Medical Practice In Rural Communities

EXECUTIVE SUMMARY: Despite the rising number of physicians in the U.S., even relative to the size of the population, physicians continue to disproportionally locate their practices in urban areas. In 1965, there was one nonfederal, patient care physician for every 807 persons in the U.S.; this ratio had reached one patient care physician for every 455 persons in 1996 (Randolph, 1997). Rural communities, however, have not shared equitably in that increase. While 24% of Americans live in nonmetro counties, only 11% of patient care physicians practice in those counties; this proportion has fallen since 1980 (Randolph, 1997). Consequently, residents of rural areas are far more likely to live in health personnel shortage areas than are urban residents. Although allopathic and osteopathic family medicine residency graduates are much more likely than other primary care residency graduates to locate in rural areas, the proportion and number of family medicine graduates doing so have been declining over the past decade (American Association of Medical Colleges, 1995). Many factors contribute to the imbalance in the distribution of physicians, including: the type of training chosen, the location of medical training sites, physicians' lifestyle preferences, and aspects of rural communities such as the strength of their economies and health care delivery systems. Training physicians in rural areas has been advocated as one strategy to attempt to increase the numbers of rural physicians. This report summarizes what is known about rural graduate medical education (GME) in family medicine, general internal medicine, pediatrics, obstetrics and gyneconology, and general surgery. It identifies barriers to rural graduate medical training and proposes actions that might be taken to reduce or remove those barriers. LITERATURE REVIEW - LIMITED PUBLISHED DATA; MOST RURAL GME IN FAMILY MEDICINE: A review of the literature reveals a dearth of information on either allopathic or osteopathic graduate medical education in rural areas. Several case-reports describe elective rotations and rural continuity clinics in general internal medicine and pediatrics residencies, and a few of these offer anecdotal reports of outcomes concerning the practice locations of the graduates of these programs. We found no published reports of organized rural training experiences in general surgery or obstetrics and gynecology. The literature did show that 15% of physicians in small rural counties are osteopathic physicians, despite their comprising only 5% of all U.S. physicians (Simpson & Simpson, 1994). Allopathic and osteopathic family practitioners are equally likely to choose rural practice, but only 11% of allopathic graduates become family practitioners, whereas 46% of osteopathic graduates do so. A larger, but still quite modest, literature report on rural training experiences in allopathic family medicine. About half of all family medicine residencies offer some type of rural experience and 40% have a required rural rotation (Bowman & Penrod, 1998). Family medicine has developed both three-year residencies based entirely in rural areas with the expressed mission of training physicians for rural practice, and "rural training track" (RTT) residency programs. In RTTs, residents spend their first year of training in a larger, more urban setting, then spend their last two years training in a much smaller, rural setting, though they usually rotate back to the larger setting for some experiences in these latter two years. The limited evidence available indicates that most RTT graduates establish practices in rural areas. A survey of 96% of all family medicine

residencies suggested that being located in a more rural state, being located in a smaller population center, having an explicit mission for rural health care, and having a required rural rotation all increased the likelihood that graduates of a program would locate in a rural area (Bowman & Penrod, 1998). INTERVIEWS WITH PERSONS INVOLVED WITH RURAL GME: We interviewd persons involved with rural graduate medical education at a number of sites. Most of the people interviewed were in family medicine, as most rural training activity appears to occur in family medicine, but we also spoke with persons involved with rural training in general internal medicine, pediatrics, and general surgery. FINANCIAL BARRIERS RELATED TO MEDICARE GME FUNDING ARE THE BIGGEST PROBLEM: By far, financial obstacles present the greatest identified barriers to increasing rural training opportunities. All GME programs depend on Medicare GME funding paid to teaching hospitals. GME funding is directly related to the hospital volume of Medicare patients and goes predominantly to states with large urban populations through urban hospitals. For example, for every Medicare enrollee in New York, hospitals receive $62 in GME payments, while the comparable amount for Idaho hospitals is $1.02. Many aspects of the GME funding ...

Dr. Frances Sage Bradley (1862--1949) was a mediating force between the urban world of her own education and experience, and that of rural Americans. As a widow with four young children, Bradley trained as a doctor and became one of the first women to graduate from Cornell University Medical School. During the height of the Progressive Era, she left her private practice to do significant field work for the newly-created Children's Bureau, working mainly in the Appalachian South. In this timely biography, Barbara Barksdale Clowse details the story of this physician, reformer, and writer, and her efforts to extend access to healthcare to rural communities. Clowse describes Bradley's important innovations in the field of public health, including physical exams or "conferences" for children and infants which simultaneously educated parents and local medical practitioners, and her advocacy for improved nutrition and modern medicine in rural areas. Finally, Clowse illustrates how Bradley's work regarding maternal mortality and morbidity in America was instrumental in demonstrating the need for what became the Sheppard--Towner Act of 1921, also known as the Maternity and Infancy Protection Act. A century has passed since Bradley lived out her commitment to social justice in healthcare, yet many of the issues that she faced still plague the United States today. A Doctor for Rural America presents a balanced portrait of an overlooked pioneer and her work to establish healthcare as an obligation that the government owed to its citizens.

This volume is a useful resource for bioethicists, members of rural bioethics committees and networks, policy makers, teachers of health care providers, and rural practitioners themselves.

Featuring contributions from practitioners, researchers, and academics, this volume synthesizes and analyzes current trends in rural social work practice and considers the most effective ways to serve rural communities. Contributors consider the history and development of rural social work from its beginnings to the present day, addressing the value of the Internet and other new information technologies in helping clients. They also examine the effects of nonprofit organizations and welfare reform on poor rural areas. Coverage of specific client populations and fields of practice includes services for rural mental healthcare; the

chronically mentally ill; healthcare for minorities; and the challenges faced by the elderly in rural areas. The contributors also consider issues affecting gays and lesbians living in rural communities and the role of religiosity and social support in the well-being of HIV/AIDS clients. The book concludes with a consideration of the unique issues associated with educating social workers for rural practice.

This volume initiates a much-needed conversation about the ethical and policy concerns facing health care providers in the rural United States. Although 21 percent of the population lives in rural areas, only 11 percent of physicians practice there. What challenges do health care workers face in remote locations? What are the differences between rural and urban health care practices? What particular ethical issues arise in treating residents of small communities? Craig M. Klugman and Pamela M. Dalinis gather philosophers, lawyers, physicians, nurses, and researchers to discuss these and other questions, offering a multidisciplinary overview of rural health care in the United States. Rural practitioners often practice within small, tight-knit communities, socializing with their patients outside the examination room. The residents are more likely to have limited finances and to lack health insurance. Physicians may have insufficient resources to treat their patients, who often have to travel great distances to see a doctor. The first part of the book analyzes the differences between rural and urban cultures and discusses the difficulties in treating patients in rural settings. The second part features the personal narratives of rural health care providers, who share their experiences and insights. The last part introduces unique ethical challenges facing rural health care providers and proposes innovative solutions to those problems. This volume is a useful resource for bioethicists, members of rural bioethics committees and networks, policy makers, teachers of health care providers, and rural practitioners themselves.

-An excellent resource for pre-med students and medical school advisors. -Possible adoptions for courses in Medical Humanities (pre-med undergraduate and medical school/graduate, first two years) and Family Practice Clerkship (medical school/graduate) -In-depth profiles reveal the everyday reality of the shortage through poignant stories and candid dialogue. -The foreword is written by Dr. Robert Taylor (Family Medicine; Fundamentals of Family Medicine)

This work provides a comprehensive review of rural medicine, including special clinical problems and approaches care, organization and management of rural health care, educational issues and lessons from abroad.

Building on the innovative Institute of Medicine reports To Err Is Human and Crossing the Quality Chasm, Quality Through Collaboration: The Future of Rural Health offers a strategy to address the quality challenges in rural communities. Rural America is a vital, diverse component of the American community, representing nearly 20 % of the population of the United States. Rural communities are heterogeneous and differ in population density, remoteness from urban areas, and the cultural norms of the regions of which they are a part. As a result, rural communities range in their demographics and environmental, economic, and social characteristics. These differences influence the magnitude and types of health problems these communities face. Quality Through Collaboration: The Future of Rural Health assesses

the quality of health care in rural areas and provides a framework for core set of services and essential infrastructure to deliver those services to rural communities. The book recommends: Adopting an integrated approach to addressing both personal and population health needs Establishing a stronger health care quality improvement support structure to assist rural health systems and professionals Enhancing the human resource capacity of health care professionals in rural communities and expanding the preparedness of rural residents to actively engage in improving their health and health care Assuring that rural health care systems are financially stable Investing in an information and communications technology infrastructure It is critical that existing and new resources be deployed strategically, recognizing the need to improve both the quality of individual-level care and the health of rural communities and populations.

Many of the 61 million people who live in rural America have limited access to health care. Almost a quarter of the nation's population lives in rural places yet only an eighth of our doctors work there. Sponsored by the U.S. Office of Rural Health Policy, this unique book provides the facts about this imbalance and interprets them in the context of government programs that promote the placement of doctors and the operation of hospitals in rural places while paying them less to treat Medicare and Medicaid beneficiaries. The authors' comprehensive analysis of rural health care delivery shows where there are differences in rates of death and disease between rural areas using maps, graphs, and plain-English descriptions. The book provides a thorough look at health care in rural America, giving a snapshot of how doctors, hospitals, and technology are unevenly distributed outside the nation's metropolitan areas.

Incorporating and balancing advancing subspecialization is a significant challenge of modern surgery. The changes of surgical education and early subspecialization is a smaller spectrum of experience of graduating surgeons joining the rural workforce. Surgeons working in rural and remote hospitals, however, must be proficient in the great breadth of current surgical practice and face a number of challenges and demands that are specific to rural surgery. This textbook provides an update on the evidence and surgical techniques for the experienced rural surgeon and most importantly is a guideline for younger surgeons and surgical trainees joining the general surgical workforce in rural and remote areas around the world.

The fourth edition of the only text to focus on nursing concepts, theory, and practice in rural settings continues to provide comprehensive and evidence-based information to nursing educators, researchers, and policy-makers. The book presents a wealth of new information that expands upon the rural nursing theory base and greatly adds to our understanding of current rural health care issues. It retains seminal chapters that consider theory and practice, client and cultural perspectives, response to illness, and community roles in sustaining good health. Authored by contributors from the United States, Canada, and Australia, the text examines rural health issues from a national and international

perspective. The 4th edition presents new chapters on: Border health issues Palliative care Research applications of rural nursing theory Resilience in rural elders Vulnerabilities Health disparities Social disparities in health Use of rural hospitals in nursing education Establishing nursing education following disaster Public health accreditation in rural and frontier counties Developing the workforce to meet the needs for rural practice, research, and theory development Key Features: Provides a single-source reference on rural nursing concepts, theory, and practice Covers critical issues regarding nursing practice in sparsely populated regions Presents a national and international focus Updates content and includes a wealth of new information Designed for nurse educators and students at the graduate level

"The health of any population is, in part, determined by access to healthcare resources including the availability of physicians. Such access is not equitably distributed being more concentrated in urban centres leading to worse health outcomes for rural citizens. Increasing the supply of rural physicians is therefore of importance to providing healthcare which meets the needs of the local population. The provisions of suitable medical education programs is an important component of meeting rural community healthcare needs; programs which explicitly do so are termed 'socially accountable'. One mechanism by which a socially accountable program can be implemented is the training of physician in their future practice context, which for rural health means training in rural communities. This comprises a form of community- and/or place-based education with the desired outcome being that the learner develops the knowledge and skills to work in such contexts as well as the desire to do so. The existing literature regarding community placements rather lacks information and analysis of the role played by the actual place the placement takes place it even though recruitment and retention of physicians is known to be influenced by community satisfaction, knowledge and integration. This portfolio aims to begin to remedy this deficiency in the literature by focusing on a type of community placement which forms part of the MD program of the Northern Ontario School of Medicine (NOSM). At NOSM learners take part in a variety of community-based experiences, two of which are the 'remote and rural community placements' in year 2, the objective of which is to teach students what it is like to work and live in rural communities. A review of the founding documents of the MD program along with interviews of those in leadership roles during the formative and start-up phases of the program indicated that the placements had three main roles (i) as a means of engaging communities as part of social accountability, (ii) to be part of a holistic program of community-based learning, and (iii) to learn the knowledge, skills and attitudes necessary to work and live in a rural community as a physician. A consideration of the existing curriculum of the placements revealed, however, that while there was a considerable focus on the regular academic sessions of the program and on learning specific clinical skills by means of time spent with community physicians, the key place-related learning about rural living and working lacked Syllabus outcomes, learning objectives and learning

activities. Such a deficiency is concluded to mean that much of the educational intent of the placements has not been made explicit. This includes allowing learners to experience and reflect on this way place and community influences medical practice and how they can successfully live and work as rural physicians, outcomes which are argued to be key to fulfulling the school's mission of a 'healthier North'. With this in mind new outcomes, objectives and educational activities for the placements are described including the inclusion of community exploration, advocacy and/or service learning opportunities, a requirement to reflect on rural medical practice, and a focus on team-based interprofessional learning during clinical and academic sessions."-- from abstract.

In 1996, the Institute of Medicine (IOM) released its report Telemedicine: A Guide to Assessing Telecommunications for Health Care. In that report, the IOM Committee on Evaluating Clinical Applications of Telemedicine found telemedicine is similar in most respects to other technologies for which better evidence of effectiveness is also being demanded. Telemedicine, however, has some special characteristics-shared with information technologies generally-that warrant particular notice from evaluators and decision makers. Since that time, attention to telehealth has continued to grow in both the public and private sectors. Peer-reviewed journals and professional societies are devoted to telehealth, the federal government provides grant funding to promote the use of telehealth, and the private technology industry continues to develop new applications for telehealth. However, barriers remain to the use of telehealth modalities, including issues related to reimbursement, licensure, workforce, and costs. Also, some areas of telehealth have developed a stronger evidence base than others. The Health Resources and Service Administration (HRSA) sponsored the IOM in holding a workshop in Washington, DC, on August 8-9 2012, to examine how the use of telehealth technology can fit into the U.S. health care system. HRSA asked the IOM to focus on the potential for telehealth to serve geographically isolated individuals and extend the reach of scarce resources while also emphasizing the quality and value in the delivery of health care services. This workshop summary discusses the evolution of telehealth since 1996, including the increasing role of the private sector, policies that have promoted or delayed the use of telehealth, and consumer acceptance of telehealth. The Role of Telehealth in an Evolving Health Care Environment: Workshop Summary discusses the current evidence base for telehealth, including available data and gaps in data; discuss how technological developments, including mobile telehealth, electronic intensive care units, remote monitoring, social networking, and wearable devices, in conjunction with the push for electronic health records, is changing the delivery of health care in rural and urban environments. This report also summarizes actions that the U.S. Department of Health and Human Services (HHS) can undertake to further the use of telehealth to improve health care outcomes while controlling costs in the current health care environment.

Rural counties make up about 80 percent of the land area of the United States, but they contain less than 20 percent of the U.S. population. The relative sparseness of the population in rural areas is one of many factors that influence the health and well-being of rural Americans. Rural areas have histories, economies, and cultures that differ from those of cities and from one rural area to another. Understanding these differences is critical to taking steps to improve health and well-being in rural areas and to reduce health disparities among rural populations. To explore the impacts of economic, demographic, and social issues in rural communities and to learn about asset-based approaches to addressing the associated challenges, the National Academies of Sciences, Engineering, and Medicine held a workshop on June 13, 2017. This publication summarizes the presentations and discussions from the workshop.

Though it is highly preventable, tooth decay is a common chronic disease both in the United States and worldwide. Evidence shows that decay and other oral diseases may be associated with adverse pregnancy outcomes, respiratory disease, cardiovascular disease, and diabetes. However, individuals and many health care professionals remain unaware of the risk factors and preventive approaches for many oral diseases. They do not fully appreciate how oral health affects overall health and well-being. In Advancing Oral Health in America, the Institute of Medicine (IOM) highlights the vital role that the Department of Health and Human Services (HHS) can play in improving oral health and oral health care in the United States. The IOM recommends that HHS design an oral health initiative which has clearly articulated goals, is coordinated effectively, adequately funded and has high-level accountability. In addition, the IOM stresses three key areas needed for successfully maintaining oral health as a priority issue: strong leadership, sustained interest, and the involvement of multiple stakeholders from both the public and private sectors. Advancing Oral Health in America provides practical recommendations that the Department of Health and Human Services can use to improve oral health care in America. The report will serve as a vital resource for federal health agencies, health care professionals, policy makers, researchers, and public and private health organizations.

"[A] welcome addition to the rural health care practitioner's tool kit. It will energize those interested in vulnerable rural residents and their unique characteristics through a public health perspective... Highly recommended."--CHOICE: Current Reviews for Academic Libraries "This call to action for healthcare providers is a comprehensive review of issues in rural healthcare, including both obstacles and ways to begin to overcome them. It is easy to read... This enjoyable book encourages healthcare providers working or considering working in rural healthcare with clear direction."--Doody's Medical Reviews "The Warren & Smalley book is an excellent look at the challenges while also presenting solutions and hope. It recognizes the medical challenges that are present and the cost of bring medical care to these communities... There is so much in this book that will be refreshing and encouraging. The book needs to be read. It is also a book that needs to be placed in the hands of the movers and shakers, as well other

interested parties who are in a position to 'make this happen.'" -- Illness, Crisis & Loss Rural residents face distinct health challenges due to economic conditions, cultural/behavioral factors, and health provider shortages that combine to impose striking disparities in health outcomes among rural populations. This comprehensive text about the issues of rural public health is the only book to focus on rural health from the perspectives of public health and prevention. It covers specific diseases and disorders faced by rural populations, service delivery challenges, practitioner shortfalls in rural areas, and promising community health approaches and preventive measures. The text also addresses rural health care ethics and international perspectives. Nearly all chapters offer best practice recommendations and evidence-based prevention programs. This book is a cohesive, centralized resource for researchers, public health practitioners, health organizations, and graduate education programs that focus on the public health of rural populations. Key Features: Comprises the only text to address rural health from the perspectives of public health and prevention Includes best practice recommendations and evidence-based prevention programs in each chapter Presents a cohesive, expansive synthesis of current research and practice Addresses specific diseases and disorders of rural populations, service delivery problems, and practitioner shortfalls in rural areas Discusses promising community health approaches and preventative measures

No other book on the subject Chronic diseases, especially those associated with poor nutrition, obesity, and addiction have grown to epidemic proportion in many poor and minority populations Covers all essential topics, including Navigating Language Barriers, Understanding Disability, Patient Education, Substance Abusers, the Care of Gay and Lesbian Patients, Reproductive Issues in Poor Women, and much more

This document represents proceedings of a workshop before the Senate Special Committee on Aging. The workshop focused on the severe shortage of health professionals in the rural health care system. Opening remarks by Portia Mittelman, Staff Director of the Special Committee on Aging and Jeffrey Human, Director of the Office of Rural Health Policy provide an overview of the problems and issues associated with delivery of rural health care services, including shortage of rural medical professionals, recruiting and training of medical students who will work in rural areas, and the existing programs focusing on rural health service delivery. The first panel of the workshop, with four speakers representing leaders in rural health care, examined national policies regarding the education of health professionals and the barriers to improvements. The panel emphasized personal sacrifices of rural health professionals, the need for professional support, medical students specialty choices, financial support for family medicine programs and primary care services, and improvement of rural manpower distribution. The second panel, consisting of five speakers, presented information on specific exemplary model programs that link medical education and training to rural areas. The appendix includes information about educational and community programs that address the health care needs of rural areas, articles addressing medical education reform, and written testimonies from various sources. (LP)

Research Paper (postgraduate) from the year 2009 in the subject Health Science, , course: Health Informatics / Information Communication Technology, language: English, abstract: Health service delivery to rural communities has always been a vexed

problem for most governments in developing countries. Several factors impeding the success of government programmes in this sub-sector include corruption, inadequate supply of drugs, paucity and/poor quality of medical personnel, lack of medical equipment and facilities, cost (transportation to the hospital, medical bills) to the patients of obtaining medical attention and interference by unorthodox medical practitioners. This paper surveys the problems that inhibit provision of adequate preventive and curative health care to rural communities and suggests affordable and sustainable ways in which ICT can be used to solve these problems. Special emphasis is given to use of ICT for public enlightenment for preventive health care and also for the implementation of affordable access to curative health care.

v. 1. Research findings -- v. 2. Concepts and methodology -- v. 3. Implementation issues -- v. 4. Programs, tools and products.

"World Health Organization (WHO) has drawn up a comprehensive set of strategies to help countries encourage health workers to live and work in remote and rural areas. These include refining the ways students are selected and educated, as well as creating better working and living conditions ... The guidelines are a practical tool all countries can use. As such, they complement the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the Sixty-third World Health Assembly."--Preface.

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In 2001, with funding from the MacArthur Foundation, sociologists Patrick J. Carr and Maria J. Kefalas moved to Iowa to understand the rural brain drain and the exodus of young people from America’s countryside. They met and followed working-class “stayers”; ambitious and college-bound “achievers”; “seekers,” who head off to war to see what the world beyond offers; and “returners,” who eventually circle back to their hometowns. What surprised them most was that adults in the community were playing a pivotal part in the town’s decline by pushing the best and brightest young people to leave. In a timely, new afterword, Carr and Kefalas address the question “so what can be done to save our communities?” They profile the efforts of dedicated community leaders actively resisting the hollowing out of Middle America. These individuals have creatively engaged small town youth—stayers and returners, seekers and achievers—and have implemented a variety of programs to combat the rural brain drain. These stories of civic engagement will certainly inspire and encourage readers struggling to defend their communities. From the Trade Paperback edition.

"In 1965, as part of the War on Poverty, the Office of Economic Opportunity approved a $1.3 million dollar grant to fund the development of the first two community health centers in the United States, The Tufts-Delta Health Center in Mound Bayou, Mississippi, and the Columbia Point Health Center in Boston, which pioneered a health care delivery system that now includes more than 1,200 community centers in every U.S. state, providing care to over 24 million Americans annually. The architect of these centers was Dr. H. Jack Geiger, now known as the father of community medicine, who

conceived of this program in 1964 along with members of the Medical Committee on Human Rights, a group of physicians active in the civil rights movement. Drawing on his experience in South Africa, where he had apprenticed under Dr. Sidney Kark, who had developed community-based health centers in African townships, Geiger proposed a similar program for the poor in the U.S. An advocate of the "social determinants of health," Geiger created a center in Mississippi that did more than just provide clinical services, but developed innovative programs in nutrition, education, and environmental services, in an attempt to deal with the question of "What does it take to be healthy and stay healthy, not just get healthy?" Out in the Rural also deals with the opposition that the center faced, from both state officials and members of the local population, providing insights into both race and class relations in Mississippi during the final years of the civil rights era. Finally, by examining the legacy of the Tufts-Delta Health Center, Out in the Rural provides a reevaluation of the War on Poverty a half-century after its inception"--Provided by publisher.

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 wen 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.