A Profile of Rural Family Physician Practices

This bulletin primarily analyzes information from the National Physician Survey\(^1\), using for the most part results of the 2010 iteration but also tracking trends from 2004 and 2007. For the purposes of this analysis, rural is based on populations the physician respondents reported serving. Grouped together as representing rural areas are: small town, rural and geographically isolated/remote. In 2010, this question was only asked of family physicians (FPs) so the following results are limited to that discipline.

There were 843 rural FP respondents in the 2010 survey, 1321 in 2007 and 1402 in 2004. All differences indicated below are statistically significant.

**Demographics**

According to the 2010 survey, there was a slightly smaller proportion of female family doctors in rural areas (36%) compared to 41% in the cities. With an average age of 48, rural physicians were a bit younger than those working in urban centres whose average age was 50. Female rural FPs, in particular, tended to be younger than their urban colleagues. Over half (55%) of female rural respondents were less than 45 years old compared to 45% for women of this age group in the cities.

It is well known that rural areas of Canada have historically offered employment to international medical graduates (IMGs) new to Canada, often under a supervised license until the IMG can complete the necessary postgraduate training to achieve full licensure and full mobility within Canada. Postgraduate training of IMGs may also involve a “return of service” agreement to practice in an underserviced area for a set period of time upon completion of training. So it is not surprising that for those who answered the question about place of MD graduation in 2010, 26% of rural family physicians were IMGs compared to 19% of FPs in a city environment. Of the 125 respondents who were rural FPs and first licensed in 2005 or later, fully 43% were IMGs. When asked in 2004 about the two main reasons for selecting their current practice location, IMGs were more likely (61%) to select “practice opportunity was available” compared to graduates of Canadian medical schools at 27%.

**Rural Workloads**

Rural family physicians in 2010 reported working on average 54 hours each week (excluding on-call) compared to the 50 hours indicated by urban family doctors. The time physicians spent providing direct patient care was also greater among rural FPs at 38 hours per week compared to 33 for urban family physicians.

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\(^1\) CFPC, CMA, Royal College. [http://nationalphysiciansurvey.ca/nps/2010_Survey/Results/physician1-e.asp](http://nationalphysiciansurvey.ca/nps/2010_Survey/Results/physician1-e.asp)
Larger differences in workload were seen when comparing on-call responsibilities. Rural family physicians reported an average of 167 hours per month compared to 126 hours indicated by their urban colleagues. The rural physicians said they spent 56 hours each month actually providing direct patient care during the time they were on-call, whereas the urban FPs reported 30 hours per month. The rural doctors also saw more patients, 94 compared to 50 patients seen while on-call that the city-based physicians averaged in a month. See Graph 1.

Graph 1: On-call responsibilities for rural versus urban family physicians.

The good news is, it appears the amount of on-call duties is decreasing over time (see graph 2). Regardless, a 2008 CMA survey of rural physicians showed that a more reasonable workload could keep physicians in rural practice with two thirds of respondents indicating this was an important improvement that could be made³.

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² On-call is time outside of regularly scheduled activity during which you are available to patients.
Graph 2: Average Number of Hours On-Call per Month for Rural and Urban FPs.

Satisfaction
The vast majority (87%) of rural family doctors are very or somewhat satisfied with their relationship with patients and for the most part are also satisfied with their FP colleagues (80%) and physicians of other specialties (72%).

More tied in with workload issues is satisfaction with their profession and the ability to balance it with other aspects of their life. Almost three quarters of the rural FPs surveyed were very or somewhat satisfied with their current professional life but 28% were dissatisfied with the balance between their personal and professional commitments compared to 23% of urban FPs.

Isolating the rural respondents who were somewhat or very dissatisfied with their work/home balance showed that they averaged 60 hours of work each week and were on-call almost 200 hours each month. In contrast, the dissatisfied urban FPs averaged 56 hours per week and were on-call for 137 per month. Both sets of figures exceed the averages mentioned above in the workload section.

Methods of Remuneration and Practice Organization
More rural family physicians are paid by a blended form of remuneration (44%) than any other method. A blended method could include one or more of the following payment mechanisms: fee-for-service, salary, capitation, sessional, contract, etc. Less than a third were paid almost exclusively fee-for-service, 31% compared to 43% of urban FPs who received at least 90% or more of their professional income from fee-for-service. See Graph 3.
The two cohorts had identical distributions with respect to practice organization. Almost half (49%) of both rural and urban family physicians are in group practices, 21% are in interprofessional practices and 23% are solo practitioners. The proportion of FPs working alone in both rural and urban settings has decreased from over 26% in 2004.

**Graph 3: Method of Remuneration for Rural and Urban Family Physicians**

![Graph showing method of remuneration for rural and urban family physicians]

**Access to Services for their Patients**

While it is assumed that many patient services are harder to access in the country than in the city, the levels of satisfaction with access to services and other specialists among rural physician respondents was no worse and in some cases better than the city physicians. For instance, 29% of rural FPs rated access to hospital care for elective procedures as fair or poor whereas the urban physicians were even more dissatisfied at 40%. Urban family physicians were more likely to rate access to orthopaedic surgeons as fair or poor (57%) than rural doctors (48%). However, rural physicians were more dissatisfied with access to physiotherapy (33% fair/poor) compared to their urban colleagues at 16%.

In terms of their own practices, a greater proportion of rural doctors (30%) have no restrictions on accepting new patients compared to 15% of urban FPs. Just over 18% of urban physicians have completely closed practices compared to 13% of rural physicians. One in five urban FPs indicated that accepting new patients was not applicable to their practice setting compared to 13% for rural doctors. See Graph 4.
A rural FP can see an urgent case on average in 1.3 days and a non-urgent case in 3.2 weeks. There is no statistical difference for this indicator among urban physicians.

**Summary**

There are clearly ongoing challenges among rural family physicians in achieving a reasonable workload and for those reporting higher than average work hours, the satisfaction with balancing home and work lives diminishes.

Rural physicians, however, seem to have had fairly positive experiences with respect to accessing services and providers for their patients. Without an exact way to measure the actual access, we cannot know from the survey results if the access is actually as good as those in urban areas or if the expectations of rural physicians are simply lower.

A significantly greater proportion of rural FPs keep their practices open to all new patients compared with their urban counterparts but this may be more a reflection of manageable patient flows than a differing mindset. It could also be an indication of less specialization among family physicians in rural areas.

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