Recruitment and retention: consensus of the conference participants, Banff 1996

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The Society of Rural Physicians of Canada (SRPC) presented a 1-day conference at its annual meeting in Banff in April 1996. The goal was to examine the success and failure of various types of initiatives used to recruit and retain doctors in rural areas and to examine the available evidence supporting their use. Consensus was sought on the elements of a framework to create a successful program for recruiting and retaining doctors in rural and remote areas. Cochairs and conference organizers were Dr. Ken Babey and Dr. James Rourke. Conference participants included representatives from the CMA and its divisions, the College of Family Physicians of Canada, the Canadian Association of Internes and Residents, medical schools and municipalities, as well as guest speakers from the United States. The conference proceedings[1] are now available from the SRPC and are summarized here.

Dr. Keith MacLellan, president of the SRPC, introduced the conference and noted that the SRPC was formed in 1992 to address issues facing rural doctors in Canada. Through lobbying, communications, education strategies and support of rural physicians and communities in crisis, the efforts of the SRPC have already led to some action at the community, provincial and national levels. Dr. Ken Babey, SRPC secretary, noted that two of the goals of the SRPC relating to recruitment and retention are sustainable working conditions and equitable treatment for rural doctors and their communities, in terms of access to quality health care.

The keynote speaker was Mr. Graham Scott, author of the Scott report.[2] Scott was asked in 1994 to look at the issues facing small rural Ontario hospital emergency departments. This venture was commissioned by the Ontario Ministry of Health, the Ontario Hospital Association and the Ontario Medical Association, all of whom acknowledged that a problem existed but who couldn't agree on whose responsibility it was or how to tackle it. Most importantly, no one wanted to pay to solve it. Scott's mission soon grew to cover delivery of primary medical care in rural Ontario.

Although his target was Ontario, the problems Scott uncovered are generic and are faced by rural doctors across Canada and worldwide. His findings highlighted many deterrents to recruitment

and retention: the sense of abandonment felt by many rural doctors who feel that their medical associations, governments and hospitals are not supporting them on rural issues; the hemorrhaging of doctors from rural practice; the inadequacies of fee for service in the rural setting, especially as payment for on-call services in low-volume ERs; the shortage of rural surgeons and GP/FPs trained in anesthesia, emergency, obstetrics and psychiatry; the fact that the unique characteristics of rural medicine are not recognized; and the onerous on-call schedules, especially those of less than 1 in 5 in a 24-hour ER, which prevent stability of medical personnel in rural communities.

Scott noted that one reason rural medicine isn't attracting recruits is because graduates are not prepared for rural practice; rural practice is not encouraged or fully appreciated by academia. Scott also found that the additional pressures of rural medicine, the unrelenting demands and overwork faced by rural physicians, make it difficult to have a balanced lifestyle, which in turn results in burn-out and high turnover.

Obtaining CME is difficult because of lack of locum coverage and the distance to be travelled and because academic health sciences centres (AHSCs) have not understood the educational needs of rural doctors. Scott noted that Ontario's medical schools and AHSCs are not in tune with rural practice or with the urgent needs of practitioners of rural medicine. He found that although it was unintentional, these bodies contribute to the negative attitude toward rural medicine. Scott found that not enough family physicians have been trained adequately in their residency programs for practice in rural areas.

Scott recommended that rural physicians receive adequate compensation, including payment for CME and holiday support; that the professional limitations of rural practice be recognized through special CME programs; and that supplementary programs be available for training and retraining, along with ready support from specialists and AHSCs.

Reform of medical education as it pertains to rural medical training must acknowledge and serve rural medicine. The focus of the medical education system should be reoriented toward rural medicine issues, and rural medicine should be a required component of both undergraduate training and residency in family practice, as well as of certain key specialities.

A distinguished list of speakers followed Scott.* They presented overviews of selected programs that have been developed to support the needs of rural medicine. Their presentations illustrated the successes and failures of different incentives, rural medical training

initiatives and CME programs that are in operation or are being developed.

Recommendations

After the formal presentations, conference participants† were divided into three groups to address (1) education, (2) practice sustainability and (3) ways in which to implement any consensus reached.

Education

The consensus was that education is the key to solving the problem of recruitment and retention of rural physicians. Appropriate education would involve ongoing training suitable for practice in rural areas, from undergraduate medical school and into practice, to meet the needs of rural areas and to meet the educational needs of rural doctors. The group had 10 key recommendations for medical schools.

1. An office of rural medicine should be established in every medical school that trains rural physicians. Its role would be to develop and coordinate medical training for rural doctors.
2. WONCA standards[3] should be followed in accrediting rural training.
3. Outreach programs aimed at high school students should be implemented to encourage and identify students interested in rural practice.
4. Exposure to rural medicine should occur early on in undergraduate medical school and should be mandatory.
5. Optional additional training in rural medicine should be available.
6. The rural background of candidates should be taken into consideration in the selection of students by medical schools.
7. Medical students who have committed themselves to rural practice should have access to bursaries.
8. Recruitment of rural doctors to the faculty -- for the teaching of rural medicine and to ensure the quality of rural preceptors -- should be improved.
9. Regional needs should be evaluated, and evidence-based approaches should be used to do so.
10. The profile of those rural doctors who train residents in rural medicine should be raised.

The group also made 7 recommendations for postgraduate training.

1. A minimum of 2 months of rural training should be mandatory for all family medicine residents.

2. More rural training streams should be developed.
3. More positions for special skills training should be developed.
4. Physicians in specialty training programs should have greater exposure to rural medicine.
5. Continuing medical education should be driven by the needs of rural physicians.
6. More re-entry positions for specialty training should be created. A supplementary salary should be considered.
7. Continuing education throughout the career of every rural physician should be promoted and supported.

Sustainable practice

If physicians are to continue to practise in rural areas, their working conditions must be conducive to encouraging them to stay. The group had 9 recommendations for sustainable practice conditions.

1. Physicians and their communities must interact regularly to discuss the problems and needs of rural doctors. A third party moderator could be used to help facilitate the process.
2. Rural physicians should be offered an option as to how they are paid, which would recognize the years they have worked, the amount and type of on-call work they do and the scope of their practices.
3. There should be contingencies to compensate for any professional or personal disruption related to the practice of rural medicine.
4. Adequate CME should be accessible both individually (including locum support) and as a group, through telemedicine and electronic media.
5. Rural doctors should have "ready" access to specialists. To facilitate access, electronic consultations and other communications systems should be further developed for rural doctors. Mechanisms for remuneration for these services should be put in place.
6. Locum relief is needed for all rural communities.
7. A minimum of 5 physicians are needed to share call in communities that have emergency services. A minimum of 3 physicians are needed in other areas.
8. Families should be given opportunities to get away for a holiday. A minimum of 6 weeks per year is recommended, and there should be travel subsidies for rural doctors practising in remote areas.

Managing the implementation of any consensus

The group was unable to come up with any specific recommendations on how to manage and implement a rural health

care strategy, but the group did identify several areas that need to be addressed if a rural health strategy is to come into being.

Any plan to solve the problem of recruitment and retention of rural doctors must be comprehensive, flexible and amenable to implementation according to each province and territory's focus. It must also outline the range of services that will be needed in all areas of rural medicine and address the quality of access to good health care by rural residents.

As Graham Scott said in his introductory remarks to the conference, the time for stopgap measures and fact finders is past. Action is required. The need for financial recognition, reasonable call schedules, quality education aimed at the needs of rural medicine and support for rural physicians in both their private and professionals lives must be met to solve the chronic problems of recruitment and retention of Canada's rural doctors.

References

1. Squires BT, recording secretary. *Banff Consensus Conference 1996: recruiting and retaining rural physicians* [unpublished proceedings]. Available from SRPC.
2. Scott GWS: *Report of the fact finder on the issue of small/rural hospital emergency department physician service*. Toronto: Ontario Ministry of Health, Ontario Hospital Association, Ontario Medical Association, 1995.
3. *Policy on training for rural practice*. World Organisation of Family Doctors (WONCA): 1995. Available from SRPC or online at http://www.cfpc.ca/carmen/woncapol.htm.

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*__Speakers:__ Ken Babey, MD, secretary, SRPC; Ian Bowmer, MD, dean, Faculty of Medicine, Memorial University of Newfoundland; Dale Dewar, MD, director, Northern Health Service Saskatchewan; Fred French, MD, cochair, Rural Physicians Committee, Newfoundland and Labrador Medical Association, and vice-president, SRPC; Sandro Galea, MD, executive secretary, Canadian Association of Internes and Residents; Jack Geller, PhD, director, Office of Rural Health, University of North Dakota; Margaret Kruk, MD, executive member at large, Provincial Association of Interns and Residents of Ontario; Michael Laskowski, PhD, professor and director, Washington, Alaska, Montana and Idaho (WAMI) Medical Program, University of Idaho; George Macey, DDS, past president, Northwestern Ontario Associated Chambers of Commerce, and chair, Marathon Physicians Crisis Coalition; Keith MacLellan, MD, president, SRPC; Larry Ohlhauser, chair, Alberta Rural Action Plan Coordinating Committee, and registrar, College of Physicians and Surgeons of Alberta; David P. O'Neill, MD, organizing chair, Section of Rural Medicine, Alberta Medical Association; James Rourke, MD, CCFP(EM), founding chair, Section of Rural Practice, Ontario Medical Association; Graham W.S. Scott, QC, author, *Report of the Fact Finder on the Issue of Small/Rural Hospital Emergency Department Physician Service*, and partner, McMillan Binch; Wally Swentko, PhD, program director, Rural Physician Associate Program, University of Minnesota; Carl Whiteside, MD, director, Community Based Residency Training Program, University of British Columbia.

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†__Participants__: In addition to the speakers, the following people were participants

at the conference: Geoffrey S. Battersby, MD, Rural Physicians Committee, British Columbia Medical Association; Judith Dowler, manager, Health Human Resources Unit, Health Services Directorate, Health Canada; Brenda Gilboe, Alberta Medical Association; Verlin Gwin, director, Health Policy Analysis, Alberta Medical Association; Lisa Harris, director, CME Program, Rural and Isolated Physicians, Ontario Medical Association; Norm Hatlevik, director, Population Health Board Development; Hal Irvine, MD, rural physician; Merv Johnson, MD, chair, Committee on Rural Practice, Saskatchewan Medical Association; Chuck MacNeil, MD, Medical Association of the Northwest Territories; Eileen Mahood, director, Northern Programs and Planning, Underserviced Area Program, Ontario Ministry of Health; Frank Peters, recruiter and coordinator, Medical Society of Nova Scotia; Raymond Pong, PhD, Northern Health Human Resources Research Unit, Laurentian University; Heather Stewart, Ontario Hospital Association; Dan Reid, MD, advisor on physician affairs, Nova Scotia Department of Health; Bruce T. Squires, MBA, executive director, Newfoundland and Labrador Medical Association; Michael Thoburn, MD, executive director, Professional Services, Ontario Medical Association; David Topps, MD, rural physician; Eric Wasylenko, MD, Physician Resource Planning Group, Alberta Medical Association; Mamoru Watanabe, MD, chair, Committee on Physician Resources, Canadian Medical Association; Judy Watts, executive director, Baffin Regional Hospital, Government of Northwest Territories; Jeff Young, Department of Health of Newfoundland and Labrador.

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