National Rural Physician Recruitment and Retention

One physician, interviewed for a North Carolina study, knew the time had come to leave his rural practice when his two-year-old son asked him where he lived. The physician noted that he had been working ninety-five hours per week and was almost never at home[1]. He had come to the very ironic conclusion that in order to enjoy a minimal family life, he would have to leave his rural community.

The reasons why physicians, and other health care professionals, leave rural practices are wide ranging but are almost always emotional in scope, not merely professional. Issues of family, community, and identity are often far more important than issues of money and prestige when a rural physician makes the final decision to leave for a more populated area. Likewise, such personal issues are most often the reasons for staying. America's rural communities are in serious need of more physicians, yet those same communities often have serious difficulties in keeping doctors once they do arrive. This report will attempt to broadly examine the issue of, not merely physician recruitment, but physician retention as well. A great deal of emphasis has been placed on recruitment in recent years nationwide, but study after study shows that if physicians continue to leave rural communities after a few short years of practice, the recruitment issue, and the larger issue of rural physician scarcity, will never be solved.

The Rural Dilemma

Nationwide, America is experiencing a growing surplus of physicians. Rising pay among the medical specialties and subspecialties in recent decades has expanded the number and proportion of medical students concentrating in such areas, while primary care practitioners (PCPs) have lagged behind in overall growth. Now, such once-lucrative fields as anesthesiology and radiology are becoming more and more competitive as the number of practitioners needed to fill the market on a national scale is ever more surpassed.

Yet, as the proportion of medical school graduates choosing a primary care field[2] has waned, the demand for such physicians has shown considerable growth. A major reason for this has been the rise of managed care. Health maintenance organizations (HMOs), especially, rely heavily upon primary care practitioners in keeping costs at a minimum. A patient's designated PCP acts as a "gatekeeper," solving simple health care problems cheaply and referring patients to more expensive specialists only when necessary and with an experienced knowledge of what specialized care the patient will need.

All of these trends bode poorly for America's rural areas. The bread and butter of health care in rural communities is the family physician. Though a patient may be sent to a larger city for specialized care, the

most basic health care needs of a rural community, both preventive and diagnostic, are handled by the primary care physician. As the proportion of PCPs within the population of physicians decreases and as demand for PCPs from managed care organizations rises dramatically, rural communities have been and are having a far more difficult time finding physicians to care for their populations.

Consider these figures:

- Although about 23% of Americans live in non-metropolitan counties, only about 11% of physicians practice in such counties.[3]

- Only 0.1% of U.S. physicians work in communities of 5,000 or less.[4]

- Nearly 30% of America's rural population live in a county with a PCP shortage.[5]

- In 1991, physicians in metropolitan settings worked 52 hours per week on average. Physicians in towns of less than 50,000 worked 57.5 hours per week. Rural physicians averaged 59 hours per week.[6]

But the problem does not end with a mere overall shortage of physicians. A myriad of obstacles exists to retaining physicians in rural communities once they are procured. Obviously, the number of physicians with a rural background is limited. Partly because of this, physicians who are recruited to rural practice areas often have difficulties adjusting to the lifestyle. This can especially be the case for graduates of medical programs from large cities. But the transition from urban to rural area is often not the only adjustment needed. Physicians normally train in large, tertiary care centers, becoming acquainted with using state of the art technology and with having experts on hand at every turn. This is not the rural experience. As one Montana physician put it: "A rural doctor has to depend on his eyes and hands for his medical judgment and learn to make do without all the technology. The younger guys just aren't being taught to do this or to feel comfortable with it[7]." Thus, new rural physicians must face culture shock both in their private and professional lives.

Why Physicians Leave

Before discussing recruitment and retention, it is important to understand what causes rural physicians to become unhappy with their situations--and what causes them to want to stay as well. First, why do physicians come to rural communities in the first place? There are often financial incentives, such as loan repayment plans and income tax credits, which many states utilize to lure physicians to underserved areas. However, such incentives alone can create a "Northern Exposure" like scenario, in which a physician, anxious to pay off debts, serves unwillingly in an area of the country or in a lifestyle totally foreign to him. After serving their obligation, such physicians are often quick to leave, fleeing the country for "civilization" again.

However, other incentives, often less tangible, exist. An individual may simply have a desire to serve others by practicing the healing skills in an underserved area. A physician may be from a rural background and yearn to return to such an area. A practitioner in a later period of his career might see rural practice as more in line with what he knows, when faced with changes in urban areas brought on by managed care.

There are many drawbacks to rural practice, however, which often serve to drive physicians away from such practices, despite their original intentions. A few of these drawbacks are professional. A rural physician can often be cut off from interaction with peers, from continuing medical education (CME), and from the latest technology. Also, rural physicians often voice concern that urban physicians

have a low opinion of them. Rural physicians are called "local medical doctors (LMDs)" and are often seen in the eyes of more urban counterparts as undertrained or underqualified.[8] No physician wants such a stigma.

However, such considerations are often secondary to more personal dilemmas that rural practice can often bring about. There is of course the obvious problem of culture shock for physicians who move to a totally unfamiliar lifestyle. A city-raised and educated physician may take years to appreciate a very rural community's qualities, if ever. But there are other factors, too. The rural physician often brings a spouse to the new practice area, who may feel even more uncomfortable in the new setting. Employment is often difficult to locate for a spouse as well, especially if the spouse has specific professional goals. Rural communities often have poor or overburdened school systems, of a lower quality or with far fewer resources than many suburban schools. Also, a rural physician and spouse may feel their child is not exposed to a broad enough range of cultures and ideas within a rural school and community, leaving them less prepared to venture forth later in life to more urban areas.

The demands on rural physicians, because of their scarcity, are often quite high. Call schedules may be unreasonable--nightly or almost nightly. Rural physicians often have more patients than they can easily handle, filling long days and still making patients wait unreasonable lengths of time for an appointment. Women physicians with young children often express frustration that working part time is almost impossible.

Rural physicians also must often take on a far heavier share of administrative duties--for which they are often undertrained and unprepared--than their urban counterparts. The lack of trained staff, or funds to hire such staff, leads to longer hours spent in the office for physicians and often less profits due to inefficiency. Physicians in rural areas often must also step into leadership and steering roles which they may not have the time for or the experience to effectively handle. Meetings, committees, reports, and other office-oriented work eat up more of a physician's time, leading almost inevitably to burnout.

Obviously, not every rural physician steps into such a situation. Many feel quite comfortable with their new community, have little problem adjusting to the special needs and limitations of their rural hospital or practice, and are not overworked. Every situation, and every individual, is different. Nevertheless, many experts feel that with some extra effort and planning, those physicians who may otherwise leave a rural setting, or never enter such a setting at all, can be salvaged. In many states work towards this goal is already being done.

Keeping Physicians in Rural Practice

Retention of rural physicians must start at the recruitment level. A recurring motto of rural health officials is, "Recruit to retain."[9] Several states have shown foresight in beginning recruitment efforts with rural high school students, who show scientific aptitude but who may not necessarily consider a medical profession without encouragement. There is a great lapse of time between high school and the completion of residency requirements, but such recruiting efforts anticipate the future by building upon what studies consistently show, and what most people can intuitively recognize: medical professionals originally from rural areas are more likely to return to such areas than their urban counterparts.[10] Activities range from summer camps for rural students interested in medicine, in states like Florida, Colorado, and Louisiana, to individual outreach by local health care professionals or medical school students, in

states like Ohio and Kentucky.[11] Such programs are designed to steer young rural students toward medical careers, with the expectation that several of them may one day return to practice within the rural settings they know.

Recruitment should also continue through college and medical school. Take the University of Minnesota, for instance, which in 1971 opened the Rural Physician Associate Program (RPAP). RPAP is a nine-month elective available to third-year medical students. According to the university's literature, "Students live and train in non-metropolitan communities under the supervision of family practice and other physicians called preceptors. The goal of RPAP is to encourage students to establish medical practices in rural areas." Since RPAP began, over 800 medical students have participated, and of those former students, 65% now practice in rural areas. Eighty-two percent of former participants chose primary care specialties.[12]

Such programs are important for drawing students toward rural practice. However, what about the more immediate topic of recruiting individuals who are already physicians, or who are soon to enter practice for the first time? A variety of innovative ideas has risen from the states regarding this topic.

Perhaps the most common methods of recruitment involve money. Obviously, most new physicians come from medical school and residency encumbered by debt. The promise of partial or full repayment through devoting a defined period of time to a particular underserved area can be very attractive. If placement is performed with dexterity, such a physician may very well continue practicing well after his commitment has ended. However, if the goal of placement is to simply "fill slots," and not to pair a physician with a compatible community for the long term, the recruiting office will find itself at work continuously.

Recruiters should first seek out individuals most likely to enjoy and be committed to life in a small community:

- Young families looking to put down roots;
- Pioneering and entrepreneurial personalities;
- Families wanting to be close to the outdoors;
- Retired military physicians (who are often used to working with limited resources or in areas removed from tertiary care centers);
- Those interested in serving as medical missionaries or overseas;
- Physicians wanting to learn about the business of medicine by working very independently.[13]

Such individuals, as well as simply those with a desire to experience or return to rural life for its own sake, often make good prospects for long-term practitioners.

However, it is also highly important to match the candidate with the correct community, and not merely "assign" one to the other, hoping for the best. Arrange for at least two visits for the physician to the community, allowing the physician, as well as his family, to see the local health care facilities, as well as the rest of the community. If a physician or the physician's family is obviously uncertain about spending any length of time in the community, it may be prudent to attempt a different placement. If health professionals within the community itself are unhappy with the candidate, that may be another sign of trouble on the horizon. And, if once a physician has begun working at a rural practice site it becomes obvious that serious problems exist, it may be best to attempt to find a different underserved site for the physician, before they simply leave the very idea of rural practice behind for good.

One important component to retaining physicians is keeping a "critical mass" of other health care practitioners close by. This is most important in the most rural areas, where a physician can feel cut off from the profession, or overwhelmed by responsibility, due to the complete lack of available peers. A critical mass of three practitioners is often necessary to keep such helplessness at bay. This team need not be comprised of three physicians in all instances--physician assistants, registered nurses, and residents can all be used to fill the gaps. What is important is that a physician in a truly isolated area does not become too isolated himself.[14]

But even for less isolated rural physicians, links to the tertiary medical world are a necessary tool in retention. Such links can often be provided through the state level. The Office of Rural Health at Oregon Health Sciences University maintains the Healthcare Experts for Rural Oregon (HERO) program. Aside from HERO's recruiting function, the program also coordinates a number of university-based initiatives to aid rural physicians who otherwise have little access to tertiary care assistance. HERO promotes a 24-hour university consultation service for tertiary advice; administers a university-based nurse telephone triage program to steer some excess calls away from overburdened physicians; allows some electronic access to the campus library from rural sites; and also administers a rural rotation program for medical students, allowing rural practitioners the opportunity to teach others--a rare experience in rural hospitals.[15]

It is important to allow rural physicians the opportunity to partake in continuing medical education whenever possible, both to increase quality of care and to maintain job satisfaction. Easy access to specialists must be maintained as well, so that a rural physician remains confident that the best avenues to care are at his fingertips, just as they may be in an urban, tertiary hospital. Telemedicine, an emerging field, is an excellent tool to utilize for this purpose.

Burnout must be prevented if at all possible, for it is the undoing of any rural recruitment program. A physician who has been stretched to the limits due to poor working conditions, exceedingly long hours, unacceptable amounts of call duty, and professional isolation is almost certain to abandon not merely the problematic practice in question, but the entire field of rural health care. Not only that, high turnover looks very bad to possible recruits as well, and can also leave the community feeling distrustful towards each new doctor. In some situations, burnout may be almost inevitable, but it can often be lessened or prevented by taking several steps. A pool of *locum tenens* physicians should be available to allow physicians occasional time off (an example of this practice is the Montana Medical Manpower Project).[16] Administrators should be provided and well-educated when possible, to allow physicians to concentrate on medicine. A critical mass of practitioners should be maintained when possible. Incoming physicians should be well-oriented to rural life, optimally through prior training as a resident. The use of mentors can lessen feelings of helplessness, and continued contact by state level recruiters can detect and divert seriously problematic cases before it is too late.[17]

Obviously, not all problem situations are solvable. For the foreseeable future, physician shortages in rural areas will be a continuing challenge to health care administrators and policymakers nationwide. However, through increased understanding of the problem, more advanced planning and detailed execution, and greater efforts to stir interest in rural practice early, this dilemma can be faced effectively.

This issue memorandum was written by William E. Pike, Fiscal Analyst for the Legislative Research Council. It is designed to supply background information on the subject and is not a policy statement made by the Legislative Research Council.

1.

Teplin, Sari and Christine Kushner. *Physician Life and Practice in Underserved Communities: Strategies for Recruitment and Retention*. The University of North Carolina Rural Health Research: Chapel Hill, NC, March 1994.

2. Primary care can often be broadly defined as including family/general practitioners, obstetrician/gynecologists, internal medicine specialists, and pediatricians.

3. Myers, Dr. Wayne, Rural Policy Research Institute. *Hearing Testimony Presented to the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives (Sept. 12, 1996)*. http://www.rupri.org/healthP96-7.html April 24, 1997.

4. Weisfeld, Victoria (ed.). *Rural Health Challenges in the 1990s*. The Robert Wood Johnson Foundation: Princeton, NJ, November 1993.

5. Teplin and Kushner.

6. Weisfeld.

7. *Ibid.*

8. Teplin and Kushner.

9. *Ibid.*

10. Morris, Tom. *Health Career Recruitment Programs in Rural Areas*. Federal Office of Rural Health: Rockville, MD, July 1995.

11. *Ibid.*

12. University of Minnesota. *Rural Physician Associate Program*. http://www.rpap.umn.edu/ May 7, 1997.

13. Teplin and Kushner.

14. The Center for the New West. *Plugging the Leaks in Health Care: Harnessing Economic Opportunity in Rural America*. December 1992.

15. Telephone conversation with HERO manager, Scott Ekblad, May 6, 1997.

16. Weisfeld.

17. Teplin and Kushner.