Goin’ to the country: challenges for women’s health care in rural Canada

Mary T. Johnston, MD, MSc

I have been a female physician in “rural” general practice for 24 years. My husband is a rural doctor, as was my father. I have seen rural medicine before and after medicare, in the east and in the west, by sea and by mountains, in depressed and in prosperous areas, and in communities supported by fishing, farming and forestry.1 As the first female physician in 2 communities and, for most of the time I’ve worked, the only female physician, I have witnessed much of what constitutes “women’s health” in rural practice.2 Yet I have become more and more discouraged as the realities of rural practice are ignored by government, professional medical bodies, universities and even the field of women’s health itself.

Of the one-third of Canadians who live in a rural setting, half are women. Rural Canadians produce 40% of the gross national product but receive only 10% of services in health and education. In one Ontario study3 30% of the population but only 11% of the physicians were rural. This is grossly unfair: apparently, it is acceptable for rural Canadians to receive third-world medicine while they subsidize first-world standards for urban areas. Twenty years ago the gap in health care between urban and rural Canada began to widen; in the last 10 years it has become vast. Although some of the incentive programs, on-call compensation and acknowledgment of the special and extensive skills needed by a rural physician have started to make an impression in eastern Canada, the problems of recruitment and retention are worsening in the west. The reduced level of service previously provided is diminishing.4,5

This situation is exacerbated by the fact that the larger numbers of women now graduating from medicine have shunned rural practice, so that the undersupply of women in rural practice is greater than that of men.4,6 Much of the current discussion about recruitment and retention of rural physicians focuses on a sustainable lifestyle, but the definition of “sustainable” must change significantly if women physicians are to consider rural practice.4 My initiation into rural practice was a patient load of 2000, over 100 obstetrics cases per year, a 100-hour work week and an on-call schedule of 1 in 4 or 1 in 6. This was heavy enough to force many women out of rural practice and makes rural practice a hard sell to female medical students. The positive aspects of rural practice — doing “real” front-line medicine, making a difference, and experiencing the welcome and appreciation of rural women — are eroded if the load is too heavy. The positive aspects of rural living — of clean and beautiful surroundings, outdoor recreation, less traffic and noise, closer contact with your community and friends, and more independence in your life and work — can only be enjoyed if you have time and energy. Merely surviving is not a sustainable lifestyle. There have been discussions recently about call responsibilities representing a second job in rural medicine on top of a doctor’s primary job — his or her practice — but this situation is intensified for a woman physician, for whom call comes third, after home and family life and her practice.1,2,7

For a rural woman, to “prefer” a female physician means travelling some distance to get medical care. Rural women are a practical lot and are grateful if they can get any medical care. For them, there is little use in preferring a female doctor if it means money and time they can ill afford on a trip to the city.8,9 In my experience, the urban woman who has moved to a rural area wants and will seek the
level of service to which she has been accustomed in the urban setting. But the rural woman wants to stay in her community for medical care. Concentrating services in urban areas does not make them available to rural women.10

The preference of women, especially younger women, for female doctors has implications for future health care, especially in rural and remote communities.11 Given the opportunity, a teenage girl will go to a female physician for her first pelvic examination, and women prefer to see women doctors for pelvic exams and treatment of gynecological problems,11 as well as for discussions about menopause; this preference is obvious in our clinic from the number of specula I use in comparison to my male colleagues. This is especially important when the patient will meet her physician on the street and at school concerts.11 Rural women want to have their babies in their home communities, with their families close by, and obstetric outcomes are better when patients are not transferred out.13–15

A recent article in Maclean’s16 suggested that the healthy menopausal woman could go to a menopause clinic for consultation with a nutritionist and a psychologist, but in rural Canada, there is only one clinic in town for everything. In underserviced areas, physician visits are usually for serious and urgent problems. The physician has a higher patient load, a greater proportion of patients needing acute care and less time per patient, so years ago I started giving 2-hour lectures to groups of 100 to 200 women in my rural community on topics related to “women’s health.” The talks I have given to teenagers on sex, birth control and personal power of choice, and the sessions I have led on sexuality, menopause, migraines and aging have allowed me to share my medical knowledge with many more women than I could possibly treat individually in underserviced rural Canada.

Small rural communities suffer from lack of continuity of care when there is a high turnover of physicians, as well as a lack of preventive care when there are insufficient staff members.4 For example, in the first rural community in which I worked, I underwent a formal investigation for diagnosing a high number of cervical cancers. However, I was the first woman physician in that community and the first to perform routine screening; because of the shortage of physicians, my predecessors had responded mostly to emergencies.5

But progress is being made. At the women’s luncheon during the 1998 annual meeting of the Society of Rural Physicians of Canada in St. John’s, you could feel the companionship and support the female rural doctors got from sharing their experiences (a common feeling in urban areas but impossible in rural Canada).

If the field of women’s health really cares about service, fairness, equity and health, it is time to actively encourage rural women to become physicians. This can be done in a number of ways. One is to encourage rural women to consider medicine as a career, by giving them preference in medical schools and helping them to maintain their rural connections throughout training.4,17 Another is to ensure that there are mentors in medical schools who know, respect and represent rural medicine as a life-long career, not a brief and scary stint that leads to burnout.7 Additional training and encouragement in obstetrics and gynecology, breast and endometrial biopsy, and pediatrics are needed for female medical students, given that they will see more women and children.18,19 Rural physicians are often the main source in town of health education, and they need additional skills in teaching. Because rural physicians are usually the marriage, family and crisis counsellors in their communities, easy, timely access (by phone and the Internet) to urban professionals would be helpful. Retaining rural physicians is related to medical confidence, so initial training and expectations are important, and there is a need for continuing medical education relevant to rural practice.4 Monash University in Australia has identified the need to bring rural doctors back into the academic centres for continuing education to counter the isolation; locum and family support is also provided.

Medical training should include discussions on balancing family needs and practice demands in rural and remote communities,20 for example by joining group practices, establishing on-site child-care facilities (because the spouses of most women physicians also have commitments outside the home)9 and developing strategies for keeping practice, family and marriage on track when you are the only female physician in a community.12,4

We need to take more seriously the consequences of having too few rural physicians and even fewer female rural physicians — for the patients, the economy and the rural physicians themselves. We need a greater outflow of information, instruction and skills development from urban women’s health clinics and academic centres to rural Canada. Rural women are resourceful and independent, and they don’t mind carrying Canada, but they don’t like being invisible to universities, medical centres and women’s health.

References


Reprint requests to: Dr. Mary T. Johnston, Selkirk Medical Clinic, Box 590, Revelstoke BC V0E 2S0; fax 250 837-9444; mtj@junction.net