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Field report

What Rural Physicians Need to Engage in Community Based Education: A Qualitative Interview Survey

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Abstract

There is systematic evidence that community-based education is effective in the recruitment of rural physicians to remote communities. However, various obstacles may exist that prevent rural physicians from sustaining their mentoring activities. The aim of this study was to explore ways for rural physicians to overcome such adversities and continue their mentoring activities. We interviewed four nominated physicians (all male, mean age 48 years) based in Hokkaido, Japan, who practiced in an area with less than 10,000 inhabitants. Semi-structured interviews of approximately 60 minutes were performed and focused on topics rural physicians' found necessary for their teaching activities. All interviews were tape-recorded and transcribed, the verbatim transcripts were analyzed and repeated themes were identified. Three themes that emerged as needs were 1. sustained significant human relationship, including the formation of a network between students and university faculty, as well as developing partnerships with many community relationships, or other medical professions; 2. intrinsic motivations and satisfaction, including pleasure in mentoring the younger generations; and 3. rewards, including financial compensation. Rural physicians as preceptors require nonremunerative, intrinsic motivational factors, such as a sense of satisfaction regarding the education of medical students and being able to relate to residents and others health-care professions, when pursuing their educational activities. To support them, focusing only on monetary facets may be unsuccessful in encouraging them to continue their educational work.

Key words: community-based education, rural physicians' needs, rewards, rewards; interview survey

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Introduction

The problem of the shortage of rural physicians has a long way to go. The history of such physicians and related problems pertaining to rural primary care has been summarized in a review article by Otaki in Academic Medicine[1]. Otaki is one of the leading researchers in this field. He described the major problems as follows: "Most primary care in Japan is provided by community-based general practitioners," "most of these community-based primary care physicians are in solo practices," and "they have never received systematic training in this field." He indicated the lack of a systematic educational curriculum in medical school in this field. Many researchers in the field of rural medicine have suggested one of the better solutions to be increasing "community-based educators." Community-based education (CBE) is defined as "a means of achieving educational relevance to community needs and, consequently, of implementing a community-oriented educational program[2]" according to a WHO study group in 1987. CBE utilizes the community as a learning environment, in which "not only students but also teachers, members of community and representatives of other sectors take part." Furthermore, community based-education is not restricted to "rural areas" but also includes suburban or urban areas. However, in this study, we focused on the context of teaching by rural physicians because serious problems of medical care, especially shortage of physicians, arise in small rural areas in Japan. A definite rationale and evidence have shown that CBE is effective as a method of medical education[3], with benefits including recruitment of new rural physicians[4], deriving students' educational satisfaction[5] or even making a favorable impression on community patients[6]. Many rural physicians have an interest in teaching students in their own community[7]; however, some obstacles, such as exorbitant clinical work and shortage of administrative support or financial

Table 1 Participants' characteristics

Physician No.	Age	Career as a Dr. (yrs)	Working years in community	Working hours per week	Hours for education per month	Years engaged in medical education
1	55	29	10	72	18	2
2	46	20	12	30	1	6
3	58	26	17	80	3	0
4	31	5	5	55	2	3

The participants were four males with a mean age of 48 years (range, 31 to 55). All physicians were engaged in community-based medical education from one to four days a month by accepting 5th grade medical students to their clinic or hospital. Teaching content included medical interviews in their outpatient ward, inpatient care, home care and case conferences by multiprofessional health care teams. The teaching strategy for these activities included a hands-on approach for medical interviews and inpatient care and an observational approach for home care and conferences.

compensation, may result in rural physician burnout and inability to sustain their educational activities[2, 8, 9]. Many studies focus on the development of an effective means to recruit and retain rural physicians as lifelong mentors[3].

While there has been a global movement to change from tertiary-based education to a CBE approach[3, 8, 10], one of the authors [MMa], while considering a Japanese setting, has repeatedly emphasized the importance of the role of rural physicians as medical educators[11]. Nevertheless, to our knowledge, there are few reports that have investigated how they view rural physicians identity or perceive their needs. Therefore, to help them overcome their difficulties and support the promotion of CBE, we explored aspects of their identity and perceptions, as well as matters concerning what rural physicians need to engage in for CBE in their own surroundings (Hokkaido, Japan). Hokkaido is the northernmost prefecture of Japan. It has vast open areas and is very cold in winter. The conditions for sustaining rural medicine are very severe in this area.

Material and Methods

To support a region in Japan with a severe shortage of rural physicians, four physicians (Table 1) who were engaging in student-driven voluntary education, such as voluntary learning or training in physicians' clinics, and were nominated by the chief director of the Japan Primary Care Association as experienced physicians were recruited. They were all males (mean age 48 years) living in Hokkaido, Japan, and were working in an area with less than 10,000 inhabitants[12]. A qualitative approach with semi-structured interviews[13, 14] was adopted in this study. Major interview topics, amended from previous studies[9, 12], were as follows:

1. What are the difficulties rural physicians face in providing community-based teaching to medical students and possible solutions;
2. What motivates rural physicians to engage in their teaching roles; and
3. What do rural physicians need to sustain their teaching activities?

All interviews lasted approximately 60 minutes in total and were transformed into verbatim script form. The scripts were independently analyzed by three researchers [MMu, HK, KK] and repeated themes, which linked the latent meanings together in the categories (i.e., groups of content that share a commonality and are mutually exclusive), identified. Finally, the senior author [MMa] supervised all analyses, and all authors approved the revised results.

Ethical approval

For interviewees' ethical confidentiality, formal ethical approval was obtained from the Ethics Committee of the Hokkaido University Graduate School of Medicine.

Results

We identified three themes that helped rural physicians overcome obstacles and prolonged their CBE activities: 1. Sustained significant human relationships, i.e., forming a network between students and university faculties, as well as developing partnerships with many community residents or other medical professions and learning new methods for teaching future doctors; 2. Intrinsic motivation and satisfaction, i.e., enjoyment in mentoring the younger generations and achieving ideal medical practice for themselves; 3. Rewards, i.e., financial compensation and infrastructural subsidies.

A few comments about remunerative or material reward emerged. For example, "Participant 1 said, "Most of our time and energy go toward mentoring students. It is natural we should be paid in proportion to the amount of work we do. We are working harder due to this duty."

However, many participants strongly desired nonremunerative personal support rather than financial subsidies. For example, Participant 2 said, "I want to get the chance to communicate with university faculty who administer the program. Mutual feedback is necessary." Participant 3 said, "Regarding the local atmosphere, community residents are

all kind and calm. Many students are rough-diamonds. But that is fine by me."

Furthermore, the most common comments were not regarding reward but were about intrinsic motivation or satisfaction. For example, Participant 4 said, "In the hope of seeing a few younger physicians, even one or two, become rural physicians someday. That's why I must continue working at the forefront." Participant 3 said, "One day, I thought a lot about my reason for living. I didn't originally aim to be a doctor specializing in a limited field. That's one of the reasons why I tried to be a rural physician."

Meanwhile, some rural physicians pointed out the reason for having lost their educational motivation, and these included such things as a full clinical workload and no response or feedback from their students: "When I cannot afford to take care of students… and when students seem to lack enthusiasm..." (Participant 4).

Discussion

Interviewees indicated they did not desire monetary or material support such as human relations between colleagues or other healthcare professionals; instead, self-satisfaction might be the key issue for what they need to sustain their CBE activities, even though some did comment about financial compensation. Our results were in accordance with other studies in this field that describe primary care physicians as not being principally inspired by financial remuneration to train medical students[4, 8]. However, fiscal incentives, such as the right to contact university faculty or browse online journals free of charge by using a local or national government funded network service seem to be valuable. The Japanese ruling party has started paying subsidies to increase new medical student enrollment through "*chiiki-waku"* (rural quotas) [15]. Medical students who make use of this system are expected to work in rural areas in the future. This strategy might be unsuccessful if only monetary terms and conditions are taken into consideration.

One significant limitation of this study was that it was conducted in one district in Japan, so the results might be biased. We must carry out further complementary interviews with another approach to validate and generalize our semi-structured interview survey. For further external generalizability, we must pay attention to the demographic characteristics of the interviewees. However, even taking this drawback into account, this survey focused on physicians at the forefront of rural practice, which is of great significance.

In August 2009, the revolutionary integration of three Japanese primary care societies, i.e., the Japanese Medical Society of Primary Care, the Japanese Academy of Family Medicine and the Japanese Society of General Medicine, into one new organization (the Japan Primary Care Association) occurred[16]. Japanese primary care physicians should cooperate with each other to overcome the difficulties associated with mentoring future generations in order to make them exceptional family physicians.

Conclusion

The real voices of four nominated rural physicians were obtained to investigate their ideas concerning requirements for sustaining their CBE activities. We found they desired intrinsic matters rather than financial aid. In order to promote CBE, we must consider the values of rural physicians, such as a sense of satisfaction regarding mentoring activities and their relationship with inhabitants and other healthcare professionals. Support based only on monetary facets may not prevent rural physicians from being overworked when engaging in CBE activities in their local community.

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