Considerations for Selecting Applicants to Rural Medicine Programs
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Abstract

The selection of medical students destined for rural practice is important to help provide access to care for the 20% of the US population who live in rural America. By 2030, there will be 25% fewer rural physicians practicing medicine. Knowing which medical school applicants will go into rural practice is an inexact science, although the objective predictive characteristics of future rural doctors are well known and evident in the literature. Admissions committees have the responsibility of determining which applicants should become physicians, but it is unclear if they should be charged with determining the likely practice locations of rural applicants. The reasons for the shortage of rural physicians include what is lacking in rural living - professional support, opportunities for spousal employment, urban amenities, and quality schools. On the other hand, factors such as societal orientation, lack of interest in research, suitable rural role models, and rural family ties are important predictors of future rural practice. Additionally, early exposure to medically underserved areas affects future practice locations. Furthermore, we are producing fewer primary care physicians because of enhanced opportunities for urban centric fellowships in “primary care” specialties. Approximately 48% of pediatricians and 80% of internal medicine residents become subspecialists. The converse is true of Family Medicine doctors; over 90% provide primary care. Family physicians only constitute 15% of the primary care workforce yet they provide 42% of the care rendered in rural areas. It is rare that subspecialists choose rural practice, thus emphasis must be placed on admitting students who will choose Family Medicine. Programs whose goal is to provide physicians to rural sites must be mindful of these facts. Therefore, the initial task of rural program directors is to identify which applicants will likely choose a FM residency, done primarily by identifying which rural predictive characteristics the applicants possess. Admissions committee members are not expected to determine the likely practice locations of rural applicants and need only have the responsibility of determining which applicants should become physicians.

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predictive value for future rural practice. Lack of undergraduate research, an idealized view of rural living, the desire to make a difference in a community and having extended family in a very rural part of the state are salient factors that interviewers may not fully grasp or uniformly explore. This knowledge gap threatens to encourage the interviewers to use “feelings” or “impressions” for student selection, which is anathema—unscientific and often sadly erroneous. Even the definition of rural may not be accurately known by admissions committees. The US Census Bureau defines rural as any population, housing, or territory NOT in an urban area. In Alabama we define rural as living in a town less than 50,000 that is not in the footprint of a larger urban area. The large western states have quite remote places more properly deemed frontier.

At the University of Alabama Birmingham School of Medicine, the responsibility for screening rural applicants lies with the rural program directors who have knowledge of both the practice of rural medicine and the literature related to the topic. This knowledge allows the broadest evaluation of rural applicants because there are students who are technically rural who manifest few characteristics predicting rural practice and some from the rural fringe who have a compelling rural sense of place. Additionally, mentees may be well known to program directors who recognize prized intangibles no interviewer is able to discern. The strongest predictor, rural upbringing, is not the only important factor associated with the choice of rural practice. Personal interests are rarely predictive unless compellingly rural, like 4H, FFA, and/or animal husbandry, but the reverse may not be true; a truly rural student may well enjoy golf, tennis, or soccer. These activities are related more to opportunity than geography. When the author practiced in a rural Mississippi town of 1,400, the other doctors in the two-county area included: An amateur astronomer with a home observatory. An expert in gourmet food and Italian opera (who had a stunning record collection). A scratch golfer who had done post-doctoral training at the Lahey Clinic. A light plane pilot who had been an engineer in a previous career. The common factor was that all of these doctors were originally from rural Mississippi, had family there and were desirous of broad scopes of practice, but their passions could be well construed as urban-centric. Dr. John Wheat published a paper showing that (Alabama) Rural Medical Scholars who chose Family Medicine had activities revealing a humanitarian personality and a commitment to rural underserved communities as well as plans to specialize in FM (urban shadowing had negative predictive value). Our data shows that the rural applicant most likely to pursue rural FM has only shadowed rural physicians, lacks urban research, uses concrete speech, does not interview well, and is from a town less than 25,000. Other predictive elements are community college attendance, extended family in rural Alabama, and lifelong rural residence. It is the obligation of all medical schools and particularly those with missions to produce rural physicians for their states to examine their admission apparatus to ensure that the process is data driven and does not unwittingly exclude qualified rural applicants by judging them through inappropriate and irrelevant measures.

References


