The lack of role models and mentors for aspiring rural physicians indicates to medical students that rural practice is not a viable option. Furthermore, medical students are being forced to decide very early in their training what direction they want to follow. Early career decision-making affects where people decide to practice (Tepper and Rourke, 1999: 1173) and rural medicine loses out when people make their career choice before a rural practice has been presented as an option.

Medical schools have started to acknowledge rural medicine. Presently, most Canadian medical schools provide some exposure to rural medicine for students who are

interested, and evaluations of those programs have been positive (Rabinowitz et al., 1999; Moores et al., 1998; CMA, 1997b). The Department of Family Practice at the University of British Columbia (UBC) initiated a rural training program in 1982 (Whiteside and Mathias, 1996: 1114). A recent evaluation of the program indicated that “graduates of the UBC rural training program consider themselves better prepared for rural practice than non-program-trained rural physicians” (Whiteside and Mathias, 1996: 1113). Moreover, the evaluation suggested that specific, structured training was indeed helpful in preparing physicians for rural practice and by extension also increased the number of new graduates practicing in rural areas (1120). Rourke (1996) also acknowledges the importance of training physicians to work in rural areas, and adds that rural doctors should have play a role as teachers in medical school.

The reasons why physicians choose to practice in rural locations are numerous and varied. In this chapter, I have presented the variables commonly identified as being important to physician recruitment. I propose the implementation of a theoretical model to best understand the social context in which those variables operate. Four Spheres of Consideration (financial, social/personal, professional, and educational) provide us with a more thorough understanding of the factors involved in rural physician recruitment. In the following chapter, I explore the methodology used to obtain original data about physician recruitment.

## **Chapter Three: Methodology**

### **Section 3.1 Research Design**

Due to differences in health care policy between provinces and the requirements of this M.A. Thesis, it is not feasible for me to include rural physicians in all provinces. To do so would mean including 13 (one for each province and territory) different health care policies which is beyond the scope of this project. Additionally, had I interviewed respondents from across the country, it would be difficult to compare the results because health care systems differ. Differences are particularly abundant in the ways in which different provincial governments have addressed and tried to resolve the problem of physician retention in rural areas. Because of the difficulty in creating a national picture due to provincial variations the task then was to choose one province as a focus for my research. As I was not confident in my ability to conduct in-depth interviews in French I looked outside my home province.

I chose Ontario for three reasons. First, Ontario boasts the largest population base of any province. My pool of potential respondents was small to begin with and Ontario's large general population indicated that there might be more rural physicians than in provinces with smaller populations. Second, I was familiar with the conditions of the Ontario health care system. Finally, Ontario is home to many professional and research-based organizations that



were able to provide substantial support to the project in terms of access to physicians and existing data.

Given the small body of both literature and research (particularly sociological) in Canadian rural health, this project is largely exploratory in nature. In order to gain the most amount of information from respondents, quantitative data collection was accomplished using the survey method. Interviews provided me with the best option for exploratory research because they are interactive in a way that mailed questionnaires are not. Furthermore, they allow the interviewer to be more responsive to the interview subject. Additionally, my respondent pool is made up of particularly busy people, and I suspected that my response rate would be greater with interviews.

More specifically, I designed an interview guide (Appendix A) constructed of both open and closed questions. Although I had several hypothesis in mind in constructing the interview guide, I decided to follow a general format of loosely structured, open questions. The reason for this was that although I had several hypotheses in mind while constructing the interview guide, I did not want to include questions that would be leading for the respondent. I wanted to know if respondents would report the same factors, and had to leave them room to reply as they desired. I was able to glean more specific information through the use of probes. Open questions permit respondents room to answer complex questions. As this research deals with an extremely complex issue, open questions were the most appropriate. Because I was looking for thoughts and opinions, I wanted to be certain that

respondents felt they were engaging in a non-hostile dialogue, with them as the primary speakers, as opposed to a formal, structured interview session.

Due to the geographical distance between myself and the respondents, as well as the distances between respondents, travelling to meet with each respondent for face-to-face interviews was not feasible. I decided instead to conduct telephone interviews. This allowed me to engage in a type of interview similar to face-to-face without additional travelling costs. While I was unable to enlist visual observation as a technique in the interview, I was able to complete the interviews faster because I was using the telephone. Finally, telephone interviews were more convenient for the respondents who, as medical professionals, are subject to last minute changes of schedule that can be more easily accommodated in telephone than in face-to-face interviews, particularly when extensive travelling is involved.

### **3.2 Research Methods**

Making contact with potential respondents was problematic at the beginning of my research for several reasons. First, I was not based in the same province as my respondents. Second, I am not in the medical community. I initially had hoped to be able to interview respondents in pre-designated communities in Ontario. Doing so would have enabled me to coordinate my research with the on-going research project of the New Rural Economy (NRE). I set about obtaining the names of the doctors in those communities from a directory that is published annually listing all licensed medical practitioners in Canada. I discovered

that due to the high turnover rate of physicians in rural areas, by the time I was able to identify who was working in a particular community, they were no longer there. Furthermore, the entire pool of potential respondents was small<sup>10</sup> and I would not have been able to interview enough respondents if even one or two were unwilling to participate in the research.

Consequently, I enlisted the assistance of the Society of Rural Physicians of Canada (SRPC) and a decision was made to access potential respondents through the SRPC listserv (RuralMed). The listserv has approximately 500 members, and although there are not strict rules about who can join (meaning that of those 500 participants, not all are rural physicians) it was the best option for finding respondents. In total, I posted two calls for participation on the server explaining who I was and what my research was about. Interested parties were asked to contact me via email or through phone, fax, or written mail. All respondents made initial contact via email and all contact, apart from the actual interview, was made through email. A mutually agreed upon time was then set for the interview. In 4 cases, the respondent did not answer the phone when I called at the designated time. In those cases I left messages saying that I would call back in 15 or 20 minutes. When I called again, all but 1 respondent

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<sup>10</sup>According to the Society of Rural Physicians of Canada, there were 1044 rural family physicians in Ontario in 1999 (SRPC, 2000).

picked up the phone. In those cases where the respondent did not answer on the second attempt, I left a message asking to reschedule via email.<sup>11</sup>

In addition to posting a call for participation on RuralMed, I enlisted the snowball technique to further expand my respondent list. This technique was ineffective. In total, I was able to recruit one more respondent because of a contact that I was given. I did not hear anything from those respondents who said that they would pass along my coordinates to friends and/or colleagues.

Respondents were advised that the interviews would last approximately 30 minutes, which was an accurate estimation. Most of the respondents were at home during the interview. Two respondents participated in the interview from their place of work. The majority of the interviews took place in the evening, during the week.

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<sup>11</sup>There are methodological implications to my use of RuralMed as the primary access point to my respondents. These implications are discussed in detail in section 3.4 of this thesis.

### **Section 3.3 Sample Selection**

Of the eleven respondents, five were at some stage of their undergraduate medical training, three were completing their residency and an additional three were general practitioners. Seven respondents were female and four were male. The youngest respondent was born in 1977 and the eldest was born in 1958. Five respondents were married, one was engaged to be married and the rest were single. Only two respondents had children.

Only one respondent was currently practicing medicine in a rural location but all but one of the respondents expressed an intention to practice in a rural area in the future (within the next five years). Six of the respondents had lived in a rural area prior to their undergraduate medical training.

All the respondents in this study were in Ontario, although I also talked to MDs from other provinces, as well as one Nurse Practitioner. I had decided not to turn away respondents since I felt that they would be able to add to my overall knowledge about the subject material and might know someone in Ontario, but I indicated that I would not be able to use the data derived from their interviews directly in my thesis. Table 1 shows a breakdown of respondents by various demographic characteristics.

**Table One: Respondent Profiles**

	Date of Birth	Gender	Marital Status	Children	Professional Stage	Currently in Rural Area	Has spent time in Rural before	Plans to practice in a rural location	Income*
R#1	1969	M	Married	no	resident	no	no	yes	C
R#2	1975	F	single	no	ugrad	no	Yes, 18 years	yes	n/a
R#3	1972	F	engaged	no	ugrad	no	Yes, 20 years	yes	A
R#4	1964	F	single	no	Fam MD	Not really	Yes, 3 years for work	yes	D
R#5	1964	F	married	2	Fam MD	no	Yes, 2 years for work	yes	C
R#6	1972	F	single	no	ugrad	no	Yes, 18 years	yes	A
R#7	1971	M	Married	no	resident	no	no	yes	B
R#8	1958	M	Married	3	Fam MD	yes	no	yes	D
R#9	1970	F	single	no	ugrad	no	no	no	A
R#10	1973	F	married	no	resident	no	yes, for work	yes	B
R#11	1977	M	single	no	ugrad	no	no	unsure	A

\* Income Categories (Gross Annual): A. \$0-19 999 B. \$20 000-49 999 C. \$50 000-74 999 D. \$75 000+

ugrad=undergraduate  
Fam MD = family doctor

### **3.4 Limitations of this study**

I made every effort to design and implement as rigorous a research design as possible. However, a number of limitations to this research need to be addressed. They can be categorized in the following manner: limitations resulting from the use of RuralMed and email, limitations in sample base and size.

As mentioned in section 3.2, there are several implications of using the RuralMed listserv as the primary source for finding respondents. A number of the problems stem from my use of email as a primary source. First, I did not ask for proof that these people were who they said they were and indeed self-presentation on the internet is a problem. However, my feeling was that an individual would have to go to great trouble to participate in this interview if they were not involved in the delivery of health care as the questions were specific to that profession. Second, and more important, the sample from which I drew my respondents was not random and therefore not necessarily generalizable to a broader population. However, this is acceptable for an exploratory study as one of my goals is to highlight various forms of further research. The people who are subscribers to RuralMed are probably more likely than others to be interested in and proactive about rural health issues. As a result, they may not be representative of the larger population of rural physicians. Again, this affects the extent to which my research can be generalized to a larger population. Respondents were responsible for making initial contact if they were interested after reading the prospectus of my study. Accessing individual respondents would have been preferable

since it may have increased my response rate. Most correspondence, including the initial call for participants, was made through email which potentially limits respondents to those with access to email. This is particularly problematic if snowballing doesn't work, and most of my respondents found me through this call. Email seems to be widely used among rural doctors who are isolated to different degrees so the effect of the problem may be somewhat neutralized.

Another limitation of my research is my small sample size. Several factors explain why I have such a small sample size. First, the pool of potential respondents is small. If it were not, there would be no cause for me to undertake this research in the first place. The size of my potential respondent pool reflects the shortage of rural physicians in Ontario and the rest of the country. Second, the pool of rural physicians is highly volatile. The high and rapid turnover rate of rural doctors complicates the process of finding people willing to participate in research. Those who are interested are busy, and it was difficult for them to find time to speak with me. Thus, the third factor influencing my sample size was the availability of people who were interested in participating. Finally, although I attempted to employ a snowball sampling technique to increase my sample size, it yielded only a few more respondents.

The implications of a small sample are numerous. As a result of the small general pool from which to select respondents, I was forced into a non-random sample. As well, I could not impose strict definitions of rural and remote, but had, rather, to rely on the



definition of the respondent. Both factors compromise the extent to which I am able to generalize findings to a broader population. However, generalizability is not as important in the context of an exploratory study as it would be in a study with different motives.

In addition to the size of the sample, the demographic characteristics of the respondents yielded some limitations. First, only one of my respondents was currently practicing in a rural location. While most others were planning to start practicing rurally, and some already had, it would have been advantageous to hear from more people who currently were working in a rural setting. Second, the majority of respondents were at the beginning of their medical careers which limited the amount of practical experience that they could have to share.

Defining rural was equally problematic. In the spirit of an exploratory study, I decided not to enforce a rigid definition for fear of limiting my potential pool of respondents too drastically. I was concerned that potential respondents might not be able to categorize their community according to a rigid set of standards. However, I have loosely followed the definition of 'rural' as suggested by the Organization for Economic Cooperation and Development (OECD) who consider that a region is "rural" if more than half the people there live in communities with a population density of fewer than 150 persons per square kilometre (Health Canada).

Finally, as I have worked on this project, the struggles of rural Canadians vis a vis their health care has moved into focus and become a hot topic. It is difficult to stay abreast of all the changes in policy and the efforts being made to solve the problem while conducting this research. For this reason, by the time this work is finished it is possible that some claims or suggestions made in this thesis will have already been addressed in other work. Nonetheless, the problem at hand is a complex one that requires extensive contemplation and discussion if sustainable solutions are to be found.

## **Chapter Four: Findings and Discussion**

### **Section 4.1: Financial Sphere of Consideration**

As discussed in Chapter Two, physician recruitment literature highlights four interrelated components within the financial sphere. According to that body of literature, the primary factors of concern to rural doctors in this sphere are: remuneration, financial incentives, debt, and tuition fees. Negotiations between physicians (as represented by the Ontario Medical Association) and the provincial government seem to be never-ending which indicates that remuneration is a topic that concerns many physicians. For that reason, I expect that my respondents will identify remuneration as being an important factor in their decision to choose rural practice. Although financial incentives are widely used to recruit and retain physicians, their use has not solved problems of rural recruitment and retention in rural Ontario. I do not expect my respondents to report that they find financial incentives an important factor in recruitment. While debt has only recently appeared as a recruitment factor in the literature, I expect that the high proportion of medical students and residents in my sample will mean that debt is something that concerns my respondents. For the same reason, I expect that tuition fees will be of concern to most respondents.

#### **4.1.1 Remuneration**

I suspected that my respondents would cite remuneration as being a factor in their decision to choose rural practice. That hypothesis was not supported by the results of my research. None of my respondents said that remuneration was an important consideration in their decision to stay in or leave rural practice, although one respondent did feel strongly that rural physicians should be paid more than urban physicians. In total, only four respondents spoke about remuneration, although all respondents expressed opinions about financial incentive programs, which I discuss below.

Respondent Two, a 25 year old female medical student who grew up in a rural area, was the only person to express strong feelings about remuneration. She felt that "...physicians are highly educated and highly skilled people and ... their pay should reflect that". She also felt that rural physicians should receive additional income because they work with less professional support and are required to perform more medical tasks than urban physicians: "If I see a sore throat in the city it's not really much different from seeing a sore throat in the country but the practice profile [in the country] is very different [than in the city]". I discuss issues surrounding "practice profiles" later in this section.

Three other respondents expressed that medicine pays well no matter where you practice. Respondent One, a 31 year old male resident, said: "doctors make a lot of money in town or out of town". Respondent Six, a 28 year old female medical student, said: "Money

isn't a big motivation for me being in medicine in the first place" and that "...medicine anywhere is pretty well paid". Respondent Nine, a 30 year old female medical student agreed that remuneration was "...good pretty much anywhere you go".

There are two possible explanations why my hypothesis was not supported. First, perhaps the physicians and medical students with whom I spoke felt that they were (or would be, in the case of medical students) well paid and that remuneration was not a factor in their decision to choose rural practice. This could change as students actually start their practice. The second possible explanation is that I did not ask the right questions. I suspect that the first explanation is more accurate than the second. My respondents felt that physicians are paid well for what they do regardless of whether they work in a rural or urban setting and that others factors, both positive and negative, eventually outweigh any monetary considerations. Financial remuneration, at least for my respondents, is not of primary importance when making decisions about practice location.

#### **4.1.2 Financial Incentives and Student Debt**

Financial incentives are often used to make rural practice seem more enticing to potential rural physicians. Three respondents (Respondents Two, Five, and Eight) felt that financial incentives were good things. Two of them (Respondents Two, and Eight) agreed that financial incentives were needed to attract and keep physicians in rural areas. Respondent Eight, a 42 year old male family physician, acknowledged that financial

incentives are now the norm. He felt that they were needed to “level the playing field” between rural and urban medicine. Respondent Two, who felt strongly that physicians should be well paid due to their skill and training, felt that financial incentives were necessary. She added that “...in an ideal world there should be no difference between practicing medicine in the city and practicing medicine in the country but we don’t live in an ideal world, and...the reality is that...you have to pay them more”.

Respondent Five, a 36 year old female family physician, felt that financial incentives were “wonderful”. When asked if they influenced her decision, she said: “I don’t know if influenced is the right word, but if you’re going to put pluses and minuses on things it would be a plus”. Respondent Five also indicated that the financial incentive she was offered in exchange for spending some time in a rural setting sparked her interest in rural medicine. It is interesting to note that the respondents who felt that incentives were positive and helpful also indicated that the reason why is because rural medicine had characteristics that required compensation, such as lack of professional support and demanding workload. All other respondents felt differently about financial incentives.

Recall the words used by Respondent Eight when discussing financial incentives. He felt that financial incentives were important because they “level the playing field” between rural and urban practice. His use of the term “level the playing field” implies that there is an inherent difference between rural and urban medicine that must be acknowledged. The ideological premise behind financial incentives is that rural practice is a chore or bad

situation that physicians should be compensated for enduring. Using financial incentives in this way creates and propagates an image of rural medicine as being undesirable – money is the only thing that can convince physicians to be in rural practice. This is why financial incentives are not a sustainable solution for rural medicine. Furthermore, I suspect that financial incentives negatively influence people’s perceptions of rural medicine’s value. Although she admitted that the financial incentives were nice, they did not motivate her decision making in terms of practice location.

The remaining respondents did not feel, as did Respondents Two and Eight, that financial incentives need to compensate rural physicians. Six people felt that financial incentives were only short term solutions to the problem of rural recruitment. Both Respondent Nine and Respondent Ten, a 27 year old female resident, identified financial incentives as being a short-term advantage to rural practice because the additional income would help newly graduated students deal with the massive debt that they had accumulated throughout their studies. Respondent One, who had spent time during his medical training in a rural setting and planned to move to a rural practice, said:

...when you see the *student loan burden* that people are graduating with right now, any type of financial incentive at the beginning of a person’s practice makes a huge difference. I don’t know about the long term....I think people might go initially for the money, and if they stay, they stay for other reasons, such as continuity of care, or because they can practice a wider ranager of medicine, or [because]

they like living in a rural area as opposed to a large city. Once people have paid off their loans and are looking at their lives in the long-term, the extra 20% [offered by a financial incentive package] isn't that big a factor [in their decision to stay in or leave rural practice]...financial incentives are a huge factor at the beginning of a person's career to *offset student loan debt* but [they are] not important beyond that (emphasis added).

Respondent Six, who stated that money did not motivate her to choose medicine as a career, said “[a financial incentive] doesn't impress me a whole lot, it's reassuring that there will be reasonable programs in place so I will be able to *pay my loans back*, that is an issue for students” (emphasis added). Financial incentives might not convince people to choose rural medicine if they were not interested in it for another reason, but financial incentives can make rural practice a more viable option for students carrying a large debt. Respondent Three felt that financial incentives are a bonus but would not influence her decision. She conceded that they might make a difference for someone with a debt to repay. Respondent Nine summarized the situation by saying: “Student debt loads are getting so unbearable that people are looking for a quicker means to get out of a bad situation ”.

This discussion about financial incentives highlights another important aspect of the financial sphere which is the impact that debt has on practice location. Respondent Four, a 36 year old female family physician recalled that “[When I was a medical student] it was an enormous amount of debt to go into and...it just puts your focus all on money, and everything



becomes about money, and I'm not sure that's really healthy." Respondent Two said: "The truth of the matter is that large debt loads force or redirect the stream of students away from family practice into higher paying specialties and family practitioners are more likely to practice in a rural setting in the first place". Respondent Three believed that debt increases the likelihood that a student will choose to move to the United States in order to make money faster to pay off loans.

Debt can represent a coercive way to get students into rural areas. Respondent Six also expressed concern about forcing or coercing people into rural areas:

The bottom line is that the only good rural health care that you're going to get is from people who want to be there, and if people are there because they were forced to be there or ... they were so financially strapped that they felt their only option was to do this program then I don't think they're gonna provide great health care.

Respondent Four was glad that she did not receive any financial compensation for the time she spent in a rural community. She was "...happy to have the freedom to go there by choice rather than 'owing time' [because of having signed a contract]. She also says that "The money is a nice benefit, but I am not convinced that you're going to get the people you want if you're just giving money, and I think people who are interested and see the draw of this kind of practice will go so long as the compensation is fair...I think protecting time and

lifestyle stuff is more important.” Respondent Nine also agreed that physicians need to be going to rural areas by their own choice.

The responses from my respondents suggest that there are many factors in the financial sphere that influence practice location. However, it is interesting to note that my respondents did not place importance on financial compensation. The primary concern, financially, was to be debt-free. Four of the seven respondents who said that incentive packages were important only to pay off loans were students and another two were residents, thereby supporting my hypothesis that the students in my sample would be particularly concerned with issues of debt. Financial considerations play a part in the decision making of physicians, but the respondents in my study were not *motivated* by money.

There seems to be, based on the literature, a perception that rural physicians place a lot of weight on financial considerations when decision-making about practice location. Mostly, that consideration is perceived to be about being compensated for the hardships of rural practice. However, my respondents were not solely concerned with being compensated financially for their work in rural areas. While money was important, particularly to those respondents concerned with paying back loans, it alone was a key variable in their decision about practice location. The reason for the discrepancy between what I expected to find and what I did find is this: Rural physicians are concerned about money, but without understanding the context for that concern, we assume that they just want more of it and that if they don't get enough, they won't go to rural areas. Once placed within a context, we see

that the reason people are concerned about money is because tuition fees are rising resulting in increased debt for medical students. These physicians are essentially forced to focus on money due to the debts that they must repay upon graduation. That is not to say that the physicians and students with whom I spoke do not feel compensated for their work. Indeed, they expect to feel compensated by the quality of interaction that they have with their patients and that outweighs questions of remuneration. Traditional literature in this field gives us a false understanding of the financial sphere. This is of grave consequence considering that the financial sphere is the one most focused on by government policies.

Understanding the social context of the financial sphere sheds light on the reasons why decisions are made in the financial sphere. As we have examined this sphere in the literature and through practical research, we see the interrelationship of financial incentives, debt and tuition fees and how they combine to influence decision making. We also, in understanding this relationship, are in a better position to suggest changes that might improve recruitment rates of physicians in rural Ontario.

#### **Section 4.2: Personal and Social Sphere of Consideration**

Recruitment literature, as discussed in Chapter Two, identifies several factors that belong to the personal and social sphere of consideration. Personal considerations include: a preference for living in a rural area, and rural origin. Not all of my respondents are of rural origin, although all are interested in rural medicine. I expect that they will have an interest

in a rural lifestyle. Social considerations include: social isolation and lack of anonymity due to the social role that a physician occupies in a rural community. I expect that my findings will mirror the literature with respect to anonymity and social isolation

#### **Section 4.2.1 Personal Considerations**

Five respondents reported that they were initially interested in rural practice because they sought a rural lifestyle. Rural lifestyle was defined by: outdoor activities and recreation (n=5), safety (n=2), no commuting (n=2). These five respondents were interested in practicing rurally before it was presented as an option in medical school. Respondent Two said:

Living in a rural area is probably one of the most important things, it's one of my main goals, I want my kids to grow up without having to worry about cars and bad people and I want them to be able to swim in the lake when they feel like it and skate on the ice in the winter and that kind of thing

Respondents whose social context included the experience of living in a rural area, perceived the characteristics of rural living as positive. Other characteristics that have been identified as negative in the literature were either not mentioned or were outweighed by the advantages. For example, Respondent Three, a medical student, acknowledged that people are concerned about the opportunities available for children in rural areas. Having grown up

in a rural area, she suggested that people supplement their children's education with specialty camps, like one for music if the music program at the child's school is not adequate. I suspect that people who grew up in rural areas are more likely to problem-solve and find solutions rather than people from urban areas who would see that as an obstacle.

Another factor mentioned in the literature is rural origin. Recall that in Chapter Two I indicated that recent studies suggest that physicians who are from rural areas tend to stay longer in rural practice. I found support for this claim in my study. For example, Respondent One suggested that:

“[the solution to rural physician shortages] starts with recruiting into medical school. The more we try to get people into medical school who are born and raised in rural areas, the more we'll keep people out there in the long term, I've met very few people from Toronto who will stay long term in rural because it's just too different, the lifestyle becomes dependent on city amenities, pretty huge change to rural area”

Respondent Four also said that people from rural areas are the best candidates for rural practice. Neither were from a rural area, but both intended to pursue rural practice. Respondent Nine, who had intended to pursue a rural practice but changed her mind because of her partner's employment restrictions, was not from a rural area either. She started medical school with an interest in underserved populations and had good experiences

working in rural areas. Respondent Ten, who also grew up in an urban area, did not start medical school with an interest in rural medicine. Her interest was sparked by a six-month rural internship in family medicine: “I was surprised that I enjoyed it because I had done a family [medicine] rotation in an urban area and hadn’t enjoyed it as much. It was both a job and a setting that suited my personality”. Clearly these respondents’ urban backgrounds has not prevented their interest in rural practice.

If rural origin is so important, how is it that my respondents from urban areas express the same interest in rural medicine as do my rural origin respondents? Once again, the answer lies in the social context. I propose that rural origin is a factor in retention because it prepares physicians for living in the social world of a rural community. Many people, rural and urban, enjoy outdoor activities, but the intimacy of social interaction in smaller towns can be daunting for an unprepared physician. Further research is needed to determine why rural origin is so important. If I am correct in my proposition, the solution lies in exposing and preparing medical school for the social and personal realities of living in rural areas. A physician’s personality (as well as his or her family) must be predisposed to living in a rural area, but personalities are flexible when given a chance.

As is expressed in the literature, respondents reported that among the most disadvantageous aspects of rural medicine were challenges relating to family. The primary concern among this grouping was finding employment opportunities for the physician’s spouse or significant other. Respondent Nine, a student had intended to pursue a career in

rural medicine, but decided against it because her fiancé's work necessitates that he live in an urban setting.

Other family-related concerns revolved around educational and recreational activities for children. Respondent Five, a family physician who is preparing to return to rural practice, noted that she and her family will not stay in a community if it does not meet her children's educational needs. Concern for a spouse or partner's happiness also influences physician practice location. Respondent Six observed that it can be hard to negotiate between one partner who wants to live in a rural area and another who does not. In her experience, the partner with rural interests is usually the one to compromise: "...it just seems too cruel to drag your urban based partner out into the country where they can't do anything". From an historical perspective, the consideration of spousal happiness is a fairly new one. Today, increasing numbers of couples live in two-income households and both partners must be able to work. As Respondent One noted, "In 1965 rural doctors were unmarried... males who could go anywhere and if they did have a wife, she didn't work."

#### **Section 4.2.2 Social Considerations**

Another problem that physicians cite as being a deterrent from rural practice is the lack of anonymity that physicians face. Respondent Ten said: "You almost become like a celebrity in a small town". To illustrate her point, she tells a story about meeting with an unmarried, male physician with whom she hoped to work. They met for lunch in the small

town in which he lived and worked. She was aware throughout their meal that people were watching and talking about them. Before long, she explained, rumour had spread that the unmarried town doctor had a girlfriend. It is a common stereotype that people living in rural towns know everything about all the other people living in the town. This stereotype seems to take on another dimension when the person being talked about occupies a highly visible social role such as town doctor.

Respondent Seven explained the difficulty associated with the role of rural doctor: “if you’re the only physician in town you’re singled out in a way and it’s often difficult to get away from your work environment - everybody in the community sees you as a physician. People expect you to be a physician whenever they see you”. In other words, there is no chance to take on the role of neighbour or fellow citizen because the physician role is so pervasive. Respondent Seven explained that it is “...challenging to never be able to leave that role [of physician]. You are always the doctor and never the guy next door”. Respondent One had similar experiences to share: “...when you’re the doctor and you’re out at the grocery store you can get cornered and asked questions about lab tests or what not.”

Recall the discussion in Chapter Two about the doctor-patient relationship and how it is different in a rural setting. In an urban setting, physicians and their patients rarely see one another outside of the doctor’s office. In rural areas, physician’s patients are also their friends and neighbours.



All of my respondents commented during the interview that the doctor-patient relationship is different in rural settings than it is in urban settings. Feelings were mixed about the potential advantage or disadvantage of the difference. Respondent Four commented that “[o]ne of the things that happens in a small place is that you...see people at work, you bump into them at the grocery store...”.

While the majority of respondents spoke favourably of the more involved relationship that rural physicians have with their patients, Respondents Two and Six expressed ambiguity about the relationships. Respondent Two said “...you might be treating people who are your friends and neighbours and that can be tricky”. Yet another Respondent, number Four, accepted that fact as an integral component of rural practice: “Treating people you know is just part of the package, and that if you are not comfortable with that, then rural practice may not be for you”.

A more involved relationship between doctors and their patients is accentuated by the very visible role that the rural physician occupies within a community. The high status of the physician role can be isolating. The professional isolation that was identified as being among the most challenging aspects of rural practice, is mirrored by the sense of personal isolation that some rural physicians experience. Respondent Six shared this:

[It is] not just the professional isolation [that can be scary] but the personal isolation is really frightening especially for people who have

never lived in a small town, and even for those who have, to go back as the doctor, one of the higher statuses in town, it's a different life you're living than when you're just in high school. It's a whole, sort of, social change that I think can be really isolating.

In addition to being a "higher status" role, the local physician can also suffer from lack of anonymity which can be hard. Respondent Five reported that a rural physician can end up feeling that "...you're in a fishbowl because you work and socialize with the same people". They noted that physicians are watched in a way that other residents are not.

It is interesting to note that there seems to be some contradiction in terms of isolation and lack of anonymity. On the one hand, physicians report that they feel isolated from the community in which they practice. They feel, as Respondent Six expressed, that they are in (or are perceived to be in) a higher social class than other residents. As a result, they feel isolated. At the same time, however, physicians report that they suffer from a lack of anonymity in rural areas. In other words, they are not isolated enough. While this may appear to be a contradiction, in fact it is not. It is, however, an interesting commentary on the personal and social sphere that rural physicians may experience. Perhaps the very reason that they feel isolated is because they are such public figures occupying prestigious social roles. My respondents reports echo the literature as discussed in Chapter Two.

Similarly, physicians must be prepared to deal with a more familiar relationship with patients than they are used to in urban areas. Medical schools train physicians to work in

urban areas and within a compatible doctor-patient relationship. The distance placed between doctors and patients rarely exists in rural areas and physicians must therefore be trained accordingly.

### **Section 4.3: Professional Sphere of Consideration**

Characteristics of the rural doctor-patient relationship as discussed in Section 4.2.2 are also relevant to the professional sphere of consideration. In the social/personal sphere, the impact of the doctor-patient relationship is seen in the social isolation and lack of anonymity that the physician may feel. The social role of 'rural physician' is a difficult one to leave at the office -- it seems to follow rural physicians through all of their social interactions. Likewise, the breadth and scope of rural practice is larger than urban practice. I expect my respondents to indicate that rural medicine is distinct from urban practice. As they are all interested in rural medicine, I expect that they will perceive those distinctions to be positive characteristics.

#### **4.3.1 The Doctor-Patient Relationship in a Rural Setting**

Within the professional sphere, the impact of the doctor-patient relationship is slightly different. In this sphere, we are more concerned with the power dynamic involved in this relationship as well as the impact that this power dynamic has on both the quality of patient care and the satisfaction and fulfillment that rural physicians get from their practice.

I propose that the power dynamic is different in rural medicine than it is in urban medicine because of the more familiar nature of the relationship between doctor and patient. Does this imply that the doctor-patient relationship in a rural setting is more egalitarian? I suggest that it does. Furthermore, I suggest that the quality of care that patients receive is better when the doctor-patient relationship is less power driven.

Respondent One agrees that patients in rural areas benefit from a familiar relationship with their doctor:

I think people, whether they realize it or not...get better care in smaller centres, because the big difference [in a rural area as opposed to an urban area] is that you tend to see the same doctor each time [that] you're cared for....In a larger centre care tends to be more fragmented because it's easier to go out and pass the problem on to a specialist or [to another] health care worker.

He elaborated by telling a story about a patient who went to see his family doctor for a minor surgical treatment. In an urban centre, Respondent One explained, the family doctor would have referred the patient to a specialist - in this case a surgeon - but there was no one nearby to whom he could refer the patient. Instead, he agreed to perform the procedure but spent the evening before learning how to do it.

While Respondent Two acknowledged that knowing your patients as friends and neighbours can be “tricky” she also indicated that it can improve the quality of care that they receive: “...a person’s social, psychological and emotional background contributes to their health, if you know [what that background is then] you’re in a better situation to help them decide how to manage their health properly”.

Respondents reported that rural practice would be more satisfying than urban practice because of the more familiar relationship that they would have with their patients. This claim was based on their rotations and electives in rural settings. Respondent Nine identified that difference as an advantage to rural practice:

[the rural physician is ] more likely to know patients on a personal level and not just professional... the relationship seems to extend outside...the clinic, so it seems a lot richer...[As a result of this relationship,] people really know their doctors as people in a comprehensive sense, they feel that this person knows them well [and] seem more content with the quality of care they get.

I was unable to ascertain why some physicians felt that a more familiar relationship was positive and why some felt it was negative. If I had to hazard a guess, I would say that those physicians who see that as a positive thing are less concerned with maintaining the traditional medical power structure (which places doctors at the top and patients at the bottom) than those who express discomfort with having a more familiar relationship with

their patients. The distinction also seems to lie in whether or not a physician feels that he is part of the community (as does Respondent Eight, who has been working and living in the same community for sixteen years) or feels like an outsider -- someone who is “living in a fishbowl” to use the words of Respondent Five.

Although I did not see this in the literature, through my respondents I have developed an understanding that the hierarchy of rural medicine is very different from urban medicine, and that rural doctors see that as a good thing. Respondent Four commented that “[o]ne of the things that happens in a small place is that you...see people at work, you bump into them at the grocery store...”. The relationship between a rural physician and his or her patient is less likely to be limited to solely a professional one, as is the norm in urban centres, because both parties are likely to have occasion to interact socially in addition to their professional interaction. The social distance between physicians and patients in rural areas is therefore smaller than in urban areas. In Section 4.2, I discussed the implications of this relationship on the personal and social sphere. There are also implications of this different relationship in the professional sphere as it influences physician satisfaction and feelings of fulfillment provided by that relationship.

#### **4.3.2 The Broad Scope of Rural Practice**

My respondents reported that one of the most important factors explaining their interest in rural medicine was that rural medicine offered practice characteristics that

urban medicine did not. All of my respondents expressed a belief that family medicine has an expanded role in a rural setting because rural physicians are involved in a greater capacity in their patient's medical care and overall well-being. Rural practice, they said, is broader than urban practice because the rural physician works without specialist back-up. As a result, rural physicians are involved in more stages of their patients health care than urban physicians. Rural physicians, for example, are more likely than urban physicians to have hospital admitting privileges. Respondent Eight (a male) said that this allowed him to follow his patients from the office into the hospital and back into the office again. The scope of rural practice is broader than urban practice and therefore rural physicians are able to be more involved in their patient's care. Respondents used the words rewarding, challenging, interesting, comprehensive, and varied to describe rural practice. Respondent Six said:

“[A rural community is] a place where you can sort of be the true well-rounded physician...the old-fashioned doctor where you really get to deal with a whole variety of things, see a variety of things, and I think it's one of the best situations in which to get to know your patients as a whole and not just see a small part of them. I think that there's a lot of opportunity for variety throughout your career, more than there could be in a city.”

Respondent Four expressed a similar sentiment when she noted that rural practice enabled her to “...become the doctor that I went to medical school to be”.

Clearly, my respondents feel that they benefit from the expanded role that they play in their patient's medical experiences. This is also identified in the literature as being an advantage of rural practice. Is it also an advantage of being a rural patient? Do rural patients receive a higher quality of care than urban patients because their family physician knows them better and accompanies them further in their medical encounters? Doctor-patient relationships have been the subject of study and analysis for a long time, however this aspect of rural health care requires further investigation<sup>12</sup>. Two of my respondents felt that rural patients often did receive better care. Care is less fragmented when a smaller number of physicians are overseeing a patient's treatment. Respondent Eight used the term "cradle to grave" to refer to the longitudinal aspect of rural medicine.

Interestingly, while all respondents said that the broad scope of rural practice was a positive thing, three also indicated that it was intimidating. The respondents who expressed intimidation were all medical students which suggests that there may be a relationship between experience and confidence, which would be reasonable. While some respondents indicated that the professional independence or isolation can be a good thing, others notes that it can be a scary thing. Respondent Six said: "Medicine is an apprenticeship, you are constantly learning from people who are above you and around you. The thought of sort of trucking out to this two-doctor town is terrifying because we're always in training

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<sup>12</sup>The impact of the doctor-patient relationship on the quality of rural health care is a subject worthy of investigation. Due to the limited scope of this work I am unfortunately unable to address the topic further at this time.



surrounded by other people....It's really scary to think of going off and doing everything on your own". Respondent Nine added: "It's very anxiety provoking to be out there treating patients on your own. I think a lot of us have been brought up more on the system of collaboration rather than individuality".

Respondent Nine clearly summarized yet another distinction between rural and urban medicine. Structurally, Western medicine is based on a "system of collaboration" in which doctors are trained in specific areas of expertise. Family doctors, trained as generalists, act as front-line personnel in the medical system. Due to a lack of specialized knowledge, one of their jobs (in an urban centre) is to refer patients to specialists. Rural family physicians often work in an independent system because there are few other health care specialists with whom they can collaborate. Therefore, they require a more extensive body of knowledge than urban family practitioners. Rural family physicians need to be trained as generalists, and they also need training in some key specialties.<sup>13</sup> Clearly, if we continue to train physicians who are able to only work within a collaborative model, we will never have enough doctors to work competently in rural areas. Physician training for rural doctors must reflect these differences in rural practice.

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<sup>13</sup>Determining which specialties should be included is a task better left to rural physicians, who know their own training needs .

### **4.3.3 Less Support and More Responsibility**

In Chapter Two, the broad scope and independent nature of rural practice, described earlier as an advantage by all of my respondents, is also described as a disadvantage of rural practice because it results in greater responsibility being placed on the shoulders of rural physicians. The tendency for rural physicians to have more responsibility with less support than urban physicians was the main disadvantage reported by all of my respondents. For example, they cited that the number of hours worked per week tends to be high, and getting time off for vacations or Continuing Medical Education (CME) is difficult. Respondent One noted: "...you are busier than you want to be and it is really hard not to be". On-call frequency can be high, and Respondent Two claimed that it is often untenable. Another respondent noted that it is "harder to set limits" in a rural area because there is no one else to take your place. Respondents also indicated that there can be a lack of professional support in rural areas. Lack of specialty back-up, limited access to lab tests and diagnostic tools make rural practice more challenging than urban where all of those facilities are readily available. These challenges can be severe, particularly if, as Respondent Nine stated, "you [the rural physician] are unsure of your skills". How can physicians become more sure of their skills? Part of the answer to that question emerges in the Educational Sphere of Consideration when it comes to exposure and training.

Being isolated and without back-up has also meant to some respondents that engaging in CME has been difficult. However, Respondent Eight has found that improved

communications technology, such as the Internet, have made accessing CME programs easier. Any training that requires travelling, however, remains difficult to manage. Because most teaching centres are affiliated with urban hospitals, incorporating an academic component into a rural practice is another challenge. Respondent Five, who is planning on returning to a rural practice from her current position in an urban setting explained: “[what] I will miss more than anything is the residents, the teaching, the academic part. There is very little opportunity [for] teaching and positions in rural settings. That’s the hardest thing to leave”.

As I suspected, my respondents mirrored the literature in their thoughts and concerns within this sphere. Rural medicine, they felt, is distinct from urban because the doctor-patient relationship is more familiar; the breadth and scope of rural practice is greater in rural practice; rural physicians operate with more responsibility and less support than urban physicians. I was also correct in expecting that those differences would be perceived as positive attributes to my respondents. Not surprisingly, nobody mentioned incorporating other ideas like training other people to provide basic medical services. Social control is an important part of the profession of medicine and I anticipated that few people, if any, would volunteer to open the doors to outsiders.

## **Section 4.4: Educational Sphere of Consideration**

Within the Educational Sphere of Consideration, six questions emerge as influential on rural recruitment. First, how is exposure important for people who end up practicing in rural areas as well as for those who never do?. Second, what profile does rural medicine have in medical schools? Third, does medical school train students adequately for rural practice? Fourth, who are the students in medical schools? Fifth, what is the impact of early career decision making on rural retention? Finally, examining CME: what opportunities exist for education after medical school?

### **4.4.1 Exposure**

In the literature, exposure to rural medicine during undergraduate medical training is emphasized as an important factor in rural recruitment. The types of exposure most commonly referred to are rural electives and rotations. Both involve the medical student or resident spending time (a few weeks to a few months) working with or shadowing a rural physician in his or her practice. Electives and rotations give the student a chance to see what rural practice is really like and allows them to experience working and living in different communities. I suspect that my respondents will report that being exposed to rural medicine early in medical training influences practice location. All of my respondents have an interest in rural medicine and I suspect that they all had early exposure to rural in medical school.

Seven respondents (Two, Three, Four, Five, Six, Seven, and Nine) reported that exposure to a rural medical setting during their medical training had launched their interest in rural practice. Of those seven people, three were from rural areas and four were from urban areas. The most common exposure occurred during undergraduate medical training and consisted of rural electives or rotations. As undergraduate students, they went to rural communities to work alongside the communities' practicing physicians. The time period lasted anywhere from several weeks to six months. Other respondents reported that they had spent time in a rural community during their residency training.

Respondent Seven was one person whose interest in rural medicine was developed due to his experience in an elective. Respondent Three noted that:

...it was really interesting to watch that first group of students go out into rural areas because a lot of them really weren't looking forward to it, [they were] wondering 'What am I going to do there for 2 weeks?', 'Is this going to be a drag?', 'Oh my gosh look at where they sent me' sort of thing. The fact that it was mandatory, I think, really annoyed quite a lot of them. But when they came back from their two weeks it seemed to me, I didn't hear any negative comments. It seemed to me that everyone enjoyed themselves immensely.<sup>14</sup>

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<sup>14</sup>This quotation from Respondent Seven leads us to wonder why levels of recruitment are still low if students are enjoying their experiences in rural areas. Further research is required in order to adequately answer that question.

Respondent Four, who grew up in a suburban neighborhood, also found that working in a rural area after her first year of medical school was very important. She was informally exposed to rural medicine in medical school through classmates who were from rural areas. Rural medicine had no formal presence in her medical school at the time that she was a student there, in the early 1990's. She summarized the importance of early exposure by saying: "If nobody ever tells you that [rural medicine] is something you can do, then you're never going to consider, so there are some people who are lost before the game even starts".

Four of my respondents felt that exposure to rural medicine is advantageous to those people who will never practice in a rural area for two reasons. First, students who go to rural areas seem to have a more hands-on experience than they do in urban areas. In other words, the student learns more and is an active participant rather than a passive spectator. Recall what Respondent Two said: "...medical students who go into rural areas have very good experiences, they do more, see more, participate more, and generally learn a lot more than [they do] in [urban] centres where they're at the bottom of the totem pole". Respondent Three had positive experiences in rural areas: "...it was excellent, the teaching and hands-on experience were always excellent".

Earlier in this chapter, I discussed that the doctor-patient dynamic in rural areas represents a different hierarchy of power than is usually seen in urban areas. This hierarchical difference emerged from comments from some of the medical students with whom I spoke

about the advantages of being a medical student in rural areas. Two respondents, both medical students, noted that doing a rotation or elective in a rural area as a medical student presented advantages over urban-based locations because students are more likely to have more hands-on experience in a rural setting than they are in an urban setting. Respondent Two commented that "...medical students who go into rural areas have very good experiences, they do more, see more, participate more, and generally learn a lot more than [they do] in [urban] centres where they're at the *bottom of the totem pole*. You're right there in a rural setting" [emphasis added]. Respondent Three said that rural practice is "an excellent venue learning as you get to do a lot of hands-on work" as opposed to urban settings where the amount of hands-on work is limited.

Second, exposure leads to a greater understanding and respect of rural medicine and works towards changing the negative perception of it that some people have. Respondent Five explained: "once people are exposed they develop more respect for the system [of rural medicine] as a whole". Respondent Four feels that it may be even more important for people who will never practice in rural areas to be exposed to rural practice:

I've had people say [to me], 'Oh, I went somewhere like that [a rural area] when I was in training, oh my god... 'I'm so glad I'm not there...I'm just so pleased it's not me out there' and that's fine, that persons never going to work in a rural area. But if they can be nice to somebody who's working in a rural area, that counts just as much.

#### 4.4.2 The Profile of Rural Medicine in Medical School

The respondents quoted above believe that there is a misrepresentation of rural medicine among many people in the medical world. It is for this reason that they feel exposing all medical students to rural medicine is so important. How is rural medicine represented in medical school? What kind of profile does it have? Is there a bias *against* rural medicine? What we are talking about here is the distinction between formal exposure and informal exposure. Formal exposure may take shape as rural elective programs or lectures. Formal exposure is what is most often talked about in the literature. It influences the context in which medical students make decisions about their practice because it presents rural medicine as an option that some people might not have thought of on their own. In this way, most of the formal exposure that medical students receive is positive. Informal exposure is not quite as clear cut. It may be, as was the case for Respondent Four, other students in the class. Or, it may be the attitude that faculty members express when Respondents indicated an interest in rural medicine. It may also be seen in the degree of difficulty or ease with which information about rural medicine can be obtained by student.

Respondent Five felt that there was an urban bias at her Ontario medical school and that it was evident in the narrow definition of family medicine that they employ: "The family doctors that we see are urban family doctors and that is very different from [rural family medicine]. We do get some perspective of patients in those areas but you never have a chance to see what it's like as a physician in those areas" (she works with the Queen's rural



outreach program to change that). Respondent Nine was in the first class of her medical school to be exposed to rural medicine. She noted that the way rural is sometimes portrayed gives it a negative image. Respondent Ten feels strongly that the training that medical students receive does not support rural medicine: “Part of the reason you don’t have physicians jumping to go out into rural settings is because they’re not being trained to do that”. People who pursue an education in rural medicine (through electives for example) do so “...despite the training [in medical school], not because of the training”. She felt that her medical school did a poor job of providing her with mentors. She described a lecture that she attended early (1st year) in her education where the key speaker denounced rural medicine. She finished by saying that

...there are eager people [in medical schools] who want to be the kind of doctor that this province needs, and a lot of us are turned off by what happens in the universities and in the training. I guess it’s just assumed that we [doctors] all have the training and that we just walk out [of rural practice]...I almost feel like there’s this portrayal of us as these selfish people that all just want to stay in the city and work five hours a day.

#### **4.4.3 Training**

Part of the reason why exposing students to the possibility of rural practice is important is because it helps to prepare them for the particular demands that a rural physician

faces. I suspect that the perception of preparation is positively associated with confidence levels. Some respondents said that they felt prepared by their medical training and others did not. Respondent Eight, for example, reported that he had done an additional year of training in a rural area and as a result did feel prepared for rural practice. He has noticed, however, that medical schools do not seem to be training people for what they will have to be doing as rural physicians:

Family Medicine programs are doing a poor job of preparing [students for rural practice]. They finish residency and think that they can practice in a rural setting until they come out here and find out what we do, and then they can't do it because they don't have the skills. They've been trained to practice in an urban setting.

Among those who did feel prepared, Respondent One admitted that he felt "reasonably prepared" by his undergraduate and residency training. However, he added that "I've come out [of medical school] feeling there are a few skills that I just haven't developed". He added that he hoped to develop those skills on the job. Respondent Three did not feel prepared, although she noted that she was in the last year before a curriculum change that incorporated more rural exposure. She noticed that the group following hers (who had benefitted from the curriculum change) tended to have a more positive outlook on rural practice than did her immediate cohorts. Respondent Ten does not feel that current training programs prepare aspiring physicians for acute care or, subsequently, for rural practice. She noted that her school did a poor job of providing mentors for students who were interested

in rural medicine. Respondent Four reported that the medical school that she attended did not provide direct exposure to rural medicine, however she did get some exposure from some of the other students in her class who were from rural areas. Respondent Six expressed that the reputation that the medical school that she is currently attending has for being rurally oriented is not entirely deserved. Respondent Seven reported having more trouble than he had anticipated trying to get some skills for rural medicine in an urban residency program. Respondent Two summarized what she felt medical schools should be doing to prepare aspiring rural physicians: "...training for rural medicine has to entail being trained for what you will be doing...[medical schools] need to get people prepared for an environment that is maybe more hostile and less supportive".

Not all respondents agreed that it was even the role of medical schools to provide training specific to rural or urban settings. Respondent Five stated that exposure to rural medicine, as opposed to training, is what a medical school can do. She was exposed to rural medicine in her undergraduate studies, but did not feel that she had the same exposure during her residency training: "I don't think that it necessarily did [provide rural exposure], but I think you can do a lot with a residency program if you have the foresight to know that that's what you want and you create it within in". Respondent Seven shared her belief that undergraduate medical training is too general to be considered preparation for rural or urban-based practice.

#### **4.4.4 Accessibility of Medical School to Rural Students**

Recall the importance of rural origin on physician retention. Rural origin is an important consideration in this sphere as well because we need to examine not only what is happening in medical schools, but who the medical students are who are being influenced.

Respondent One feels that the way to improve rural retention is to get rurally-raised people into medical schools. Urbanites are unlikely to stay, he says, because the difference between rural and urban is too great and the change is too much to bear. Respondent Two also feels that rural origin is important: "My experience and the experience of other rural students is that [medicine] is not an option, it's just not something really thought about by rural students...if you're a smart kid from a rural area you go into Education". Why would rural students feel less inclined to pursue a career in medicine than urban students? Because medicine is so urbanly biased?

Respondent Three expressed concern about tuition deregulation and the impact that it would have on admissions:

...one of the things that it's going to do, in my opinion, it's going to bias admissions towards students from urban areas to begin with. If you are starting to bias your pool of applicants...towards people from wealthy families and from urban areas, I think you're gonna have less

success in getting those urban raised people to consider rural practice and to stay in rural practice.

Are high school students in rural areas at a disadvantage compared to urban high school students? Do rural high school students receive a poorer quality of education than urban students? Respondent Three, a medical student who went through the rural high school system believes that “education is what you make of it”. She adds, however, that “...most of the physicians I’ve met, and a lot of my classmates, doubt that the rural education system is very good”. She was not sure what caused the bias. As I reported in Section 4.2.1, she suggested that education can easily be supplemented by summer programs, like specialty music camps.

Respondent Six thinks that “...rural kids in high school need to know that medicine is a great career and that it is totally attainable. the support systems need to be in place to make that true, they shouldn’t...have to be rich, they should be well supported by their communities and by the greater community of Canada”

#### **4.4.5 Early Career Decision Making**

Two respondents stated that the pressure on medical students to make decisions about their careers early in their training is disadvantageous to rural medicine. Respondent Four

said “[m]ore and more people are being forced to make decisions early on in their medical school training - it’s crazy, medical students are having to get research papers published in order to get into the residency [program] that they want and I think that is really going to have a negative impact on people’s abilities to do electives in rural places.” Respondent Six expressed concern about the implication of early career decision making on rural recruitment:

...even by second year [of medical school] we feel the pressure [to decide on a career path]. To pick rural medicine at that point [in first year] is a pretty big thing to ask someone to do. People are having to make decisions too early, and it’s really hurting rural Canada.

## **Chapter Five: Conclusions and Recommendations**

Health care in rural Canada is in crisis. Rural communities struggle to recruit and to retain physicians. While the recruitment and retention of rural physicians are problems facing the entire country, this thesis has focused on the province of Ontario. In Chapter Two, I identified the factors commonly reported as being important to physician recruitment. I introduced a theoretical framework called Spheres of Consideration that clarifies the social context in which those factors exist. In Chapter Three, I discussed the methodology employed in obtaining my data. Telephone interviews with five undergraduate medical students, three residents, and three doctors further informed the discussion in Chapter Four. In this chapter I offer my conclusions and recommendations for rural communities, governments, the medical community, and for further research.

### **5.1 Financial Sphere of Consideration**

#### **5.1.1 Conclusions**

In Chapter Two I introduced literature on remuneration, financial incentives, debt, and tuition and discussed how they influence rural physician recruitment. In Chapter Four I compared my findings from Chapter Two with the findings from my interviews. The results of my study indicate that physicians who choose rural practice do so because they are drawn to its practice characteristics, not because of the remuneration or financial incentives that

they receive<sup>15</sup>. Many current efforts employed to remedy the crisis in rural health care overemphasize the importance of this sphere which is why the proposed solutions do not work. Physicians are mostly concerned with the financial sphere if they are students and carrying a debt and are concerned with paying it off as soon as possible. Furthermore, I suggest that financial incentives portray rural medicine as an undesirable form of medical practice and that this portrayal is detrimental to recruitment as well as the general practice of rural medicine.

Based on news reports, it seems as though physicians generally express a feeling that their pay should reflect the years of formal training they receive before being licensed to practice medicine. Only one of the respondents in this study expressed a similar sentiment. Others felt that medical practices pay well regardless of whether you are in a rural or urban location. Financial considerations were not high on their list of reasons why they would or would not stay in a rural community. Two questions emerge about the role that money plays in recruiting physicians to work in rural communities. News reports often refer to salary negotiations between doctors and government. It seems that the respondents in this study do not share the concerns of their colleagues. Could that be merely due to the small sample size? In part, it is. My sample, as I discuss in Chapter Three, consists mostly of medical students and residents. Perhaps salary concerns emerge later in a physician's career as being

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<sup>15</sup>Recall that, due to my small sample, I cannot generalize my findings to the broader rural medical community.



important. However, it was a medical student who was the only respondent to mention the importance of paying doctors well.

Financial incentive packages have not solved the shortage of physicians in rural areas. According to the respondents of this study, they do not attract the right kind of physician to rural practice. While there is nothing wrong with compensating physicians who work in rural parts of Canada, current efforts and policies direct the wrong message at the wrong people. The people towards whom the message is directed are those physicians who are interested only in the financial benefits of the practice of medicine. Rural practice requires a high level of commitment from its practitioner. Rural medicine in Canada is portrayed as a convenient stopping point for physicians wanting to pay off their debts and get on with their lives. Not all physicians who are attracted by incentive packages are interested solely in the money. Respondent Five's interest in rural medicine was sparked in part by the financial compensation that she received. However, by not acknowledging and providing for the more serious considerations of rural practice, even those physicians whose interest is sparked will lose their motivation. Incentive packages are a place to start. The danger is that they have been used in isolation from any other effort.

Resources, in this case financial, are funnelled into people who are not going to stay in rural areas. I propose that those resources be redirected towards creating sustainable working conditions for physicians who are genuinely committed to rural practice. Incentive packages can be used, but must be used as part of a larger package and not in isolation. Two

aspects of the financial sphere of consideration require further attention. The rising cost of a medical education will exacerbate current physician shortages. Likewise, the deregulation of tuition fees will reinforce an image of medical education as being for the wealthy and elite members of society.

Finally, a note about compensation. Compensation can be made in more than financial ways. Clearly, the respondents with whom I spoke support the notion put forth by Pope et al. (1998) that we need to rethink the definition of the word. Both the literature and the interviews I conducted demonstrate that physicians who stay in rural practice feel that the benefits outweigh the drawbacks. They do not express a need for compensation, for they are rewarded by the work itself. Reducing rural practice to a question of compensation betrays its unique and appreciable characteristics.

### **5.1.2 Recommendations for Rural Communities**

Communities should not expect financial incentives to single-handedly solve their recruitment problems. They must ensure that the doctor they recruit has interests in rural medicine beyond financial gain. A percentage of the money that is currently ear-marked for recruitment initiatives might, for example, be used to sponsor their students' medical school education.

### **5.1.3 Recommendations for Governments**

As I indicate throughout this thesis, the impact of the financial sphere on rural recruitment is over-emphasized. Financial incentives are likely a permanent component of rural physician recruitment. However, coercive measures are unacceptable and reflect a negative and damaging perception of rural medicine. Provincial and federal governments should re-invest the time, money and energy that is currently directed at this sphere in other spheres as indicated below. Governments should work with medical community to regulate tuition and decrease student debt. Likewise, governments should make debt easier to handle for students by, for example, giving them longer to pay it back interest-free.

### **5.1.4 Recommendations for the Medical Community**

According to the results of my study, rural physicians feel adequately remunerated for their work. As a result I can make no specific recommendation to the medical community with respect to this sphere of consideration.

### **5.1.5 Indications for Further Research**

The use of financial incentives is widespread in this, and other, countries. Do financial incentives work to keep doctors in rural areas? I suggest, as do my respondents, that they do not. However, research is needed to more adequately answer this question.

In this thesis I suggest that the message portrayed through the frequent use of financial incentives is that rural practice is a burden and the only way that physicians would work in rural areas is if they are paid a lot of money. I suspect that physicians with little or no experience of rural medicine will be influenced by this negative image. Research is needed to explore the ideological message of financial incentives as well as to explore implications of that message. - the impact of financial incentives: how are they working? what is the ideological message?

## **5.2 Personal/Social Sphere of Consideration**

### **5.2.1 Conclusions**

In many ways, this is the sphere with the largest obstacles because it comes down to personal preference -- personality. Rural practice is different from urban practice, as the literature suggests and my respondents concur. Ultimately, it takes a person who enjoys those differences to choose rural practice. The personality of the physician must match the lifestyle. But more than that, in most cases the personality of the physician's spouse or partner and children must also match the lifestyle. This brings us back to the idea that we must recruit medical students from rural areas since they will be predisposed towards rural life because they are familiar with it. Social integration plays a tremendous role in the development of this compatibility. Taking on a high-profile social role in a small community

can be taxing for those physicians who are not prepared for playing a central role in the social dynamics of a small town.

### **5.2.2 Recommendations for Rural Communities**

Rural communities play a role in the social integration of physicians. Community members must be active participants in facilitating this integration. Likewise, community members must be prepared for the arrival of a new physician. They must understand that a physician needs to leave behind her professional role when not working. Individual rural communities should work in tandem with the medical community to develop guidelines so as not to overtax a new physician.

When recruiting physicians, rural communities must also think of the physician's spouse or partner and families. Are there employment opportunities for the spouse or partner? What educational opportunities exist for children? When a community reaches out to a physician, families must be included.

### **5.2.3 Recommendations for Governments**

Rural physicians are concerned about available facilities in rural communities and governments can provide funds to support community development projects. Some examples

of important resources for the community are: schools, camps, internet access, libraries, and youth programmes.

#### **5.2.4 Recommendations for the Medical Community**

The medical community should work with rural communities to help them explore their needs and expectations of physicians. They should also work together to determine appropriate boundaries so that the physician will maintain a sense of privacy. To do so, a liaison officer should be appointed at the Ontario Medical Association to work with rural communities, individual doctors and the medical community

#### **5.2.5 Indications for Further Research**

How does the social role of doctor differ between rural and urban communities? What are the social and personal implications of a change in that role? How do doctors relate with other medical personnel? How do doctors and medical personnel relate to members of the community? These are research questions that should be addressed.

## **5.3 Professional Sphere of Consideration**

### **5.3.1 Conclusions**

One of the reasons that I interviewed so few practicing rural physicians is because they were too busy to speak with me. The initial response that I had to my request for participants was good. People were interested, but it was difficult to find a time that was convenient to do the interview. Rural physicians tend to have very demanding and somewhat unpredictable schedules, so even if we made an appointment there would be no guarantee that an emergency of some sort would not arise and impede even our very best efforts to connect. Hectic schedules are one characteristic of the profile of rural practice. Another profile characteristic of rural medicine is that it is distinct from urban practice. The difference between urban and rural medicine is seen primarily in: the broad scope of rural practice, the lack of support that rural physicians face, and the nature of the doctor-patient relationship. Rural health care must take its place as a viable specialty of family medicine and medical students interested in pursuing a career in rural health must be trained accordingly.

Professional isolation is a great concern among my respondents, as it is in the literature. However, this is a good example of how physicians can see the same situation very differently depending on their experience and perspective. Most of my respondents viewed the isolation as independence. Contrary to being overwhelming, they saw it as a challenge. I propose that physicians who feel confident in their medical skills will be more open to that

challenge. Confidence, I believe, develops from experience and training. Therefore, physicians who are trained for the specific rigours of rural medicine will feel more confident of their skills.

Part of the unique and distinctive nature that my respondents spoke of is that rural practice is more varied and interested. They also spoke of a different, more intimate, relationship with their patients than urban doctors have. Does this imply that rural doctors care for their patients differently? When rural residents get care, is it of a higher quality?

### **5.3.2 Recommendations for Rural Communities**

The suggestion made by Barer and Stoddart (as discussed in Chapter Two) that the practice of basic medical services be opened to other people is one that I address fully in Section 5.3.4. That recommendation obviously has implications for rural communities. Under such a model, rural citizens will be responsible for providing basic services. Doing so requires a great deal of organization and training that requires, above all, dedication on the part of interested community members.

### **5.3.3 Recommendations for Governments**

Governments must stop all coercive measures, including forced service and restricting billing numbers. Not only do coercive measures fail to solve the crisis of rural



recruitment, they exacerbate the problem by enforcing a negative stereotype of rural medicine that is inaccurate. This thesis is predicated on the assumption that the physician must be the centre of any health care model. That assumption may need to be challenged in order to create sustainable rural health care solutions. If physician recruitment continues to be a problem, will we not be forced to adjust that model to make room for other health care workers? What is the most appropriate and beneficial role for nurse practitioners to play in a rural health model? Might opening up licensing to other medical personnel be required? What aspects of the physicians' current role may be supplemented by other health care professionals? The application and impact of these changes warrant substantial investigation.

#### **5.3.4 Recommendations for the Medical Community**

Nowhere is the medical community's role in solving the crisis in rural health care more evident than in the professional sphere of consideration. The medicine that is taught and practiced in Ontario, and the rest of the country, has an urban bias that is detrimental to the health of rural Canadians. Rural medicine must be acknowledged as a specialty of family practice. Making rural medicine a sub-specialty will validate its differences thereby changing its negative image. Specializing rural medicine will also make room for changes in medical education. Students who are interested in rural practice need to feel confident in more skills than do students pursuing an urban practice. They must be trained to work in rural settings. Additionally, rural physicians work within a doctor-patient relationship that is more familiar than its urban counterpart. Rural physicians have a fuller knowledge of their patients) are

likely to know their patients better than urban doctors because they know them in various capacities and not just as a patient. Rural physicians can and should be prepared to deal with those differences.

### **5.3.5 Indications for Further Research**

Many rural physicians (or aspiring rural physicians) believe that the quality of care that people receive in rural settings is better than the care that people receive in urban settings. Two reasons explain this perception. First, rural care is less fragmented. Rural physicians seem to follow their patients through a broader spectrum of their health care experiences than do urban physicians. Second, the doctor-patient relationship in a rural area is not limited to a professional one. Doctors and patients interact socially and therefore know one another better than they might in an urban setting. One hypothesis worth exploring is that health care in rural areas is harder to get, but that when people do get it, it is better because it is more personalized care than they would get in an urban centre. If rural care is better then does that not have implications for the way that care is structured in urban centres? Does that mean that city dwellers should have the kind of relationship with their family doctor that people in rural areas do?

As mentioned in Section 5.3.4, the profile of rural medicine within the broader medical community needs to be changed. There is a bias against rural medicine, and the main thing we can do to change that bias is to make rural medicine a specialty. There needs to be

more research done to investigate how this could happen and what the obstacles are that prevent it from happening

## **5.4 Educational Sphere of Consideration**

### **5.4.1 Conclusions**

Early exposure to rural practice was important for my respondents, as it is argued in much of the literature. Threatening that exposure is the pressure on medical students to make major career decisions very early in their training. My respondents added something that I did not come across in the literature. Early exposure, some said, was also beneficial for students who would never practice in a rural area. Might this indicate that the process of professionalization differs somewhat between regions? As medical students complete their education, they learn the scientific rules that govern the art and practice of medicine. They also learn the norms that govern the profession of medicine. For example, medical students learn that they must be emotionally detached from their patients. In urban areas, medical students compete with one another to gain experience. Learning is often by watching. In rural areas, according to my respondents, students are brought into the inner-circle with the attending physician. Learning is by watching and doing. In short, the type of training that occurs in a rural area differs from training in urban centres because students are more involved. That implies that the hierarchy within the physician's world is less pronounced and rigid in rural areas.

Physicians of rural origin, as has been discussed several times in this chapter and this thesis, are more likely to stay in rural practice than are their urban counterparts. I suggest some reasons why this may be so in Section 5.2.1. If rural high school students are to be recruited for medical school, they need first to see medical school as a viable option. I recommend below that rural communities, governments and the medical community work together to reach those students.

Youth out-migration is a huge problem in many rural communities. One of the main reasons that youth cite for leaving their communities is that there are no jobs available for them. Perhaps if more rural students saw medicine as a viable career choice, we could work towards solving both problems of youth out-migration and rural physician recruitment.

#### **5.4.2 Recommendations for Rural Communities**

Exposing rural high school students to the possibility of practicing medicine and preparing them to do so should be the mandate of rural communities. Inviting physicians to speak to high school students, taking students on medical tours, and other special events support the goal of exposing and preparing students for a career in medicine. Communities should work with governments and the medical community to achieve these goals.

### **5.4.3 Recommendations for Governments**

Governments should work with rural communities and the medical community to encourage rural high school students to pursue a career in rural medicine. Funding and organizational support can be provided for exchanges between high school students and physicians.

### **5.4.4 Recommendations for the Medical Community**

Medical schools should recruit medical students from rural areas and they should adequately train the students that they do have. Early exposure to rural medicine in medical school is important and medical schools must ensure that all students have the opportunity to consider a career in rural practice. Creating that opportunity also means that the pressure on students to make major decisions early in their education must be eased. These steps are the first in ensuring that the urban bias in medical schools be addressed and changed. Physicians trained in a social context that is hostile to rural medicine will be likewise hostile.

### **5.4.5 Indications for Further Research**

Is the process of professionalization in rural areas different than the process in urban areas? What are the implications of a possible difference? What barriers, if any, stand in the way of rural high school students who wish to pursue a career in rural medicine? How can

medical school be made accessible to these students? What impact will that have on rural recruitment? All of these questions emerge from my research as worthy of investigation. I suggest, in Section 5.4.1, that encouraging rural youth to pursue a career in medicine may be a step towards solving problems of youth out-migration in addition to improving rural physician recruitment. The existence and impact of this relationship also warrants investigation.

Five research questions guided my research: What issues are cited in the literature regarding rural physician recruitment and retention? What issues are cited regarding rural recruitment and retention by physicians and medical students? To what extent are these issues congruent and comprehensive? What is a useful framework for research into rural recruitment and retention? What is a useful framework for policy suggestions to improve the present situation of rural recruitment and retention? This chapter has been devoted to answering those questions within the context of four Spheres of Consideration.

Underlying many of the struggles and concerns expressed by my respondents is a question of the legitimacy, perceived or otherwise, of rural medicine within the dominant medical structure. Rural medicine must be legitimized if physicians are to see rural practice as a viable career choice. Without that legitimacy, rural medicine will not be able to occupy enough space in medical schools to adequately prepare physicians for rural practice. As an exploratory study, this thesis has raised many questions that await further investigation.

Health care was a dominant topic of discussion in the most recent Canadian election. Among the topics being debated by party leaders and the Canadian public was the question: 'What is the future of Medicare in Canada?'. Many Canadians are concerned that our Medicare system is deteriorating into a two-tier system, a system where money shortens waiting times for tests and essential medical procedures. This thesis has demonstrated that a two-tier health care system already does exist in Canada. While we fight off the implementation of a financially-based two-tier system, a geographically based two-tier system has already replaced the universality of 'our' Medicare. The Canadian health care system is in crisis, how much longer will it take for us to respond?

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## **APPENDIX A: INTERVIEW GUIDE**

*[TO BE READ AT THE VERY BEGINNING OF THE INTERVIEW]*

Hello, this is Jennifer Perzow. Thank you again for agreeing to speak with me. Before we continue, I'd like to know if you would mind if I tape record this conversation. (That will make it easier for me to reflect on your comments). [Start tape now] As you know, I am doing research for my Master's Thesis on the retention of physicians in rural Ontario. The interview should last roughly 30 minutes. I will first read through a consent form with you, to satisfy the requirements of my ethics committee. Then we'll go through a few questions and end with some basic demographic information. Does that sound okay? Please feel free to stop me at any point if you have any questions or concerns.

### **CONSENT FORM TO PARTICIPATE IN RESEARCH**

I agree to participate in a program of research being conducted by Jennifer Perzow as part of her Master's Degree under the supervision of Dr. Bill Reimer of the Department of Sociology and Anthropology at Concordia University.

#### **A. PURPOSE**

I have been informed that the purpose of the research is to explore the factors that improve the retention rates of physicians in rural Ontario.

## **B. PROCEDURES**

I have been informed that this research will be conducted via telephone interview during which time I will be asked questions about my personal feelings regarding medical practice. I understand that the interview is expected to last 30 minutes, although I may extend that time if I wish.

## **C. CONDITIONS OF PARTICIPATION**

- I understand that I am free to withdraw my consent and discontinue my participation at any time without negative consequences. I am under no obligation to answer any questions that I do not feel comfortable answering.
- I understand that my participation in this study is confidential (ie. the researcher will know, but will not disclose my identity).
- I understand that the data from this study may be published.
- I understand the purpose of this study and know that there is no hidden motive of which I have not been informed.

*HAVING READ THAT INFORMATION, DO YOU CONSENT TO PARTICIPATE IN THIS INTERVIEW?*

## DEMOGRAPHIC INFORMATION

1. In what year were you born?

2. What is your Marital Status?

3. Do you have any children

[if no, move to question 4]

[if yes move to question 3a]

3a. How many children do you have?

3b. What are the ages of your children?

4. Have you ever lived in a rural area before? When and for how long?

5. Where did you do your medical training? What training did you do?

6. I will provide you with four income categories. Please choose the category that best represents your annual gross income:

A: \$0-19 999

B: \$20 000 - 49 999

C: \$50 000 - 74 999

D: \$75 000+

## **INTERVIEW QUESTIONS**

### **QUESTION 1:**

**What sparked your interest in rural practice?**

**Probes:**

**childhood experience, popular media, professor, colleague, family, financial incentives, rural experience, medical training**

### **QUESTION 2:**

**What factors were most influential in deciding to try rural practice?**

**Probes:**

**Did knowing you'd receive more money influence your decision to practice in a rural community?**

**Before your medical training, had you ever lived in a rural area? [If yes] For how many years? In which country? If Canada, in which province? Had you intended to return to a rural community?**

**What aspects of rural life do you find attractive? What aspects of rural life do you find unattractive?**

**What are your plans for your professional career?**

**Is a rural practice an asset or impediment to your professional aspirations?**

**Was it your choice to be in rural practice? At what stage in your career did you make this choice? Was it your first choice? Why or why not?**

### **QUESTION 3:**

**What factors were most influential in deciding to stay in/leave rural practice?**

**Probes:**

**Is your partner employed in or near the community in which you live?**

**Do you think that your partner is content or not content living in a rural area?**

How do you think that your partner feels about your rural practice being in a rural area?

Have your partner's feelings about rural practice influenced your own feelings about rural practice?

Did your children grow up in this community?

Do your children attend a school(s) in your community or in another community?

What schools are there for children in this area? (ie. elementary, high school, college, university)

Is there a choice of schools in your area?

How do you rate the quality of those schools? Why? To what schools are you comparing them?

What are the advantages for your children in the schools in this region? What are the disadvantages?

Do you feel that this community is typical of rural communities with respect to raising children? Why or why not?

Is there adequate child care available in the community?

How often do/did you use child care services? (ie. baby sitting, day care)

What type of transportation is available for children/teenagers?

Do you feel that your children are content living in a rural area?

To what extent are your children integrated into the community? Examples?

Have your children's feelings about rural living influenced your own feelings about rural practice?

Does having children affect your decision to stay in or leave a rural community? [If yes] In what ways?

Are you currently receiving financial compensation?

Is it a factor in your staying or not?

In what way has being a rural physician influenced your professional aspirations?

#### QUESTION 4:

What do you consider to be the major advantages of having a rural practices? of being a rural physician?

Probes:

Did you receive financial compensation for establishing a rural practice?

What aspects of rural practice are the most satisfying? What aspects of rural practice are the least satisfying?

#### QUESTION 5:

What do you consider to be the major disadvantages of having a rural practice? of being a rural physician?

Probes:

Do you feel that you have adequate professional support? Why or why not?

Do you have time to maintain a program of CME (Continuing Medical Education)? Do you have access to CME opportunities? How often do you participate?

#### QUESTION 6:

When you started your rural practice, did you feel prepared or unprepared for rural medical practice? In what ways prepared? In what ways unprepared?

Probes:

In your undergraduate medical training, did you have any exposure to rural practice?

Did you discuss rural medicine in your courses?

Did you spend time working in a rural community (ie. during the summer, as part of an elective?)

Did you find this training to be useful or not useful? In what ways?

At the time that you first started rural practice, what part of your training did you find particularly appropriate for rural practice?



**QUESTION 7:**

**Do you feel that rural practice is different from or similar to urban practice? In what ways are they different? In what ways are they similar?**

**Probes:**

**What types of professional support do you require in your rural practice? (ie. specialists to whom you can refer patients, laboratory facilities, hospital privileges)**

**What types of professional support do you have?**

**QUESTION 8:**

**What suggestions do you have to improve the retention rates of physicians in rural Ontario?**

**Probes:**

**Should the government be using financial incentive programmes to get and keep more doctors in rural practice? Why or why not?**

**What other things could be done to recruit rural physicians? To retain rural physicians?**

**QUESTION 9:**

**Is there anything that I did not ask that you would like to comment upon?**

**WRAP-UP**

**I would like to thank you one more time for agreeing to participate in this interview. Your participation has been instrumental in this study. If you think of anything that you would like to add, or any other comments that you would like to make, then feel free to contact**

me. If I have any questions about what you've said, would it be okay if I contacted you for a confirmation? Would you like me to keep you updated as to the progress that I am making with respect to my research and thesis? Thank you very much!