Opinions of Rural Physicians About Their Practices, Community Medical Needs, and Rural Medical Care

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THE PROBLEMS OF AND POTENTIAL SOLUTIONS for providing medical care in rural areas are a constant concern. Most of this concern is based on the general impressions of policymakers and the analysis of such secondary data as physician-population ratios *(1–5)*. Although impressions of policymakers and the analysis of secondary data are essential in examining the rural medical care situation and in suggesting solutions, it is also essential to consider the first-hand views of rural physicians. However, their views have rarely been polled.

The views of rural physicians are important for at least two reasons. First, because they are directly engaged in the delivery of medical care they are in a unique position to comment on such issues as the pros and cons of rural practice and the medical care needs of rural communities. Second, a proposed "solution" to a particular problem is more difficult to implement unless physicians believe that the problem exists and unless they agree with the proposed solution. In short, the power of the physician in identifying and solving problems, although not necessarily desirable, is certainly real. Perhaps Knowles *(6)* said it best when he noted:

> It is [the physician] who determines the need for and utilization of other health workers. It is he who controls the organization, distribution, and utilization of health services. It is he who ultmately controls and determines health expenditures and the cost of medical services, be they drugs, hospitals, laboratories, or office visits. Finally, it is he who controls the numbers recruited, produced, and retained in the profession, largely through his membership in medical school faculty, teaching hospital staff, the American Medical Association, the Association of American Medical Colleges, specialty board, or special public or private commissions.

The study reported here was conducted in the State of Washington during 1971–73 to (*a*) determine certain characteristics, attitudes, and opinions of a sample of rural general practitioners (GPs) and (*b*) determine if any differences existed in physician productivity among rural practices of different sizes (*7*). This report focuses on the first objective. The second objective resulted in a sample of rural physicians that included a small number of solo practitioners and a disproportionately large number who were in group practices. The extent to which group practice influences physicians' attitudes and opinions is not known—but if significant influence does exist, it would be invalid to generalize the results of this study to all of rural Washington's GPs.

Methodology

The study physicians were selected from a master list of all physicians in Washington. The master list, supplied by the Washington Medical Education and Research Foundation, included all physicians' addresses. Therefore, it was possible to identify those physicians practicing in rural communities. A "rural community" was defined as a place of 10,000 population or less that was not part of a larger population center. The rural physicians were categorized according to the number of physicians in a practice. Practices staffed by persons other than GPs were eliminated from consideration, and cooperation was sought from physicians in a sample of the remaining

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practices. Information was obtained from a total of 41 GPs in 17 practices; 5 practices were solo, and the remaining 12 were evenly divided among 2-, 3-, and 4-man groups.

The 12 counties in which the practices were located had only 87 physicians per 100,000 population, a figure well below the national and Washington State averages of 130 and 131, respectively (*8*). The average distance of the 17 practices to a standard metropolitan statistical area was 69 miles.

In interviews with the 41 GPs, they were asked their opinions about their present practices, the medical care needs of their communities, and rural medical care in general.

Opinions About Present Practice

It is important to document the negative aspects of rural practice so that these aspects may be reduced or eliminated, if possible, and it is equally important to document the positive aspects. Documentation of the positive aspects is especially important from the standpoint of recruitment of physicians if prospective physicians, policymakers, and the general public believe that rural practice has little or nothing to offer the physician—a belief that has been reported in a number of articles (*9–14*). Therefore, the physicians in this study were asked which aspects of their practices were enjoyable, as well as which were negative. Their responses are shown in table 1.

Forty-four percent of the respondents mentioned the "variety and challenge of medical problems confronted" as an enjoyable aspect of their practice. This response may simply reflect the fact that all the physicians were GPs—the type of physician most likely to be challenged by a variety of medical prob-

Table 1. Responses of 41 physicians to selected questions about their present practices

Questions and responses	Physicians	
	Number [1]	Percent
What do you enjoy about your present practice?		
Variety and challenge of medical problems confronted	18	44
Favorable working conditions of the practice	18	44
Type of community in which the practice is located	15	37
Compatibility and personal relationship with patients	11	27
General satisfaction of medicine and relating to people	7	17
Financial rewards	4	10
No response	2	5
What do you find frustrating about your present practice?		
Excess work, responsibility, demands, and expectations by patients and community	27	66
Too much paperwork, government regulations, and medical abuses	8	20
Medical isolation and limitations of facilities	6	15
Incompatibility with certain patients	6	15
Personal disadvantages of small-town living	3	7
Other reasons	6	15
No frustrations	1	2
Is your caseload too large, too small, or just right?		
Too large	25	61
Too small	1	2
Just right	15	37

[1] The column sums for the first two questions are more than the sample size because of multiple responses by some physicians.

lems regardless of rural or urban location. However, one can also hypothesize that a greater percentage of rural than urban GPs would mention this factor because the greater backdrop of specialists in urban areas may reduce the variety of medical problems confronted by urban GPs or at least reduce their role in the management of these problems.

Two other enjoyable aspects of the present practice frequently mentioned were (*a*) "favorable working conditions of the practice" and (*b*) "type of community in which the practice is located." The significance of these two factors is that the first one suggests that rural practice—at least rural group practice—does have positive professional aspects, and the second one suggests that rural communities have positive aspects as a place to live and work. As noted earlier, the positive aspects of rural practice and rural community life are rarely mentioned in either the popular or professional literature. Examples of some of the specific statements made in reference to "favorable working conditions of the practice" and "type of community in which the practice is located" included: "convenience of being three minutes from office," "in small town everyone knows and respects the physician," "small-town closeness," "opportunity for community involvement," "less competition from other doctors in a small town and this allows me to do more things in practicing medicine," and "can do surgery that I might not be able to do in a large city."

The most infrequently mentioned enjoyable aspect was "financial rewards." This does not mean that the physicians viewed their incomes as inadequate. Indeed, when asked which aspects of their practices were frustrating, only one physician expressed concern about his income. Thus, it appears that the physicians were satisfied with their incomes, but they received most satisfaction from noneconomic considerations. Reports of other studies (*15–24*) also indicate that in choosing a place to practice physicians consider economic factors but place greater importance on nonecomonic considerations.

By far the most frequently cited sources of the physicians' frustration were "excess work, responsibility, demands, and expectations by patients and community;" 66 percent of the physicians mentioned these (table 1). The importance of this frustrating aspect of rural practice is consistent with other reports on rural practice (*16, 23, 25*). However, a number of observers of rural practice also attach great importance to professional isolation, inadequate professional support, and the disadvantages of small-town living (*9–14*). Surprisingly, in this study only 15 percent of the physicians mentioned "medical isolation and limitations of facilities" as a frustrating aspect of their practice, and only 7 percent mentioned "personal disadvantages of small-town living." It may be that much of the rhetoric regarding the professional disadvantages of small-town practice overlooks the empirical evidence suggesting that specialized facilities and supportive personnel are not as important to primary care physicians—the type typically practicing in rural areas—as they are to nonprimary care physicians (*26–29*). Another possibility is that "medical isolation and limitations of facilities" are greater problems for rural solo practitioners, and, since most of the physicians in this study were in group practice, these problems may be relatively unimportant. The potential of group practice as a way to attract and retain physicians in rural areas has been suggested elsewhere (*30*).

The physicians' frustration with the overall burden of their workloads is consistent with their responses to the question about their caseloads (table 1). Specifically, 61 percent thought that their caseloads were too large; 37 percent, just right; and only 2 percent, too small.

Opinions About Community Medical Needs

Concerning the most pressing medical needs in their communities, 10 of the 41 physicians mentioned "more doctors," and 8 mentioned "more adequate hospitals and ancillary facilities" (table 2). The majority of the remaining concerns focused on special problems and people. For example, 16 physicians mentioned the needs of at least one of the following: the poor, immobile, elderly, and persons with personal or mental problems.

In view of the extensive literature on physician shortages in rural areas and the fact that 66 percent of the physicians in this study were frustrated by the "excess work, responsibility, demands, and expectations by patients and community," it is interesting that only 10 of the 41 physicians mentioned "more doctors" as a pressing medical need in their communities. Nine respondents said that their communities could support another physician, and although an additional 25 respondents expressed this belief, they apparently did not regard additional physicians as a pressing need. Of these 34 physicians, most thought that only 1 or 2 more physicians could be supported and that they should be GPs (tables 2 and 3). With one exception, the types of specialists mentioned were primary care physicians—internists, pediatricians, general surgeons, and obstetrician-gynecologists. These responses support the frequent

recommendation that medical education must increase emphasis on producing more primary care physicians in order to increase the number of practitioners in rural areas (*3, 31–35*).

Opinions About Rural Medical Care

Tables 4–6 summarize the physicians' evaluation of rural medical care and their recommendations for improving its adequacy. The question providing the framework for table 4 originally asked the physicians to compare the medical care received by Washington's rural patients with that received by urban patients. However, many did not feel qualified to judge the medical care situation in all of rural Washington, and these physicians were instead asked to compare medical care in their particular community with that in urban Washington. These two bases for comparison resulted in an interesting observation. Only 1 of 23 physicians thought that urban care in Washington was superior to that in his community. However, 54 percent of those who compared rural

Table 2. Responses of 41 physicians to selected questions about community medical needs

Questions and responses	Physicians	
	Number [1]	Percent
What are the most pressing medical needs in your community?		
More physicians	10	24
More adequate hospital and ancillary facilities	8	20
Programs, personnel, or facilities to meet the needs of:		
The poor and immobile	7	17
The elderly	4	10
Those with personal or mental problems	5	12
Better cooperation and coordination among physicians	3	7
Other needs	4	10
Needs are adequately met	5	12
No response	1	2
Under present conditions could your community support another physician?		
Yes	34	83
No	7	17
Number of additional physicians community could support		
None	7	17
One	10	24
Two	18	44
Three	4	10
Four or more	1	2
No response	1	2

[1] The column sum for the first question is more than the sample size because of multiple responses by some physicians.

Table 3. Types of physicians that 34 study physicians believed their communities could support

Types of physicians	Study physicians	
	Number	Percent
Only general practitioners	23	68
Only specialists	3	9
General practitioners and certain specialists equally appropriate	7	21
No response	1	3

Table 4. Study physicians' comparisons of urban medical care with medical care in their communities or in all rural areas of Washington

Comparison of medical care	Based on physicians' communities (N=23)		Based on rural Washington (N=13)	
	Number	Percent	Number	Percent
Superior in urban Washington	1	4	7	54
Inferior in urban Washington	12	52	4	31
Comparable in urban and rural Washington	10	43	2	15

NOTE: 1 physician responded to the question from both geographic perspectives, and 6 physicians did not respond to the question.

Table 5. Responses to selected questions about urban medical care by 24 physicians who considered it either superior or inferior to rural medical care

Questions and responses	Physicians	
	Number [1]	Percent
Why is medical care in urban Washington superior?		
More physicians	6	25
More continuing education and professional stimulus for urban physicians	3	12
Less problems of time and distance	2	8
Superior facilities	2	8
Why is medical care in urban Washington inferior?		
Less personalized care	7	29
Physicians and facilities are less responsive to patients' needs	7	29
Less cooperative and coordinated medical community	3	12
Other reasons	6	25
No reasons given	1	4

[1] The column sum is more than the number of respondents because of multiple responses by some physicians.

Table 6. Suggestions by 41 physicians for improving medical care in rural Washington

Suggestions	Physicians	
	Number [1]	Percent
Increase the supply of physicians or paramedical personnel, or both	16	39
Measures to alter the geographic distribution of physicians	9	22
Better medical facilities	7	17
Provision of specialists on a rotating basis	5	12
More health education for rural citizens	4	10
More continuing education for rural physicians	3	7
Other reasons	6	15
No opinion	6	15

[1] The column sum is more than sample size because of multiple responses by some physicians.

with urban Washington said that urban care was superior. At least two possible explanations for these differing views are (*a*) those physicians who stated that urban care was not superior to that in their communities were, in fact, located in communities that were not representative of other rural communities or (*b*) these communities were representative, but the physicians were reluctant to find fault with the care in their communities. That is, to find fault may have been perceived by them as an admission of their inadequacy.

Those who considered the medical care in urban Washington different (either inferior or superior) from the care in their communities or in rural Washington, were then asked why they thought so. Their responses are summarized in table 5. As a broad generalization, those who thought the medical care in urban areas was inferior based their opinions on the belief that the urban delivery system was generally too unresponsive, impersonal, and unwieldy. Those who thought that urban care was superior based their views on what they believed were some quantitative or technical advantages of the urban medical care system, for example, "more doctors," "superior facilities," and "less problems of time and distance."

The categories "more doctors" and "less problems of time and distance in urban areas" are related to availability, that is, the urban patient can reach a physician's office or hospital more quickly than the rural patient. On the other hand, the response categories suggesting that the urban medical care system is less personal and responsive than the rural system are related to the belief that in urban areas (*a*) there is a problem of accessibility because of difficulty in scheduling appointments and locating a physician for emergency needs and (*b*) it is difficult for a patient to develop a close personal relationship with the physician.

The physicians' suggestions for improving the delivery of medical care to Washington's rural citizens are shown in table 6. The two most frequently mentioned categories were (*a*) increasing the supply of physicians or paramedical personnel, or both, and (*b*) altering the geographic distribution of physicians. In general, the suggestions dealt with a need to increase the resources—especially manpower resources—used to produce medical care. An interesting observation stems from this finding. Many of the frequently mentioned medical needs in the physicians' communities (for example, the need for more cooperation among physicians and the need for special measures to assist the poor, immobile, elderly, and those with personal or mental problems) cannot be solved by simply increasing the resources used to produce medical care. The solution will require basic structural changes in the way medical care is organized, delivered, and financed. The failure to mention such structural changes is consistent with the widely held belief that organized medicine opposes basic structural changes. Such opposition presents a barrier to solving the special medical problems of some people, such as the poor, immobile, and elderly, and it was the needs of these people that the study physicians frequently mentioned as the most pressing in their communities.

Discussion

Although economic reward—or lack of such reward—was not viewed as a problem by the physicians in this study, the most frequently mentioned sources of satisfaction were noneconomic considerations, including the variety and challenge of medical problems, the favorable working conditions of the practice, and the kind of community in which the practice was located.

The most frequently cited sources of physicians' frustration were the "excess work, responsibility, demands, and expectations by patients and community." Contrary to expectations, professional isolation, inadequate professional support, and the disadvantages of small-town living were infrequently mentioned as sources of frustration to the physicians in this study. The reason for the relatively infrequent mention of professional isolation may stem from the overrepresentation of group practices in the sample.

To the extent that the literature rarely mentions the positive aspects of rural practice and emphasizes the negative aspects (for example, the alleged professional isolation, inadequate professional support, and the disadvantages of small-town living), nonrural physicians and medical students may have a view of rural practice—at least rural group practice—that is unrealistically negative. Such unwarranted negativity increases the difficulty of recruiting physicians into rural communities, and efforts aimed at its eradication are needed. Unfortunately, any existing negativity toward rural practice may be reinforced in medical schools (*36–38*). For example, after reviewing a number of studies on physicians' locations, Lave and associates (*38*) concluded that:

> . . . the bulk of physicians come from urban backgrounds and as they pass through the medical education system, they acquire a set of values that reinforces their predisposition to choose an urban location for their practice.

Exposure to rural areas may be the best way to overcome prejudices and misconceptions regarding rural practice. For example, Steinwald and Steinwald (*39*) argued that:

> . . . a primary value of preceptorships and similar rural programs may lie in their role as sources of information about unfamiliar life and medical practice styles, and that an increased orientation of rural programs toward urban-reared students may prove fruitful.

Related to this need for exposure to rural areas is recent evidence from the Indian Health Service (IHS) that widespread dissemination of information about the IHS, personal visits to potential recruits by IHS personnel, and visits to or experiences on Indian reservations by potential recruits were important variables in influencing physicians to practice in the IHS (*40*).

Physicians were more reluctant to criticize the care received by residents of their communities than they were to be critical of the care received by patients in other rural areas. In general, they thought that urban medical care was superior to rural care in terms of availability and technological superiority but that urban care was too unresponsive and impersonal.

If these perceptions of rural-urban differences in medical care are correct, an interesting and important policy question emerges: How can rural areas improve their technological capabilities and their availability of medical resources without creating an unresponsive and impersonal delivery system? The physicians interviewed in this study seemed to be implying that policymakers will have to look somewhere other than to urban areas to find a satisfactory answer to this question.

In assessing the medical care needs of their communities, the study physicians showed considerable concern for the needs of special populations, such as the poor, immobile, elderly, and those with personal or mental problems. Less than 25 percent of the physicians mentioned the need for more practitioners, although a much larger percentage thought that their communities could support another physician. Primary care physicians were the kind most often mentioned. This response supports the frequent argument that medical education should give greater emphasis to the training of primary care physicians.

Suggestions for improving medical care in rural Washington emphasized increasing the number of resources used to produce medical care. This was an unexpected response because less than 25 percent of the respondents thought that additional physicians was a pressing need in their community, and because of the emphasis that the respondents placed on the needs of the special populations, just mentioned. It would seem that meeting the needs of these special populations would require basic structural changes in the way medical care is organized, delivered, and financed, rather than simply an increase in the number of resources used to produce medical care. If basic structural changes are needed and if these changes are not acceptable to practicing rural physicians, many of the problems of delivery of rural medical care may persist indefinitely.

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SYNOPSIS

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In a study in the State of Washington during 1971–73, 41 general practitioners in rural areas were asked their opinions about (*a*) their present practices, (*b*) the medical care needs of their communities, and (*c*) rural medical care in general.

The most frequently mentioned enjoyable aspects of their practices were the variety and challenge of medical problems confronted, the favorable working conditions of the practices, and the types of communities in which the practices were located. The most frequently mentioned sources of frustration to the physicians were the "excess work, responsibility, demands and expectations by patients and community."

The physicians were more reluctant to criticize the care received by the residents of their communities than they were to criticize the care that patients received in other rural areas.

Suggestions made by the physicians for improving medical care in rural Washington focused on ways to increase the number of resources used to produce medical care, rather than on structural changes in the way medical care is organized, delivered, and financed.