

NEEDS OF RURAL PHYSICIANS

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SUMMARY

In order to assure sustainable physician-based health care services in a rural community, the David Thompson Regional Health Authority must ensure that there is enough volume of a wide enough range of services to allow sufficient funding for enough doctors to be able to support each other in a reasonable call schedule.

INTRODUCTION

The David Thompson Health Region is fortunate to have a strong group of rural physicians providing a wide range of services. Underserved areas remain; however the profound loss of rural physician services being experienced in Ontario and many American states is not present in most of our region([1](#)).

With changes brought about through health care reform, it is possible that some areas of the David Thompson Health Region may inadvertently be without physician resources. The needs of rural physicians must be considered in any decisions regarding changes to the current health care system. The purpose of this document is to outline the needs of rural physicians to the Regional Health Authority.

This document represents a consensus of opinion derived from semi-structured interviews held with 18 rural physicians practicing in 8 rural communities within the David Thompson Health Care Region.

Physician needs can be organised into three main areas:

- Professional satisfaction
- Financial remuneration
- Lifestyle

PROFESSIONAL SATISFACTION

Many primary care doctors who come to rural areas have received extra training in various aspects of medicine that enables them to provide additional technical services

to their patients in areas such as obstetrics, surgery, anesthesia or emergency medicine (2). Professional satisfaction comes from being able to use successfully the skills and knowledge one has to offer. Higgins found that the most frequently expressed reason for entering rural practice was the opportunity for a variety of medical experiences (2), and the interviewees for this document confirmed this. Few rural physicians would be happy working solely in their clinics without the variety and challenges and rewards that comes from caring for hospital patients. If hospital services in a community are significantly cut back then some of the physicians in that community may leave.

FINANCIAL REMUNERATION

Another need of physicians is to receive adequate remuneration for their services. Most of us in rural practice derive a significant portion of our income from services provided in hospitals. If significant services are cut from a hospital in a community, the physicians may find that the remaining services do not allow them sufficient income in the current fee-for-vice funding model. Under the current funding system, hospital work is generally more lucrative than clinic based work. Most physicians polled stated that 40 - 50% of their income is derived from hospital based services, and that they could not afford their clinic overhead expenses without this income. Twelve of 16 physicians who were asked believed that their ability to remain financially viable would be compromised if existing services were cut from their community. Again, physicians may leave the community for this reason.

LIFESTYLE

Physicians need to enjoy a reasonable lifestyle that allows adequate time away from the demands of medical practice for family and leisure. The practice of medicine involves a 24 hour commitment to one's patients. If a physician is unable to personally provide 24 hour service, s/he ethically must make arrangements for another physician to assist in this regard. Virtually all physicians do this by "sharing call" with a group of physicians. In order to enjoy a reasonable lifestyle, there must be enough physicians in the group so that the call commitment does not become extraordinarily onerous.

"Taking call" means being responsible for all urgent or emergent medical problems which arise, in addition to providing the services one usually does. Taking call results in significant loss of time available for family responsibilities and leisure activities as well as significant disruption of sleep. This is often done with little remuneration; one can be awakened several times through the night for telephone assessment and advice and receive no compensation whatsoever. Higgins found the heavy workload was a major reason for physicians leaving rural practices. Of the 18 rural physicians polled in preparing this document, only one was willing to work a call schedule of less than 1 in 4, and only 5 were willing to take call as often as 1 in 4.

Many stressful lifestyle issues arise in rural practice other than the responsibility for emergency call. There is no anonymity in a small town, and often physicians feel they have little personal time or privacy. Patients or colleagues may call for assistance at any

time, even when one is not on call. The wide range of skills required to provide quality care in a rural setting requires more continuing medical education in order to keep current. Single physicians may have a significant lack of social opportunities, and spouses may be discontent in a rural setting. These issues contribute to the difficulty attracting and retaining physicians in rural practice.

The rural physicians interviewed for this document expressed significant concern and anxiety that health care reform may make their already stressful situations worse. Areas currently underserved are having difficulty recruiting physicians to help with their heavy workload because of uncertainty for the future. Physicians are concerned that if hospital services are cut and other health professionals take over managing less complex cases, they will have to work harder with fewer resources providing home care to more complex cases. Under the current fee-for-service funding model, the result would be more work for less pay. Commuting to other communities to provide hospital care will increase stress while adding more time pressures to one's day. We anticipate more frustration struggling as patient advocates to obtain needed services for our patients. Already it is not unusual to spend one or two hours on the telephone trying to arrange specialized care for a patient and this will only get worse with the next round of acute care bed closures.

DOMINO EFFECT

If any of the three legs of the tripod of physician needs (professional satisfaction, financial remuneration, lifestyle) is eroded the stability of physician-based resources is compromised.

For example, in Sundre there are five physicians who provide 24 hour emergency and obstetrical services through the Sundre General Hospital. Two of these physicians are a married couple, and they plan to leave Sundre in May 1995 because the call schedule of 2 in 5 is too heavy for them, as well as other lifestyle issues. If significant services are cut from the hospital (such as obstetrics and acute inpatient care), it will be difficult to recruit replacements due to both lack of opportunity for medical experience and because of insufficient volume of services to generate adequate income. The remaining physicians will be unable to cope with the demands of responding to our many emergencies on a 1 in 3 roster. The potential result of what may appear to be a reasonable reduction in services is a domino effect ending in loss of all physician-based health care in the community. This domino effect has already taken its toll in communities such as Provost, Elnora, and Eckville.

1. *Existing Physician Services in Alberta Health Care Region Six*. Prepared by the Steering Committee of the Regional Medical Staff of Alberta Health Care Region 6 at the Invitation of the Regional Health Authority. August 21, 1994

2. Higgins, G.L. and Szafran, O. *Profile of Rural Physicians in Alberta*. Can Fam. Physician 1990. 36:1275- 1280