Recruitment: a perennial question

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I have been a rural generalist physician for decades, and the interest in recruitment is no less today than when I entered practice. This issue of the *CJRM* is dedicated to the topic, and no wonder. In 2015, only 8% of physicians were practising in rural regions of Canada, where 18% of the population live.[1]

A decade earlier, 10% of physicians practised rurally.[2] Why are we failing to meet the needs of some of the most disadvantaged populations in our country?

Some of the problems are identified in Mathews, Ryan and Samarasena's study of Memorial University of Newfoundland (MUN) medical graduates published in this issue (page 54). Despite having above-average results for Canadian medical schools, MUN's rural output has decreased, from 14% for 1989–1998 graduates to 9% for 1999–2008 graduates. Not surprisingly, specialty training was negatively associated with rural practice, and having a rural background was found to be positively related to rural practice. However, it cannot be just about recruiting students of rural origin, because even in Newfoundland and Labrador most students with a rural background end up practising in urban areas. One new finding was that rural family medicine training (at MUN) was associated with rural practice. We need to have family practice residents train close to where society needs them to work.

Witt's work in Manitoba (page 43) delves into the issues of incentives. We know that rural income is an attraction that counterbalances the workload expectations. Witt used the discrete choice experiment approach to value some stressors of rural practice. An additional hour of work was valued at $183. More can be done with this technique in describing the value of the burdens of rural medical work.

A group of medical students from Western University, Robinson and colleagues, publish in this issue (page 62) a paper on a medical school outreach and mentorship program for rural secondary school students. It is a little early to say whether the pilot program they describe will increase enrolment of rural students in medical school, much less increase output of rural practitioners at the Schulich School of Medicine and Dentistry. However, it is not too early to support such experiments in doing something at the medical school level to meet society's needs.

There is a lot more to be done for rural medicine. We need to determine why the bright lights of the city attract students of rural origin. We need to know the psychological causes for urban students to go against the grain and choose rural practice. We need to better understand why some universities are better at producing rural-practising graduates than others.

Finally, we need, like the medical students from Western, to act on it.

REFERENCES

1. CMA Masterfile: Physicians within and outside Census Metropolitan Areas (CMA) and Census Agglomerations (CA) — 2015 [tables]. Ottawa: Canadian Medical Association; 2015. Available: www.cma.ca/Assets/assets-library/document/en/advocacy/13cma_ca_outside.pdf (accessed 2017 Feb. 6).
2. Hutten-Czapski P. Rural healthcare — the chasm not crossed. Presentation to the Commission on the Future of Health Care in Canada; 2002 Apr. 11; Sudbury (ON).