

# CFMS/FEMC POSITION PAPER

## Mandatory Return of Service



### BACKGROUND

Health human resource policies of the 1990s that limited the supply of health care professionals and Canada's aging population have combined to create a situation in which healthcare demand significantly exceeds healthcare supply and this shortage is most acutely felt in rural and other traditionally under-serviced areas.

Within this health care climate, the use of public funds to contribute to medical training is resulting in the sentiment that new physicians should be expected to pay back their country for their investment via a Mandatory Return of Service for all medical trainees. To date there is no single model for Mandatory Return of Service, and various forms have been proposed informally in Newfoundland, Saskatchewan, Manitoba, and other regions, with no steadfast implementation.

Differing from Mandatory Return of Service, there currently exist a variety of Return of Service incentive strategies in under-serviced regions across Canada which provide bursary and practice incentives via a contractual agreement to senior medical students who have often decided on their field of practice. These contracts provide students with a tangible income or bursary in exchange for a commitment to practice in a specified area once certified. As fully licensed physicians they are employed under the same conditions as any physician in the area in which they've committed to practice. Overall, these programs are based on informed decisions and compensation rather than coercion and provide a tangible benefit for both young physicians who are agreeing to enter into these challenging practices and the communities in need of additional healthcare providers.

Despite the successes of many existing Return of Service incentives, the CFMS/FEMC believes that a Mandatory Return of Service program for medical graduates does not recognize the current systemic health care imbalances that contribute to physician shortages in underserved areas, or the complex realities of current medical training programs. As a result, any such program would be unsuccessful in retaining physicians and providing quality medical care to communities and patients in need.

A Mandatory Return of Service program would simply create the illusion of more complete physician coverage while reinforcing a rotating door in under-serviced regions where physicians frequently leave a community once their service is complete and the community is hampered with a perpetual recruitment and retention problem. Such a situation does not ease the true difficulties of practice in these regions that contribute to the insufficient health care services in these areas. It is important to recognize that the areas currently experiencing physician undersupply are often those with the areas with the greatest clinical demands including onerous call schedules, hard to procure locum

relief, and limited opportunities for Continuing Medical Education. Without an investment in physician supports to facilitate health care in these areas, Mandatory Return of Service will do little to encourage physicians to stay and continue to service the region once their contract obligations are fulfilled. While appearing to provide patient care by filling difficult practice locations with short term new practice physicians, the gaps in continuity of care currently experienced by patients in these communities will continue to widen in comparison to patients in communities and no long-term solution for physician shortages will be attained.

Mandatory Return of Service also fails to recognize the complexities of current medical graduates. With increasing areas of specialization and subsequent lengthy residency requirements, ranging from two years for family practice to five or more in diverse areas of internal medicine, surgery and many others, it is no longer common practice for new medical graduates to seek rural experiences to further their skills in general areas of practice, as has been done in the past. In addition, increased competition for medical school entrance positions has resulted in new medical graduates with multiple post-secondary qualifications and experiences who consequently tend to be older and have more family ties and responsibilities than the new graduates of twenty years ago. Within the realities of the current medical education system, a Mandatory Return of Service commitment for new graduates without consideration of area of specialty and familial obligations is both unreasonable and unwieldy within an already strained health care system.

## **RECOMMENDATIONS**

A Mandatory Return of Service program for new medical graduates would not resolve current physician shortages. In order to meet the health care needs of underserved areas the CFMS/FEMC recommends all levels of government work together to:

- Increase the number and value of bursaries for medical undergraduate and residency electives in rural areas;
- Designate retraining spots for those currently completing underserved commitment;
- Increase recruitment and incentives for those in family practice residency programs, who are more likely to provide rural service and have been previously overlooked in many recruitment strategies;
- Increase available technology and support resources for physicians practicing in rural and remote areas to pursue Continuing Medical Education (CME) opportunities.

***First Drafted***

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