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Medical Practice in Rural Communities

With a Foreword by Milton I. Roemer

With 43 Figures

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Foreword

Despite the urbanization of the United States, the rural population exceeds 60 million, and the provision of health services to these people remains a difficult problem. This volume addresses one crucial aspect of that problem—the task of attracting physicians to rural medical practice. It does this by carefully analyzing the special health problems and the general features of rural society in which the young doctor would be working.

Rural health needs have been recognized in America for well over a century. In response, many organized health programs have, in fact, improved the situation. Compared to 1930, the present coverage of rural counties by public health agencies has been greatly extended. Thanks to the Hill-Burton Act of 1946, the availability of general hospital beds has become virtually equalized among the states with varying degrees of rurality. Federally subsidized and locally organized health programs are serving migratory workers, American Indians, the people of Appalachia, and other rural groups. Voluntary health insurance covers millions of rural families, even though the extent of this economic protection is less than among urban families. Medicare helps to protect the rural aged, as it does the urban. Medicaid finances health services for the rural poor far more effectively than the purely local welfare programs of 1930.

There is no question, then, about the improvement in rural health resources and services in America over the last 50 years. The problems

perceived are rather in the persistent *gaps* between urban and rural health conditions. Rural people still receive fewer physician services per capita than urban. Insofar as rural-urban health care differentials have, in fact, grown smaller (according to the U.S. National Health Survey), this has been due mainly to improved transportation to the cities. Hundreds of counties and thousands of rural communities still lack a local and conveniently available physician.

Perhaps the most promising U.S. development toward the achievement of improved rural medical care has been the greatly increased *overall* output of physicians. Between 1950 and 1980, active physicians in the nation increased from 142 to 202 per 100,000 population. From a purely economic perspective, therefore, physicians have become more available to rural areas, if only because the urban medical market is becoming saturated. But young medical graduates must still decide to locate in a rural community, and it is to help prepare them for such a decision that this book is devoted. (The mandatory rural service that many national governments require of all new medical graduates could hardly be expected in modern America.) The rich citations at the end of each chapter provide the interested reader with many further sources of study.

Another important development that should contribute to rural health care equity is the rise of family practice as a medical "specialty." One need not review the many reasons for mounting specialization in American medicine (to a greater extent, moreover, than in any other nation) to appreciate the social reaction that has arisen against it and in favor of greater attention to broad-gauged primary health care. Both the needs and the opportunities for such generalized medical service are greatest in rural areas, so that the substantial interest in family practice shown by current medical students happily coincides with rural needs.

Many volumes and articles have been produced on rural health needs and rural health programs in the United States. This is the first book, however, focused sharply on the challenge of preparing and—inevitably, to some degree—*encouraging* young medical graduates to engage in rural practice. Realistically, this does not necessarily mean private solo medical practice, because group practice clinics, community health centers, and other growing patterns of organized service are fully recognized. The authors have described the conditions of rural medical practice, against the background of a comprehensive account on the overall health care system in rural America.

In having this rural focus, one need not overlook the contribution of the cities to rural welfare. There is a natural tendency to stress the differentials in health care between town and country, and yet the two are actually interdependent. The economic development and general affluence of the United States are due mainly to industrialization. Cities, therefore, produce much of the wealth that has led to improvements in rural standards of living. Further rural improvement in health care, as in

other sectors, must depend on broad national strategies that mobilize urban wealth for the benefit of everyone. Cities, of course, must serve as centers for medical education, for medical research, and for delivery of highly complex medical service, when it is needed.

All over the world, there is a trend—not strong, but growing—toward more “community-oriented” medical education. Medical graduates, in other words, are to be inculcated with a spirit of serving the needs of people, rather than advancing their own personal wealth or status. Community needs, rather than faculty interests, are to shape the curriculum. The World Health Organization has even formed a special international association of medical schools, promoting these concepts. In the United States, as well as in most other countries today, achievement of adequate rural medical service is one important aspect of such an orientation. This book, therefore, should contribute a great deal to strengthening community-oriented medical education throughout America.

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Preface

We wrote this book hoping to increase the reader's understanding of rural health problems and modern rural medical practice. We also wanted to propose an extended role in community health for tomorrow's rural physicians. Medical students understanding these aspects of rural practice should be better able to choose their practice location. Those who select rural practice will be better able to serve their patient populations. We hope that the book contributes to these ends by encouraging discourse between medical students and interested faculty members or rural practitioners in the first few years of the student's training.

The five chapters of this book fulfill these objectives by addressing several specific needs. First, to decide their interest in and suitability for rural practice, medical students need a factual understanding of modern rural practice and practitioners. Chapter 1 describes factors that practicing physicians considered when choosing a rural practice location, evaluations of rural practice by today's practitioners, and characteristics of modern office practice. If students comprehend these traits, they can compare urban and rural practice rather than rejecting rural primary care because of lack of information.

Second, students need basic training in health problems specific to rural areas; therefore, Chapters 3 and 4 describe environmental and occupational health problems of rural populations. Chapter 2 outlines demographic and socioeconomic characteristics of rural populations, emphasizing qualities that may accentuate these and other health problems.

Because all rural health problems cannot be covered in this small book, only major problems are introduced and, more importantly, approaches to anticipating, recognizing, treating, and preventing these problems are suggested. The student who prefers rural practice can adjust his or her schedule to include course work relevant to these health problems and to allow additional exposure to rural areas. Our treatment of the problems will be important for future urban specialists as well, since some of their referrals will be from rural areas.

Third, in order to practice effectively and efficiently, future rural physicians need to consider their roles in community involvement, patient education, and preventive medicine. Also, because resources usually are less available in rural areas than in urban centers, full use of community resources should be encouraged to increase the physician's ability to respond to the public's needs and deliver the best medical care possible. Chapter 5 describes techniques for involvement of physicians with other local health care providers and with the community.

A book of this size cannot treat its subject definitively, nor would definitive coverage be advantageous for the first- or second-year medical students who constitute our target audience. Attempts were made to keep the book as short as possible while providing enough information to portray major aspects of health and health care of rural (as opposed to urban) populations. We also wanted to break down myths about rural primary care that are commonly held in urban medical training centers: myths of poor-quality care, myths of overworked and underpaid physicians, myths of insufficient professional contact and stimulation, myths of inadequate medical coverage unless a physician constantly refers patients to urban consultants. Additional training materials that approach the subject from different angles are badly needed; we hope that our work will stimulate others to join in meeting this need.

Although we attempted to remain as factual as possible and to point out problems as well as benefits of rural practice, we cannot claim to have written a completely unbiased report. Perhaps our bias is most evident in Chapter 5, with its emphasis on community health. We hope that this public health orientation will help medical students perceive the challenges and rewards of physicians who find a suitable match between personalities, professional goals, and traits of America's rural areas.

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To these, to numerous others not mentioned who answered our questions and contributed their expertise, including all who granted us permission to reprint their writing or describe their efforts, and to all those who through their research and experience laid the groundwork on which a book such as this is based, we express our thanks and our indebtedness.

Suggestions for Use

Ideally, this text would provide the framework for a minicourse on rural medical practice, to be delivered to first- or second-year medical students enrolled in a community medicine or public health course. Students would read the five chapters in preparation for five lecture-discussion sessions, each led by a faculty member (or guest lecturer) who would develop relevant ideas through discussing personal experiences and local case examples.

Obviously, any text can be used in a manner other than that preferred by its authors. Therefore, each chapter has been written to be useful independently or in combination with any of the other four. If, owing to time limitations, certain chapters must be omitted or presented only to students with a strong interest in rural practice, we would recommend that these be Chapters 2 and 5, and that Chapters 1, 3, and 4 be retained. Chapter 1 will encourage the urban-oriented student to consider at least minimally the rural alternative, and Chapters 3 and 4 will help the future urban physician understand occupational and environmental health problems of his or her rural referrals.

Alternative potential formats for classroom use of the text are numerous. For example, if knowledgeable faculty leaders or guest speakers cannot be located, this text could be used as a faculty (rather than student) guide, with materials then being presented to students through lectures. Because of their factual nature, Chapters 3 and 4 lend themselves particularly well to straight lectures. In contrast, students could read Chapter 5 as background for a panel discussion with panel members representing

a variety of health care disciplines. Such a discussion was successfully held at an American Medical Student Association Conference in Iowa City in 1981, and we encourage its repetition. Any of the chapters could provide discussion material for student clubs (such as family practice or interdisciplinary health clubs), discussion groups, or seminars, and some students doubtlessly will find this material interesting reading even if it has not been assigned for classroom use.

Regardless of format, we recommend that classroom presentations focus on examples relevant to the immediate area, such as case studies involving local folk treatments, pesticide poisonings, or injuries from agricultural machinery. Speakers also could describe practice organizations of nearby rural areas and reasons for their success or failure. Speakers need not be content experts, and their case examples need not be elaborate. The personal experiences and opinions of local practitioners (or other class leaders) typically will be sufficient to involve students and stimulate discourse.

Extremely careful consideration should be given to recruitment of discussion leaders. Ideally, the leaders would all be dynamic, positive-thinking rural practitioners (or faculty members who have previously enjoyed a rural practice experience) who practice high-quality community medicine and who reflect on their work and its implications. "Burned-out" physicians or physicians who may not be credible to students should be avoided, since discussion leaders, by virtue of personal experience, will be validating the general ideas presented in the text, and will be serving as role models to students who may have no other opportunity for such contact. We recommend that there be at least two or three leaders if all five chapters are used, because the chapters represent different areas of expertise and because students will benefit from exposure to several viewpoints.

A set of such ideal leaders may be impossible to locate. Although we feel that a rural practitioner should present Chapters 1 and 5, leaders for Chapters 3 and 4 could be academic physicians, environmental health specialists, or anyone who is able to describe local case examples of these problems. Discussion of Chapter 2 could be led by a rural sociologist, or by a person with other training who is able to pinpoint which (if any) of the sociological factors described are locally relevant.

What about use by students at other levels of training? We feel that this book could be used to good end by nearly any medical protégé, from the neophyte medical student vaguely interested in living in the country, to the physician completing a family practice residency and contemplating rural practice, to the physician embarking on a rural National Health Service Corps tenure. The book could even be recommended reading for applicants to medical schools that specialize in training students for rural practice and primary care. However, optimal use would be by a student in the first two years of medical training, for two reasons. First, the book is more conceptual than clinical and, as such, probably

would be received most readily by students early in their training. Second, the text is intended to help students choose a practice location so that they can adjust their curriculum accordingly during their last two years of medical school.

What curriculum modifications could be suggested to those students who are strongly inclined toward rural practice? Such students' course work can include topics germane to rural practice, such as rural sociology, rural epidemiology, occupational health problems of agricultural workers, and courses discussing other environmental and occupational topics discussed in Chapters 3 and 4. Students should be encouraged to mix this course work with a rural practice experience, ideally a carefully structured rural preceptorship that assures a student's involvement in the community and with patients' families. In addition to allowing the student to observe a rural physician in action, preceptorships offer a unique opportunity to see patients with a variety of problems, some peculiar to rural areas, in their early stages. Students may learn to diagnose and treat illnesses using time and multiple patient visits rather than through more speedy, technologically based methods used in a tertiary care center. And, preceptorships demonstrate the physician's role in community health education and other community-based activities. Academic content can be integrated into the preceptorship by telephone conferences, faculty visits, assigned readings, and required student projects. When a rural preceptorship is unavailable, students can construct a "hands-on" rural experience on their own. By visiting a rural community for a few days, students can make rounds with nurses in the visiting nurses association; talk to employees of the public health department or of social service agencies, asking them what services they provide, to whom, and who pays for these services; visit a local factory and farm, asking its employees about their health care concerns; or construct any other activity that helps them understand rural life, health care needs, and health care services.

One final note: we realize that our readers may disagree with some of the views presented in the text. When this occurs, we encourage faculty leaders to recall that the guiding principle in preparing these materials has been to assist students in developing attitudes and approaches toward rural practice. We see this text more as a stimulus to discussion than as a stock list of irrefutable facts and ideas. Although we have attempted to be as factual and as unbiased as possible, much remains shaped by our perceptions of rural practice and by our conceptions of how it could be improved. If perceptions and conceptions of faculty users differ, we ask these users, rather than discarding the text, to present their differences openly, using them to stimulate healthy discussions with students. We would prefer that discussions be led by interested, enthusiastic faculty members rather than having sessions that always parallel the text. Energetic discussions, in themselves, demonstrate to students that faculty leaders consider rural practice to be a viable career choice.