COMMENTARY

Recruitment of medical practitioners to rural areas: A practical approach from the coalface

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Abstract

The successful recruitment of medical staff to country areas is a difficult process. This paper outlines strategies designed to increase the probability of a successful recruitment program. Strategies include determining if the position is truly required, designing an advertising campaign that reaches the target audience and addressing the significant regional and medical factors influencing the attractiveness of positions. Other areas discussed include the role of local hospitals, factors unique to individual medical practitioners, contracts and two possible long-term solutions – familiarising medical students with rural practice and recruiting overseas doctors.

Introduction

The recruitment of specialists and general practitioners to rural areas is becoming increasingly difficult. When I first began as a Medical Director at the Base Hospital at Horsham 12 years ago, our physician had been in the town for 18 years and one of our surgeons for 25 years. That type of stability has not, however, been the pattern over the past decade. Medicine is becoming more

complicated and specialists are often confining their practices to sub-specialty areas, making the true general physician and surgeon a rare breed. How then do rural hospitals provide general practitioner and specialist services to substantial populations located outside of capital cities?

This paper will focus on factors that have been critical in recruiting medical practitioners in the Wimmera region of Victoria over the past decade. These factors can be broadly grouped into those of the town, medical practice arrangements, hospital, spouse, income and individual factors for particular doctors. Addressing all these factors will, unfortunately, not guarantee a successful long-term medical appointment, but addressing many of the factors will improve the probability of a successful recruitment. On the other hand, it has been my experience that more doctors are lost to rural towns due to lack of attention to many of these basic factors than is generally appreciated.

Is the position required?

The first factor that needs to be considered is whether the position is truly required. That may sound a strange question but it is the critical point at which to start. Firstly, the proposed recruitment must have the support of the existing specialists and general practitioners. Secondly, the workload must be sufficient to justify an additional doctor. Nothing is more disheartening than to bring a second specialist to an area with a view to sharing the workload with the existing specialist only to find that there is not enough work in that specialty to sustain two specialists. General practitioners may say that the waiting time to see a particular solo specialist is too long, but that does not automatically mean that there is work for a second full-time specialist in the region.

Many of the medical colleges have developed population ratios for individual specialists, such as one specialist required per 20 000 population. In my experience, these figures can be extremely misleading, especially in rural areas. They do not take into account the competencies of some general practitioners in particular specialist areas, thereby limiting their referrals in that specialty. General practitioners in rural areas who have been managing patients without a nearby specialist physician, paediatrician or psychiatrist for many years are unlikely to suddenly change their medical practice and referral patterns when these specialists set up practice in their town. In general practice, if a small town has been without a solo general practitioner for a long period of time, patients may have dissipated to doctors in surrounding towns. The remaining practice may no longer be a full-time workload. Therefore, a 'recruitment at all costs' approach by the town may be futile in terms of a viable long-term appointment.

Having determined that an additional doctor is required, a suitable budget needs to be established. This should include advertising, information packages and visits by prospective doctors, as well as determining the details of the package to be offered.

Advertising

Obtaining an initial approach from a doctor willing to come to a rural area is probably the most difficult task in the recruitment process. Getting that initial telephone call or application is obviously a vital starting point. Advertising can be expensive and it may be difficult to judge if the advertisement is reaching its target audience. Advertisements can be placed in newspapers, the *Medical Journal of Australia* or specialist journals. Unfortunately, to compete with the myriad of advertisements found in these places, advertisements will need to be of a reasonable size and eye-catching, adding further to costs.

The advertisement details must be honest and give a reasonably detailed picture of the position, facilities and the region. We have found it useful to add an after-hours telephone number as well as the usual contact details. Doctors are busy people, especially during the day, and will probably be reading your advertisement at night or on weekends. We have had a number of calls from doctors who have read our advertisements out of normal working hours and have immediately picked up the phone to obtain further details or indicate their interest. Such calls are less likely to be interrupted and can be made in complete privacy by the doctor.

Unfortunately, from time to time the only response that the advertisement will elicit will be from recruitment agencies who have seen the advertisement and would like you to engage them to find the right applicant. While recruitment agencies can save considerable leg work, they are expensive, sometimes charging up to 25 per cent of the first year's salary. Locum agencies are another source of medical practitioners, more so for general practitioners than for specialists. More than one town in my part of Victoria initially engaged a doctor through one of the locum agencies and then had the person stay beyond their initial locum contract and sometimes permanently. These agencies may charge 10 per cent or more of the locum's fee and many agencies do not seem to have a great interest in long-term placements.

Medical colleges can be very useful. At the start of a recruitment campaign they may be able to supply a list of recent fellows of the college, or those about to complete their fellowship, and their addresses. A personal letter to each fellow, together with an information package, is a very cheap way of obtaining some

initial interest in a position when compared with the more expensive approaches outlined above. Direct contact with the relevant specialist department in the large teaching hospitals is also an inexpensive way of making contact. Most departments are happy to display copies of advertisements or posters on their notice-boards or to circulate the information to their trainees. This may result in direct discussions with specialists about to complete their training. While most will wish to stay in the cities, a brief presentation may broaden their appreciation of rural practice. Local practitioners are also a valuable resource. They may know of a colleague looking for a position or have direct contacts in larger centres. This networking approach by existing medical practitioners may be more useful than advertising.

Having obtained an initial phone call or letter from a prospective doctor, it is time to send them a comprehensive information package. This should include details about the position as well as information about the area, schooling, employment and social activities. A number of towns and hospitals have had packages professionally produced, which enhances that all-important first impression to prospective applicants. The initial contact by a doctor is a valuable opportunity to find out as much as possible about this potential applicant and their spouse or partner, if applicable. The material sent can then be tailored to the individual practitioner's needs and interests.

Regional factors

The next important major area that requires attention is regional factors. There is not much a town can do about its climate, but I have no doubt that doctors are easier to recruit in areas where the climate is not extreme. Beaches seem to be an attraction, as do snowfields. Wineries in the region also seem to have strong appeal. Extensive facilities in a town, such as sporting, cultural and educational facilities, are strong pluses. A good golf course is an advantage, as are high standard private schools. Many doctors do not wish to send their children away to boarding school to obtain a private education.

Towns need to promote all their positives. Even small rural towns have their positive aspects. Also, the social dynamics of the town are extremely important. Is the town friendly? Will people embrace the new general practitioner or specialist coming to the town? Will they invite them to their homes? There is no point in spending huge amounts on expensive advertising if there is not an active program to make the doctor and their family feel welcome and one of the town once they arrive. Some rural towns are not as receptive as they could be to doctors, especially doctors with cultural differences. The town must strive to

develop a general appeal as a good place to live for the doctor and their spouse or partner and children.

Medical factors

Medical factors are also important. The issue of professional isolation is a real one for solo general practitioners and specialists. For example, if a town has a solo paediatrician and the nearest paediatrician is 200 kilometres away, feelings of professional isolation may well occur. New technologies such as teleconferencing may reduce this isolation. Another crucial issue is adequate support for specialist services by the general practitioner referral base. Specialists sometimes find that they have to prove themselves professionally to general practitioners before they receive a substantial number of referrals. Some general practitioners are also competent to deal with a very wide range of problems and have minimal need for a specialist. An adequate clinical workload in the first few weeks is vital for a new specialist in a town for the recruitment program to be successful in the long term. Another significant medical factor is whether the practice will offer autonomy and the opportunity to develop programs.

Arrangements also need to be made for an equitable division of out of hours work and sensible periods of time off. A burnt out general practitioner or specialist who has been working excessive hours over long periods is not the desired end point. They are also not a good advertisement for other doctors expressing an interest in coming to the area. To prevent this situation, arrangements for doctors to cover each other's practices out of hours should be established before the recruitment process starts. In addition, opportunities should be available to doctors to attend peer support meetings and regional postgraduate education sessions. Time allocated to these activities could be written into the employment contract to reinforce to prospective applicants the commitment of the employing organisation to the doctor's professional development, health and welfare.

The role of the local hospital

Local hospitals, whether they be base or district, play a key role in the recruitment process. Hospitals must decide what level of facilities, equipment and access they will give medical practitioners willing to come to their region. Having state-of-the-art facilities alone will not guarantee a successful long-term appointment. Hospitals should have a vision of what type of hospital they want to be and the range of services they wish to provide. A critical question that must

be resolved is which doctors will be granted clinical privileges in each service area. If recruiting a specialist surgeon is being contemplated, will general practitioners continue to have surgical privileges and, if so, at what level? Having general practitioners and specialists competing for the same patients can be counterproductive. Usually, specialist skills need to be utilised fully to secure a long-term commitment by specialists to stay in a rural area. A rational plan for who will provide particular medical services and where they will be provided is required for a consistent delivery of medical services and will help potential rural practitioners to determine the viability of practising in particular areas.

Small hospitals may lack the expertise and medical leadership to undertake an extensive recruitment program. They may enlist assistance from larger hospitals, doctors in neighbouring towns or divisions of general practice. Once an appointment has been made, hospital boards of management must actively make medical practitioners and their families welcome in the region and offer a high level of support. Many doctors are keen to control their work environment and to have a substantial say in how medical services are provided. I believe that if a medical practitioner is interested enough in his work environment to wish to actively contribute to hospital management issues or be a member of the local hospital board of management, that they should be openly welcomed and made to feel part of the team. This may require rural hospital boards overcoming their sometimes conservative approach and being open and receptive to the different points of view that new doctors may bring. I have seen a number of instances where there has been open antagonism between medical practitioners and hospital boards over such appointments. In each instance it has significantly soured the relationship between the hospital and the doctors, in some cases leading to doctors leaving the town. Although doctors have a vested interest in how their hospital is run, they are often well aware of the day-to-day activities and problems within the hospital, and may be able to provide useful advice.

In day-to-day matters, the chief executive and medical director of a hospital have key roles. The avoidance of power struggles over minor issues and unnecessary interference in clinical areas is essential. The medical director will need to be in regular contact with all new practitioners to determine how they are fitting in. This will include ensuring that the medical practitioner has a sufficient workload, that the out of hours work is not excessive, and that the practitioner and his family are being actively welcomed into the town. With a new doctor joining the health team, changes in the way things are done will be inevitable. Some staff may be used to long-standing practices with previous doctors. A consultation process should be established. In small towns this may be as simple as a regular meeting between hospital staff and the new doctor to discuss issues or specific

problems. This open communication approach can be used as a positive in promoting the position.

Income

Income is often thought to be the most important factor in influencing a practitioner's decision to come to a rural area. In my experience, although it is an important issue, it is not the critical issue in many cases. However, it may be the major issue in small, isolated towns or with individual practitioners. Nonetheless, it is important to find out exactly what the doctor's expectations of income are and to be realistic if stating potential income levels in advertisements. It is also important to discuss alternative methods of payment with the practitioner, such as providing assistance with consulting rooms. Would a salaried appointment, at least initially in the establishment phase, be more satisfactory than fee-for-service payment. Relocation costs, housing and cars, surgery costs and financial incentives are also key issues. Some doctors may insist on all these things being provided at little or no cost to them.

Spouse/partner

Of all the factors that may have substantial impact on whether an appointment is successful or not, I believe the spouse/partner is the critical factor. Considerable attention must be paid to ensuring that the spouse/partner is both occupied and happy in the town. This requires providing social support and, in some cases, work opportunities. If all the attention is given to the medical practitioner and little is paid to the spouse/partner, the probability of a successful appointment is significantly reduced. With the increasing number of female doctors, the male partner may need even further support in rural areas.

Individual factors

Individual practitioners may have their own areas of interest. Some may be interested in research and want to be part of large multi-centre trials or develop their own research activities. The hospital supplying secretarial assistance, computer access or library services, together with a small amount of financial support, may be viewed extremely positively by potential applicants. A demonstrable track record of quality assurance activities and a true commitment to quality may attract other applicants. Other areas that have interested doctors coming to the Wimmera have included medical student and resident medical

officer teaching, cardiac rehabilitation, urodynamics and time to do a regular outpatient clinic at a larger hospital. Find out what areas of interest applicants have or would like to develop and see if the hospital can help. The hospital should be able to demonstrate a clear track record of innovation so that potential applicants can see that new ideas and changes in practice can be developed. The practitioner should have some autonomy and the opportunity to develop programs in accordance with their skills.

Contracts

Contractual arrangements are also important. Obviously, a hospital or the recruiting practice will have spent a considerable amount of money in interesting an applicant and bringing them to the town. This is particularly so in the case of overseas applicants. A reasonable return on that investment will be a contract for the doctor to provide medical services for three to five years. The contract should include a penalty clause to regain the recruitment costs involved if the doctor stays less than this period of time,. The hospital should also include a clause to allow it to terminate the contract after one year if its clinical privileges committee is not satisfied with the practitioner's clinical performance.

Having said all this, sometimes it is just not possible to keep doctors in a rural area. Even with the best will on both sides, things may not work out. The doctor may find that rural practice or living in the country is not for them. It can be similar to a marriage, where the true personalities of the partners will take time to be revealed. Often though, the relationship will sour over a considerable period of time, usually not related to a single large event but to many small events, resulting in a breakdown in communication and reduction in goodwill. After a few months, it may be obvious to all that the relationship is irreconcilable. Hard as it may seem at the time, it is a matter of taking a deep breath, breaking the relationship and starting the recruitment process again.

Long-term issues

There are also a number of long-term issues with regard to increasing the number of medical practitioners interested in coming to rural areas. Medical students are certainly being educated about rural practice to a greater degree than they have been previously. We have taken medical students at the hospital for a long time and, more recently, have become affiliated with the University of Melbourne Clinical School, taking fourth year surgical students for nine-week rotations three times a year. The students appear pleased with the rotation and a number have come to us again as interns and registrars. However, the program has not

translated into bringing one specialist or general practitioner to the region in recent years. Some medical schools are taking an increased number of students from the country in their initial intakes. It will be interesting to see if this results in a greater number of graduates wishing to come to the country when they have finished their training.

Rotating resident medical officers to the country has been a long-standing practice at my hospital. Most of them, however, seem firmly on the road to moving to a sub-specialty, which often precludes them coming to the country.

Some new technologies may assist in the rural shortage of specialists. In particular, teleradiology, which allows images to be read by radiologists in larger centres, can provide a seven day a week, twenty-four hour a day service for reading urgent films and can provide a regular reporting service. There are some moves afoot to expand teleconferencing to include psychiatry and some aspects of general medicine.

The recruitment of overseas doctors has provided a long-standing solution to difficulties in recruitment in rural areas. However, this is becoming more difficult, with some colleges now requiring all overseas doctors to sit examinations before they can be recognised as a specialist in Australia. This is extremely restrictive and actively discourages specialists in training programs directly comparable with those in Australia from applying. Restrictions on provider numbers for overseas doctors may completely close a previous source of general practitioners and specialists for rural areas.

Conclusion

The game plan for the successful recruitment of medical practitioners to rural areas involves concentrating on those factors which are controllable. Firstly, ensure the position is truly required. Secondly, design the recruitment campaign to reach the target audience. Thirdly, make sure that there are strong positive aspects to the job and the town, and promote them. Fourthly, find out the doctor's expectations and individual needs and, where possible, meet them. Fifthly, after a successful recruitment program, continue to look after the doctor and their family.

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