



The incentive gravy train

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When a community is trying to attract industry it seems many things are possible. When they are trying to attract doctors, although there have been some successes, by and large a successful model for recruitment and retention has not emerged. Why is this?

Although communities unquestionably require and are thankful for the presence of physicians, the attitude toward providing concrete incentives out of community capital is more complex.

By many community standards the income of physicians is well above average, particularly rural averages. They are perceived as being the beneficiaries (as they are) of generous government subsidies in both education and practice. No matter that in spite of all this new physicians are graduating buried in mountains of debt, or that rural physicians compare on the earn-

reluctance?) of rural communities to expend scarce community resources to further subsidize physicians. Contrast this to the million dollars raised in record time by our community to purchase a CT scanner for the hospital. There is perhaps some wisdom in their choices. The CT scanner may still be in the community in 5 years, the physician may well not!

It is becoming clear to me that incentives are a win-lose proposition. On the positive side of the ledger they work to attract warm bodies into cold gaps in service. They give welcome respite to those who have been overworking to try to bridge to better times, but they conveniently avoid probing too deeply into the motivations of the candidates. Along the way many compromises are made. So what if the candidate does not plan to practise obstetrics — at least the ED is covered! It doesn't take too many turns of this wheel before the vision of "polyvalence" fades and is replaced by expediency.

Maybe it is time to put an end to "signing bonuses" and the incentive gravy train, and integrate differentials related to the full-service profile that characterizes rural practice. This way, all rural physicians see their commitment valued, and new candidates can decide if they are up to the challenge.

This might mean one pay scale for those who function in one dimension, another for those who function in several (such as office and ED) and yet another for true rural "polyvalence" for those who cover all the bases (office/ED/admissions/obstetrics/etc.) — all weighted, of course, to the degree of involvement in each sector.

Anyone interested?

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ing ladder to the office manager of your typical high tech firm. What is important is that perception inevitably becomes a barrier to providing further support to new physicians, this time out of the local purse.

Many mayors of small communities whom I met during my time at Health Canada, were seeking federal subsidies to help them provide "turnkey" solutions to new graduates, in the form of fully staffed and equipped offices. They were clearly reflecting the inability (or