ETHICS

What should rural doctors expect?

A basic ethical challenge for rural practice

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Most physicians and medical students have some appreciation for the unique character of rural medicine, even if they have never experienced it first-hand. It is well understood that relative scarcity of medical facilities, technologies, specialists, and administrative support must always be a constant of rural practice. It is equally well understood that, as a result of this scarcity, rural physicians must be prepared to be generalists: they must perform multiple roles in their host communities and provide a wider range of health care services than they otherwise would in an urban setting. Yet for most physicians and physicians-in-training considering a job in a remote community, the social and professional aspects of rural medicine remain a mystery—perhaps coloured by preconceived notions of the simple pleasures and conservative ways of small-town life. The present brief article is intended to shed some light on a basic ethical challenge readers of this journal may expect to face when considering rural practice: the strong temptation to use a rural job as a waypoint to urban employment, at the expense of their host community.

NO ONE IS TO BLAME: FINANCIAL REALITIES AND RECRUITMENT STRATEGIES

An important source of conflict in rural health care is the potentially competing incentives of young physicians, their prospective rural employers, and neighbouring communities. A majority of medical students surveyed by one study reported feeling financial pressures (largely due to high levels of indebtedness) to consider taking jobs in rural areas, which routinely offer financial incentives, such as signing bonuses and debt repayment, in order to attract physicians.¹ With sharply rising medical school tuition rates, these financial pressures on students will only continue to increase. The same medical students surveyed in the study also reported that when choosing where to practice long-term, they were swayed just as much by nonfinancial considerations—especially by relative geographical proximity to their own families, employment for their partners or spouses (which may be harder to find in remote areas), and conveniences of urban life to which they have become accustomed. Thus, nonfinancial considerations seem to incline physicians to prefer urban practice. This may help to explain why, by at least one measure, 20% of Canadians live in rural areas, while only 10% of Canadian physicians service those same areas.¹

While rural communities’ recruitment strategies may be effective in attracting some physicians immediately after graduation, a significant proportion of these doctors may actually intend for their rural employment to be only a temporary step towards eventual urban employment. As a result, the relatively poor physician retention rates in rural communities create a revolving door effect in which continuity of care may be interrupted, patients may lose trust in their doctors, and quality of care may suffer.²³ To add to these difficulties, neighbouring communities hard-pressed to find doctors may try to take advantage of each other by “poaching” each other’s physicians—only to create further uncertainty and instability.²

Yet no part of the above is intended to cast blame on rural communities or on physicians making decisions based on self-interest ed considerations. These problems are simply the consequences of the nature of the health care system in a country such as Canada. Within the prevailing legal and policy framework (see “Legal and policy issues in rural and remote medicine”, in this issue), we could hardly demand that physicians selflessly sacrifice career goals or access to their families in order to service rural communities in need of their expertise, just as we can hardly blame those same communities for pursuing strategies that incidentally harm quality of care throughout the system. This is reflected by the fact that even the World Health Organization (in its 2010 “Global Policy Recommendations”) effectively endorses recruitment strategies currently practiced by rural communities.⁴

These systemic (economic, social, and geographical) constraints notwithstanding, it would be a mistake to deny the possibility of meaningful ethical deliberation and choice within the context of rural medical practice. Recent literature on the ethics of rural medicine hints at a certain possibility of ethical resolution to the rural recruitment and retention dilemma we have just sketched.

AN ETHICAL CHALLENGE AND AN ETHICAL POSSIBILITY

One problematic consequence of existing rural recruitment strategies is that physicians and their rural employers are both tempted to misrepresent their long-term interests. Physicians—who may only want to stay for a few years to pay off their loans—may be inclined to promise a much longer time commitment to rural communities than they are actually willing to honour. Similarly, those same communities may be inclined to misrepresent the actual workload and range of responsibilities their hires would have to take on. The obvious ethical challenge here is one of mutual duplicity—a problem that is difficult to redress directly (as we have suggested) due to the incentive structure that exists in our health care system. Yet there is also to be found here a promising ethical possibility. The clash of incentives is probably unavoidable, but perhaps a reassessment of values—on both sides—can pave the way to a happy (or happier) solution for all parties.

It is true that, as we have already mentioned, medical students and young physicians express a strong preference for an urban way of life. Yet the preferences of Generation X and Y physicians (born 1962-77 and 1978-94, respectively) turn out to be much more complicated than they appear. In addition to wanting the many modern conveniences they can find in the city, those surveyed also reported...
being attracted to rural employment because of the interconnectedness, familiarity, and sense of community that exist in rural settings, but are often absent in urban ones.\textsuperscript{2,3} Physicians want opportunities for more interaction with their patients, and to develop deeper relationships of mutual trust, since physicians believe these interactions and relationships would improve quality of care as well as their own job satisfaction. One might think it possible for physicians to combine these two distinct goals (ie, urban comforts on the one hand and rural connectedness on the other) by seeking out rural communities that have, if not all, then at least many of the attractions of urban life: a well-trained support staff; quality medical equipment; amenities for life and leisure such as gyms, parks, restaurants and shops; and so on. Such a community would not be simply rural, but—as one interviewed physician put it—“latte rural”.\textsuperscript{5}

Should we then conclude that “latte rural” is the sought-after solution to the ethical problem faced by rural physicians? On the contrary, it takes only a little reflection to see that, in the first place, very few actual rural towns would be able to meet the requisite criteria of “latte rural.” Most rural towns simply do not have the resources to create the sort of infrastructure that physicians covet. And, even if a community should have the option to expand so as to accommodate the tastes of affluent professionals, it is entirely possible that the very sense of togetherness and interconnectedness that physicians find so charming would diminish or even disappear as the town grows.

Nevertheless, the simple awareness that rural practice does offer unique advantages that cannot be found in urban centres is crucial, since it may lead physicians to re-evaluate their priorities in a new light, and to make a choice. If physicians are truly serious when they claim (as attested by the cited studies) that they value the unique advantages—both professional and personal—of small-town life, then they would do well to re-examine their preferences and to question both their presumption in favour of urban employment as well as the soundness of the tempting, but illusory, “latte rural” ideal. This could lead them to reconsider their priorities as to the relative importance (for themselves) of urban conveniences, on the one hand, and intimate community involvement on the other. To be sure, even after reassessing their priorities many physicians may continue to prefer urban over rural practice. Yet perhaps even if only a (not-insignificant) minority changed their minds, rural communities would begin to find themselves recruiting more willing and loyal doctors.

Rural recruiters could potentially play an important role in this process, by helping physicians to reassess their priorities. Currently, it may be tempting for rural communities to try to embody the “latte rural” ideal, which they believe most appeals to urban-educated physicians. They may even be tempted to go so far as to embellish the range of modern conveniences they have to offer to prospective hires. Or, perhaps more likely, rural communities may feel compelled to compensate for what they perceive are disadvantages of their remoteness by emphasizing what prospective hires stand to gain in terms of financial rewards. Thus far, this approach has not yielded satisfactory results. The problem may simply be one of rural recruiters underestimating the appeal of small-town life to urban doctors. The alternative is for rural recruiters to develop strategies to introduce physicians to the unique charms of small-town life, and to persuade them of the real professional advantages of rural medical practice. Such an approach would decrease the need for duplicity, and at the same time may prove to be more effective in the long run.

REFERENCES
3. Simpson C, McDonald F. ‘Any body is better than nobody?’ Ethical questions around recruiting and/or retaining health professionals in rural areas. Rural Remote Health. 2011;11(4):1867.