CMA POLICY

RURAL AND REMOTE PRACTICE ISSUES

The Canadian Medical Association (CMA) believes that all Canadians should have reasonable access to uniform, high quality medical care. The CMA is concerned, however, that the health care infrastructure and level of professional support in rural and remote areas are insufficient to provide quality care and retain and recruit physicians relative to community needs. The CMA has developed this policy to outline specific issues and recommendations that may help retain and recruit physicians to rural and remote areas of Canada and thereby improve the health status of rural and remote populations. The following 3 key issue areas are addressed in this policy: training, compensation and work/lifestyle support. Commitment and action by all stakeholders, including governments, medical schools, professional associations and others, are urgently required.

Canadian physicians and other health care professionals are greatly frustrated by the impact that health care budget cuts and reorganization have had, and continue to have, on the timely provision of quality care to patients and general working conditions. For many physicians who practise in rural and remote communities, the impact is exacerbated by the breadth of their practice, as well as long working hours, geographic isolation, and lack of professional backup and access to specialist services.

This policy has been prepared to help governments, policy-makers, communities and others involved in the retention and recruitment of physicians understand the various professional and personal factors that must be addressed to retain and recruit physicians to rural and remote areas of Canada. This policy applies to both general practitioners/family physicians as well as specialists. The CMA believes that this policy must be considered in the context of other relevant CMA policies, including but not limited to *Physician Health and Wellbeing*, *Physician Compensation*, *Physician Resource Planning*, *Principles for a Re-entry System in Canadian Postgraduate Medical Education* and *Charter for Physicians*. In addition, any strategies that are developed should not be coercive and must include community and physician input; they must also be comprehensive, flexible and varied to meet and respond to local needs and interests.

Definitions

Rural and remote

There are no standard, broadly accepted terms or definitions for "rural" and "remote" since they cannot be sufficiently defined to reflect the unique and dynamic nature of the various regions and communities that could presumably be labelled as such.

The terms "rural" or "remote" medicine may be applied to many things: the physicians themselves, the population they serve, the geography of the community or access to medical services. For each of these factors, there are a number of ways to define and measure rurality. For example, a 1999 CMA survey of rural physicians showed that the most frequently mentioned characteristics of a rural community were (1) high level of on-call responsibilities, (2) long distance to a secondary referral centre, (3) lack of specialist services and (4) insufficient family physicians. As another example, Statistics Canada defines rural and small town residents for some analyses as those living in communities outside Census Metropolitan Areas (population of at least 100 000) or Census Agglomerations (population between 10 000 and 99 999), and where less than 50% of the workforce commute to a larger urban centre.

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Medical school

For the purposes of this policy, a medical school is understood to encompass the entire continuum of medical education, i.e., undergraduate, postgraduate, continuing medical education and maintenance of competence.

Training

Some Canadian studies have shown that medical trainees who were raised in rural communities have a greater tendency to return to these or similar communities to practise medicine. Some studies also show that individuals who do clerkships in rural or remote communities, or have some exposure to the rural practice environment during residency training, have a greater tendency to consider practising in rural or remote communities upon graduation. The CMA applauds those medical schools that promote careers in medicine to individuals from rural and remote areas and provide medical students and residents with exposure to rural practice during their training. Regular collaboration and communication among training directors for rural and remote programs, as well as rural medical educators and leaders from other health disciplines, are strongly encouraged so that rural training issues and possible linkages may be discussed. The benefits of rural training extend not only to those physicians who ultimately end up in rural practice; those who remain in urban areas also benefit by having an enhanced understanding of the challenges of rural and remote practice.

As outlined in the CMA's 1992 *Report of the Advisory Panel on the Provision of Medical Services in Underserviced Regions*, the CMA believes that partnerships among medical schools, the practising profession and communities need to be formalized, particularly since medical schools have a crucial role in helping to recruit and retain physicians for rural and remote communities. The medical school's role in such a partnership takes the form of a social contract. This contract begins with the admission of students who demonstrate a prior interest in working in rural or remote communities and may come from these communities. It also includes the exposure of students to rural practice during their undergraduate and postgraduate training. It is followed by the provision of specialized training for the conditions in which they will work and ongoing educational support during their rural and remote practice. For these reasons, the CMA strongly encourages academic health science centres (AHSCs), provincial governments, professional associations and rural communities to work together to formally define the geographic regions for which each AHSC is responsible. The AHSCs are also encouraged to include within their mission a social contract to contribute to meeting the health needs of their rural or remote populations.

Practising physicians are committed to lifelong learning. In order to preserve a high standard of quality care to their patients, they must be knowledgeable about new clinical and technological advances in medicine; they must also continually develop advanced or additional clinical skills in, for example, obstetrics, general surgery and anaesthesia, to better serve the patients in their communities, especially when specialist services are not readily available. There are many practical and financial barriers that physicians in rural and remote communities face in obtaining and maintaining additional skills training, including housing, practice and other costs (e.g., locum tenens replacement expenses) while they are away from work. The CMA strongly encourages governments to develop and maintain mechanisms, such as compensation or additional tax relief, to reduce the barriers associated with obtaining advanced or additional skills training.

In light of these issues, the CMA recommends that

1. *Universities, governments and others encourage and fund research into criteria that predispose students to select and succeed in rural practice.*
2. *All medical students, as early as possible at the undergraduate level, be exposed to appropriately funded and accredited rural practice environments.*
3. *Medical schools develop training programs that encourage and promote the selection of rural practice as a career.*
4. *Universities work with professional associations, governments and rural communities to determine the barriers that prevent rural students from entering the profession, and take appropriate action to eliminate or reduce these barriers.*
5. *A Web site based compendium of rural experiences and electives for medical students be developed, maintained and adequately funded. Advanced skills acquisition and maintenance opportunities be provided to physicians practising in or going to rural and remote areas.*
6. *Advanced skills acquisition and maintenance opportunities be provided to physicians practising in or going to rural and remote areas.*
7. *CMA divisions and provincial/territorial governments ensure that physicians who work in rural and remote areas receive full remuneration while obtaining advanced skills, including support for the locum tenens who will replace them.*
8. *Any individual formally enrolled in a Royal College of Physicians and Surgeons of Canada or College of Family Physicians of Canada program be covered by the collective agreement of their housestaff organization.*
9. *Providers, funders and accreditors of continuing medical education for rural physicians ensure that the continuing medical education is developed in close collaboration with rural physicians and is accessible, needs-based and reflective of rural physicians' scope of practice.*
10. *Physicians who practise in rural or remote areas be given reasonable opportunities to re-enter training in a postgraduate program without any return-in-service obligations.*
11. *In order to promote mutual understanding, universities encourage teaching faculty to work in rural practices and that rural physicians be invited to teach in academic health science centres.*
12. *Medical schools develop training programs for both students and residents that encourage and promote the*

provision of skills appropriate to rural practice needs.

13. *Medical schools support rural faculty development and provide full faculty status to these individuals.*

Compensation

The CMA believes that compensation for physicians who practise in rural and remote areas must be flexible and reflect the full spectrum of professional and personal factors that are often inherent to practising and living in such a setting. These professional factors may include long working hours and the need for additional competencies to meet community needs, such as advanced obstetrics, anaesthesia and general surgery, as well as psychotherapy and chemotherapy. They may also include a high level of on-call responsibilities as well as a lack or total absence of backup from specialists, nurses and other complementary services that are usually available in an urban environment. Other challenges are professional isolation, limited opportunities for education or training, and high practice start-up costs. Also, if for a number of reasons a physician wishes to relocate to an urban setting, he or she may face billing restrictions as well as challenges in finding a replacement physician. Compensation for these factors is necessary to help retain physicians and recruit new ones. In addition, compensation should guarantee protected time off, paid continuing medical education or additional skills training, and locum tenens coverage. Any pool of locum tenens for rural and remote practice should be adequately funded and cross-jurisdictional licensure issues should be minimized.

Living in a rural or remote community can be very satisfying for many physicians and their families; however, they must usually forgo — often for an extended period of time — a number of urban advantages and amenities. These include educational, cultural, recreational and social opportunities for their spouse or partner, their children and themselves. They may also face altered family dynamics due to a decrease or significant loss of family income if there are limited or no suitable employment opportunities for their spouse or partner.

The CMA believes that all physicians should have a choice of payment options and service delivery models to reflect their needs as well as those of their patients. Physicians must receive fair and equitable remuneration and have a practice environment that allows for a reasonable quality of life. Although the CMA does not advocate one payment system for urban physicians and another for rural physicians, it believes that enhanced total compensation should be provided to physicians who work and live in rural and remote communities.

In recognition of these issues, the CMA recommends that

14. *Additional compensation to physicians working in rural and remote areas reflect the following areas: degree of isolation, level of responsibility, frequency of on-call, breadth of practice and additional skills.*
15. *In recognition of the differences among communities, payment modalities retain flexibility and reflect community needs and physician choice.*
16. *Financial incentives focus on retaining physicians currently practising in rural or remote areas and include a retention bonus based on duration of service.*
17. *Factors affecting the social and professional isolation of physicians and their families be considered in the development of compensation packages and working conditions.*
18. *Eligibility criteria for including physicians in a pool of locum tenens for rural or remote practice be developed in consultation with rural physicians.*
19. *Provincial/territorial licensing bodies establish portability of licensure for locum tenens and ensure that any fees or processes associated with licensure do not serve as barriers to interprovincial mobility.*
20. *Rural locum tenens programs be funded by provincial/territorial governments and include adequate compensation for accommodation, transportation and remuneration.*

As previously noted, some studies show that exposure to rural and remote areas during training influences students' decision to practise in those communities upon graduation. The CMA is concerned, however, that travel and accommodation costs relating to these experiences place an undue financial burden on students. In addition, most physicians in rural and remote areas are already burdened with significant patient loads and find that they have limited time and resources to act as preceptors. The CMA believes that, to ensure the ongoing viability of student rural experiences, physician preceptors should be compensated for their participation and should not incur any additional expenses, such as student or resident accommodation costs.

The CMA recommends that

21. *Costs for accommodation and travel for student and resident rural training experiences in Canada not be borne by the trainees or the preceptors.*
22. *Training programs assume responsibility for adequately remunerating preceptors in rural or remote areas.*

Work and lifestyle support issues

To retain and recruit physicians in rural and remote communities, there are issues beyond fair and adequate compensation that must be considered. It is crucial that the aforementioned working conditions, professional issues and array of personal and family-related issues be addressed. The ultimate goal should be to promote physician retention and implement measures that reduce the possibility of physician burnout.

Like most people, physicians want to balance their professional and personal responsibilities to allow for a reasonable quality of life. Physicians in rural and remote areas practise in high stress environments that can negatively affect their health and well-being; as a consequence, the standard of care to their patients can suffer. The stress is intensified by excessive work hours, limited professional backup or support (including locum tenens), limited access to special-

ists, inadequate diagnostic and treatment resources, and limited or no opportunity for vacation or personal leave. At particular risk for burnout is the physician who practises in isolation. For these reasons many physicians, when considering practice opportunities, tend to seek working conditions that will not generate an excessive toll on their non-working lives. This reinforces the need for rural and remote practice environments that facilitate a balance between physicians' professional and personal lives.

In light of these issues, the CMA recommends that

23. *Regardless of community size, there should always be at least 2 physicians available to serve the needs of the community.*
24. *Ideally, the on-call requirement for weekends never exceed 1 in 5 in any Canadian practice. (This is consistent with current CMA policy.)*
25. *Provincial/territorial governments have professional support and other mechanisms readily available to physicians who practise in rural and remote areas, such as sabbaticals and locum tenens.*
26. *Governments recognize the service of rural and remote physicians by ensuring that mechanisms exist to allow future access to practise in an urban area of their choice.*

The CMA believes that rural and remote physician retention and recruitment initiatives must address matters relating to professional isolation as well as social isolation for physicians and their families. This sense of isolation can increase when there are cultural, religious or other differences. For unattached physicians, zero tolerance and unreasonable restrictions with regard to relationships with potential patients can be disincentives to practise in rural or remote communities. Although the CMA believes that such policies and restrictions should be reviewed, the CMA encourages physicians to refer to the CMA policy *The Patient–Physician Relationship and the Sexual Abuse of Patients* and the *Code of Ethics of the Canadian Medical Association*. Also, the CMA recommends that physicians abide by any provincial/territorial policies or legislation that may currently be in place.

The medical services infrastructure in rural and remote areas is usually very different from that in urban settings. In addition to a lack of specialist services, physicians in these areas may often have to cope with a number of other factors such as limited or no appropriate diagnostic equipment or limited hospital beds. Physicians and their patients expect and deserve quality care. The diversity and needs of the populations, as well as the needs of the physicians who practise in rural and remote areas, must also be recognized and reflected in the infrastructure (e.g., demographic and geographical considerations).

The CMA recommends that

27. *A basic medical services infrastructure for rural and remote areas be defined, such as hospital beds, paramedical staff, diagnostic equipment, transportation, ready access to secondary and tertiary services, as well as information technology tools and support.*
28. *Provincial/territorial governments recognize that physicians who work in rural and remote areas need an environment that appropriately supports them in providing service to the local population.*