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FOR YOUR INFORMATION
Times-News
Twin Falls, Idaho
Sunday May 27, 2018
by Gretel Kauffman

THE BIG STORY: Rural doctor shortage

The problem persists, but solutions could be on the horizon

SHOSHONE — Keith Davis became Lincoln County's only doctor at the stroke of midnight.

It was a late summer night in 1985, and Davis had recently completed his residency, the last month of it spent working at Shoshone Family Medical Center. The center's lone doctor, Royal "R.G." Neher, M.D., was retiring, and he needed a replacement.

Davis had interviewed at clinics in slightly larger cities in Idaho and Washington. But neither city offered the same opportunity for long-term employment that Shoshone did. So when the clock chimed midnight on Aug. 1, Neher stepped down and Davis took his place.

On his first day, Dr. Davis saw 52 patients and delivered a baby with nurse practitioner Janet Sandy. Almost 33 years later, he and Sandy are still seeing patients together at their office on Apple Street. And almost 33 years later, Davis is still the only doctor in a county the size of Rhode Island.

With just one practicing physician, Lincoln County is one of seven counties in south-central Idaho that's a federally designated Health Professional Shortage Area (HPSA) for primary care physicians. And it's not just the Magic Valley – a recent report by the Association of American Medical Colleges placed Idaho 49th in the nation for the number of physicians per capita.

Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls counties are all HPSA-designated in primary care. Blaine County isn't, but one of its towns, Carey, is. Low-income residents in Jerome and Gooding counties are particularly underserved, according to data from the U.S. Department of Health and Human Services.

There aren't necessarily fewer doctors today than in the past. Davis has been the only practicing doctor in Lincoln County for more than 30 years, and Neher ran a one-man operation there for decades before him. But as the average age of the rural Idaho physician increases — and many begin considering retirement — a new question has emerged: Who will replace them, and how?

If that question isn't answered soon, the state could find itself in trouble, said Dr. Ted Epperly, director of the Family Medicine Residency of Idaho. But Epperly and other leaders in the medical field see reason for hope.

Several statewide initiatives to bring young doctors to small towns have cropped up in recent years, including loan repayment programs and a plan to increase the number of residencies in medically underserved areas. And some of the young doctors taking advantage of these programs in the Magic Valley say the advent of the internet and social media is helping break down some of the negative stereotypes that can deter young people from going into rural medicine in the first place.

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"The problem's getting worse, not better, primarily because of the aging of the physicians," Epperly said. "I would say what's getting better, though, is the awareness."

Roughly one in three physicians in Idaho are at least 60 years old, meaning a significant chunk of the state's doctors are expected to retire in the next decade or so. In rural areas, where physicians are typically family doctors trained to deal with a broad scope of medical situations, replacing them could prove especially difficult.

"It's a problem most notably in the rural areas," Epperly said, "because it takes a certain type of doctor to go out there."

Residencies

One strategy for getting more young doctors into underserved rural areas: offering more residencies in those areas.

Almost 60 percent of family medicine residents end up practicing within 100 miles of where they completed their residency, according to a 2013 study by the Robert Graham Center for Policy Studies in Family Medicine and Primary Care. Nationally, Idaho also ranks 49th in the number of resident physicians per capita, leaving fewer opportunities for young doctors to get to know, and eventually settle down in, the state.

The Magic Valley Rural Training Track, a residency program for family doctors, has trained two residents per year in the Magic Valley since 2009. The program is a sub-branch of the Family Medicine Residency of Idaho, which is based out of Boise.

"With these types of programs you want to sort of seed your area with your graduates, train good doctors, and then keep them in your location where you need them," said Dr. Joshua Kern, site director for the Magic Valley program.

One graduate of the program has stayed on to work in Jerome so far, Kern said. Roughly 80 percent of the Magic Valley residency graduates go on to work in rural medicine, and about half stay in-state.

A 10-year plan approved by the state's Board of Education in December would expand the Magic Valley Rural Training Track and other rural residency programs across Idaho. Statewide, the plan would train an additional 1,440 physicians over the span of a decade, gradually adding new programs and more residency positions.

In the Magic Valley, that would ideally mean expanding the Rural Training Track program by two more doctors per year, Epperly said. The extra funding would also allow residents to spend the full three years of their residency in the Magic Valley, rather than spending the first year in Boise, as they do now.

The state legislature agreed during the last legislative session to partially fund the first year of the plan, approving nearly $2 million of the requested $5 million. The lack of full funding doesn't directly impact the size

of the Magic Valley program, which wasn't planning on expanding this year. But funding decisions in the coming years will determine whether and to what extent it grows.

Epperly says he was happy with the $2 million, which was roughly twice the amount that Gov. C.L. "Butch" Otter recommended in his budget. But he worries that newly established programs could be damaged if the funding doesn't continue.

"Sometimes, sadly, I think things like this aren't seen as investments for the future. They're seen as short-term costs," Epperly said. "And there's a difference. Because these physicians will practice for 30 to 40 years in communities and be bedrocks in those communities."

Statewide programs

It's hard to compare the number of doctors in Idaho today to the number in previous decades, as the state hasn't tracked that data through the years, said Niki Forbing-Orr, spokeswoman for the Idaho Department of Health and Welfare.

But there hasn't been much change in HPSA-designated areas since Mary Sheridan, bureau chief of the state's Bureau of Rural Health and Primary Care, started her position 15 years ago.

"I would say, in general, how we speak about it today is not very different than how we spoke about it even a decade ago," Sheridan said.

What has changed over that time is the state's approach to addressing the problem.

Idaho is in its fourth year of a statewide loan repayment program for young clinicians working in health professional shortage areas, paid for through a federal grant. Doctors, dentists, psychiatrists, and licensed clinical school workers can receive up to $50,000 in loan repayments over a two-year service obligation. A total of 40 people have taken advantage of the program so far.

The state also offers a loan repayment program exclusively for primary care physicians in federally designated shortage areas. The Rural Physician Incentive Program provides young doctors with up to $25,000 a year for four years.

RPIC used to be funded entirely through student fees. That changed this year, when the state legislature appropriated $640,000 to the program.

"I think some of the greatest successes that we've had would be in that pipeline and in loan repayment," Sheridan said. "We've made incredible strides in the resources that we now provide in terms of supporting recruitment and retention."

The Bureau of Rural Health and Primary Care has also begun to provide more opportunities for young doctors to connect with rural hospitals and clinics, including a biannual "Meet the Residents" event for resident physicians to mingle with potential employers.

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When job-hunting time rolls around, residents can log on to the National Rural Recruitment and Retention Network website — otherwise known as 3RNet — to find vacancies posted by rural clinics across the country. Idaho is one of 49 states that participates in the network.

It's a "more focused" network than other job-posting websites, said Casey Suter, manager of the Idaho Primary Care Office within the Bureau of Rural Health and Primary Care. "And I think that there's a lot of value in that, certainly when states across the nation are currently experiencing shortages as well."

How rural?

With a growing number of resources, incentives, and residency positions available, it might seem easier than ever to get young doctors into rural areas.

But solving the shortage is not as simple as a policy or monetary fix. Some of the biggest obstacles in rural recruitment and retention aren't professional or financial hurdles, but social ones.

Many doctors work long, taxing hours. But when you're the only doctor for miles around, there's even more pressure to be on call at all hours of the day and all days of the week.

In some cases, the biggest challenge in rural recruitment isn't convincing the doctors themselves to move to a rural area. Oftentimes, it's persuading a reluctant spouse to move to a small town, where social and work-related opportunities for young professionals are less abundant.

"Most rural areas know if their population can support a physician," said Davis, the Lincoln County doctor. "What is hard to know and match is a spouse's desire to have a career, be near resources like shopping and entertainment, a church of desired faith or denomination."

Shoshone had a population of about 1,150 when Davis settled there 35 years ago. For the young doctor who grew up in the 300-person town of Tangent, Ore., that was more than enough.

"Shoshone had a city park with swimming pool, a bowling alley and a movie theater, as well as several restaurants," he recalled. "No problem!"

One of the biggest predictors of whether a doctor will settle down in a rural area — and stay there long term — is whether he or she, like Davis, grew up in a rural area, according to Kern of the Magic Valley RTT. It's one of the things he looks for in applicants to the program: "How 'rural' are they?"

"A lot of people who are applying in family medicine are interested in getting broad, full spectrum training," Kern said. "But that doesn't mean they're necessarily going to end up in a rural place."

Rewards

The work is hard, the hours are long, and the move might strain your romantic and social relationships. So what makes aspiring physicians want to go into rural medicine?

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Dr. Andrew Schweitzer, a third-year resident in the Magic Valley RTT program, grew up watching his podiatrist father make house calls around his hometown of Vashon Island, Wash. Schweitzer knew from a young age that he wanted to go into rural family medicine and set his sights on Idaho after hearing an NPR story about the state's doctor shortage.

For Schweitzer, the personal nature of rural medicine outweighs the challenges.

"You take care of patients in the community…and you live alongside them," Schweitzer said. "That's very appealing to me, to take care of your neighbors, your friends, and all be sort of in the same boat, so to speak."

Another third-year resident, Dr. Robert Crouch, grew up watching his obstetrician father serve his hometown of Rexburg. He describes his relationship with rural medicine as an "evolving dream." For Crouch and his wife, an Idaho native who works for Fish and Game, settling down in a rural part of the state was an easy decision.

Both Crouch and Schweitzer say they believe the biggest obstacle to getting young doctors into scarcely populated areas is a lack of information and the pervasion of negative stereotypes about rural medicine and its challenges. But the internet, with its educational resources and opportunities for social connection, may be changing that.

"One thing that we've been seeing is that a lot of doctors feel very isolated, historically, in a rural setting," Crouch said. "But with the internet and online learning and social media…it's getting broken down a little bit."

Cell phones and other portable technology have also made it easier for in-demand physicians to work remotely, Schweitzer points out. These days, a doctor can answer a patient's question or order a prescription from the sidelines of their child's soccer game.

Crouch and Schweitzer both plan to participate in obstetrics fellowships after graduation to expand their family medicine skill set. After that, Crouch isn't sure where he'll end up. Schweitzer hopes to eventually work in Cottonwood, a north Idaho town where he previously spent time shadowing doctors and working as an EMT.

In the meantime, Schweitzer wants to help guide others interested in pursuing the same path. He's in the process of launching a website to serve as a resource for young potential doctors who are considering going into rural medicine.

"I think a big part of it is getting information out there and accessible," he said. "You can have a wife and be a rural doctor. You can find balance. It's not easy, but it's there. And together with our hospitals, I think we can come up with solutions."

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