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Recruitment trumps retention: results of the 2008/09 CMA Rural Practice Survey

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Introduction: In 2008, the Canadian Medical Association (CMA) conducted a survey of rural practitioners. The survey covered incentives to choose rural medicine, current satisfaction, plans for future migration and strategies for retention.
Methods: The CMA Canadian Collaborative Centre for Physician Resources, in collaboration with the Society of Rural Physicians of Canada, surveyed 1960 rural practitioners and received 642 responses (33% response rate). Because of similarities with earlier surveys, longitudinal analyses were possible.
Results: More than 70% of physicians older than 45 years received no incentives for setting up rural practice, compared with 41% of younger physicians. Younger physicians attached greater importance to financial incentives than older physicians, but personal incentives, such as accommodations in the community, were also important. The opportunity to practise one's full skill set was considered important (84%) as was liking the lifestyle (82%). One in 7 (14%) respondents planned to move from their communities within the next 2 years. They reported they might stay if they had a more reasonable workload, professional backup and locums.
Conclusion: Although increasingly common, cash incentives are not the main reason physicians choose rural practice. Practice and lifestyle factors are even more important. Communities need to focus as much on retention issues to protect their investment in the long term.

Introduction : En 2008, l'Association médicale canadienne (AMC) a effectué un sondage auprès des médecins qui travaillent en milieu rural. Le sondage abordait les motifs qui incitent les médecins à pratiquer en milieu rural, leur taux actuel de satisfaction, leur intention de quitter le milieu et les stratégies de rétention.
Méthodes : Le Centre canadien de collaboration sur les effectifs médicaux, en partenariat avec la Société de la médecine rurale du Canada, a interrogé 1960 médecins en milieu rural et 642 ont répondu (taux de réponse 33 %). Compte tenu de la similitude de ce sondage avec des sondages précédents, il a été possible d'effectuer des analyses longitudinales.
Résultats : Plus de 70 % des médecins de plus de 45 ans n'ont bénéficié d'aucune mesure incitative pour s'établir en région rurale, contre 41 % des médecins plus jeunes. Ces derniers ont semblé accorder plus d'importance aux mesures incitatives de nature économique que les médecins plus âgés, mais les motifs de nature personnelle, comme le milieu de vie communautaire, ont aussi paru importants. Les répondants ont en effet déclaré accorder de l'importance à leur capacité d'exploiter leur plein potentiel professionnel (84 %) et au style de vie (82 %). Un répondant sur sept (14 %) prévoyait quitter le milieu d'ici les deux années suivantes. Ces répondants affirmaient toutefois qu'ils resteraient peut-être plus longtemps si leur fardeau de travail diminuait et s'ils pouvaient compter sur une relève ou des médecins suppléants.
Conclusion : Bien que de plus en plus courantes, les mesures incitatives d'ordre économique ne sont pas la principale raison pour laquelle les médecins choisissent

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d'exercer en milieu rural. Les facteurs liés à la qualité de la pratique elle-même et au mode de vie revêtent encore plus d'importance. Les communautés doivent donc accorder autant d'attention aux facteurs de rétention si elles veulent protéger leur investissement à long terme.

INTRODUCTION

The 2008/09 Rural Practice Survey was conducted by the Canadian Medical Association (CMA) in collaboration with the Society of Rural Physicians of Canada. One of its purposes was to monitor trends at the national level with respect to the most likely predictors of migration from rural to urban areas, and to determine what initiatives could perhaps mitigate the flow.

Studies from Canada, Australia, South Africa and the United States have shown that physicians originating from a rural community are 2.5 to 3.5 times more likely to be in a rural practice.[1–6] Training in rural settings at both undergraduate and postgraduate levels has been shown to be positively associated with the decision to practise in a rural community.[3,7–12] The success of scholarships or bursaries with rural return of service agreements is highly variable, and these agreements have an impact mainly on recruitment and not retention.[13–15]

The CMA conducted surveys of physicians in rural practice in 1991, 1999 and 2001. The research showed that satisfaction levels of both personal and professional aspects of rural practice deteriorated between 1991 and 2001. A 2007 study showed that career satisfaction for small-town physicians was associated with being able to cope with the challenges of a variety of clinical conditions with little or no support.[16]

In the 1991 CMA study, more than half of the rural physicians who were planning to move felt that additional colleagues, locum tenens and alternative compensation might influence them to reconsider. In Australia, the top 3 issues determining retention of general practitioners in rural and remote areas were on-call arrangements, professional support and the variety of cases in rural practice.[17] A 2003 study in Ontario came to similar conclusions with respect to limits on on-call requirements; better locum programs; sessional payment for emergency, anesthetic and obstetric services; and a network for specialist referral.[18] The high levels of recruitment to rural practice of graduates from the Rural Clinical Schools in Australia occurred only when matched by a supportive clinical workplace environment.[19]

A study of graduates of northern Ontario family medicine programs who chose urban practice indicated that although there were multiple reasons for choosing to work in urban areas, family and personal factors were most frequently mentioned as reasons for deciding on an urban option.[20]

METHODS

In 2008, CMA staff from the Canadian Collaborative Centre for Physician Resources, in collaboration with the Society of Rural Physicians of Canada, designed a survey instrument for rural physicians. The survey was approved by the Human Investigation Committee of Memorial University. The survey was sent to 1960 physicians in rural practice, randomly selected from those with a zero as the second digit of their business postal code. Although this method is not ideal for quantifying all rural physicians, it was believed to be adequate for a sample survey. The selected sample was checked for appropriate demographic representation. A filter-type question about geographic characteristics of the primary population served by the physician was used to further isolate an appropriate population for the study.

The survey was bimodal (paper and Web-based) and in the field from mid-October 2008 until the end of January 2009. There was an advance email invitation to identify invalid addresses and 2 full invitations for both paper and online surveys.

Because the questions in the 2008/09 questionnaire were very similar to those used in earlier surveys, some longitudinal analysis of the results was possible, particularly with respect to satisfaction, reasons for moving and factors that might have kept physicians in rural practice.

RESULTS

Of the physicians contacted, 642 responded to the survey, for a response rate of 33%.

Demographic representativeness of the sample

Using the January 2008 CMA masterfile of physician data,[21] a comparison of the demographic compo-

sition of the rural survey respondents against those of the rural physician population in Canada in general was possible. In terms of sex, age group and broad specialty (i.e., family medicine or other specialty), the proportional breakdown of the survey respondents was representative of the rural physician population as a whole. Most jurisdictions were proportionally represented, with the exception of Quebec, Ontario and British Columbia. Quebec accounts for almost one-quarter of the rural physician population but only 16% of respondents. Ontario and British Columbia were slightly overrepresented, with 31% of respondents from Ontario and 19% from British Columbia, although these provinces comprise only 27% and 15% of Canada's rural doctors, respectively.

Incentive

Survey respondents were asked what, if any, incentives they received to encourage them to set up a rural practice, as well as what specific factors they considered were important in their decision to practise in a rural community.

When divided into 2 groups of "younger physicians" (≤ 45 yr) and "older physicians" (> 45 yr), a smaller proportion of older physicians received an incentive than younger ones, with 71% of older physicians reporting "no incentive" compared with 41% of younger physicians indicating the same.

Regardless of age, cash incentives were the most frequently offered inducement to encourage physicians to establish a practice in a rural location. More than half (58%) of younger physicians who received an incentive indicated that they received cash, compared with 39% of older physicians.

Almost 1 in 5 (19%) younger physicians who received incentives were offered accommodations in their rural community and 14% benefitted from family-oriented, nonfinancial incentives such as paid vacation, assistance with finding their spouses employment, daycare and proximity to family. Tuition repayment was used to encourage 13% of younger respondents to settle in a rural community. Figure 1 compares the various incentives received, by age group.

Choosing rural practice

The factors that received ratings of positive importance (very or somewhat important) in terms of making the decision to practise in a rural area included the following: "opportunity to practise full skill set" (with 84% of overall respondents providing a positive rating), "liked the rural lifestyle" (82% positive), "practice opportunity was available" (79% positive), "community needs a good match with my career interests" (75% positive) and "overall preference for rural practice" (71% positive).

Younger physicians attached greater importance to "financial recruitment/retention incentives" than did older ones. Almost half of younger physicians (49%) indicated that this factor was very or somewhat important (positive response) in their decision to practise in a rural location, compared with less

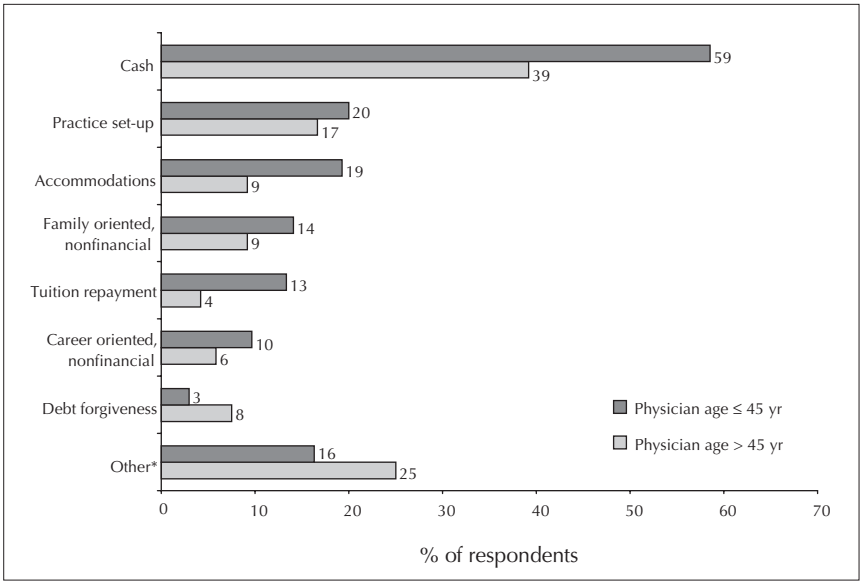


Fig. 1. Incentives received by the 255 physicians who were given incentives for practising in a rural setting, by age. *Other incentives listed by respondents included assistance with moving (including expenses), immigration assistance, vehicles, other financial benefits and other material tokens.

than one-third (32%) of their older colleagues. In fact, 38% of older physicians indicated this was very or somewhat unimportant (negative response), compared with 24% of younger physicians. Factors that were considered important in choosing a rural practice can be seen by age group in Figure 2.

A greater proportion of international medical graduates rated "financial recruitment/retention incentives" positively (56%) compared with 33% of graduates of Canadian medical schools. International medical graduates also attached greater importance to nonfinancial incentives than did graduates of Canadian medical schools (45% positive v. 21%). In addition, international medical graduates were significantly more likely to indicate that the availability of a practice opportunity was their number one reason for setting up a rural practice, with 18% selecting this option compared with 6% of graduates of Canadian medical schools.

"Rural experience in training" was more often rated positively by younger physicians (71%) than older physicians (40%). An absence of rural training experience by older physicians does not explain this difference, as these data excluded "not applicable" responses. However, younger physicians were far more likely to have done a rural rotation and they were also more likely to have spent more time in rural training. Younger physicians also expressed greater satisfaction with their level of preparation for rural practice, with 79% of younger physicians overall indicating they were very or somewhat satisfied, compared with less than two-thirds (64%) of older physicians.

Current personal and professional satisfaction

In general, rural physicians appear relatively satisfied with most aspects of their practice and personal lives in rural communities. Factors that drew the most dissatisfied responses were "ability to find locum tenens coverage" with well over half (60%) being very or somewhat dissatisfied (negative response) followed by "availability of professional backup" at 43%. Although the latter is less than half, only 40% gave this factor a positive rating and the rest remained neutral or did not respond. These 2 factors were also poorly rated in CMA surveys conducted in 1991[22] and 1999[23] and appear to be rated more poorly over time. When asked about professional backup, 28%[22] indicated they were very satisfied in 1991, compared with 14%[23] in 1999 and 11% in 2008.

Though a gradual decrease can be seen, "recreational opportunities" has maintained high rates of satisfaction over time with 51%,[22] 44%[23] and 43% indicating they were very satisfied in 1991, 1999 and 2008, respectively.

Increased satisfaction over the past decade can be seen in numerous factors as well. For example, "availability of CME/CPD opportunities" had 53%[23] of respondents indicating they were very or somewhat satisfied in 1999 and 60% in 2008. Similarly, "availability of hospital facilities/services" got a positive response from 57% of respondents in 1999[23] and 65% in 2008. Improvements were also seen in satisfaction with "earnings potential" (63% positive in 1999[23] and 72% in 2008) and "regular work hours"

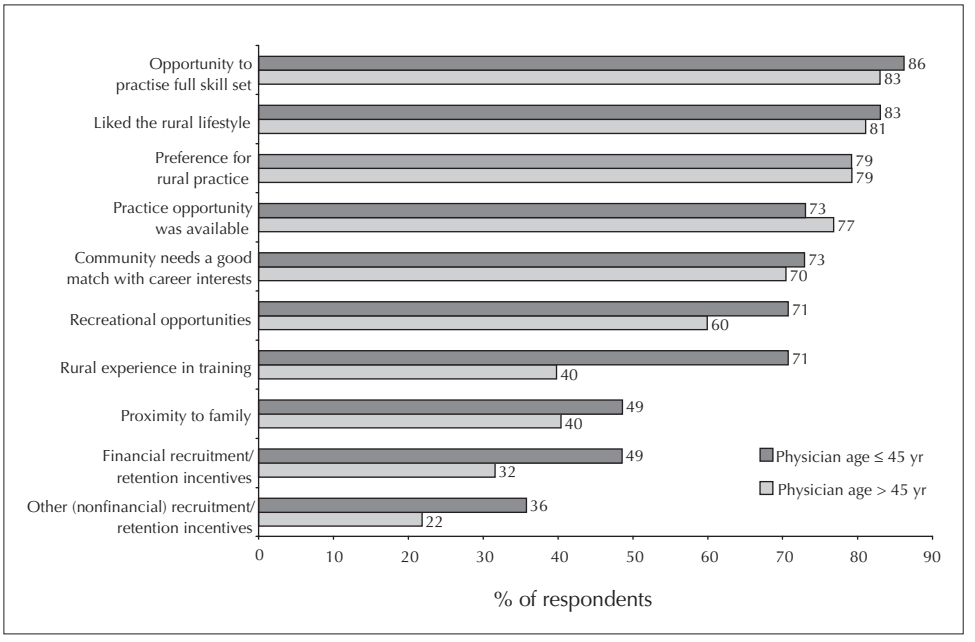


Fig. 2. Factors that were considered important (very or somewhat important) in choosing to practise in a rural area by 642 physicians, by age.

(53% positive in 1999[23] and 75% in 2008).

In 2008, the vast majority of respondents felt appreciated by the community (84%) and three-quarters (76%) had a positive sense of belonging to the community.

Despite these data demonstrating a relatively positive attitude toward their rural practices, 14% of respondents indicated a plan to move from their current communities within the next 2 years; 4% were planning on doing so within the next 6 months. About 41% of physicians planning a move within the next 2 years intended to set up practice in an urban location and 7% intended to do so in another country entirely.

Improvements that would most influence physicians to remain in rural Canada were as follows: "more reasonable hours of work" (66% of respondents), "availability of locum tenens" (63%), "availability of professional backup" (63%) and "educational opportunities for children" (63%) for those for whom this factor was applicable. The survey revealed no statistically significant differences between the age groups with respect to important factors that would influence physicians to remain.

Prospects of a more prestigious position or availability of academic/research opportunities were not seen as particularly tempting nor were improvements to emergency transportation services.

Rural training

Although having had at least one rural experience in medical education versus no rural rotations at all appears to have no bearing on intention to leave rural practice, this kind of experience may affect the attitudes of physicians.

As mentioned, younger physicians were far more likely to have done a rural rotation (89% v. 57% of older physicians), and were also more likely to have spent more time in rural training, with 36% having spent more than 6 months in rural rotations over the course of their education, compared with 14% of older physicians. Almost one-third of older physicians (29%) who had done a rural rotation indicated they had spent just a month or less in the rotation, and only 1 in 10 (9%) of younger physicians spent this shorter amount of time.

Rural physicians who had done at least one rural rotation were more likely to be satisfied with their level of preparation for rural practice (73%) than those who had never done a rural rotation (57%). However, 41% of those never having done a rural rotation indicated that they were not likely to take advantage of financial support to train for additional skill sets for rural practice, compared with one-quarter of those with a rural rotation experience. Note, though, that the vast majority (95%) of that 41% were older than 45 years and therefore may be less likely to seek additional training in general.

Those having done at least one rural rotation were more than twice as likely to have had a return of service provision attached to their first rural practice, with 23% indicating so, compared with 11% of those with no rural rotation. They were also more likely to have received an incentive to set up rural practice. About 57% of those who had done a rural rotation indicated receiving no incentive at all, compared with 70% of those with no rural rotation experience. Of those who did receive an incentive, 56% with experience in rural rotations were offered cash, compared with 36% of those with no experience in rural rotations.

The single most important factor in choosing rural practice, indicated by physicians who did a rural rotation, was a preference for rural practice (23%), whereas those who never did a rural rotation most often indicated a desire to practise their full skill set (25%). Those with no rural rotation in schooling were more than twice as likely to indicate that their most important reason for setting up rural practice was because the opportunity was available (14% v. 6%). As mentioned earlier, international medical graduates were more likely than graduates of Canadian medical schools to be influenced by a practice opportunity.

DISCUSSION

The Rural Practice Survey conducted in 2008/09 yielded a modest 33% response rate; however, the respondent profile reflected that of the general rural physician population with respect to sex, age group and broad specialty. With respect to province, physicians in Quebec were underrepresented in the results, and physicians in Ontario and British Columbia were slightly overrepresented.

The response rate to the survey may also be biased toward those physicians who remain interested in rural medicine. It is likely that our sample is missing those who were planning to leave and had little vested interest in rural practice and thus were unlikely to complete a survey on the topic. The letter that accompanied the survey indicated that it would take about 15 minutes to complete and this may be too long for those who are very busy in their practice and those who have just started their career.

Given that the survey results showed that 14% of rural physicians intended to leave rural Canada within the next 2 years, communities will have to continue to create new and more effective recruitment and retention plans. The struggle to retain physicians in rural Canada is nothing new. This does not bode well for rural Canada and there is some urgency in responding to the crisis in rural physician human resources.

Strides appear to have been made over time in encouraging more physicians to settle in rural areas, as demonstrated by the fact that younger physicians are vastly more likely to have been offered enticements. Though cash incentives seem to be the most popular, it is noteworthy that financial incentives were not among the most influential reasons why physicians in this sample chose a rural practice.

Having the opportunity to practise a full skill set was the most important factor overall that attracted physicians to rural communities. Yet one respondent wrote, "I really enjoy rural practice, [but] more and more we lose privileges to do small surgical procedures, which narrows 'fun parts' of scope of practice."

It seems that the gradual increase of young physicians gaining rural experience in education is a step in the right direction, given the high importance attributed to the rural lifestyle and an overall preference for rural practice. Rural experience in training was important to the majority (71%) of younger physicians when they were making their decision to choose rural practice. Exposure to rural communities and practices during training not only helps young physicians decide whether this is the type of practice they would prefer, but also gives them the confidence to take on the realities of rural practice down the road. These data lend support to the continued establishment of specialized and comprehensive rural curricula for medical schools. The data also support the continuation of the mandatory 8-week rural rotation by The College of Family Physicians Canada for family medicine residency.[24] Perhaps a similar requirement should be considered for training programs for the general specialties.

Nevertheless, it seems that rural experience in training does not necessarily improve retention rates for communities. Physicians with this kind of educational background were equally likely to indicate a desire to move as those without. However, physicians who had a rural rotation in medical school felt better prepared for their practice and appeared more eager to continue to improve their skills. Physicians who participated in rural rotations in school, and who therefore may be more suited to rural practice, were also more often offered enticements (e.g., return of service provisions, cash and various other incentives).

Of course, mentioning an intention to move does not necessarily cast this fate in stone. Respondents to this survey have informed us that improvements can be made to discourage migration to urban centres, especially where professional relief is concerned. With the availability of locums and professional backup rating poorly on the satisfaction scale and high with respect to the need for improvement, further work on streamlining the ease with which colleagues (even out of province) can provide locum tenens services, are needed. It is also necessary to optimize intraprofessional collaboration with formalized linkage between rural physicians and their colleagues in the referral centres, and use of technology to improve professional backup.

CONCLUSION

With cash incentives being more popular among younger physicians and international medical graduates, this type of incentive still has its place in bringing more physicians to rural practice. However, close attention should be paid to the practice and lifestyle factors that appear to have greater importance. Preserving these advantages of rural practice and improving awareness of them among younger physicians may serve to attract physicians and keep them practising in Canadian rural communities.

Competing interests: None declared.

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