



**A BLUEPRINT FOR ADDRESSING PHYSICIAN
RECRUITMENT AND RETENTION IN RURAL AND
REMOTE ONTARIO**

A Joint Project Convened by the Ontario Regional Committee of the [Society of Rural Physicians of Canada](#) and the [Professional Association of Internes and Residents of Ontario](#)

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EXECUTIVE SUMMARY

The past decade has witnessed a dramatic increase in awareness of the difficulties of providing medical care in rural and remote areas. This has been accompanied by the development of various piecemeal initiatives in an attempt to address the problems of recruiting and retaining physicians. Because these initiatives have been implemented with inadequate attention to their feasibility, effectiveness and how they fit and work together in an integrated plan, they have been unsuccessful in redressing the mounting imbalance between physician resources and community need.

We know that Ontario's rural and small town population continues to increase (by over 10% in the last decade), while the number of doctors in rural and remote Ontario continues to decline (by over 10% between 1994 and 1997 alone). There are a variety of factors which account for the current obstacles to effective recruitment and sustainable retention of physicians. Ultimately, the public policy task is to develop a comprehensive, integrated package of measures which will remove these obstacles. Failure to take urgent action to address the current imbalance will result in serious further decline in the number of rural generalist and specialist physicians, and the vital services that they provide.

Ultimately, the fact remains that the well-trained generalist rural physician provides the core of medical care to just under one-quarter of the population of this province, spanning the vast majority of Ontario's geographic area. The Ministry of Health itself has acknowledged that access to quality health care in Rural and Northern Ontario will require "improved strategies for training, recruiting, retaining and supporting rural health providers" and "facilitating education and training an adequate number of rural physicians."

Recognizing the need for a comprehensive Blueprint to address physician recruitment and retention in Ontario's Rural and Northern communities, a group of knowledgeable and committed representatives of rural medicine and medical training met in April, 1998 under the joint sponsorship of the Ontario Regional Committee of the Society of Rural Physicians of Canada and the Professional Association of Internes and Residents of Ontario (PAIRO). Over the next seven months, drawing on its collective expertise and experience, the group worked together to produce this Blueprint.

The Blueprint is intended to provide a comprehensive and integrated package of measures which, if implemented as a whole, would address the need for effective and sustainable physician recruitment and retention in remote and rural communities.

We begin with an overview of the extent and magnitude of the present problem, including underlying demographic trends (both in the general population at large and in the physician

population in particular) as well as a summary of the current needs for physician services.

We then turn to the heart of the Blueprint. In twenty seven key areas involving rural medical education and rural medical practice, the Blueprint identifies the present obstacles and barriers to improved recruitment and retention, explains why present strategies have not worked, reviews those strategies which have demonstrated success in other jurisdictions, and recommends specific measures for implementation.

One of the key features of this Blueprint lies in its comprehensive and integrated approach. The Blueprint commences with key foundation issues, examining the medical education life cycle of the rural doctor. This begins as early as secondary school education, through selection to medical school, undergraduate medical education, residency training, re-entry and advanced skills training for established physicians, training rural physicians as medical educators and continuing medical education. The goal is to remove barriers and reduce disincentives so that training opportunities for rural medical practice can be optimized, to increase the number of choice points for individuals to enter the field of rural medicine and develop and enhance their skills, and to equip future and established rural physicians so that they can provide the broad scope of care required of them.

After building a solid foundation, the Blueprint then addresses the structure: the life cycle of the practicing rural doctor, both generalist and specialist. It highlights the many existing barriers and disincentives, recommending viable strategies to overcome them. The discussion of rural practice includes remuneration and various working conditions, rural medical practice supports (including specialist back-up, medical informatics, telephone triage, licensure issues, and the role of allied health professionals) and spousal and family concerns. Here, the goal is to ensure that the resulting structure for rural practice is free of the perpetual cycle of physician burnout, and the resulting crisis of failed physician recruitment and retention.

Finally, the Blueprint turns to the infrastructure needed to implement and sustain successful recruitment and retention measures, including a new Rural and Remote Areas Program. To be workable, this new structure must be as simple, responsive, and transparent as the Blueprint is comprehensive and integrated.

The unifying principles of this document strive to create sustainable working conditions for rural doctors, and provide equitable health care for rural citizens. The hope is to develop centres of medical excellence throughout Rural and Northern Ontario. Only then will the access to quality care be a sustainable reality.

As with any Blueprint, there are many groups whose participation is essential to building a sound structure, in this case a new way of recruiting and retaining physicians. The

participants in the preparation of this Blueprint are hopeful that it will provide the impetus to allow all of these groups (including government, the medical profession and its associations, communities and community organizations, universities, hospitals and municipalities) to work together to build sustainable working conditions for rural physicians, and provide equitable health care for all Ontario's citizens.

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I Introduction

On April 4th and 5th, 1998, at the invitation of the Ontario Regional Committee of the Society of Rural Physicians of Canada (SRPC) and PAIRO (Professional Association of Internes and Residents of Ontario), a group of physicians in practise and training, medical students and other experts¹ met to develop a Blueprint of strategies and initiatives needed to remedy the longstanding problem of recruiting and retaining physicians in Northern and Rural communities. The group focused on practical solutions, asking practical questions of what has worked, and what has not worked, in Ontario and in other jurisdictions.

In fact, in June, 1997, the Ontario Ministry of Health released its policy document, Access to Quality Care in Rural and Northern Ontario - The Rural and Northern Health Care Framework. That document states that implementation of the Rural and Northern Health Care Framework will require "improved strategies for training, recruiting, retaining and supporting rural health providers including physicians, specialists and specially trained nurses" and "facilitating education and training an adequate number of rural physicians".

As a result, the group believed that this was now an opportune time to provide the Government and various other stakeholders (including educators, hospitals, communities and physicians) with a roadmap for more effective recruitment, retention, support and education initiatives. This seems particularly timely, given the increasing number of designated underserved communities in rural Ontario, coupled with the absence of any significant change in the Government's traditional piecemeal approach and programs.

In this context, the recommendations that follow lay out a Blueprint for a comprehensive and integrated package of measures, beginning with initial recruitment to medical school, through residency programs that effectively train physicians for rural and remote practice, and measures to ensure that established physicians are provided with the support and resources required to break the perpetual cycle of burn-out and crisis which has plagued Northern and Rural areas for decades.

Effective measures must also take account of underlying demographic trends, including the aging physician population currently serving Northern and Rural Ontario, as well as the reality that new physicians (including an ever increasing number of female physicians who are more likely to practise primary care) are increasingly concerned with maintaining a sustainable practice by balancing lifestyle and family with work demands.²

Ultimately, accessible, quality medical care is dependent on an adequate number of appropriately trained and distributed physicians or "critical mass"³ working within an integrated, supported health care system. The need for a large enough critical mass of

physicians in rural communities has been recognized by various reports in this area, including the Scott⁴ and NAWG reports.⁵

Closely tied to the need for self-sufficiency and critical mass is the objective of self-sustaining "local centres of excellence". The term "centres of excellence" has most often been equated with the cluster of specialty/high tech services that have evolved in large cities and around Academic Health Science Centres. However, many Rural and Northern area facilities have always been or have become centres of excellence. That is to say that the care given there, within their scope of practice, has been exemplary and the outcomes as good or better than in large high tech centres. This has been achieved through the diligence of the health care providers and with the support and vision of their local communities. Key features found in these local centres of excellence include the maintenance of a critical mass of physicians through their participation in teaching, organization, planning and contribution to policy generation.

Why talk about rural centres of excellence? Because it allows the vision of rural health care to be "turned on its head". Rather than the goal of trying to entice physicians to go to communities that are underserved, disadvantaged and struggling, the goal becomes the highest quality medical care through the provision of critical mass physician staffing adequate for professional and administrative activity, education (of students, residents, nurse practitioners as well as continuing medical education), locum provision, research and acceptable lifestyle.

As has been repeatedly emphasized, and repeated since the recognition of the need to improve access to rural medical services, "recruitment and retention will no longer be a problem, if we make it a job someone would want".⁶

How this could be done is the subject of this Blueprint.

1. See Appendix 1 for a list of participants.

2. See for example, Pong and Reamy, "Physician Workforce Composition By Gender: Implications for Managing Physician Supply", presented at the Fourth FICOSSER General Conference, Cuernavaca, Mexico: July 28-30, 1998.

Pong, "Changing Sex Composition in the Canadian Physician Workforce: Implications for Health Care", paper presented at the Canadian Population Society Annual Meeting, St. John's, Newfoundland, July 9-11, 1997.

3. "Critical Mass to the minimum number of physicians in a particular specialty required within a given geographical region to allow for acceptable provision of service to patients, as well as adequate professional support for existing physicians in the area. This takes into account such factors as call requirements and the minimum volume of work required to maintain competence and a viable practice. Critical mass requirements for certain specialties and geographic areas may exceed those suggested by recommended physician / population ratios. In a rural and remote setting, for instance, physician requirements may be larger to improve retention rates and to counter the outward migration of physicians resulting from unmanageable workloads." (Report of the National Ad Hoc Working Group on Physician Resource Planning, entitled Physician Resource Planning in Canada, 1995).

4. Scott, report of the Factfinder on the Issue of: Small/Rural Emergency Department Physician Service, a Report commissioned by Ontario Ministry of Health, Ontario Hospital Association, Ontario Medical Association, Toronto, March 1995.

5. Report of the National Ad Hoc Working Group on Physician Resource Planning, entitled Physician Resource Planning in Canada,

1995.

6. Fletcher, "Physician Manpower: Solving the Problem", a paper presented to the Honourable Ruth Grier, Minister of Health and her staff.

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A. Introduction 

II DEMOGRAPHIC OVERVIEW

A. INTRODUCTION

By the 1970's, many rural "baby boomers" had left rural Ontario to find jobs in the cities. However, baby boomers are now increasingly moving back to rural areas. This is expected to peak the rural population by the mid 2010's, producing peak rural health care demands as baby boomers age.⁷

Meanwhile, current trends suggest that there may be few physicians left in rural areas to care for that population. Traditionally, the capacity of family practice programs across the country to produce rural physicians has been low. The percentage of certificants of the College of Family Physicians of Canada in Ontario practising with a rural address in 1998 is only 7.9%. The low number of family physicians entering rural practice, combined with attrition of existing rural physicians to retirement, specialist residencies, urban areas and abroad, resulted in a drop in rural Ontario GP/FPs numbers between 1994 and 1997 of 12% (138 physicians). Rural specialists experienced a similar percentage decline.

This worrisome trend is compounded by changes in medical care delivery. Younger physicians are increasingly unwilling to tolerate the excessive workload and on-call responsibilities that have often led to burn-out of their established physician colleagues, particularly given the increasing number of physicians - both male and female - committed to balancing work with family and personal commitments. New family physicians are also less likely to be trained to practise special skills needed in rural areas, such as anesthesia, obstetrics and surgery. Unfortunately, current training structures create impediments for practising and aspiring rural physicians to obtain training and certification in these special skills.

To begin to simply level off this decline in rural physician numbers, the output of training programs in the production of rural physicians would have to increase by 15% of all Ontario family practice graduates (i.e. at least 35 additional physicians/year). When one factors in the existing shortfall of rural physicians, practice patterns of newer physicians, and demographic changes in rural Ontario, it is clear that even such a significant change would be the bare minimum, and that any delay in implementing a comprehensive and integrated package of recruitment and retention measures will increase the enormity of the problem.

7. Foot, Boom, Bust and Echo: How to Profit from the Coming Demographic Shift, 1996.

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B. Rural and Northern Population and Geography 

II DEMOGRAPHIC OVERVIEW

B. RURAL AND NORTHERN POPULATION AND GEOGRAPHY

Ontario has a population of 10,753,573, with a geographic area of 1.1 million square kilometers. Just over 23% of Ontario's population lives in towns less than 10,000 people.

The population and geography of Ontario's different regions (Northeast, Northwest, East, Central East, Central West, and Southwest: See Maps & Tables, Appendix 2-18) are very different. In most of Northern Ontario the population is very sparse and separated by enormous distances. Distance, often complicated by winter driving or flying conditions, provides a major access barrier for the Northern population. In addition, most of Ontario's First Nations' population resides in Northern Ontario and generally has poor health outcome measures. Even the large cities in Northern Ontario are small compared to those in Southern Ontario.

Although Southern Ontario does not involve the same distances as exist in the North, nonetheless, some parts of Southern Ontario are very rural (whatever the specific definition, it is fair to say that approximately 40% of the population of Southwestern Ontario can be considered rural).


Compared with their urban counterparts, rural people are more likely to be employed in high-risk occupations including mining, farming, fishing or logging. Educational status and family income are lower and the average age is higher. Illness and injury patterns, and social context and support are also considerably different.

Like people everywhere, Rural and Northern Ontarians need access to primary care services by family physicians, emergency medical care within a reasonable time and distance, local low risk maternity/birth services, general specialist care in mid-sized regional communities and system-wide access to tertiary and quaternary care provided in large urban centres.

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C. Rural and Northern Community Needs
for Primary and Hospital Care 

II DEMOGRAPHIC OVERVIEW

C. RURAL AND NORTHERN COMMUNITY NEEDS FOR PRIMARY AND HOSPITAL CARE

To provide reasonable access to quality care, an equitable distribution of family physicians is needed. Even a uniform distribution of family physicians per population may underestimate the number of family physicians that are actually required in Rural and Northern areas. The fact is that many family physicians in Rural and Northern areas are much more actively involved in hospital responsibilities than their urban counterparts, leaving less time for office-based primary care.

As well, many family physicians in Rural and Northern areas need to provide more complex office and hospital-based patient care than their urban counterparts, because of limited or distant access to specialist care. Furthermore, as noted above, in smaller communities, a critical mass of physicians is required in order to provide sustainable working conditions.

Turning to hospital-based primary care, it is important to recognize that, despite the current restructuring and consolidation of small hospital services, family physicians will continue to play a large in-hospital role in Rural and Northern areas. In most Rural and Northern Ontario communities, emergency and in-hospital care for patients with multiple trauma, myocardial infarction and a wide variety of minor and major conditions is provided mainly by family physicians. In these small active hospitals family physicians deliver babies and provide anaesthesia services. There will remain, particularly at B-level hospitals⁸ a critical need to maintain a sufficient number of family physicians with advanced skills, such as anaesthesia, surgery and advanced obstetrical skills, to ensure availability of these crucial medical services.

Even at C-level hospitals⁹, particularly in Northern Ontario, family physicians will continue to need to play a major role in providing many services which in Southern urban centres are provided largely by specialists.

Clearly, by any measures, more family physicians are needed for Rural and Northern Ontario. In many Northern Ontario communities, including the larger cities, it is still difficult for people to find a family doctor. In Southwestern Ontario the problem continues to grow, with almost every community outside of London needing significantly more family physicians¹⁰. Much of Central West Ontario outside of Hamilton-Wentworth is similarly underserved as are some communities in East and Central East.

As to hospital based services, there is a developing shortage of family physicians doing emergency department work, anæsthesia and attending births. Licensing changes requiring certification of family medicine or specialty training prior to licensure contributed to the small hospital emergency department medical care shortage that developed earlier this decade. This became a crisis in some rural communities, prior to the move to sessional payments following the recommendations of the 1995 Scott Report¹¹,

which did stabilize the number of physicians providing emergency medical services in small rural hospitals. Nonetheless, in some communities in Southwestern Ontario, there is a renewed crisis, partly as a result of the loss of the ability for licensed residents to practise outside of their training programs at small hospital emergency departments.

Between 1988 and 1995, the number of hospitals providing obstetrical services declined, and the number of family physicians providing these services dropped 17%. Similarly over the same period, the number of GP anæsthesists dropped 24%, reducing the availability of anæsthesia services, particularly outside of regular hours.¹² There is a clear need for more family physicians to attend births and to provide GP anæsthesia and do emergency department shifts in small, active hospitals (B-level hospitals) throughout Rural and Northern Ontario. As well there is a need for more family physicians to attend births and do emergency department shifts in both B-level and C-level hospitals in larger communities in Rural and Northern Ontario.

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D. Rural and Northern Community Needs for
Specialists 

II DEMOGRAPHIC OVERVIEW

D. RURAL AND NORTHERN NEEDS FOR SPECIALISTS

The general surgeon has been the dominant specialist in most small hospitals, providing a broad spectrum of surgical care from trauma to caesarean sections. Large B level hospitals require general internal medicine specialists and at least visiting service from radiologists and psychiatrist services. C level facilities, functioning as regional support hospitals require a complement of general specialists including internal medicine, obs/gyn, paediatrics and psychiatry. Depending on need, they may also require subspecialty services such as otolaryngology, orthopaedics, cardiology and gastroenterology. An integrated program that facilitates transfer of more difficult cases to a higher level of care and provides information and clinical support to the lower levels of care is urgently needed. Both B and C level Rural and Northern hospitals continue to have difficulty recruiting adequate numbers of specialists. This situation is made worse by the advancing age of the present cohort of rural general surgeons. Psychiatry has always been and remains one of the most maldistributed of all specialty fields in Ontario.¹³

13. The Population per psychiatrist ratio in Northern Ontario is 16 972. By way of comparison, Ottawa-Carleton has a 3031 population per psychiatrist ratio.

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C. Rural and Northern Community Needs for Primary and
Hospital Care

III SOLUTIONS

We turn now to the core of this Blueprint, our recommendations for program changes and new programs across the entire medical life cycle continuum. Section A focuses on the full range of measures needed in medical education for rural practice, from the period before medical school through to continuing medical education and retraining opportunities for established physicians. Section B turns to a variety of key reforms needed to recruit, and more importantly support and retain, both new and established physicians in rural practice.

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D. Rural and Northern Needs for Specialists

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A. Medical Education 

III SOLUTIONS

A. MEDICAL EDUCATION

The uniqueness of rural practice¹⁴, together with the need for rural physicians, highlights the critical importance of education for rural practice. "Education for rural medical practice is a continuum that starts before medical school and extends to life-long practice-based continuing medical education. This process needs to be developed and supported at each stage as part of the goal of providing high quality rural medical care."¹⁵

Sustainability of human resources for rural medical practice will be achieved when medicine attracts a sufficient number of individuals who:

- a. find rural lifestyles enjoyable and desirable and
- b. find rural medical practice exciting and fulfilling
- c. find training for rural medical practice available, appropriate and respected

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III SOLUTIONS

A. MEDICAL EDUCATION

1. Before Medical School: High School

While the literature is not conclusive, there is support for the proposition that early attempts to interest high school students in rural areas in a medical career can result in those individuals becoming rural physicians. There is also evidence that presentation of careers in rural health care as an attractive career option to high school students can have a positive impact¹⁶. As one participant noted, "the best fertilizer is a farmer's footprint".

Longstanding examples of successful programs include the Memorial University Med Quest Program, the University of Missouri-Kansas City School of Medicine talent-identification program (TIP) and the University of Alabama Biomedical Sciences Prep Program (Bioprep). A similar program may well be successful in attracting non-rural students to rural practice.¹⁷


Several universities and organizations have also developed video packages and other counseling aids that can be presented at rural high schools to encourage students to pursue higher education and medical education in particular.

Recommendations:

1. A rural recruitment program should be organized and supported by universities and the Provincial Government. This may be best achieved through high school visits by community physicians and by residents/medical students who are themselves training on rural rotations or in rural programs.
2. There should be a university based health science week/day to which interested rural high school students would be invited (not unlike a basketball or hockey camp).
3. Local school boards should direct career counselors to encourage rural students to develop an interest in medicine as a career, and proactively identify students with an aptitude for or potential interest in medicine. Some innovative medical school recruitment programs (for example, the Med Quest Program in Newfoundland) place particular emphasis on identifying potential medical students from rural areas and assist them in applying and preparing for medical school.
4. High school work study placements and summer student placements in rural hospitals with rural physicians should be encouraged, and made available to interested high school students and encouraged.

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A. Medical Education

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A. 2. Pre-Medical Undergraduate Rural Exposure
to Rural Medical Experiences 

III SOLUTIONS

A. MEDICAL EDUCATION

2. Pre-Medical Undergraduate Rural Exposure to Rural Medical Experiences

Currently, many undergraduate university students with an interest in medicine participate in volunteer work through local tertiary care hospitals and/or research facilities. For the vast majority of undergraduate university students, a rural medical exposure is not feasible for financial and practical considerations. Funded opportunities for rural undergraduate exposure should be made available to students in all universities in the province, including those without medical schools.

Recommendations:

1. A one week rural medical experience should be developed for interested undergraduate (pre-medical) university students to enable them to have exposure to rural medical practice and the rural community, co-ordinated through rural hospitals. Within this program, there should be an opportunity for identifying and mentoring promising students.
 2. A limited number of advanced studentships of one to four months duration would provide further experience for "rural stream" students. These experiences could involve research or participatory observation (as is currently available for high school co-op work study placements).
 3. Such programs should be promoted by rural medical clubs at the universities with medical faculties, the Offices of Rural Medicine (see Section 4, recommendation 1) in each medical school, and by Community Development Officers (see Section 25) in all regions. In this respect, there is tremendous energy in the undergraduate segment of the student body making application to medicine, so that there may be merit in involving this group in promoting and maintaining such a program.
 4. Government needs to make funding available for transportation and accommodation of students, and for participating preceptors. In addition, community support infrastructure can be developed with the aid of existing community organizations, such as OMAFRA (Ontario Ministry of Agriculture and Rural Affairs), WRED (Women for Rural Economic Development), ROMA (Rural Ontario Municipal Association) and OFA (Ontario Federation of Agriculture).
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A. 1. Before Medical School: High
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A. 3. Medical School Admission Committees



III SOLUTIONS

A. MEDICAL EDUCATION

3. Medical School Admission Committees

Medical schools select the "best" candidates available to attend and succeed in those institutions. Qualifiers other than academic standing are currently included in the selection process.

Having rural "roots" is a complicated and poorly understood predictor, yet there is some clear documentation of the increased likelihood of students of rural background to choose rural practice.¹⁸ As one participant observed, "banana trees don't grow in cold weather".

There would also appear to be no intrinsic association between academic standing and probability of rural practice (and perhaps being a good generalist).

As the Edinburgh Declaration of the World Rural Health Conference stated, "medical school admission procedures should be based on institutional mission and capacity, and national health work force target. The open entry system is obsolete".

There is evidence¹⁹ that the development of decentralized medical schools, or at least a separate admissions/application stream for Rural and Northern training, can be instrumental in admitting medical students more likely to establish Rural and Northern practices.

Recommendations:

1. Admission committees should make it known that they intend to admit more students who are more likely to serve in rural communities. Admission should be based both on academic and other criteria relevant to future success as a physician, including likelihood of serving underserved populations. As well, consideration must be given to implementing and even requiring separate rural admission streams.
2. Medical student admission committees/interviews should include at least one rural clinician. The participation of rural physicians in this process must be adequately funded.
3. Research should be undertaken and analyzed to determine other effective admission level strategies.
4. The extent to which admissions standards encourage/facilitate the admission of students with a rural background should be included as part of the medical school accreditation process.

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A. 4. Undergraduate Core Rural
Curriculum Component 

III SOLUTIONS

A. MEDICAL EDUCATION

4. Undergraduate Core Rural Curriculum Component

"You can take the boy out of the country....but once the boy becomes a doctor how do you get him back there again?"²⁰

Whether or not a medical student will eventually practise urban subspecialty care or rural primary care, there are benefits of exposure to rural medical practice. Urban sub-specialists need to understand the pressures and work realities of rural practice when treating patients referred to them by rural colleagues or giving telemedicine advice. Similarly, urban primary care providers can better interact with their rural colleagues if there is shared awareness of the realities of rural medical practice. Even more important, the generalist nature of rural medical practice with less reliance on specialists and high technology investigation and intervention is a desirable influence on urban practitioners.

Rural medical practice should be viewed as a unique discipline, warranting specific training and exposure for all medical students. Many medical schools provide some counterbalance to the predominantly urban experience by providing a short rural practice experience, usually during the final family medicine year, or community medicine clerkship. Students generally rate these rural rotations as a positive learning experience. Even for students who do not choose rural practice as a career, rural rotations can provide insights into the difficulties faced by rural patients and rural physicians and may help them be more effective in their role as specialists or consultant urban physicians.

A desire for rural practice is the most important factor in the choice of rural practice as a career.²¹ A positive rural practice experience during medical school positively influences students' attitudes towards rural practice.²² Often, however, this rural preceptorship experience may be too little and too late, occurring at a time when many students have already formulated their career choices based on their predominantly urban experiences and role models in medical school. As a result, it is more appropriate that rural practice experience be spread throughout medical school, ideally with a component in every year. Interest and desire for rural practice can also be encouraged at the universities through rural practice clubs and mentoring involving rural physicians.

There are streamed models and core models for rural exposure. Rural training streams are of particular benefit to students who have shown an early interest or commitment to rural practice as a career. Rural streams that are currently offered by some medical schools

usually emphasize early and extensive clinical experience in rural settings combined with rural-oriented curriculum. These programs tend to have a high percentage of graduates who go on to rural practice.

At the present time, Ontario does not have a rural stream. However, the implementation of special rural streams would not detract from the necessity to provide all students with an appropriately integrated rural medicine curriculum and positive rural experiences that will interest and equip more students for rural practice and provide others with the appropriate understanding and knowledge to provide regional support for rural physicians and their patients.

Successfully developing and implementing a rural curriculum requires the development and input of rural faculty, combined with central faculty and management support. Integrating rural medicine into medical school goals, mission statements and curricula has been a major factor in the success of some medical schools in producing significant numbers of appropriately trained physicians for rural practice.²³

In the United States, 12 out of 126 medical schools produce 25% of the nation's practising rural physicians.²⁴ The medical schools that are the most successful in producing physicians who will practise in rural areas are those with co-ordinated rural-oriented medical education programs that provide early and extensive rural experience combined with positive general medical school support for rural practice.²⁵ While it is difficult to isolate and measure the effects of the rural practice experience in these programs, their overall success is due to a combination of integrated factors, often including selective admission, a rural-oriented curriculum, supportive central faculty and extensive involvement of a rural practice faculty.

Although rural students are more likely to enter rural practice than urban students, urban students are still the significant majority in most medical schools. Given these numbers, a significant portion of future rural physicians will need to come from urban students. The number of students with both the desire and appropriate education for rural practice can be raised by increasing the rural practice experience and focus of medical schools.

The most successful programs for producing physicians who will go into rural practice are co-ordinated programs that provide a wide variety of rural practice initiatives and it is often difficult to separate the effects of the different components. They include "teaching staff who work every day with physicians with patients in little towns and rural settings and hold rural physicians in high regard and honestly support students when interested in rural medicine".²⁶

As well, the importance of the dean in setting the tone of the medical school cannot be understated. "When someone in the dean's office keeps hammering away on something, it is amazing how some of the most resistant faculty suddenly take for granted that it is going to change."²⁷

Recommendations:

1. An Office of Rural Medicine should be established in each Faculty of Medicine, whose function would include co-ordinating medical school rural education activities.
2. Learning relevant to rural medical practice needs to be integrated into undergraduate medical curriculums in Ontario's medical schools.
3. Practising rural physicians must be included on medical school faculties, and provide input into curriculum design and implementation. This inclusion of rural faculty needs to be developed and fostered through adequate funding and other supports.
4. All students should have a rural clerkship experience to consolidate their learning in a low tech, high self-reliance environment.
5. A continuous rural stream should exist in at least one medical faculty and be developed in others if shown to be successful. This would provide constant rural contact as well as an important counterbalance to the tendency of undergraduate medical students being subtly dissuaded from developing an interest in rural practice.
6. Where appropriate, participating students with spouses/significant others should have an opportunity to integrate them into the rural experience, rather than be separated from them by the experience.²⁸

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III SOLUTIONS

A. MEDICAL EDUCATION

5. Undergraduate Medical Student Electives

Increasingly, medical students are requesting rural elective opportunities, but they encounter resistance and lack of infrastructure, funding and support from their medical schools, for such basic items as accommodation and travel. The evidence is clear that the earlier the exposure to rural practice and the longer the duration of that exposure, the more likely the student will adopt a rural style of practice.²⁹ As a result, there must be opportunities for increased rural electives, as well as counseling regarding suitability of electives for rural practice.

Opportunities for regular block electives can meet individual needs as they do now, but there should also be the opportunity for rural stream students to have long (summer or even up to seven months) electives in the rural setting, as in the Minnesota Rural Medical Associate Program.³⁰ Electives should include both primary care placements, as well as "generalist" specialist placements outside Academic Health Science Centres (AHSC).

Recommendations:

1. Medical schools must ensure that rural faculty have the resources they need to provide counseling regarding suitable electives for rural practice with an emphasis on procedural and acute care skills.
2. Four to six week block electives should be offered to all medical students. Opportunities need to be cultivated community by community to maximize the number of placement opportunities.
3. Additional funding must be provided for electives. The funding should be learner-centred (i.e. flow to students), thereby allowing for greater student choice and flexibility.
4. In addition to electives, a rural training stream, (which could include a Rural Physician Associate Program such as the Minnesota Program) should be examined and piloted in Ontario. This could include a six to nine month placement in a rural community.
5. Even if electives are made more widely available, early career path selection needs to be de-emphasized for medical students, since medical students tend to make the "safer" choice of steering away from training for rural practice if forced to choose too early. In this respect, serious consideration should be given to bringing back the rotating internship year, which gave students the opportunity to make later, and thus more informed and mature, career choices.

6. Barriers to medical students undertaking electives should be removed. These not only include lack of funding but also elective fees charged by medical schools.

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A. 4. Undergraduate Core Rural
Curriculum Component

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A. 6. Undergraduate Return of Service
Agreements 

III SOLUTIONS

A. MEDICAL EDUCATION

6. Undergraduate Return of Service Agreements

Increasing exposure to rural practice opportunities for medical students will lead to increasing interest in practice in rural areas. Voluntary return of service agreements can encourage such interest and help medical students with increasingly burdensome medical education costs.

There is reason to believe that students from rural backgrounds and/or who are interested in rural practice as a career choice may be attracted to scholarships and loans in exchange for return of service to rural areas.

Recent studies in the United States indicate that physicians forced to enter rural practice because of mandated return of service obligations are less likely to be satisfied or stay in rural practice than their rural colleagues.³¹ Clearly, the more important factors in successfully retaining physicians in rural practice are programs and supports making rural practice sustainable. Thus, implementing more extensive voluntary return of service programs must not be used as an excuse to do nothing else, and to replace other more critically needed and required initiatives.

Ontario's previous undergraduate medical student Return of Service Bursary Program was canceled in 1997. However, Saskatchewan has a highly successful Undergraduate Medical Student Bursary Program. In large measure, this likely reflects the significant amount of funding available to individuals under the Saskatchewan program.

Return of service has increasingly been discussed in response to the rapidly rising tuition fees in medical school, and the resulting economic hardship on students. Student bursaries and loans are not keeping up with these changes. The situation is made even worse by the implementation of tuition fees at the residency level. Students in rural areas are one of the groups most affected by these changes, because they will face higher living and travel costs throughout their training, and generally tend to have access to fewer economic resources. In this respect, unlike medical students from urban areas, those from rural areas cannot reside at home during their studies. They have always absorbed this additional cost, which is believed to have discouraged some qualified rural students from applying for medical studies. Even if loan programs are enhanced, potential medical students from rural areas will face an enormous psychological barrier in assuming such a large debt load.

The spiraling of tuition fees particularly threatens the access of women from rural areas as

they are more likely to practise flexible hours and take leaves of absence from their practice. Such a large debt load may perhaps discourage potential women medical students from rural areas from considering a medical career.³²

Recommendations:

1. Undergraduate voluntary return of service agreements should be re-introduced and expanded.
2. Return of service commitments should not be tied to particular communities, but rather should be sufficiently flexible to allow for physician and community choice.
3. Voluntary return of service programs should not be limited to undergraduate medical students, but should be extended to residents. Residents are closer to completing their training, have a clearer idea of their practice goals, and may be even more interested in programs which offer them the opportunity to reduce their considerable debts.
4. Return of service arrangements must be voluntary. Coercive measures result in recruitment of physicians who are only looking to leave the community and do nothing to enhance retention.
5. Relief from the imposition of excessive tuition fees on medical students, and residents, should not be used as a tool to coerce individuals to agree to practise in rural communities. Likewise, return of service should not be used as a requirement for admission to medical school.

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A. 5. Undergraduate Medical Student
Electives

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A. 7. Postgraduate Rural Medical
Training 

III SOLUTIONS

A. MEDICAL EDUCATION

7. Postgraduate Rural Medical Training

"Teaching hospitals are run by physicians who have chosen a small area of medicine in which, with the aid of expensive technology, they have become expert. How can physicians be expected to feel competent or wish to practise in country areas hundreds of kilometres away from such technology? The country preceptor has to show the student the satisfaction and fun of rural practice and how it is possible to practise high quality but cost effective medicine without....a CT scanner."³³

Traditionally, the residency training experience primarily takes place in urban-based teaching hospitals with medical teachers who have never practised in a rural setting and have little understanding of the joys and challenges of rural practice. Even for students from a rural background who tend to favour rural practice as a career choice upon entering medical school, this desire may fade as a result of the prolonged social, cultural and medical urban experience. As well, urban based training programs can create significant inertia and are unlikely to effectively decentralize without strong motivation (probably external) to do so.

Numerous models for postgraduate rural medical training have been tried. A positive impact on rural recruitment and retention seems related to;

- a. duration of the rural component of training,
- b. preparedness for rural practice.

Decentralized models for postgraduate residency training seem more effective in placement of graduates in rural communities. On the national level the joint CFPC (College of Family Physicians of Canada) and SRPC Working Group on Family Practice Curriculum is currently examining rural training programs and developing recommendations for training in rural family practice. In Ontario, the Northern training programs (NOMP and NOMECC) have made progress in terms of location of practice following training, with graduates found predominantly in Rural and Northern areas.³⁴ However, while programs such as SWORM (Southwestern Ontario Rural Medicine) are a hopeful beginning, the fact remains that Southern Ontario residency programs have not yet sufficiently addressed the need for residency training in rural communities.

Recommendations:


1. Training with significant rural content and exposure, must be offered by all family medicine training programs, made available to any interested family medicine residents, and strongly encouraged for all family medicine residents. While the minimum period of training should be one month, longer periods of training are less disruptive and more effective.
2. For aspiring rural physicians, there must be a separate rural stream, with a rural core component of no less than four months of rural family medicine plus two months training in each of emergency medicine, obstetrics and ICU/anæsthesia. The B.C. experience of total rural immersion provides one successful model.
3. While some existing funding could be redistributed to rural training routes and programs, new funding is required to remove barriers (such as transportation and accommodation costs), to develop sites, and to pay the costs of faculty support including preceptor stipends.
4. The number of residents training in a rural training stream should be substantially increased. In the case of family medicine training positions, Graham Scott's recommendation that 30% of training positions be dedicated to rural streaming³⁵ should be implemented as the absolute minimum target.
5. There is a need for appropriate, dedicated rural faculty support and development (see Section 8).
6. Specialist based training programs, initially in the priority areas of general surgery, obstetrics, pædiatrics, internal medicine and psychiatry, should be established/piloted in mid-sized communities (of 20 to 25 thousand). In this respect, the multi-specialty community training network, recently established in Southwestern Ontario, provides a workable model.³⁶
7. Urban-based specialty training programs must include opportunities for training outside Academic Health Science Centres, the length of which may vary depending upon the program involved.
8. Enhanced flexibility for residents to change or augment training programs is needed, particularly when requested by candidates committed to rural practice.


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A. 6. Undergraduate Return of Service
Agreements

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A. 8. Rural Physician Faculty
Appointments / Teaching Activities 

III SOLUTIONS

A. MEDICAL EDUCATION

8. Rural Physician Faculty Appointments / Teaching Activities

Increasing rural education opportunities for medical and pre-medical trainees at all levels will increase the number of rural clinicians needed for rural medical education. Rural clinician support for existing rural education programs is an indicator of the enthusiasm, often poorly rewarded, for teaching. Rural physicians are effective teachers, and rural doctor-preceptors are more likely to stay in rural areas than their non-preceptor counterparts.³⁷

Faculty appointments for rural clinicians should be facilitated and encouraged, in order to provide concrete recognition for their work. Faculty appointments may contribute to job satisfaction and may have an impact on long-term sustainability. Funding issues are also an important concern, since rural faculty need to be compensated for clinical work lost as a result of time spent in various teaching functions.

Increasing the number of rural physician/teachers will require medical schools to increase their commitment to faculty development. This includes providing appropriate academic faculty positions for rural doctor/teachers, with adequate faculty resources, developing practice arrangements suitable for teaching rural general practice, and involving rural physicians/teachers in training, program policy and curriculum development.

With these general requirements in mind, the more specific recommendations in relation to rural faculty appointments and activities are as follows.

Recommendations:

1. Ontario's five medical schools should actively work to appoint rural clinicians to faculty positions.
2. Opportunities for rural faculty to work in both Academic Health Science Centres and in their rural communities should create a viable academic career path that values and rewards practitioners/teachers of rural medicine.
3. Information services and travel support must be provided to rural faculty.
4. In order to sustain the teaching function in qualifying rural communities, an additional physician must be added to the community complement which the Ministry of Health is prepared to fund, through alternate payment plans or other Ministry programs. This will allow both practice and education to coexist effectively in these communities.
5. Rural faculty must be supported and encouraged to become involved in supporting

their surrounding communities, through a variety of activities, such as outreach, education, shared coverage, and locums.

6. A core of AHSC faculty should be encouraged to serve as a locum pool to foster rural liaison between the Academic Health Science Centre and the rural community. This would allow a high degree of cross education between the faculty and practising physicians in the rural community.
7. Specialists involved in training physicians for advanced skills, outside the formal Royal College certification process, need academic recognition and support from their university based peers.

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A. 7. Postgraduate Rural Medical Training

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A. 9. Training of Rural Teachers 

III SOLUTIONS

A. MEDICAL EDUCATION

9. Training of Rural Teachers

Formalizing the role of rural physicians as teachers requires an expanded "teach the rural teacher" program. Wide experience has shown that rural physicians with an interest in teaching are naturally good teachers. The role of any training program for training of rural physicians to become effective teachers must seek to build on that, without restricting it to the urban family practice model.

Just as rural physicians learn best from other rural physicians, rural teachers will learn best from other rural teachers. Training for rural clinical teachers should be held at rural regional hubs. These can be facilitated by a Regional Director of Rural Training (as recommended below), with input from the CFPC Section of Teachers, the SRPC Education Committee and appropriate university resources.

Participation in rural clinical teacher training should be an important consideration in retaining faculty status. The opportunity to qualify for teaching should be available to interested experienced rural clinicians, irrespective of CFPC certification.


It is to be expected that rural communities and individual clinicians will move in and out of the teaching stream. This sharing of the teaching function will enrich the life of many clinicians rather than only a few, and contribute to more communities becoming local centres of excellence rather than centres of burned out rural physicians.


Recommendations:

1. Implement a funded faculty position (the Regional Director of Rural Training, for further discussion see also Section 25, recommendation 2) in each Ontario medical school, who would be responsible for ensuring appropriate faculty development of rural teachers.
2. There needs to be increased funding and support for community physicians providing special skills training with a view to enhancing their teaching skills and resources.
3. There needs to be increased involvement and commitment by medical schools and their faculties, and by supporting organizations such as the College of Family Physicians of Canada (CFPC), the Royal College of Physicians and Surgeons of Canada (RCPSC) and its representative specialty organizations, and the SRPC, to training family physicians in advanced skills, in the areas of surgery, obstetrics, anaesthesia and psychiatry.

4. Funding of rural practices needs to take into account the importance of, and need for, training rural physicians by rural physicians.³⁸

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A. 8. Rural Physician Faculty
Appointments / Teaching Activities

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A. 10. Advanced Skills Training for Residents
and Practising Rural Physicians 

III SOLUTIONS

A. MEDICAL EDUCATION

10. Advanced Skills Training for Residents and Practising Rural Physicians

It is well-recognized that providing care in rural settings requires a broader base of skills than in urban areas. Opportunities for this training have most often been accomplished satisfactorily in secondary rather than tertiary centres.

Postgraduate trainees and practising rural physicians (both generalist and specialist) need opportunities to acquire training in skills integral to rural practice. These include, among others, endoscopy, minor and advanced surgical skills (including caesarean section), anaesthesia, orthopaedics, internal medicine, trauma, radiology and mental health.

Recommendations:

1. Postgraduate training for rural practice should be flexible and include as much opportunity for advanced skills as possible, even within the two year FP envelope.
2. Programs for advanced skills training in FP anaesthesia, FP surgery and advanced FP obstetrics with caesarian section skills and psychiatry should be available in sufficient numbers to supply projected needs. They should be accessible to third year family medicine residents, and established physicians with a demonstrated commitment to rural practice. In principle, subject to availability of mentors and teaching opportunities, these skills could be acquired in a teaching centre, a regional hospital, a rural hospital or a combination of sites.
3. Length of Advanced Skills Training should be flexible with opportunities for skill maintenance readily available.
4. Advanced skills training needs to be competency based. Thus, applicants for training should be evaluated for previous training, existing skills and community resources and support. The proposed duration and scope of training should be sufficiently flexible to meet the needs of individual trainees, and communities.
5. Regional Directors of Rural Training should have some responsibility for the development and maintenance of these programs.
6. Sabbaticals at appropriate pay for qualified rural physicians need to be made available, and funded by government, for longer special skills training, i.e., surgery and anaesthesia.
7. An alternate pathway for skills should be made available within a regional centre or local community, providing for a horizontal training program (i.e., without requiring commitment of an extended block period of time), as has been piloted in rural B.C.
8. Advanced skills development should be accredited, evaluated and recognized by

appropriate national and provincial organizations. Maintenance of competency programs should be a requirement of advanced skills training.

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A. 9. Training of Rural Teachers

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A. 11. Re-entry Training Positions 

III SOLUTIONS

A. MEDICAL EDUCATION

11. Re-entry Training Positions

The most recent OMA/Government Agreement provided for improved access for a limited number of physicians to undergo advanced skills training. This can allow practising rural family physicians to obtain training to expand their role (currently in GP anaesthesia, emergency medicine and care of the elderly), or to change their clinical direction and enter RCPSC training programs (with the current priority being in general surgery, obstetrics and gynaecology, internal medicine and psychiatry and anaesthesia). One year of return of service in rural communities is required for each year of training.

However, as presently structured, re-entry training is not providing special nor enhanced skills training for family physicians in Royal College specialty areas (i.e. GP surgery and anaesthesia) outside formal Royal College programs which are four to five years in duration.

One barrier to re-entry for established physicians is that they are paid only at the residency salary levels during their re-entry training. Some provinces, including Alberta, Saskatchewan and New Brunswick, have recognized this financial disincentive and provide additional compensation for re-entry positions. Physicians have also raised concerns that the time lines for applying for a re-entry position are too tight.

Recommendations:

1. Re-entry training positions must be maintained and expanded.
2. Re-entry for one year special skills training, in areas such as obstetrics and surgery, should be provided.
3. Preference should be given to those physicians seeking re-entry training in obstetrics, anaesthesia, and surgery, since these skills are the most needed in rural communities.
4. The current standard of one year return of service for each year of postgraduate training should be re-examined in light of experience, which has indicated that this may be too onerous a requirement to attract established physicians to re-enter RCPSC specialty programs involving 4-5 years of training.
5. Permit established rural physicians to compete for re-entry positions after five years of rural practice, with no return of service commitment (in effect, prepaid return of service). This would promote career flexibility for physicians who choose rural practice.
6. Re-entry programs need to have clearly defined exit requirements and long term

follow-up to determine whether or not they are successful in sustaining and introducing special and advanced skills to rural communities. The Centre for Rural and Northern Health Research at Laurentian University is currently involved in the long term evaluation of the existing re-entry program, and their efforts could be assisted by the Community Development Officers in conjunction with the Offices of Rural Medicine (see Section 4, recommendation 1).

7. Re-entry positions should not be created at the expense of training spots currently allocated to residency training positions for medical school graduates.
8. Established physicians should be compensated at reasonable levels, beyond residency salaries, in light of the reality of their financial needs and experience.

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A. 10. Advanced Skills Training for Residents
and Practising Rural Physicians

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A. 12. Continuing Medical
Education 

III SOLUTIONS

A. MEDICAL EDUCATION

12. Continuing Medical Education

The difficulty of accessing appropriate Continuing Medical Education (CME) for rural physicians and securing locum replacement remains a significant hurdle. Instability of CME funding, and unequal distribution of the funding, continues to be problematic.

Since the 1993 OMA/Government Agreement, funding has been provided to the OMA to administer a Continuing Medical Education program for physicians living and practising in rural communities. The program provides assistance to physicians to offset the high costs associated with obtaining CME in remote and rural areas. The program operates with a flexible, self-directed, learner-driven approach, allowing the rural physician to determine his or her own CME needs while assisting the physician in accessing these needs.

There is an uneasy relationship between rural physicians (both generalists and specialists) who practise "advanced" skills and specialist physicians who consider these skills their domain. This creates both a dearth of adequate training for advanced skills in rural practice and hesitancy on the part of rural physicians to acquire the skills they need. In this respect, the body of knowledge necessary for proficiency in rural practice is large and includes a significant technical component.

Rural physicians have much to contribute to the CME of their colleagues.

Recommendations:

1. There should continue to be a separate, dedicated, stable fund for learner- driven CME for rural physicians, administered by the OMA.
2. Rural CME needs to be developed by rural physicians for rural physicians with less reliance on Academic Health Science Centres and the urban perspective and centralization they necessarily impose. There should be increased flexibility to allow for the rural physician to choose from whom and where they will receive their CME.
3. To the extent that urban-based Academic Health Science Centre faculty are involved in providing training in rural areas, they should also be involved in teaching rural CME.
4. Alternate payment plan arrangements must include allotted time off, both to attend CME and to teach it.
5. The SRPC model for rural CME should be supported for its low cost, stability, portability and integral locum service.

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A. 11. Re-entry Training Positions

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B. RURAL PRACTICE ISSUES
13. Referral / Support Network 

III SOLUTIONS

B. RURAL PRACTICE ISSUES

13. Referral / Support Network

One of the most intimidating features of Rural and Northern medicine practice for new clinicians is obtaining willing and useful specialist backup. It has often been said that the most useful survival skill is sound training in telephone aggression.

Present referral patterns are informal and place onerous and often unremunerated demands on regional consultants. The current *Rural and Northern Health: Parameters and Benchmarks Report*³⁹ may clarify linkages and, to some degree, support. However, larger issues of specialist remuneration and availability of beds in the receiving institution will require a higher level of co-ordination.

Recommendations:

1. A user friendly specialist referral network with appropriate remuneration for consultants needs to be established and reliably available. This should exist in two tiers: a "corridor consultation", with a 24 hour turn around of information and a real time teleconsultation for more urgent issues.
2. The network should be coordinated through regionally based hospitals. However, for subspecialty consultations, the support infrastructure may necessarily cross regional and even provincial boundaries.
3. Referral/support networks should be integrated with development of user friendly medical information technology (see section 14), including flexible access via phone, fax and the Internet.
4. The referral/support network should be reviewed by an external body (potentially linked to hospital accreditation), with the power to recommend and make changes.
5. A commitment to developing local centres of excellence, with sufficient critical mass for integrated service provision and teaching, would reduce the need for specialist referral and support.

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A. 12. Continuing Medical Education

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B. 14. Medical Informatics 

III SOLUTIONS

B. RURAL PRACTICE ISSUES

14. Medical Informatics

The development of Telemedicine is plagued everywhere with three basic problems:

- a. Unclear remuneration/liability for consultants rendering opinions
- b. Unsatisfactory infrastructure for reliable transmission of suitable imagery
- c. A "top down planning" error of attempting to compensate for inadequate training of rural physicians by providing "hand holding" Telemedicine links.

An effective Telemedicine system needs to be built in the field, and then linked to appropriate supports. The focus of medical informatics must always be on supplementing and enriching rural practitioners, and neither replacing them nor the consultant services their patients need. For this reason, medical informatics should be regionally based, reflecting the rural referral/support networks (as recommended in Section 13), since this builds a stronger team and supportive network. In short, current referral patterns should be supported, not thwarted, by medical informatics.⁴⁰

Equally important, the development of Telemedicine must not take precedence over the need for a critical mass of physicians in each community, i.e. as one participant noted, "fancy toys do not help on-call coverage". Medical informatics can enhance rural practice, but in itself cannot solve underserved problems.

Medical informatics goes far beyond Telemedicine, to include computerized patient record systems and computer/internet access to medical informatics for physicians, other health care workers and patients. Medical informatics has a great potential to improve patient care and physician connectivity in a rural area.

Unfortunately, it is very difficult for rural physicians to buy, develop and effectively use medical informatics because of lack of local resources and support. Significant financial and medical informatics support is required to make it possible for rural physicians to harness the potential advancement in medical practice that medical informatics can make. Local hospitals can play an important role in medical informatics system development, integration and support. Patient confidentiality, security and systems compatibility are important considerations.

Recommendations:

1. The development of Telemedicine must not take precedence over the need to provide adequate training in skills like radiology and EKG interpretation for rural physicians.
2. Telediagnostic imaging transmission is the highest priority in terms of development of medical informatics, but there is a need to ensure broad compatibility standards.
3. Substantial investment in infrastructure, training and support is needed when medical informatics programs are initiated.
4. Wide consultation among workers in the field, both provincially and nationally, should precede development.
5. Consideration should be given to encouraging Web Site "virtual" hallway consultations which are national in scope, with costs shared among provinces.
6. Communications technology should be developed to promote networking and communications among rural physicians, as well as with their urban counterparts.
7. Direct medical informatics grants should be provided to rural physicians for:
 - i. physicians and staff medical informatics training and support; and
 - ii. purchase or lease of computerized patient record systems and medical information sources and systems

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B. 13. Referral / Support Network

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B. 15. Telephone Triage 

III SOLUTIONS

B. RURAL PRACTICE ISSUES

15. Telephone Triage

Telephone triage is an important component of the primary care reform process currently being considered in Ontario. The potential for easing the workload of rural physicians, particularly during after-office hours is real and should be further explored. However, there is a concern that the province-wide "1-800 numbers" might offer solutions primarily directed towards urban areas with their easy access to fully staffed emergency departments and walk-in clinics. Historically, telephone triage in rural areas has usually been provided by RNs in local hospitals, who often have the important advantage of previous knowledge of the caller's medical and social history which will influence the advice provided. These RNs also have an in-depth knowledge of exactly what services the local hospital and physicians are able to provide, and the hours during which these services are best provided.

Recommendations:

1. Telephone triage in rural areas should be provided by experienced RNs, expanded role nurses and physicians working through the local or nearest hospital.
2. Province-wide triage systems should be avoided in rural areas. If such a system is implemented, information about each rural area should be built into the design, and advice should be based on these characteristics. Except in life-threatening situations, patients should be advised to call the local hospital before going there.

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B. 14. Medical Informatics

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B. 16 Physician Licensing 

III SOLUTIONS

B. RURAL PRACTICE ISSUES

16. Physician Licensing

The elimination of licensure after one year of residency training, and restriction on licensure and certification of international medical graduates (IMGs) have had a significant adverse impact on medical service provision to rural communities. As a result of these changes to licensure and certification, the role of foreign-trained physicians in serving rural and isolated communities has been substantially diminished. Furthermore, the removal of the one year internship licensure stream has eliminated the opportunity for new general practitioners, to practise in rural and isolated communities before proceeding to further training, or to provide locum support while continuing their specialty training.

Recommendations:

1. Governments and licensing bodies should consider providing forms of licensure to:
 - i. enable qualified trainees to provide locum and hospital call coverage, and
 - ii. permit rural physicians to cross provincial borders in order to provide locum services as well as teach rural CME (an initiative already started by SRPC).⁴¹

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III SOLUTIONS

B. RURAL PRACTICE ISSUES

17. Allied Health Professionals

Ontario has developed training routes intended to prepare nurse practitioners and midwives for expanded diagnostic and therapeutic roles. However, in the rural context, it is particularly important to give sufficient attention to the different roles that these practitioners may play in rural communities, and the training required for those roles.

While the scope of practice of a rural family physician, spanning the ER/ICU/in-patient/delivery room/nursing home/office, cannot be replaced by allied health professionals, there is scope for a supportive and collaborative relationship among all of these practitioners. Essential to developing such complementary relationships is the development of funding models which prevent duplication and competition. It must be stressed, however, that the expanded nursing role does not remove the need for a critical mass of physicians to ensure access to medical care for the community.

At the recent SRPC Annual Policy Conference in May, 1998, the participants adopted the following five resolutions:

- i. There should be a national process to develop guidelines for the scope of practice of nurse practitioners.
- ii. There is an enhanced skill set and education required by nurse practitioners.
- iii. The activities within the role of nurse practitioners are location specific.
- iv. Funding models must be developed to enhance cooperative and collaborative care.
- v. Innovative education is needed to provide core competency and an enhanced skill set.

Rural communities also require significantly more support and funding for physiotherapists, occupational therapists, speech therapists and audiologists and other similar allied health professionals. There should also be funding for continuing education and support to enhance the roles and skills of these allied health professionals.

Recommendations:

1. Improved dialogue must be established between rural physicians and rural nurse practitioners/midwives. It is essential that these groups establish a cooperative working relationship that will be complementary and lead to quality outcomes for all rural communities.

2. Urgent attention should be given to issues of training and role development, especially for nurse practitioners establishing rural practice. In this regard, government, medical organizations and other stakeholders should consider the SRPC resolutions in developing further policy in this area.
3. Development of community mental health models with wider use of allied health professionals would make the work of rural psychiatrists much more manageable and sustainable.

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B. 16. Physician Licensing

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B. 18. Rural Physician Clinical Support Program 

III SOLUTIONS

B. RURAL PRACTICE ISSUES

18. Rural Physician Clinical Support Program

Rural communities have traditionally had their medical care provided by independent physicians working from their own private offices, either solo or in small groups of two or three. This has become a barrier both to recruiting new physicians and retaining existing physicians. Many longstanding, independent rural physicians are becoming desperate to escape the onerous management and fiscal burden that independent office ownership requires. Moreover, small private practices have become almost worthless as new graduates generally do not wish to assume the responsibilities of office management and ownership in addition to their professional roles. Most graduating physicians are more likely to be attracted to communities where, regardless of the payment mechanism, there is a group clinic facility, with staffing and information system and administrative support provided.

As part of reforming the physician remuneration system, separate government funding for the provision of excellent group clinic facilities, clinical support staff and administrative information system support would have an enormous positive effect in facilitating group practice arrangements that provide better patient care availability, at the same time relieving physicians of day to day management and administrative responsibilities, enabling them to concentrate on delivering medical care, and providing more opportunity for a sustainable lifestyle.

These facilities and supports would singlehandedly provide more attractive group practice working conditions as well as an indirect and long overdue financial benefit for rural practice. They would also provide increased opportunities and space needed to integrate allied health professionals, including nurses and nurse practitioners, and promote a more effective and efficient integrated rural health care system. For any such program to succeed, however, it is critical that it be designed and implemented in a manner which is sensitive to the need to respect and protect physician autonomy and independence.

Recommendations:

1. Government should provide special funding and support for rural practice clinics, including group clinic facilities, clinical support staff and administrative information system support.

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B. 17. Allied Health Professionals B. 19. Remuneration for Family Physicians 

III SOLUTIONS

B. RURAL PRACTICE ISSUES

19. Remuneration for Family Physicians

Many physicians in rural and remote communities have concluded that the current fee-for-service system is inadequate to meet the unique skills and demands of their medical practices. Moreover, for many new physicians, alternate payment plans are a more attractive method of remuneration for practising medicine, and their availability in underserved communities would serve as an incentive for them setting up practice.

To some extent, both the Government and the OMA have recognized this, but in practice little has been done to offer workable alternate payment plans that would truly serve the needs of rural and remote communities and their physicians. However, this lack of progress does not diminish the critical importance of alternate payment plans for sustainable physician recruitment and retention.

One successful application of alternate payment plans has been the Community Sponsored Contract (CSC), which provides for a reasonable annual payment, together with paid overhead and expenses. Unfortunately, CSCs have only been offered in the smallest and most remote of Northern communities, and despite their significant success, the government has been unwilling to expand the eligibility for CSCs to communities with an Underserved Area Program (UAP) complement of three or more, or to rural communities in the near-North and South.

Instead, the government has insisted that communities with a UAP complement between three and seven physicians can only access Alternate Payment Plans [variously described as Globally Funded Group Practice Agreements (GFGPAs), Rural Alternative Payment Plans (RAPPs), or Northern Group Funding Plans (NGFPs)]. However, the funding for these Alternate Payment Plans (APPs) continues to be based on the bare minimum numbers under the UAP program, rather than the critical mass needed for sustainable physician recruitment and retention. Furthermore, the funding offered per physician still fails to recognize the unique skills and responsibilities of rural and remote physicians.

In this respect, the document *Toward a New Vision for Globally Funded Group Practice Agreements* produced in January, 1998 by the Northwest Ontario Physicians, has outlined what would be required to make GFGPAs work. The Executive summary of that document is attached as Appendix 19 to this Blueprint.

At the same time, other payment systems, including fee-for-service, remain the payment

system of choice for many established rural physicians, and should be supported as viable options in rural areas. No one payment system will solve the needs of all rural practice, particularly when attempting to address the many diverse lifecycle and lifestyle needs and choices of rural physicians.

Recommendations:

1. Different communities have different capabilities and different needs, so that there can be no single rigid alternate payment plan model imposed by government. Rather, any alternate payment plan needs to be flexibly available to any underserved community, if they are to act as incentives and not disincentives.
2. For those rural physicians choosing to remain on fee-for-service, medical associations and government should incorporate specific fee codes and/or rural modifiers which properly reimburse rural physicians for the unique services which they provide. In addition, other payment systems including salary and capitation models should be supported where requested by rural physicians.
3. The principles of sustainability, critical mass and remuneration commensurate with the unique skills and responsibilities of rural and remote physicians, as contained in *Toward a New Vision for Globally Funded Group Practice Agreements* should be incorporated in future efforts to develop alternate payment programs. This includes the need to fully address the issue of funding for an adequate physician complement (critical mass) in rural areas in various proposed systems for physician reimbursement in these areas. While there are significant difficulties with relying on crude doctor/population ratios, if they are to be used then a distinct rural doctor/population FTE (full time equivalent) benchmark, (perhaps set at no less than 75% of the provincial doctor/population average of 1:1150, i.e. at 1:862) should be the starting point. However, this must be subject to further adjustment based on individual community and physician needs.
4. Any funding formula adopted for an alternate payment plan must reflect the unique nature of work provided by rural practitioners and compensate them fairly by providing a significant premium for their work. This will require an adequate baseline formula supplemented by additional incentive fees to recognize clinical work requiring both generalist and advanced skills. These skills include GP anaesthesia, in-patient care, obstetrics, night call, GP surgery, administrative responsibilities, CME/teaching roles, and supervision of programs such as dialysis, chemotherapy, emergency departments and mini-ICUs.
5. Sessional funding should be extended beyond the current hourly "Scott sessional fee" for on-call emergency coverage, to apply at least to GP anaesthesia and obstetrics. As well, the current sessional fee for emergency coverage should be revised to reflect market realities.
6. The remuneration for individual physicians or groups of physicians should

incorporate an isolation support payment, based on the degree on "rurality" or "remoteness", including distance from referral centres, the size and demographics of the community, and the complexity of the services provided (see Section 27 for additional discussion of this concept).

7. Alternate payment plans should include additional leave/time off in recognition of longer service, as a retention bonus. This should include credit for up to ten years of prior rural practice service.
8. Sabbatical programs should also be offered both as a retention incentive and as a method of allowing a periodic break from the stresses of rural practice while at the same time offering an opportunity for professional development.⁴²
9. Consistent with the recommended Rural Physician Clinical Support Program (see Section 18), hospitals should offer to provide clinic/office space, as well as nursing information and administrative support, to physicians. This would create a central, sustainable practice environment drawing on the administrative and other resources of the hospital, help offset overhead costs, and provide attractive and sustainable rural practice conditions. Overhead assistance is an important recruitment and retention incentive for rural physicians. For those who choose to practise in their own offices, this would take the form of direct financial support.
10. An effort should be made to minimize the administrative and legal obligations inherent within any rural alternate payment plan. In particular, formal legal partnerships should not be mandatory and the obligations of shadow billing, timesheets, and patient satisfaction surveys should be either eliminated or supported with additional funding.
11. Rural and remote physicians, and their communities, should not suffer because of ongoing disputes between the Government and the OMA over who is responsible for providing the necessary funding for effective and sustainable alternate payment plans.
12. Fee disincentives and other restrictive measures aimed at new physicians form no part of a sustainable solution to the underlying challenges of Rural and Northern practice, fail to remove long-standing barriers to physician recruitment, do nothing to improve the conditions and supports necessary for physician retention, and only end up "ghettoizing" rural medicine by making it appear less attractive.

42. [The Alberta Section of Rural Medicine, Sabbatical Proposal, August, 1997.](#)

III SOLUTIONS

B. RURAL PRACTICE ISSUES

20. Physician Payment / Specialists

Although there has been considerable debate and discussion of alternate payment plans for rural primary care providers, the equivalent has not been the case for rural specialists.

This has largely been a function of the smaller number of rural specialists. However, rural specialists share many of the same problems as their rural FP/GP counterparts, including isolation and high call frequency with low volume.

Recommendations:

1. More attention must be devoted to alternate payment plans, and/or sessional payments, for specialists in rural and remote areas.
2. Core specialties in rural medicine (i.e. comprehensive general surgery, pædiatrics, obstetrics/gynæcology, internal medicine, psychiatry, anæsthesia and orthopædics) should be eligible for some form of "block" remuneration for call (such as hourly remuneration for night time and weekend call and/or special premiums for the fee for service services they perform while on-call during evenings and on weekends).
3. Special, urgent consideration needs to be given to alternate payment plans for psychiatry, in view of the failure of the fee-for-service system to compensate them for their various activities and services, including coordinating with social services and families.
4. Hospitals should provide office and clinical support for specialists.
5. Specialists in regional hospitals must be compensated for telephone advice/consultations.
6. Visiting specialists should be given access to clinic space and support staff, reimbursed for traveling expenses and travel time, and provided with a stipend for teaching and educational activities.

III SOLUTIONS

B. RURAL PRACTICE ISSUES

21. Natural Limits, Including Retirement and Burnout

Exit incentives are attractive to both physicians and governments for a variety of reasons. The idea of a retirement payment or incentive for a long-serving physician is both reasonable and justified. Historically, physicians have not shown expertise in the area of retirement planning, and this situation is worsened by the absence of formal pension plans. For some physicians, retirement is not financially feasible due to poor financial planning, and the option of working harder under fee-for-service is often taken. Finally, medical associations and governments recognize that exit incentives could be helpful in addressing the issues of physician distribution and utilization, given the current "hard-cap" provincial funding system.

It will be necessary to proceed with caution in encouraging retirement among our valuable senior rural physicians, at least until they can be properly replaced. At the same time, we want to create incentives for retention of rural physicians, by offering recognition for their valuable service, and encouraging future physicians to establish rural practice, perhaps by a facilitated retirement plan. Hopefully, with appropriate physician recruitment and retention measures in place, long term planning should be possible including provision of planned physician retirement.

Recommendations:

1. Payment plans for rural physicians should include retirement packages that are flexible enough to meet the varying and different needs of rural physicians.
2. It is not acceptable for exit incentive plans to be offered only in over-supplied urban areas.
3. Any retirement incentive must reconcile the need to ensure that rural and remote communities are not deprived of critical and needed medical services, while recognizing the importance of rewarding and not penalizing long-service rural physicians for their valuable services over the years. Possible options to consider include offering rural physicians the option of accepting a partial retirement payment in return for a reduced billing number or adjusted APP, thereby allowing part-time practice, or even in some cases providing physicians with the full retirement amount but allowing them to continue to practise without penalty until a replacement physician is recruited.
4. Consideration should be given to the introduction of physician retirement packages to help existing rural physicians, who have worked a fixed combination of years of

practice and age, to retire. In this respect, the Newfoundland PRAG Report proposed a point system which not only takes into account years of practice and age but also isolation and time on-call.⁴³ As well, a blended sabbatical/retirement system as proposed in Alberta should be examined as a retention tool (see also Section 19, recommendation 8).

5. Retirement planning needs to happen in conjunction with improved recruitment and retention measures.
6. The "back before burnout" concept, which creates viable options for time off after a certain number of years of rural practice, as promoted by the New Zealand Government, should be examined.⁴⁴ This would provide opportunities for teaching, administration, further training or sabbatical after a certain number of years of rural service.
7. There must be improved education with respect to retirement planning, to avoid physicians perceiving that they are not able to afford to retire.
8. After 20 to 25 years of practice, rural/remote physicians should not be required to take overnight call. This is only workable if funding is sufficient to ensure that there is a sufficient complement of remaining physicians to permit for a reasonable call schedule.

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III SOLUTIONS

B. RURAL PRACTICE ISSUES

22. Physician "Turf" Issues

An important disincentive to new physicians moving to a small rural community can occur when the established physician (or physicians) resists the perceived "encroachment" on their territory. This occurs in various ways, both overt and covert, including simply not sharing patients, or insisting that new physicians join an existing group and then make the working conditions and remuneration less than tolerable. There are numerous possible motivations for this behavior, but the fee-for-service payment system and the potential loss of income for physicians with significant debt loads or who are financially ill prepared to retire has certainly been a significant contributing factor.

It is possible that, with the introduction of alternate payment plans for physicians in rural and remote communities, this will be less of an issue in the future. However, it must also be recognized that alternate payment plans can become disincentives in their own right if absolute limits placed on overall remuneration lead the existing physicians to resist new physicians being added to the plan. As a result, alternate payment plans should be designed so as to avoid this disincentive against new physicians establishing practice in a community.

It is important to address these issues honestly and openly and ensure that community needs are met. In this respect, external mentoring from physicians outside the community⁴⁵ has been useful in helping to resolve such problems in the past.

Recommendations:

1. Effective and attractive alternate payment plans for rural physicians need to be offered in order to minimize the competition often arising in the fee-for-service payment system.
2. The Rural and Remote Areas Program (as proposed in Section 26) needs to incorporate mechanisms to respond to community or physician concerns, especially where they obstruct qualified new physicians from coming to a community where they are needed. Community Development Officers should also be aware of such problem areas and facilitate their resolution.
3. The Society of Rural Physicians Initiative of Community to Community Support is a sensitive and workable option for responding to this issue, but should be integrated with the efforts of Community Development Officers in identifying problem areas and facilitating their resolution.

4. A voluntary retirement program with buyout package may be the least expensive and most effective method of resolving these issues if other efforts fail to do so.

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B. 21. Natural Limits, Including Retirement
and Burnout

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B. 23. Spousal and Family Concerns



III SOLUTIONS

B. RURAL PRACTICE ISSUES

23. Spousal and Family Concerns

The difficulties faced by spouses and families of rural physicians are well documented and known to be a significant factor affecting both recruitment and retention. The realities of life in small rural communities, their limited resources, population and economic base can limit spousal employment opportunities as well as family education and social opportunities.

The inordinate demands on both male and female physicians, especially with regards to onerous on-call time and administrative responsibilities, limit family time, increase spousal isolation and generally impose an excessive toll on their non-working lives, ultimately leading to physician burnout.

Zero tolerance legislation for physicians having relationships with patients can also significantly increase the isolation of single physicians, especially in more isolated communities where a physician is potentially the care giver for the entire population.

Recommendations:

1. No physician should be required to provide on-call services more frequently than one night in five, as consistently recognized and recommended by the CMA, the Scott Report, and other expert bodies and reports. These limitations on excessive call reflect not only the needs of the physician, but the very real needs of her/his spouse and family.
2. CDOs should foster relationships with municipal boards and community leaders to facilitate integration of physicians, spouses and families into the community.
3. To the extent possible, spouses and family members should be included in medical school and residency placements,⁴⁶ since the evidence suggests that early involvement creates spousal and family expectations more favourable to rural life.
4. A rural medical family network has proven successful in other jurisdictions, including Australia, in providing support to and nurturing of spouses and family members, through personal contacts, mentoring, newsletters, help pamphlets, and conferences.⁴⁷ A similar network should be established and funded in Ontario.
5. The Rural and Remote Areas Program (as discussed in Section 26), in conjunction with CDOs, communities and other physicians, needs to place priority focus on identifying and accommodating spousal requirements wherever possible, including at

the initial recruitment stage.

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B. 22. Physician "Turf" Issues

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B. 24. Locum Programs 

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B. RURAL PRACTICE ISSUES

24. Locum Programs

The lack of a functional, accessible locum program continues to be one of the most significant disincentives to physicians locating and staying in rural areas. It is also an important hurdle to physicians seeking holiday time and CME. The problem is most acute in smaller communities with one to six physicians. Unfortunately, existing programs often operate at cross purposes, with little coordination, and an inadequate or unpredictable funding base.

Recommendations:

1. A provincial locum program must have independent, responsive administration that can update and fill physician need in rural areas rapidly from a roster of "registered" physicians.
2. The locum program should operate in conjunction with an expanded physician and community registry, either building on the PAIRO Registry or a specialized locum registry.
3. University faculty involved in training physicians destined for rural practice or providing CME to rural physicians should be recognized as an important source of locum service to rural areas.
4. Consultants in regional and tertiary referral centres should be encouraged to serve as locums as part of their commitment to a rural service network.
5. The SRPC CME/Locum Service should continue to be developed and work towards generating local centres of excellence (as detailed in Section 12).
6. Provision of time limited interprovincial licenses would allow physicians to cross provincial boundaries to provide locum service. This would both broaden the interest and expand the pool of available locums.
7. Similar reciprocal arrangements should be developed for international exchanges, particularly since Canadian physicians are already encouraged and licensed to serve as locums for fixed periods of time (i.e. on an annual basis) in other countries, such as Australia.
8. "In place" regional locums should be added to the critical mass required for local communities so that communities within a region can better provide self-sufficient locum coverage on a regional basis. This regional structure could also be more closely integrated with existing or new training programs.
9. Disincentives to newly trained physicians serving as locums should be eliminated, including the imposition of restrictive measures, the threat of such restrictive

measures, licensure rules which have eliminated the ability of residents to provide locum services during their residency training programs, and the failure to provide timely provision of OHIP billing numbers to residents completing their training.

10. Locum programs must be sufficiently flexible to allow physicians to sign up as locums for varying periods of time (i.e. ranging from a weekend, to a week or month, to a longer period) without rigid, fixed requirements or minimums.
11. Payment plans for locums should be generous, in recognition of the historical difficulty in recruiting physicians for this role, the challenge of providing service in a series of varying practice settings, and the inevitable gaps in scheduling. Assistance for travel, accommodation and CME (especially advanced life support courses) along with a guaranteed minimum income, should be included.
12. Recruiting communities and physicians should be provided with a checklist of practical, proven suggestions for attracting locums, and providing a positive working experience.

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B. 23. Spousal and Family Concerns

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C. INFRASTRUCTURE

25. Community Development Officers 

III SOLUTIONS

C. INFRASTRUCTURE

25. Community Development Officers

The momentum created by early success of the Community Development Officer in Northwestern Ontario has been somewhat stalled by inertia in expanding the CDO program to include other rural regions. Important issues, including the development of the CDO role, accountability and reporting structure, need to be further clarified.

Recommendations:

1. Six Community Development Officers should be in place with appropriate program support and funding, to serve defined regions within the province: Northwest, Northeast, Southwest, Southeast, Central, as well as underserved urban domains of practice within the province.
2. CDOs should function as local operatives of the Rural and Remote Areas Program (as discussed in Section 26), responsible to communities rather than the Ministry. They must be in constant communication with their communities and responsive to needs as they arise. They should work towards meeting short and long term physician needs in the communities, and work in close cooperation with university-based Regional Director of Rural Training (see also Section 9, recommendation 1).
3. CDOs would have the primary responsibility for facilitating and improving physician recruitment, with an intimate knowledge of the communities and physicians they serve. However, the role of the CDO must also include matters such as physician retention, participation in the co-ordination of locum tenens arrangements, and the integration of recruitment and medical education activities.

III SOLUTIONS

C. INFRASTRUCTURE

26. Rural and Remote Areas Program (RRAP)

The current "Underserviced Area Program" has come to be perceived as distant from and unresponsive to the needs of rural and remote communities. A clear consensus has evolved that the current UAP approach results, at best, in an inadequate estimate of the true levels of medical need within rural areas, providing an uncoordinated and ad-hoc array of different programs. The effectiveness and transparency of the program must be increased and the program's directions and actions must be realized to meet the changing needs of rural and remote communities.

Recommendations:

1. Renaming and restructuring of the current UAP program to the "Rural and Remote Areas Program" would help to refocus the core objective of ensuring that communities are no longer underserved, and would be a positive step in refocusing the government's direction, responsiveness and renewed commitment.
2. The mandate of RRAP should include developing, funding and implementing programs and support to recruit and retain an adequate and equitable number of appropriately trained and skilled rural physicians to provide accessible, quality medical care in all rural areas of the province. The ultimate goal of RRAP should be to remove the notion of "underservice" from Rural and Northern planning.
3. RRAP should receive government funding needed to support the initiatives required in order to recruit, retain and support the necessary number of rural physicians. This should include funding for the Rural Physician Clinical Support (as detailed in section 18), locum programs and the negotiations of alternate payment plans to meet the needs of each community.
4. RRAP should be responsible to an Assistant Deputy Minister for Rural and Northern Health, but administered by a small and responsive Board, which includes membership from the community, rural health providers and rural and health care organizations.
5. The Board would be responsible for selecting the Director of the Program. The Director would be responsible for the day to day operation of the Program.
6. RRAP should have a clear line of communication with the newly created Executive Director of Rural Health at Health Canada.
7. RRAP's structure and mandate should include funding and staff to conduct and review relevant research and ideas from other jurisdictions working on similar rural and remote access problems.

8. One of the first responsibilities of RRAP would be to work with communities, physicians and other stakeholders to develop more workable and effective criteria for defining rural and underserviced designations, as well as proactively developing permanent community recruitment committees.
9. RRAP would work in an integrated and co-ordinated fashion with university medical schools on education and training activities, through the University Offices of Rural Medicine (as proposed in Section 4, recommendation 1).
10. CDOs would be co-ordinated through RRAP, providing integrated planning of recruitment, retention and locum activities and services.

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C. 25. Community Development Officers

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C. 27. Rurality Index 

III SOLUTIONS

C. INFRASTRUCTURE

27. Rurality Index

Rural is a perspective, dependent on person, place and context. As such, the definition and meaning of rural practice will vary considerably, depending on whether the person is a rural patient trying to access care, a rural doctor or other rural health care worker, a researcher or a government planner.

In general terms, rural practice can be defined as practice in non-urban areas, where most medical care is provided by a small number of general practitioners with limited or distant access to specialist resources and high technology health care facilities.⁴⁸ In Canada, communities of up to 10,000 are often classified as rural. An agreement between the Ontario Ministry of Health and the Ontario Medical Association identifies communities of fewer than 10,000, greater than 80 km from a regional centre of more than 50,000 people as "specified" or "isolated" communities. The Rural Committee of the Canadian Association of Emergency Physicians defines "rural remote" as "rural communities about 80-400 km or about one to four hours transport in good weather from a major regional hospital" and "rural isolated" as "rural communities greater than about 400 km or about four hours transport in good weather from a major regional hospital".

Definitions such as these, however, fail to include or measure the depth and variety of rural practice and the many factors important to recruitment and retention of rural physicians. The practice of medicine becomes more challenging as distances from urban areas and isolation increase, while local resources decrease. Rural physicians in many settings may be called upon to have a much broader scope of practice than physicians in urban practice. In fact, a practical definition of rural practice used by the Royal Australian College of General Practitioners, Faculty of Rural Medicine, is "medical practice outside of urban areas where the location of practice obliges some general/family practitioners to have or acquire procedural or other skills not usually required in urban practice". Physicians in the smallest, most remote settings have to cope with the difficulties of help being a long time and distance away. In larger rural communities with a small, active hospital many rural physicians have an extremely active hospital role that may include emergency medicine, obstetrics and sometimes GP anaesthesia. Acquiring and maintaining the necessary knowledge and skills is a daunting challenge.

In the smaller, more distant communities, educational facilities, job opportunities, religious/cultural access and potential mate pool for unmarried physicians are all less available. Transportation for these activities are both time-consuming and expensive.


Given the broad diversity of rural settings, it is important to offer payment plans and other incentive programs in these varied settings in a graduated fashion. Sometimes measures adopted to address the problems in one rural area will cause unexpected adverse consequences in other rural areas. For example, incentive plans offered in one rural locale might result in a movement of physicians away from another rural area, simply shifting the undersupply problem from one area to another. Tailoring programs based on a measure of rurality would reduce the likelihood of such unintended consequences.

In the case of some recruitment and retention programs, it may be possible to utilize a rather simple rural index, but other programs will likely require a more detailed index which incorporates a wide variety of parameters. A valid rural index would also be of value to researchers and to those engaged in other aspects of health care planning in rural areas.

General practice rurality indexes need to be developed and assessed by how well they reflect where physicians practise (community and lifestyle factors), what these physicians do (scope of practice and on-call burden), what professional isolation and support they experience and how these three main considerations are weighted.

Recommendations:

1. That an ad-hoc committee with adequate resources be immediately struck to:
 - i. examine current rural index proposals;
 - ii. propose a model which utilizes the best features of the various current proposals;
 - iii. initiate a detailed assessment/validation of the model;
 - iv. formulate final adjustments to create a usable, reliable rurality index.
 2. In the interim, as a temporary measure only, the current accepted Ontario Ministry of Health/Ontario Medical Association definition of "practising in communities with fewer than 10,000 people, greater than 80 km from a regional centre with more than 50,000 people" should be used as a base definition for rural practice incentive programs. The most generous incentives and other positive measures and supports would be available for the smallest and most remote communities (for example, communities with less than 3,000 people and most distant communities, i.e. more than 160 or 200 km from a regional centre with more than 50,000 people). Varying levels of incentives and supports would be available, as the size of the community increases and/or the community is closer to a larger regional centre.
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C. 26. Rural and Remote Areas
Program (RRAP)

next...**IV - Future Directions**
A. THE NEED FOR OTHER HEALTH CARE
REFORMS 

IV FUTURE DIRECTIONS

A. THE NEED FOR OTHER HEALTH CARE REFORMS

The practice of medicine in the rural setting depends on ensuring that rural physicians are properly prepared for the challenge, competitively remunerated, and provided with a sustainable work and living environment. This Blueprint document represents an outline toward achieving these goals.

Nevertheless, because of its focus on training, remuneration, and retention initiatives for rural physicians, it is beyond the scope of this paper to discuss in detail a number of other issues that are of critical importance in achieving the greater goal of full and sustainable health care as a whole for the people of rural Ontario. This final section of the document enumerates some of these key issues that must also be dealt with to ensure that the working milieu of rural physicians, and other health care workers, will be equal to the tasks ahead.

Rural hospitals are different than those in urban areas. Important as they are in cities, hospitals are perceived in rural areas as being among the most important local institutions. They provide a different, and in some respects a broader, range of services than in cities because they are often the only resource available to rural physicians. For example, many rural towns do not have a shelter for battered women and sometimes the hospital might be the only safe place immediately available. Few small towns have "half-way" houses. Services such as physiotherapy, radiology, and laboratory are usually located in the rural hospital, in contrast to urban areas where private facilities outnumber public ones. As well, rural hospitals can be one of the major employers in rural towns. The presence or absence of a rural hospital may also determine which industries (including tourism) can survive in a rural area.

It should go without saying that rural physicians absolutely require hospitals in order to provide the wide range of services needed in rural areas, from emergency care to in-patient admissions, from obstetrics to surgery, from diagnostic studies to dialysis, from chemotherapy to palliative care. From the perspective of the rural patient, the value of care "as close to home as possible" must not be overlooked. Outcomes in the care of emergencies frequently depend on the provision of care within the "golden hour". A properly supported local rural hospital can provide a critical personal touch, particularly for the elderly, the young, and the palliative care patient. It can also provide the opportunity for frequent supportive visits from family and friends, and a significant reduction in travel costs for both the ambulance system and for the patients themselves. Some important preventative health care opportunities, such as mammography and cardiac rehabilitation, will not be taken advantage of if not provided locally. Finally, an integrated

system of pre-operative evaluation provided to rural patients in local hospitals can eliminate duplication of tests and save both time and money for rural residents. The true value to the patient of the rural hospital seems apparent, but it is our contention that these hospitals are also cost efficient when all factors (including ambulance costs, travel costs for families, and the greater per diem and other costs incurred in tertiary care centres) are included. Research into this proposition is urgently needed.

For all these and many other reasons, the rural hospital occupies an extremely important niche in rural Ontario both for physicians and the general public. Any restructuring initiatives such as those found in proposals for regionalization, and in recent recommendations by the HSRC (Health Services Restructuring Commission),⁴⁹ will likely be met with stiff community and physician opposition. While the special consideration given rural hospitals through the "Framework"⁵⁰ and "Benchmark"⁵¹ documents is appreciated, the implementation of the recommendations remains open to interpretation of the various District Health Councils, DHCs, (which are now urban-based, with limited representation from rural areas), and it is not at all clear that the thresholds which have been established will ensure the continued thriving of rural hospitals, let alone the expansion and repatriation of services in rural areas that are needed for the times ahead. (It must be born in mind that demographic shifts from urban to rural, accelerated by the demographic shift of "boomers" into rural settings, plus the advances in information technology allowing ever-increasing numbers of at-home workers, mean that the demand for health care services in rural areas will probably outpace the growth rate in urban areas).

It is of the greatest importance that clear plans to sustain and nurture rural hospitals be developed now and implemented as soon as possible and that there be firm opposition to the shift toward centralization of services inherent in the trend to regionalization.

Along similar lines, concern must be directed toward the "downloading" of many services from Provincial to Local Governments. Public health and ambulance services are complex and expensive but essential services for rural areas. Particularly with the closure or reduced capacity for rural hospitals expected to come from DHCs, based on directions established by the HSRC, the importance of ambulance services grows ever larger. The economies and efficiencies of scale enjoyed by running such programs on a province-wide scale have now been sacrificed. Of great concern as well is the limited revenue base that many rural areas have to draw upon to sustain such downloaded services. This is particularly ironic given the disproportionately large amount of economic activity generated in rural areas.

Rural health care is limited not only by chronic shortages of physicians but of other health care professionals as well. Virtually all areas, including nursing, laboratory services, occupational therapy, physiotherapy, respiratory therapy, nutrition services, mental health

services, and pharmacy services, to name but a few, are chronically understaffed. What is not generally appreciated is the ongoing shortage of skilled administrators, financial officers, and other key management personnel.

A particular concern in these days of cutbacks is the rural home care nurse. More and more, patients are sent home "quicker and sicker" and reliance on this essential service is growing. However, in rural areas, while this service may be even more important than in urban areas, sustaining and enhancing this service does not seem to be a government priority at present. One of the problems is that patients are scattered over large, sometimes vast distances, and travel time can consume a significant amount of a nurse's day. It is key that formulas for determination of provision of home-care nursing hours be based on the amount of time nurses actually spend with patients, not the total number of hours on the job per day, to account for "down time" incurred during travel between patients. (In this context, the relative economic value of rural hospitals might be enhanced, as the true cost of nursing at home for a widely scattered, low-density population is probably not being fully calculated at present.)

There are similar concerns about long-term care in rural areas. Due to insufficient family and home-care support, there is generally a greater need for long-term care beds in rural areas. Furthermore, because of the relative lack of such beds in rural areas, acute-care beds are frequently blocked by patients for whom placement in a nursing home far away from family and friends would be inappropriate and potentially deleterious to their health. Such situations arise, for example, when a person is placed in a setting where her or his mother tongue is not spoken. Elderly residents of Thunder Bay are not routinely placed in nursing homes in Ottawa, distant from their life-long support networks. Rural residents deserve the same.

Other elements of infrastructure within rural society also affect the recruitment and retention of rural physicians. Anything making rural areas better places to live, be they excellent schools, police and fire services, or cultural and social outlets, improves the chances of retaining rural physicians and other health care professionals. Unfortunately, many recent changes in Ontario have been felt by many in rural Ontario to be working in just the opposite direction. Downloading of other services such as highways, reduced snow-plowing operations, threat to funding for education and the loss of local control for rural schools, deregulation of bus services, ever-worsening postal services, and so on, contribute to making rural practice less attractive, particularly to those born and raised in urban settings. Both Federal and Provincial Governments must re-examine this situation and institute measures to reverse this trend.


A program to sustain rural physicians must include measures to sustain the infra-structure required to deliver health-care services. While beyond the scope of this paper, it is

necessary to address these issues as part of a larger integrated plan for rural health care. It is suggested that this ought to be the work of a new task force, perhaps one involving a range of "stakeholders".

Recommendations:

1. That the government strike a commission (perhaps similar in scope and powers to the HSRC) dedicated to the issues involved in providing health care to rural areas; its mandate should include the coordination of the efforts of the many organizations and committees currently working on rural health care.

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B. A CALL TO ACTION 

IV FUTURE DIRECTIONS

B. A CALL TO ACTION

Much work needs to be done to improve physician recruitment and retention in remote and rural Ontario. It is our hope that the process of renewal can be assisted by the discussion and recommendations contained within this Blueprint. Now is the time to put a comprehensive and integrated plan into action - to use this Blueprint and the work of other stakeholders to collectively build the health care structure that rural Ontarians need and deserve.

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**A. THE NEED FOR OTHER HEALTH CARE
REFORMS**

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Appendix 1 

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APPENDIX 1

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B. A CALL TO ACTION

2. Ontario Population Breakdown by Region 

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APPENDIX 2

Ontario Population Breakdown by Region*

	Total	500 000 and over	100 000 to 499 999	50 000 to 99 999	10 000 to 49 999	< 10 000 incl. Rural
Ontario	10 753 573	5 095 295 47.38%	1 763 657 16.40%	674 172 6.27%	711 095 6.61%	2 509 358 23.34%
South West	1 440 509	0.00%	565 820 39.28%	79 204 5.50%	231 268 16.05%	564 217 39.17%
Central West	2 050 804	702 461 34.25%	656 072 31.99%	180 995 8.83%	101 369 4.94%	409 907 19.99%
Central East	4 907 360	3 796 434 77.36%	214 867 4.38%	107 143 2.18%	181 562 3.70%	544 354 11.09%
East	1 478 161	596 398 40.35%	107 229 7.25%	118 456 8.01%	106 996 7.24%	549 082 37.15%
North East	632 622	0.00%	111 536 17.63%	125 374 19.82%	77 779 12.29%	317 933 50.26%
North West	244 117	0.00%	108 132 44.30%	0.00%	12 121 4.97%	123 864 50.74%

* Central West includes Halton County to be consistent with other tables.

Data Source:

Statistics Canada. A National Overview. Ottawa: Industry Canada, 1997. 1996 Census of Canada.



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APPENDIX 3

Population per Active Physician in Ontario by Planning Region

	Total Physicians	Non Specialists	Specialists
Ontario	550	1124	1075
Central East	506	1042	983
Central West*	637	1286	1264
Eastern	465	1011	860
North East	730	1206	1851
North West	719	1130	1973
South West	636	1358	1197

* Central West includes Halton County as data previous to 1998 boundary change.

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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97 PPAP ON by region % 24/11/98

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2. Ontario Population Breakdown
by Region

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4. Population per Non-Specialist in Central East
Ontario by County ▶

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APPENDIX 4

Population per Non-Specialist in Central East* Ontario by County

Ontario	1124
Central East	1042
Durham	1632
Haliburton	1335
Northumberland	1503
Peel	1449
Peterborough	1095
Simcoe	1259
Toronto Metro.	824
Victoria	1483
York	1218

* Central West includes Halton County as data previous to 1998 boundary change.

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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APPENDIX 5

Population per Non-Specialist in Central West* Ontario by County

Ontario	1124
Central West	1286
Brant	1391
Dufferin	1470
Haldimand-Norfolk	1843
Halton	1102
Hamilton-Wentworth	1125
Niagara	1519
Waterloo	1370
Wellington	1212

* Central West includes Halton County as data previous to 1998 boundary change.

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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APPENDIX 6

Population per Non-Specialist in East Ontario by County

Ontario	1124
East	1011
Frontenac	708
Hastings	1341
Lanark	1138
Leeds & Grenville	1314
Lennox & Addington	1340
Ottawa-Carleton	887
Rescott & Russell	1505
Prince Edward	1064
Renfrew	1275
Stormfront, Dundas & Glengarry	1592

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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APPENDIX 7

Population per Non-Specialist in North East Ontario by County

Ontario	1124
North East	1206
Algoma	1240
Cochrane	1235
Manitoulin	827
Muskoka	830
Nipissing	1143
Parry Sound	1465
Sudbury D. M.	2618
Sudbury R. M.	1283
Timiskaming	1100

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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97 PPNS NE by county 24/11/98

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8. Population per Non-Specialist in North
West Ontario by County ▶

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APPENDIX 8

Population per Non-Specialist in North West Ontario by County

Ontario	1124
North West	1130
Kenora	957
Rainy River	1140
Thunder Bay	1216

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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9. Population per Non-Specialist in South
West Ontario by County ▶

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APPENDIX 9

Population per Non-Specialist in South West Ontario by County

Ontario	1124
South West	1358
Bruce	1420
Elgin	1856
Essex	1570
Grey	1198
Huron	1304
Kent	1669
Lambton	1893
Middlesex	1000
Oxford	1858
Perth	1328

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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APPENDIX 10

Population per GP / FP Billing \$60K by Planning Region*

	Population	GP/FP Billing \$60K	Population per GP/FP
Ontario	10 753 573	8077	1331
Central East	4 907 360	3915	1253
Central West*	2 050 804	1283	1598
Eastern	1 478 161	1157	1278
North East	632 622	415	1524
North West	244 117	181	1349
South West	1440	1358	1197

* Central West includes Halton County.

Data Source:

Statistics Canada. A National Overview. Ottawa: Industry Canada, 1997. 1996 Census of Canada.

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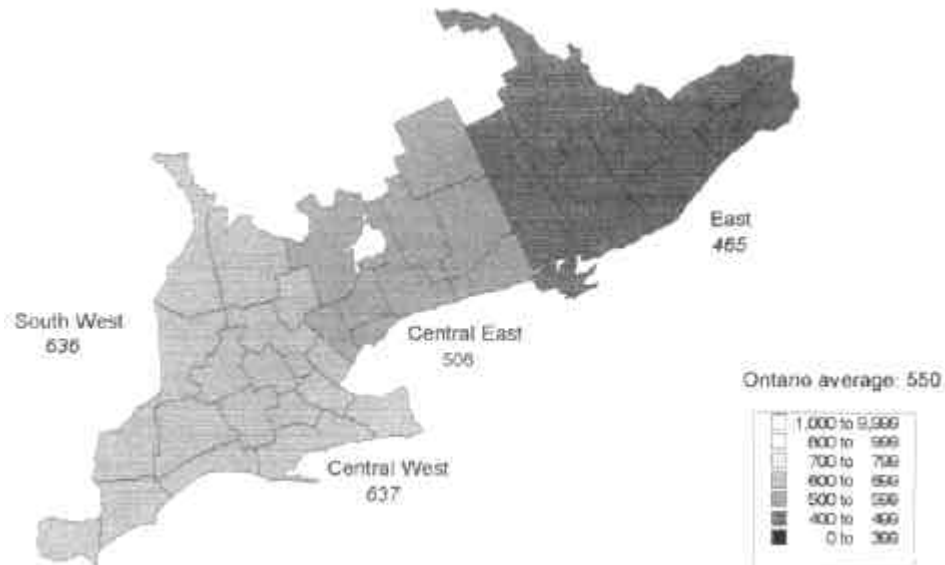


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APPENDIX 11

Population per Active Physician in Southern Ontario by Planning Region



* Central West includes Halton County as data previous to 1998 boundary change.

Prepared by SWORM

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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10. Population per GP / FP Billing
\$60K by Planning Region

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12. Population per Active Physician in
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APPENDIX 12

Population per Active Physician in Northern Ontario by Planning Region



Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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11. Population per Active Physician in
Southern Ontario by Planning Region

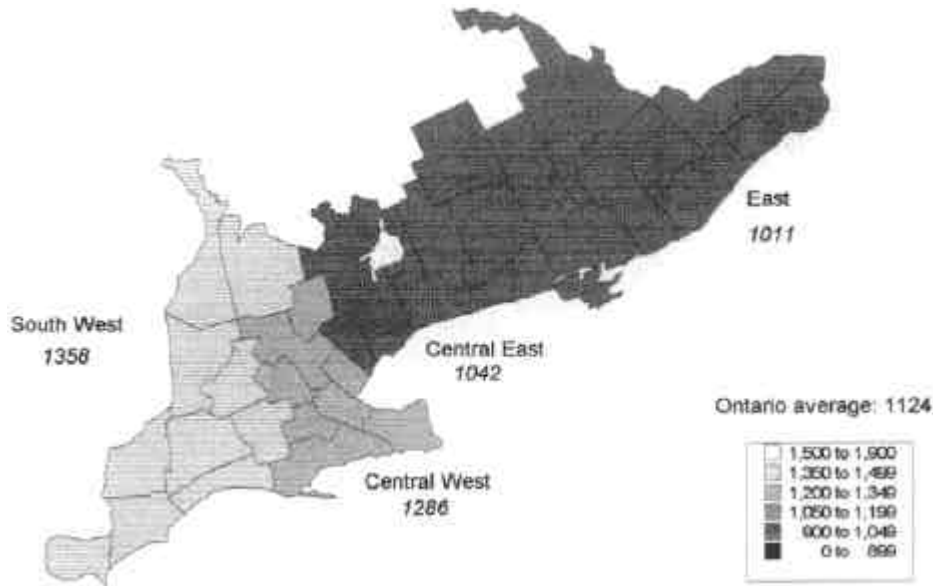
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13. Population per Non-Specialist in
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APPENDIX 13

Population per Active Physician in Southern Ontario by Planning Region *



* Central West includes Halton County as data previous to 1998 boundary change.

Prepared by SWORM

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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12. Population per Active Physician in
Northern Ontario by Planning Region

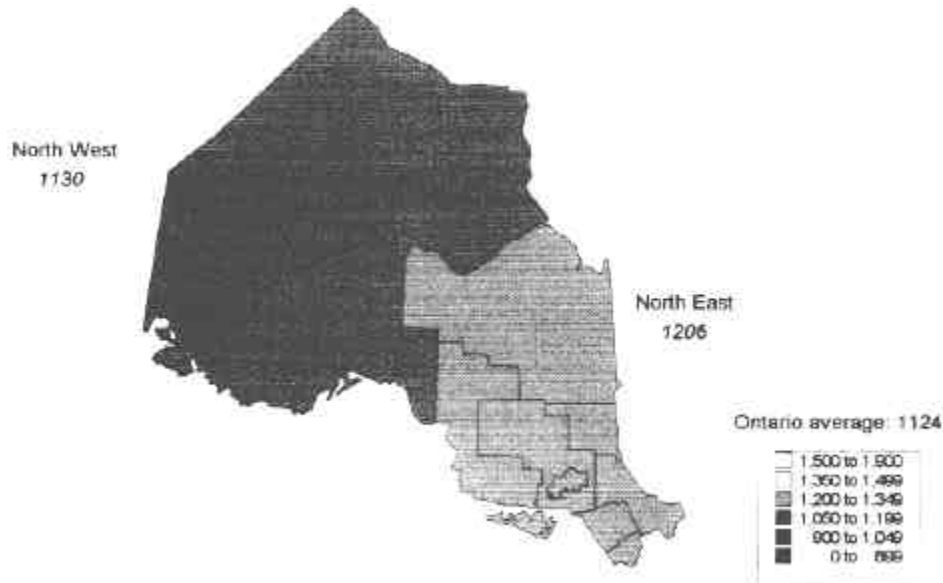
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APPENDIX 14

Population per Non-Specialist in Northern Ontario by Planning Region



Prepared by SWORM

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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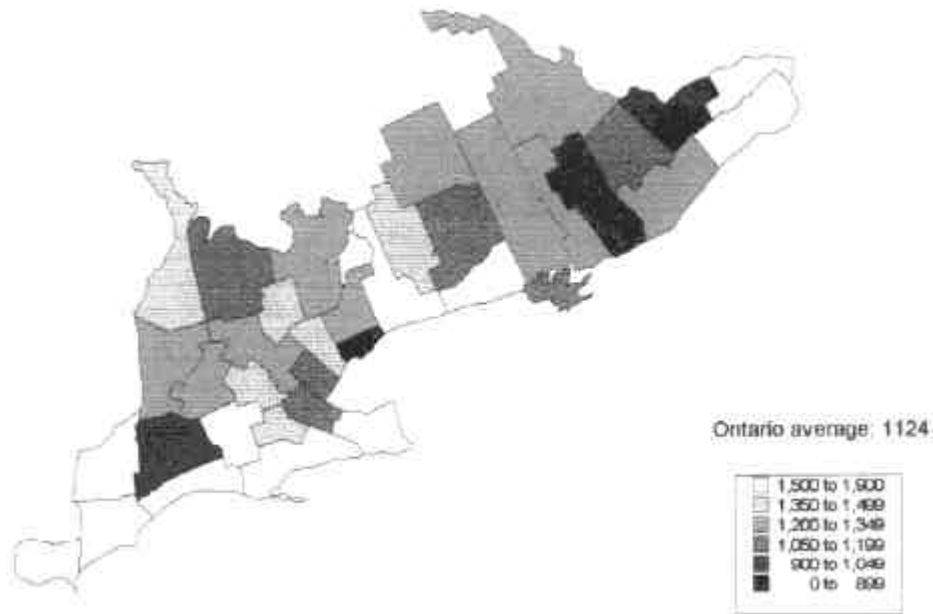
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APPENDIX 15

Population per Non-Specialist in Southern Ontario by County



Prepared by SWORM

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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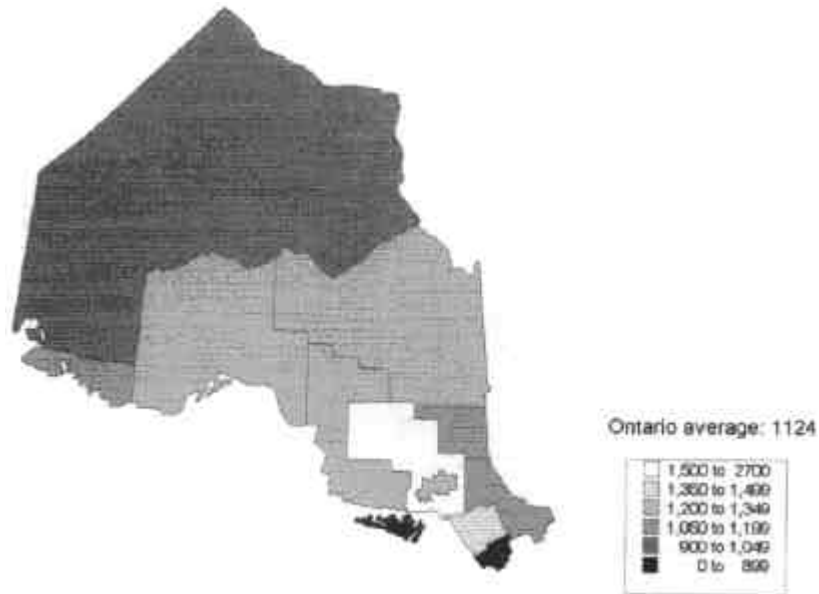
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16. Population per Specialist in Northern
Ontario by Planning Region ▶

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APPENDIX 16

Population per Non-Specialist in Northern Ontario by County



Prepared by SWORM

Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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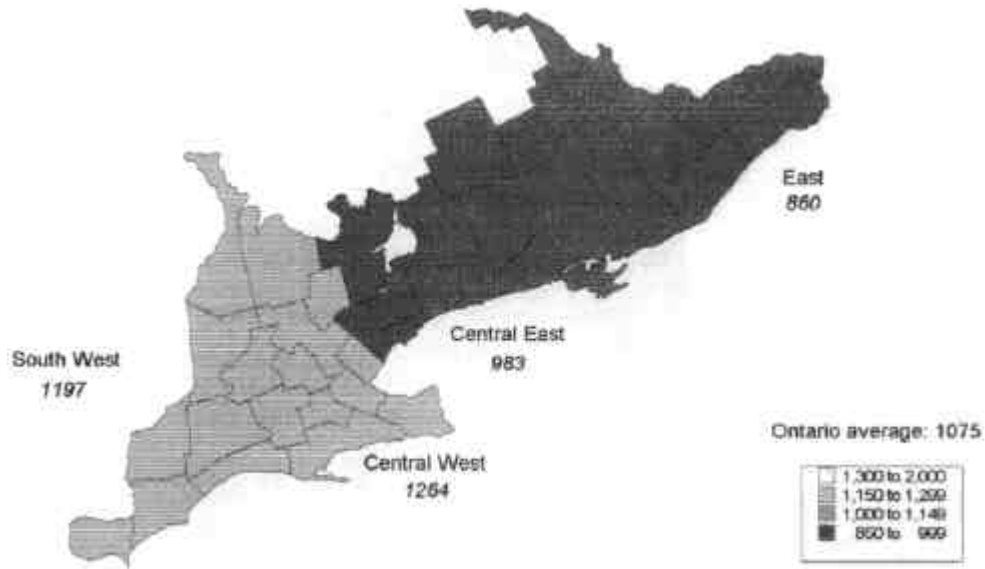
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17. Population per Non-Specialist in
Southern Ontario by Planning County ▶

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APPENDIX 17

Population per Specialist in Southern Ontario by Planning Region *



* Central West includes Halton County as data previous to 1998 boundary change.

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Data Source:

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18. Population per Specialist in Northern
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APPENDIX 18

Population per Specialist in Northern Ontario by Planning Region



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Data Source:

Clements K, Johnston N. Physicians in Ontario 1997. Hamilton: Ontario Physician Human Resources Data Centre, 1998.



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19. Toward a New Vision for Globally
Funded Group Practice Agreements ▶

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APPENDIX 19

TOWARD A NEW VISION FOR GLOBALLY FUNDED GROUP PRACTICE AGREEMENTS

EXECUTIVE SUMMARY

Successful implementation of Globally Funded Group Practice Agreements (GFGPAs) would be a significant step towards establishing a stable basis for the provision of medical services in Northern, underserved communities. However, this requires a shift in the present Ministry approach, so that global funding would be based on a sustainable physician complement (a "critical mass") in each community, rather than the present Underserved Area Program (UAP) minimum designations. It also requires that the funding provided for physician services recognize the special and unique workload and responsibilities of physicians practising in Northern underserved communities.

This document summarizes the components of GFGPAs that, in the view of physicians in Northwestern Ontario, are essential to making these agreements workable and sustainable.

Service

A key element of the GFGPA model is that the group of physicians would be responsible for providing 24-hour access to emergency services, palliative care services, and obstetrical services (where provided by members of the physician group).

The physician group would provide basic or core medical services during the regular working day.

Special services, which may be provided by one or more physicians in the group, would include obstetrical services, surgery and surgical assists, and anaesthesia.

Non-emergency services would be available from the group for five days per week during regular office hours for at least forty hours per week (excluding statutory holidays).

Complement

Basing the GFGPA "complement" (i.e. the number of physicians the Ministry will provide funding for in any one community, which effectively determines the overall budget for GFGPA communities) on the present UAP numbers, as proposed by the Ministry of Health, fails to respond to the needs of physicians and underserved communities. The UAP numbers have, time and time again, proven to be inaccurate, arbitrary and not reflective of the real physician need in any given community. As long as the GFGPA funding model is based on the minimum number established for the purposes of underserved area designations, it will fail to provide for the sustainable number of physicians needed to avoid physician burnout and therefore needed for physician recruitment and retention.

In any community where there are on-call and emergency services to be provided in a hospital, the funding formula, and therefore the physician complement on which the formula is based, must take into account the reality that communities need, at the very least, six physicians in order to maintain a sustainable on-call practice. This is the only arrangement consistent with the recognition by the OMA, OHA and the "Scott Report" that an on-call schedule of more than one in five is not sustainable or reasonable, since it imposes an onerous and unreasonable workload on the community's physicians.

The appropriate number of physicians required in each community can be characterized as the necessary "critical mass" required for sustainable recruitment and retention, including on-call coverage. This "critical mass" can be expressed as the minimum UAP complement, "plus" the additional number of physicians required to service the community and meet the needs of recruitment and retention. Critical mass will vary with the experience and needs of different communities, but must be no fewer than six physicians.

In certain smaller communities, it may not be realistic or possible to have a sufficient number of physicians to provide 24 hour access to certain services, as envisioned under the GFGPA model. As a result, in these smaller communities (i.e. those that cannot realistically support funding for at least six physicians), access to Community Sponsored Contract (CSC) arrangements, as presently available for one and two doctor communities, must also be extended.

Baseline Funding

Any consideration of baseline funding per physician is meaningless if the "number of physicians" is not a proper reflection of the number of physicians that are realistically

required in a given community in order to ensure that burnout is avoided and that a sustainable, stable physician complement can be preserved in each community.

The GFGPA global funding would be comprised of the following elements:

- a multiple of an appropriately determined amount of baseline funding and the appropriate complement of physicians. The baseline funding could be based on a fee for service average with a premium in recognition of the special demands and responsibilities of Northern, underserved community physicians, or based on some other measure which is comparable to the funding already provided to physicians under community sponsored contracts or in community health centres in the North;
- the Scott sessional funding (as provided under the Ministry's present draft GFGPA contract);
- separate funding for locums (as provided under the Ministry's present draft contract, but for all CME and vacation time);
- specific funding for additional services and benefits (which, in general terms, are already contained in the present government GFGPA proposed contract).

Time Off for Physicians

Each GFGPA physician should be entitled to a total of eight weeks paid vacation and CME per year (four weeks time off for CME per annum together with four weeks paid vacation).

Locums

In keeping with the vacation and CME time off for each physician, locum replacement services would be required for two months per year for each group physician.

Funding for other Services and Benefits

This would be a reasonable annual stipend for those physicians who provide special services (i.e. obstetrical services, anaesthesia and surgery), which reflects the increased responsibility and dedication (in particular through extra, unpaid call requirements) that these special services require. There should also be specific funding for a completion bonus, and for paid maternity leave.

Conclusion

We are at a critical turning point for the future provision of medical services in our

communities. The present system is not working. We need to move quickly from paper commitments (including the \$36.4 million under the Government/OMA Agreement) to real world implementation. While we neither support coercive measures nor believe that they will work, we do believe that a comprehensive package of recruitment and retention measures, of which the GFGPA model forms a key component, would work.

The Northwest Ontario physicians are hopeful that this document will lead to renewed discussions for the negotiation and implementation of a GFGPA funding model, and so to sustainable physician recruitment and retention in our communities.

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18. Population per Specialist in Northern
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VI BIBLIOGRAPHY

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