The University of Colorado Denver School of Medicine will soon receive $575,000 to ease the physician shortage in rural Colorado. The money, a tiny portion of the $447 billion federal spending bill President Barack Obama signed in December, will be used to enhance the rural training activities of the Area Health Education Center and the Rural Track.

The Rural Track, launched in 2005, aims to provide students interested in rural practice with mentorship, skills, and hands-on experience in dealing with the challenges – and benefits – of doctoring far from major academic medical centers such as University of Colorado Hospital.

The first cohort of 12 students graduated in 2009. The track now hosts about 10 percent of the 160 students in each medical school class.

A Growing Program. Student interest in the Rural Track is growing. In 2006, there were 62 applicants. By 2009, there were 130, and this year there will be roughly 160.

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Deutchman directs the UCD School of Medicine’s Rural Track program.

In 2006, there were 62 Rural Track applicants. By 2009, there were 130, and this year there will be roughly 160.
On the Track. Grants from the Colorado Trust, the Kaiser Foundation and the School of Medicine itself provide the roughly $250,000 a year it takes to operate the Rural Track. In addition to providing seminars that focus on the realities of rural practice, the track creates a cohort of students with a common interest in rural medicine. Their shared focus confirms that such an interest is “normal,” as Deutchman put it.

“When you’re at an academic health center, what model do you see around you? You see a high degree of subspecialization that may lead you to believe that you can only practice medicine if you have a 500-bed hospital around the corner,” Deutchman said. “What students in the Rural Track understand is that you can practice good medicine in a rural environment.”

The federal money will have a big impact, Deutchman said, in helping the school to keep up with growing student interest in the program as well as in enhancing the teaching skills of the rural doctors who host students during month-long “clerkships.” All UCD School of Medicine students – Rural Track and otherwise – do such a rural tour, but students in the Rural Track do an extra month very early in their training and frequently elect to return to rural areas for additional months later in their training.

The infusion of money is a big deal in and of itself, Deutchman said, “plus what it means in terms of recognizing the importance of – and commitment to – the rural medical workforce.”

The funding will also help to enhance the rural experience of all medical students, not just those in the Rural Track, he said.

The Data. The rural physician shortage is acute. The roughly 13,000 physicians in Colorado are focused in five counties with more than 1,000 each, and there are 3,300 physicians in Denver alone.

In contrast, Bent and Washington counties had no licensed physicians at all in 2009, according to Colorado Health Institute (CHI) data. Costilla, Mineral and San Juan counties had one physician each. Fifteen counties had three or fewer physicians.

While population density plays a role in the relative availability of physicians in a county (Adams County, with 579 physicians, has the same ratio of 1.3 docs per 1,000 population as Jackson and Kiowa counties, which have two physicians each), the life of the rural doctor has challenges that have made it difficult to attract more providers.

For example, a June 2009 CHI survey of the roughly 1,300 licensed physicians in rural Colorado found that fully 14 percent expected to leave their practices within a year. One-third of respondents cited retirement as a “very important factor.” Twenty-nine percent cited “professional isolation” as the reason for leaving.

Christine Demont-Heinrich, CHI’s interim workforce program manager, said reimbursement can be another factor.

“If someone walks into a clinic without insurance, you’re less likely to turn them away if the next doctor’s office is 100 miles away,” she said.

Mr. Brightside. Deutchman spent 12 years practicing rural medicine in White Salmon, Washington, a town of 2,000 in
“The days of someone being a solo practitioner in an isolated area are mostly over.”

the Columbia River Gorge. In his office hangs a cedar shingle bearing his name. Photos of a waterfall and of Mount Adams grace the opposite wall.

“Everything that’s an advantage can be viewed as a disadvantage and vice-versa, depending on your viewpoint,” he said.

Deciding to practice rural medicine, he added, is a lifestyle decision and a family decision. He believes rural doctors have a much greater impact on the health care system and on communities as a whole.

“If you don’t want to be asked to be on the school board, you shouldn’t live in a rural area,” Deutchman said. “If you want to live in isolation from your patients, don’t go to a rural area. Your patients are going to be your friends and in your church; you will see them in the grocery store, at the barber shop and when they wave at your car when you drive by. Their kids are going to go to school with your kids. Your kid may get into a fight with your patient’s kid.”

But, he said, some of the cons of rural practice may be overstated. For one, it’s a rich professional life, he says. Rural doctors have deeper relationships with patients because they treat a range of conditions. Rural physicians take the edge off of professional isolation by practicing in small groups, hosting visiting specialists on a regular basis, and keeping connected through various digital means, Deutchman says.

“The days of someone being a solo practitioner in an isolated area are mostly over,” Deutchman said.

Even reimbursement isn’t the problem it might at first seem, Deutchman says.

“If you look at the data on what primary care physicians earn in the city versus in a rural area, they’re better off in a rural area,” Deutchman said. “One of the reasons is that rural primary care physicians have broader areas of care. They’re busier.” In addition, the cost of living is often lower, he said although Colorado’s rural resort areas can be very expensive.

Small Town Values. Kenya May, a fourth-year CU medical student in the Rural Track, is looking at the bigger picture. She hails from Columbia Falls, Montana, a town of 3,000 at the doorstep of Glacier National Park. A four-week rural clerkship nearly three years ago set her course in stone, she says. The variety of cases and the broad responsibility for a patient’s health were part of her decision, as was the fact that the rural medicine experience was, contrary to stereotype, “a little chaotic.”

But it’s the small-town values that mean the most, she says.

“There’s a sense of community,” she says. “If you’re in trouble, you will have people you don’t know – or the entire town – come to help you.”

May said she feels that the Rural Track has prepared her for the challenges ahead – in June, she’ll embark on a Family Medicine residency with a rural focus. She commended Deutchman in particular for his ability to address the needs of a wide range of Rural Track students.

“What we want to know as a fourth-year student is different than it was as a first-year,” May said. “If I said, I want to know more about obstetrical ultrasound, he’ll put together a workshop for us. It’s fantastic.”
Laura Holder, a third-year CU medical student, sees the Rural Track as a return to her roots. She grew up in Crested Butte, population 1,500.

“I grew up seeing a model of care where the doctor who delivered me is the doctor who wrote my letter of recommendation for medical school,” Holder said. “You have to be ready for basically anything that walks through the door. That’s what interested me.”

Holder said the Rural Track’s social support network has been of particular value. “You’re surrounded by other students who have the same interests as you do, and people like Dr. Deutchman who have resources available to you,” she said.

Michael Boyson, CHI’s director of health information, says the Rural Track is vital to addressing the dearth of countryside physicians in Colorado.

“The Rural Track is really going to make a significant dent in access to primary care, recruitment and retention of these folks,” Boyson said. “It will really help fill the gap.”