

Concerns about Return of Service Contracts from Medical Learners

Position Paper

Canadian Federation of Medical Students

Spring General Meeting

April 11-13, 2019

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Background

Throughout Canada, there has long existed an uneven distribution of physicians serving its communities. Rural areas in Canada constitute 18% of the Canadian population, but are served by only 8% of the physicians practicing in Canada.^{1,2} Due to various geographic, environmental and systemic factors, Canadians living in rural areas continue to face numerous barriers in accessing healthcare. In fact, in 2014, the College of Family Physicians of Canada (CFPC) and the Society of Rural Physicians of Canada (SRPC) formed a joint task force solely with the goal to improve the health of rural Canadians.³

Among the strategies used by governments to increase physician services in rural communities are Return of Service (ROS) contracts. An ROS contract is an agreement undertaken by a graduating medical student at the beginning of their residency training, which imposes an obligation to work in an underserved area for a set number of years upon finishing medical residency. Specific ROS obligations vary from province to province. Although traditionally meant for International Medical Graduates (IMGs) looking to relocate to Canada and obtain full medical licensure, ROS contracts have recently permeated agreements with Canadian Medical Graduates (CMGs). In 2018, as a response to advocacy efforts by medical students to increase residency spots, the Ministry of Health and Long-Term Care in Ontario created 33 new one-time residency positions; however, all of them were tied to an ROS contract.⁴ Recently, select second iteration spots in CaRMS across Canada have now also added an ROS contract tied to their programs.⁵ Additionally, for the first time in the 2018-2019 CaRMS cycle, a dermatology residency spot in British Columbia was tied to an ROS contract in the first iteration CaRMS match.⁶

Unfortunately, data has shown that ROS contracts are ineffective long-term strategies that fail to address underlying issues. IMGs who accept ROS contracts have an incredibly high turnover rate.^{7,8} It has been shown that IMGs will often agree to complete their training in certain underserved areas of Canada as “entry-points” to obtain full licensure in Canada, and leave once their contract is over.^{7,8} Moreover, a study examining retention of both IMGs and CMGs in rural Newfoundland found that not only was turnover high amongst IMGs, it was also equally high among CMGs who had graduated from a medical school that wasn't Memorial University (in Newfoundland).⁹ Clearly, physicians who are newly working in an area - where they were not trained and have no ties to - are less likely to stay and practice there long-term. A temporary relocation of these physicians to rural areas essentially creates a “revolving-door” of physicians in underserved areas with perpetually reduced continuity of care. This is detrimental to patient care, as continuity of care has been well-documented in the literature to be beneficial and associated with lower morbidity and mortality rates.^{10,11}

In our search of the literature, there is no published data demonstrating that ROS contracts work to increase retention rates in rural areas. The existence of an ROS contract appears to be simply a short-term, “band-aid” solution that is unsustainable and potentially detrimental to healthcare delivery. Moreover, mandating a contractual obligation for new medical graduates to

work in underserved areas presents rural medicine in a negative light, as it would appear that graduates are being forced to move against their will, as if in punishment. The reality is that rural medicine is incredibly challenging and rewarding work that many physicians enjoy; it simply is not suited for everyone.

For historical context, the issue of provincial governments instituting controversial policies to improve healthcare presence in rural communities is not new. In 1997, a lawsuit was filed against the Medical Services Commission of British Columbia by the Professional Association of Residents in BC (PAR-BC, now known as Resident Doctors of BC) for the creation of “restricted billing numbers”. Similar to ROS contracts, this was an attempt to relieve medically underserved areas. Under this model, new physicians who received a billing number after 1994 would receive a “restricted billing number.” This meant they could only receive 50% of their billing amounts if they were servicing an “over-served”/urban area, but would receive 100% of their billings if servicing an “underserved”/rural area. This lawsuit eventually escalated to the Supreme Court of British Columbia where it was found to be in violation of the Canadian Charter of Rights and Freedoms - specifically Section 6, Mobility Rights.¹² As a result, the new measures introduced by the Medical Services Commission were ultimately struck down.^{13,14} ROS contracts similarly restrict the portability of the medical profession and physicians’ right to move within Canada, and thus may be subject to similar legal challenge under the Canadian Charter of Rights and Freedoms as well.

Finally, it is unreasonable for provincial governments to place the burden of healthcare delivery and distribution onto graduating medical students, who are in a very vulnerable position. Currently, as medical students are facing increased pressures at matching to a residency, they may hastily apply for an ROS residency position out of fear of going unmatched. With fear acting as their motivation to agree to a ROS contract and no true desire to work in a rural area following full licensure, the ROS model will continue to exacerbate the “revolving-door” in rural healthcare delivery, and add to the stigma of rural medicine as an undesirable outcome. Ultimately, unequal healthcare distribution is an age-old issue in Canada, and it should not be up to newly trained physicians and medical students to resolve this issue.

Please note that as this position paper is presented to the CFMS (Canadian Federation of Medical Students), it is meant to advocate specifically for Canadian medical students, as we are only able to speak to the unique experience of Canadian medical students. This paper is thus against ROS contracts for CMGs.

Principles/Stance

The CFMS endorses the following principles in support of a stance discouraging the use of ROS contracts to assist with recruitment and retention of physicians in underserved areas.

1. ROS contracts for CMGs are not an appropriate nor sustainable solution to the current issue of rural and underserved areas. This model creates a lack of proper long-term care for patients in rural areas, communicates an inaccurate negative message about rural medicine, places an inappropriate burden on vulnerable medical students, and inappropriately limits the freedoms of medical students and CMGs.
2. More effort should be placed on finding alternative solutions to serving the healthcare needs of rural and remote areas.
3. Collaboration between the CFMS and medical student societies should ensure that discouraging the use of ROS contracts remains an important advocacy piece in the context of advocating for more residency spots from our provincial governments.

Concerns

Concern 1: ROS contracts are ineffective and inappropriate, and are increasingly being tied to residency positions for CMGs.

ROS contracts need to be discouraged, as there is no data to support that ROS contracts are effective for long-term healthcare delivery in rural areas. As ROS contracts have slowly been introduced for CMGs - now even during the first iteration of the CaRMS match - there is significant concern that this will set a precedent for use by other programs in other provinces. As more and more ROS contracts become established, this will normalize the practice of ROS contracts, and could potentially create a system where physicians cannot expect control over their location of practice once graduating residency. This is a clear violation of physicians' freedoms and thus efforts must be made to prevent ROS contracts from increasing and spreading to other programs across Canada.

Concern 2: ROS positions may appear to resolve the issue of underserved areas but are only exacerbating issues of long-term healthcare delivery in these areas. They distract us from addressing the true underlying causes for a lack of physician presence in rural areas.

One of the underlying issues for lack of retention in rural areas is the historically low interest in rural medicine at the medical student level. Most individuals who enter medical school are urban-born and urban-raised Canadians¹⁵ who have family commitments and familiarity with the city they grew up in, and therefore have a desire to stay in a similar urban environment. Furthermore, medical schools themselves are mostly located in larger urban centres and medical students grow accustomed to living in these cities during their time in medical school.

The creation of the University of British Columbia's (UBC's) distributed medical education model, which offers medical training sites in rural locations (Prince George, Kelowna) is an excellent approach to alleviate this issue. These sites offer a preference for selection of medical students who have a background of living or working in rural areas through a supplemental application that calculates a candidate's "rural suitability score."¹⁶ Similarly, the existence of the Northern Ontario School of Medicine also attracts rurally-born and rurally-raised Canadians to a school that trains students in a rural environment, with the prospect that they will continue their career in a rural area. Effort and trust should be placed into more initiatives such as these, which have been shown to work. In fact, data from the UBC Faculty of Medicine demonstrates that the distributed medical education model is having a positive impact on the supply of primary care physicians as well as rural physicians in British Columbia. Of all students trained in a rural setting at UBC (such as Prince George or Kelowna), 59% went into Family Medicine, and 66% pursued training in a rural setting.¹⁷

The issue with these initiatives is that, while more effective, they take time to show results, whereas a ROS contract is an immediate, but short-sighted, "guarantee" to have physicians in a rural areas. In the grand scheme, however, focus should arguably be placed on initiatives that are sustainable and beneficial for all parties - both patients and future physicians.

Concern 3: In the context of medical student advocacy to increase residency spots across Canada, provincial governments may attempt to tie new residency spots to ROS contracts, placing medical students in a difficult position.

This strategy should be strongly discouraged as it takes advantage of the vulnerability of medical students, who are already facing extreme pressures attempting to match to scant residency positions. It is well documented that medical students experience extreme burnout and higher rates of depressive symptoms and suicidal ideation compared to the general population.^{18, 19} The medical profession is already a career path that provides very delayed gratification. Adding an additional layer of complexity to medical training that requires relocation to an underserved area after residency only contributes further to burnout and delays career aspirations. Furthermore, if medical students accept ROS contracts solely out of the need to obtain licensure and a residency spot (as would be the case if governments add new positions with ROS contracts in response to unmatched CMG advocacy efforts), this clearly indicates that students are exclusively accepting ROS contracts out of need rather than a genuine desire to serve rural areas, as should be the case.

Due to the cost of medical education, the amount of student debt accrued by medical students is consistently very high. For most schools, provincial student loans are not able to cover all costs, so students seek out lines of credits from banks to cover their medical school costs. This is another primary driver of why medical students are seeking to match to residencies, as receiving payment in residency will help to begin paying down their medical student debt. However, under ROS contract terms, if a trainee breaks their contract, they would have a

contractual obligation to pay an exorbitant fee. As an example, for the dermatology ROS contract introduced this past year in the 1st iteration of CaRMS, the “repayment on termination” amount was \$979,581 - nearly 1 million dollars!⁷ This is an undeniably unreasonable fee to pay for any working professional, much less a medical trainee with a large amount of debt. Additionally, the dermatology ROS contract also stipulates

In short, the need for more residency spots and the need for more physicians in rural areas are equally concerning but nonetheless separate issues, which cannot be solved together with the “quick fix” of a ROS contracts.

Recommendations

1. In lobbying provincial governments for increased residency spots, medical student societies should seek support from their faculty, provincial, resident, and medical associations, and any necessary regulatory bodies to present a unified stance discouraging the use of ROS contracts for CMGs.
 - a. Medical student societies should attempt to prioritize a response to any provincial government utilizing ROS contracts for CMGs by offering the perspectives outlined in this position paper.
 - b. Efforts from each medical student society should be placed on raising awareness to their wider student body of the realities of ROS contracts and how they may be detrimental to future physicians and rural communities.

2. Focus should be placed on other strategies to increase physician recruitment to underserved areas, as well as novel approaches to provide rural areas with the same level of service as urban areas.
 - a. This includes increased establishment and enrolment of students into medical education models that train medical students from rural communities within rural communities (such as UBC’s distributed program or the Northern Ontario School of Medicine).
 - b. Increased effort should be placed on immersive rural exposure during medical school consistently across all schools in Canada.
 - c. The usage of telemedicine or other innovative information technology to provide healthcare from a distance (including services such as www.consultderm.com) should also be pursued more intensively.

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