Factors that influence Canadian Physician Assistants to Practice Rurally: A Survey Response

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Abstract

Introduction: A shortage of healthcare professionals is thought to be a driving force behind access barriers in rural Canada. The use of Physician assistants (PAs) as healthcare providers in remote areas can help mitigate this shortage. There is currently no research available on rural Canadian PAs to assess factors that influence the choice to practice rurally.

Objective: The purpose of this study was to examine specific factors that had influenced currently practicing rural Canadian PAs to choose rural practice. This study also served to assess whether having a rural upbringing or participating in a rural rotation is positively related to choosing to practice medicine rurally.

Methods: This is a cross sectional descriptive study conducted through an electronic survey. Main outcomes of this study included examining the significance of 12 factors on the choice to practice rurally as well as whether completing a rural rotation or having a rural upbringing was significantly correlated to rural practice.

Results: The top three factors most significantly influencing a PAs decision to practice rurally were (1) increased level of autonomy, (2) type of practice, (3) scope of practice. There was a positive relationship between having a rural upbringing and practicing. There was no relationship between completing a rural rotation and practicing rurally.

Conclusions: Individuals are more likely to choose rural practice if they had a rural upbringing. Canadian PA schools wishing to possibly increase recruitment can use the above results. Prospective employers can also use the above results to help attract more PAs to rural opportunities.

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Introduction

Canadian Healthcare – Rural versus Urban

Rural Canadians often encounter a lack of access to adequate healthcare services in their communities. The shortage of primary care physicians and other healthcare professionals that is thought to contribute to the barrier of obtaining healthcare in remote areas (1). Although rural Canadians constitute one fifth of Canada's population, rural communities are only served by 8% of physicians practicing in Canada (2). Moreover, in a 2018 Canadian study, it was further found that there was a threefold gap in physician numbers as well as twice as many nurses when comparing urban to their rural counterparts (3). These significant differences in the distribution of healthcare workers promotes several health disparities that exist between rural and urban Canadians.

The rural population in Canada is older, less affluent, has higher death rates and shorter life expectancies than urban Canadians (1, 2). Similarly, a 2006 study demonstrated that rural Canadians typically were of lower socioeconomic status, obtained less education and exhibited poor health behaviours. More specifically, rural residents were more likely to be overweight, smoke and have higher blood pressure than their urban counterparts (3, 4).

Many initiatives have been started in an attempt to increase recruitment and retainment of family physicians and other healthcare professionals in rural areas. Some of these strategies include providing student loan forgiveness for primary care physicians and nurses for those choosing to practice rurally (5). The vast majority of provinces in Canada also provide monetary incentives or bonuses for physicians that opt to practice in a remote community (6, 7, 8). Additionally, there is also the University of Manitoba International Medical Graduate (IMG) Program that requires all IMGs to complete a return of service in rural and northern Manitoba

(9). Another proposed strategy to mitigate the imbalance in availability of healthcare workers in remote communities would be to maximize the use of non-physician providers such as physician assistants.

History of Physician Assistants

In the United States, the physician assistant (PA) profession began in the 1960's to help combat the shortage of physicians in the country. PAs are medically trained professionals who practice medicine within a formalized relationship with physicians to deliver quality healthcare to patients (10). They are able to perform medical histories and physical exams, order diagnostic tests, develop and manage treatment plans, as well as prescribe medications (11). In Canada, PAs were first introduced 40 years ago by the Canadian Armed Forces (12). PAs then became regulated in 1999 in the Province of Manitoba where the first civilian licensed PA began practicing in 2003. Currently, there are approximately 650 certified PAs practicing in Canada within a variety of specialties.

Rural Physician Assistants in the United States

In the United States, PAs are being used as a way to increase access to care in rural areas. According to the American Academy of Physician Assistants in 2017, one in eight PAs worked in a rural location and more than one in three rural PAs were practicing in primary care (13). A multitude of studies have been conducted in the United States regarding the scope of practice of a PA when practicing rurally as well as factors influencing job satisfaction and choice of location of practice.

In 2011, it was determined that PAs are a cost effective solution to increasing access to care in underserved areas (14). One of the main incentives to practicing in remote areas was that rural PAs possessed a broader scope of practice when compared to their urban counterparts (14).

Other significant factors that influenced PAs to choose rurally included a strong desire to serve the needs of the smaller community, the type of practice and the characteristics of the supervising physician (15, 16). Support for the PAs significant other as well as possible spousal opportunities held the most weight when making a decision about where to practice (17). In addition, the strongest predictor of job satisfaction of a rural PA was related to community satisfaction (16). Contrarily, certain concerns that negatively influenced job satisfaction included the lack of educational opportunities and isolation from peers that PAs faced in remote communities. Many rural practicing PAs felt that they often had to go outside of their scope of practice to meet the needs of their patients which was thought to be taxing to a PAs sense of role (14). Other studies also looked at the possible association between having a rural upbringing and ultimately choosing to practice medicine rurally. In 2012, it was demonstrated that if a PA had a rural upbringing, they were more likely to practice in a rural setting than those that did not (17).

Purpose of Study

In the wake of the current shortage of primary health care professionals in rural areas, PAs will play a major role in providing health care services to underserviced populations in Canada. As the need for PAs in rural settings grows, it is necessary to investigate the factors that influence Canadian PAs to choose a rural practice. The purpose of this study was to examine specific factors that had influenced currently practicing rural PAs to choose rural practice. Additionally, this study also served to assess whether having a rural upbringing or participating in a rural rotation is positively related to choosing to practice rurally. Currently, this is the first study that uses the Canadian PA population as the study population.

The significance of this study lies in its ability to inform potential employers about the perceived barriers and incentives that current PAs are encountering while working in rural areas.

Moreover, the results of this study may help PA programs that wish to increase the number of graduates that practice medicine rurally. Ultimately, this will hopefully serve as a tool to increase recruitment and retainment of Canadian PAs in rural areas.

Study Objectives

The primary objective of this study is to determine the factors that influence Canadian PAs to choose to practice rurally. Another primary objective is to assess whether having a rural upbringing or participating in a rural rotation was positively related to opting to practice rurally. Secondary objectives of this study include determining the current distribution of PAs practicing in rural Canada as well as examining the areas or specialties in which Canadian PAs are practicing. Do rural PAs mainly practice in primary medicine or do they work in other specialties?

Methods

This was a cross sectional survey study conducted through an electronic survey, SurveyMonkey. Participants were recruited through the Canadian Association of Physician Assistant's Facebook page as well as from various provincial Canadian PA Facebook pages. Participants were also recruited through the Canadian Association of Physician Assistants email list. The target population for this study included Canadian PAs that have obtained their CCPA designation. PAs that did not meet the selection criteria were excluded from the survey.

Included in the survey was an initial question to ensure that the respondent is a Canadian PA that has obtained their CCPA designation. The second question inquired if the participant had a rural, suburban or urban upbringing. As the definition of rural in Canada is constantly changing and given the varying ages of the respondents, it was decided that self-classification was the best method to employ. This self-classification method has also been used widely in

many similar studies in the United States (14, 18). The questionnaire then asks about whether the respondent participated in a rural rotation during their education as a PA student. The following question asks about the current PAs field of practice. The initial part of the survey was designed to be filled out by all that choose to participate as it allows for assessment of whether rural upbringing and rural rotation is associated with choosing rural location to practice as well as the current distribution of PAs that practice in Canada.

The remainder part of the survey will only be filled by respondents who answer yes to currently practicing rurally. For those that answer no to the question, the survey will end. As of 2016, Statistics Canada is using population center definitions to define the distribution of the Canadian population. Specifically, small population centers are centers with population between 1,000 and 29,999. Therefore, for the purpose of this study, rural will be defined as an area that has a population less than 30,000.

Those that continued with the questionnaire were presented with a list of factors to be rated on the level of influence it had on the respondent's decision to choose to practice rurally. The factors listed were adapted from findings of previous similar studies focusing on PAs in the United States regarding location of practice and job satisfaction among rural PAs. The list of factors included scope of practice (14, 15), desire to serve smaller community (14-17), proximity to family/colleagues (15, 17), income potential, influence of spouse/partner (15, 17), level of autonomy, recreational activities and climate/geographic factors (15), characteristics of supervising physician, and availability of supervising physician (15). For each factor, the respondent was presented with 5 point Likert scale ranging from not influential to extremely influential. Lastly, the participants were asked to select their level of agreement with two statements regarding their scope of practice and level of autonomy as a rural PA.

All survey responses were anonymous and no identifying information was collected from participants. A consent disclosure statement was inserted in the beginning of the survey, discussing the risks and benefits of completing the survey. Completion of the survey was taken as implied consent.

Statistical analysis was performed using Microsoft Excel. Chi-square tests were used to evaluate the relationship between rural upbringing and rural practice as well as the relationship between having a rural rotation and practicing rurally. Descriptive statistics were used to assess the rate of influence that each factor had on choosing to practice rurally.

Results

The survey collected 66 responses in total. Of those 66 responses, 2 respondents were excluded as they didn't meet the inclusion criteria and 3 respondents did not complete the survey. Therefore, there were a total of 61 respondents that finished the survey and met the inclusion criteria.

Participants were asked to classify their upbringing as either rural, suburban or urban. For the purposes of the study, the responses for the suburban category were added to the urban category. As demonstrated in Figure 1, 48 (78.7%) of participants stated they had an urban upbringing whereas 13 (21.3%) had a rural upbringing. Next, respondents were asked whether they had participated in a rural rotation during their PA education. The majority of respondents (86.9%) participated in a rural rotation/clerkship whereas only 13.1% did not participate in a rural rotation (Figure 2).

When asked about whether they practice medicine rurally vs in an urban location, only 13 (21.3%) individuals stated they currently practice in a rural location (Figure 3). As delineated in Figure 4, 100% of individuals that practiced medicine rurally participated in a rural rotation. In

contrast, 83% of individuals that practice in an urban setting also completed a rural rotation. A chi square test could not be completed in this case due to the fact that n was less than 5 in the group that practiced medicine in a rural location without having completed a rural rotation. It was determined that there is no significant relationship between completing a rural rotation and practicing medicine rurally.

Furthermore, 10 (76.9%) out of the 13 individuals that practice medicine rurally also identified as having a rural upbringing (Figure 4). A chi-square test of independence was performed to examine the relation between practicing medicine rurally and having a rural upbringing. The relation between these variables was significant, X^2 (1, N = 61) = 30.47, p <.001. Therefore, individuals who had a rural upbringing were more likely to practice medicine in a rural location than those who identified as having an urban upbringing.

Respondents were then asked to identify which field of medicine that they currently work in (Table 1). Twenty-one point three percent of participants work in primary care, 18% work in a subspecialty, 16.4% work in surgery, 16.4% also work in emergency medicine, 13.1% work in internal medicine, 4.91% work in pediatrics, an additional 4.91% work in psychiatry, 3.28% work in hematology/oncology and 1.6% works in addiction medicine. When looking specifically at the population of individuals that practice rurally, the majority (38.5%) practice in emergency medicine, 30.8% practice in family medicine, 15.4% practice in internal medicine, and 15.4% practice in surgery (Figure 5).

Individuals who answered yes to practicing medicine in a rural location then moved on to complete the second part of the survey. They were asked to rank the level of influence of several factors on their choice to practice medicine in a rural location (Figure 6). The factors that were rated as being not at all influential in having an impact on their choice to practice rurally was

first climate or geographic factors (53.9%), next was income potential (46.2%) and the third was access to educational facilities/resources. In contrast, the factor that was most rated as very/extremely influential and had the most impact was level of autonomy (84.6%), followed by type of practice (69.2%), then scope of practice (61.5%).

Next, the rural practicing respondents were asked to rate their level agreement with two statements. The first statement was "I feel that I have more autonomy as a rural practicing PA". 76.9% of participants agreed or strongly agreed with the statement, whereas 23.1% rated the statement as having a neutral opinion (Figure 7). No participants chose to disagree or strongly disagree with the first statement. The second statement was "I feel that I have a broader scope of practice as a rural practicing PA". 8 respondents (61.5%) stated that they agreed with the above statement and the remaining 5 respondents (38.5%) strongly agreed (Figure 7). No respondents picked the neutral, disagree or strongly disagree options regarding this statement.

Discussion

Initially, military Canadian PAs were trained as physician extenders and were designed to provide healthcare to individuals in remote and rural locations (19). As the profession continued to evolve in Canada with the development of civilian PA programs, more PAs were being employed in an urban setting. Given the major health disparities that exist between rural and urban Canadians and the shortage of healthcare professionals, the idea of PAs as a possible solution to this complex issue should be revisited.

In assessing the Canadian PA population demographics, it was demonstrated that the majority of PAs were raised primarily in an urban setting as well as completed a rural rotation in their educational training. Moreover, the study found that 21.3% of respondents practiced in a rural location meaning approximately 1 in 5 Canadian PAs practice rurally. Study findings

indicate that those raised in a rural setting were significantly more likely to practice medicine in a rural setting. These results were replicated in several studies completed on the PA population in the United States (15, 17). Given the findings above, Canadian PA schools could place more weight on admission applications if the applicant identified as having a rural upbringing. This could be one way to increase the amount of rural PAs in Canada. It was also noted that all of the current rural practicing PAs completed a rural clerkship during their PA education. Given this information, a statistically significant relationship could not be found between participating in a rural rotation and practicing rural medicine. The causality could not be assessed within this study as rural PAs were not asked to assess the level of influence that a rural rotation played in impacting their decision to practice rurally.

The top three popular fields of practice among Canadian PAs include primary care (21.3%), followed by subspecialty (18%) and then emergency medicine (16.4%). Despite the fact that more PAs seem to be finding employment within subspecialty areas, primary care still remains to be a top contender in the type of practice for practicing Canadian PAs. In addition, of those PAs that work rurally, the most common areas of practice include emergency medicine (38.5%) and primary care (30.8%). These results lend support to the idea that PAs can be an effective strategy to combat the shortage of healthcare providers in rural settings as the majority of current rural PAs are employed in both emergency and primary care medicine.

Previous research on the PA population in the United States has demonstrated that the most significant factors influencing the decision to practice in a rural location include scope of practice, desire to serve the needs of a smaller community, type of practice, spousal opportunities as well as the characteristics of the supervising physician (15-17). The results of this study revealed that the top three factors influencing a PA's decision to practice rurally was first the

level of autonomy (84.6%), followed by type of practice (69.2%) and scope of practice (61.5%). Results further established that 100% of rural PAs strongly agreed/agreed that they have a broader scope of practice when compared to their urban counterparts. It was also demonstrated that 76.9% of rural PAs agreed or strongly agreed that they have more autonomy than an urban practicing PA. For future studies, it may be helpful to create a specific scale or questionnaire to objectively measure scope of practice to validate whether rural PAs in fact have a broader scope of practice and more autonomy than their urban counterparts.

In knowing that the most popular types of practice include primary care and emergency medicine and given that type and scope of practice significantly influence the decision to work rurally, it can be said that creating more primary care/emergency roles may attract more PAs to work in a rural setting. As the number of working PAs in Canada continues to increase, employers should look at creating jobs in primary care and emergency care for rural locations. In addition, ensuring that PAs working in rural locations are satisfied with the level of autonomy may increase satisfaction and therefore retainment of PAs working in a rural location. Another method that may aid in advertising rural opportunities would be to publicize that rural PAs felt that they had a broader scope of practice and more autonomy than their urban counterparts.

Contrary to previous studies completed, respondents' votes were evenly distributed between not influential and extremely influential for factors such as desire to serve a smaller community and influence of spouse/partner. It was also demonstrated that supervising physician characteristics and availability were moderately influential among rural PAs as the majority of respondents rated it between somewhat influential to extremely influential. To help increase retainment of rural PAs, it would be useful to know what specific physician characteristics have the highest impact on their decision.

The factors that were rated as least influential factors for Canadian PAs included climate and geographic factors, income potential and access to educational facilities. In knowing that income potential was one of the lowest influential factors, it should be determined whether there is indeed a lack of financial incentives for the PA community leading participants to choose not influential (i.e. the salary for an urban PA is the same as a rural PA). On the other hand, it must also be considered that salary does not influence the decision to practice rurally. Currently, there is no published information lending evidence to the fact that rural PAs have a higher starting salary or receive any financial incentives such as loan forgiveness. Perhaps creating financial incentives for PAs similar to those that are available to physicians and nurses, may help prospective employers increase recruitment to much needed rural areas.

Study Limitations

This pilot study was intended to understand what influenced the choice of Canadian PAs to practice medicine in a rural location. The ultimate goal of this study was to gather results that aided Canadian employers in attracting PAs to rural locations as well as to help Canadian PA programs that wish to increase the number of graduates that practice rurally. The results stated in this research study should be interpreted in light of several study limitations.

The first limitation of this study was the low respondent rate. According to the Canadian Association of Physician Assistants, there are approximately 587 licenced PAs. Given that there were only 61 respondents, there was a response rate of 10.4%. The small sample size of this study limits the analysis of the data. Since only 13 respondents identified as rural practicing PAs, the results are not necessarily generalizable to all rural practicing PAs in Canada. Considering the low response rate, the results of this study may not reflect the true distribution of urban vs rural PAs. Additionally, a proper chi square analysis could not be done to analyze or establish a

causal link between participating in a rural rotation or clerkship and choosing to practice in a rural location. Furthermore, this study did not assess which province each respondent was from. In knowing this, it is hard to say whether there was an inaccurate representation of data due to a low respondent rate from certain provinces. The low respondent rate also contributes to the difficulty in generalizing these results to the entire Canadian PA population.

Another limitation of the study involves the method of survey distribution. The survey was distributed primarily through Canadian Physician Assistants email list and Facebook groups. If participants didn't have a working email or were not signed up in the Facebook group, they would not be able to participate in the survey, thus contributing to a low respondent rate.

A third limitation to this study may be the definition of rural as a community of less than 30,000 people. The definition may have been too narrow and missed possible PAs working in a rural area. Often the definition or criteria of a rural area may not be congruent with an individual's perception of that area. As an example, some people who live in Brandon, Manitoba may believe that it is a rural town. However, the definition employed in this study would not allow an individual to state they work rurally given the current population of Brandon of 48,859. Given the fact that the definition of rural community in Canada is constantly changing and subject to change given the resource, it is difficult to classify a rural community/area. Perhaps a better system would have allowed participants to self-classify if they work in a rural location or broaden the definition to allow rural as populations consisting of less than 50,000 individuals.

A fourth limitation to this study is that individuals self-identified whether they had a rural, suburban or urban upbringing. Nevertheless, the analysis grouped together the results from the suburban and the urban category in the statistics calculations.

A fifth limitation to this study is the fact that only current practicing rural PAs answered questions regarding factors that influenced their choice to practice rurally. PAs that chose to work in an urban setting were not asked about their views or perceptions regarding the barriers or incentives to practicing rurally. This information would also be useful to prospective employers trying to advertise or increase recruitment of rural PAs.

A sixth limitation experienced in this study, is that it excluded PAs who came from the United States to practice in Canada. Given that United States trained PAs are able to practice in Canada, they do not necessarily have a CCPA designation. There are several PAs who could have been missed given the strict inclusion criteria to have a CCPA designation.

Another limitation to the study is that it is descriptive and qualitative in nature. Study mainly relied on looking at major trends in the data as opposed to objective measurements/quantifiable results. For instance, participants were asked to rate their level of agreement with the statements of having a broader scope of practice than urban PAs. It may be helpful for future studies to delve into the details of why rural PAs agreed with the statement as well as to create an objective scale to measure scope of practice.

Lastly, when asking respondents to choose their current field of practice, they were only allowed to select one option. For example, many individuals working in a rural area work as a primary care provider and in emergency medicine. A PAs scope can be multidimensional and that several PAs work in multitude of areas, the distribution of Canadian PAs presented in the study may be inaccurate.

Future Directions

As this is the first study of its kind to assess Canadian PAs beliefs regarding rural practice, more studies should be done to replicate and validate these findings given the low

respondent rate. Several new studies can be done to build off the findings of this pilot study and focus on asking more questions to the urban population of PAs to gain insight regarding their perceived barriers to working in a rural setting. Or by contrast, another direction for future research may look at motives behind individuals leaving a rural position in favor for an urban site. If these reasons were addressed, this could help to increase retainment of currently working rural PAs. Another novel study could assess job satisfaction within the rural Canadian PA population. Perhaps in the future, as the number of working rural PAs increases in Canada, studies can assess the difference in health outcomes in rural populations prior to and after PAs began working in the community.

In addition, further research could be targeted at recent physician assistant graduates to gain a sense of what influences their first choice to practice in a rural or urban location. This information may be more useful to employers looking to attract new graduates to rural opportunities. Finally, future research could specifically look at the demographics of the PA student population and their first choice of practice. It would be useful to note if all Canadian programs made it mandatory to participate in a rural rotation whether this would translate to an increase in the number of individuals choosing to practice rurally after graduation. It might also be beneficial to assess whether the number of years an individual spent living in a rural town is positively related to the choice to practice rurally. This could also influence the admissions of Canadian PA programs looking to increase the number of rural PAs in their province.

Conclusion

The utilization of PAs in rural areas can help to increase access to healthcare and thus lessen the health disparities that exist between rural and urban citizens. As the PA profession continues to grow and evolve in Canada, it is important to determine perceived attitudes

surrounding employment in rural areas. Prospective employers can use this information to attract more PAs to rural opportunities as well as increase retainment of PAs in rural areas.

This unique pilot study demonstrated that the most important factors that influence rural PAs include level of autonomy, type of practice and scope of practice. More research could be done to develop objective ways to measure scope of practice and level of autonomy between rural and urban working PAs. The factors that had the least influence on rural PAs were climate and geographic factors, income potential and access to educational facilities. Currently, there are no documented rural incentives offered to rural PAs. More research can be completed to further assess whether having rural incentives would actually make a rural work opportunity more attractive. Additionally, this study revealed individuals are more likely to practice rurally if they identified as having a rural upbringing. Canadian PA schools wishing to increase the number of graduates that choose to practice rurally may decide to ask whether prospective applicants identify with having a rural background.

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Appendix

Online Survey Questions

Q1: Are you a Canadian Physician Assistant with a CCPA designation and currently practicing in Canada?

a) Yes
b) No

Q2: Which of the following best describes the area in which you grew up?

a) Urban
b) Suburban
c) Rural

Q3: During your education as a PA student, did you participate in a rural rotation/clerkship?

a) Yes
b) No

Q4: What is your current field of practice?

a) Primary Care (Family Med/General Practice)
b) Surgery
c) Internal Med – General Practice
d) Internal Med – Subspecialties
e) Emergency
f) Pediatrics
g) Dermatology
h) Other, please specify: _____

Q5: Do you currently practice as a PA in a rural area (population less than 30,000 people)?

a) Yes
b) No

Q6: Please rate the following factors in terms of how significant they were in influencing your decision to practice as a PA in a rural community.

a) Scope of Practice
b) Desire to Work in a Smaller Community
c) Proximity to Family
d) Proximity to Friends/Colleagues
e) Income Potential
f) Influence of Spouse/Partner
g) Supervising Physician(s) Characteristics
h) Supervising Physician(s) Availability
i) Level of Autonomy
j) Recreational and cultural activities
k) Access to Educational Facilities
l) Type of Practice

Online Survey Questions

Q6: Please rate the following factors in terms of how significant they were in influencing your decision to practice as a PA in a rural community.

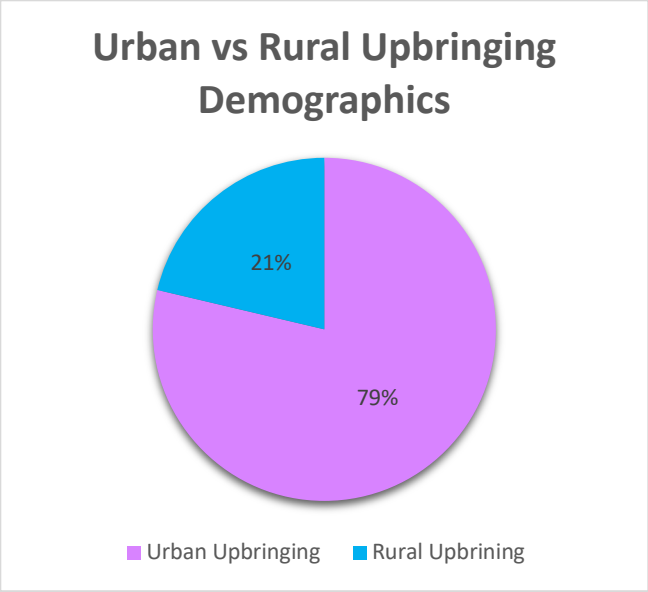
m) Climate or Geographic Factors
- i. Not influential
- ii. Slightly influential
- iii. Somewhat influential
- iv. Very influential
- v. Extremely Influential

Q7: Kindly indicate your level of agreement with the following statements.

"I feel that I have more autonomy as a rural practicing PA"
- c) Strongly Agree
- d) Agree
- e) Undecided
- f) Disagree
- g) Strongly Disagree

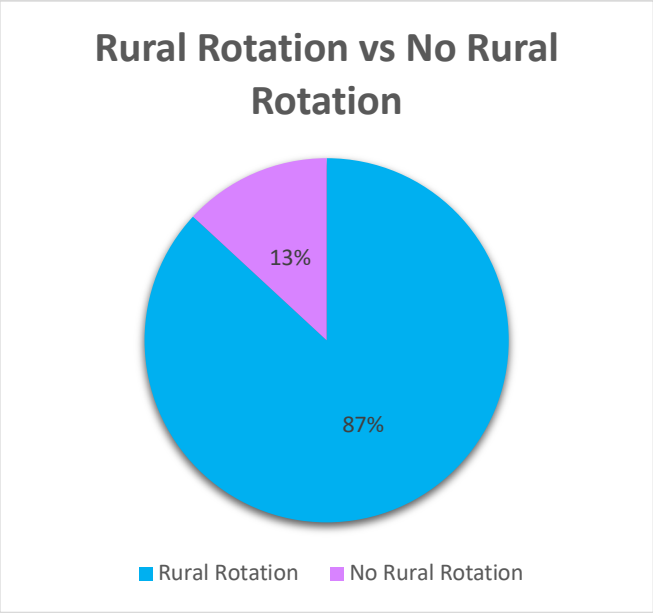
"I feel that I have a broader scope of practice as a rural practicing PA"
- f) Strongly Agree
- g) Agree
- h) Undecided
- i) Disagree
- j) Strongly Disagree

Figure 1:



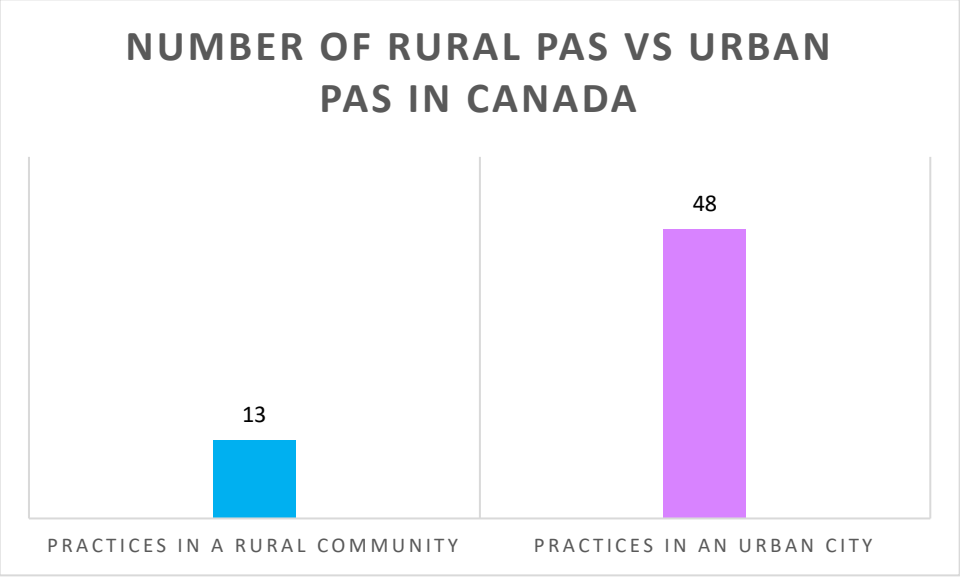
This figure illustrates the number of individuals that identified as having a rural upbringing (13) vs the number that identified as an having urban upbringing (48)

Figure 2:



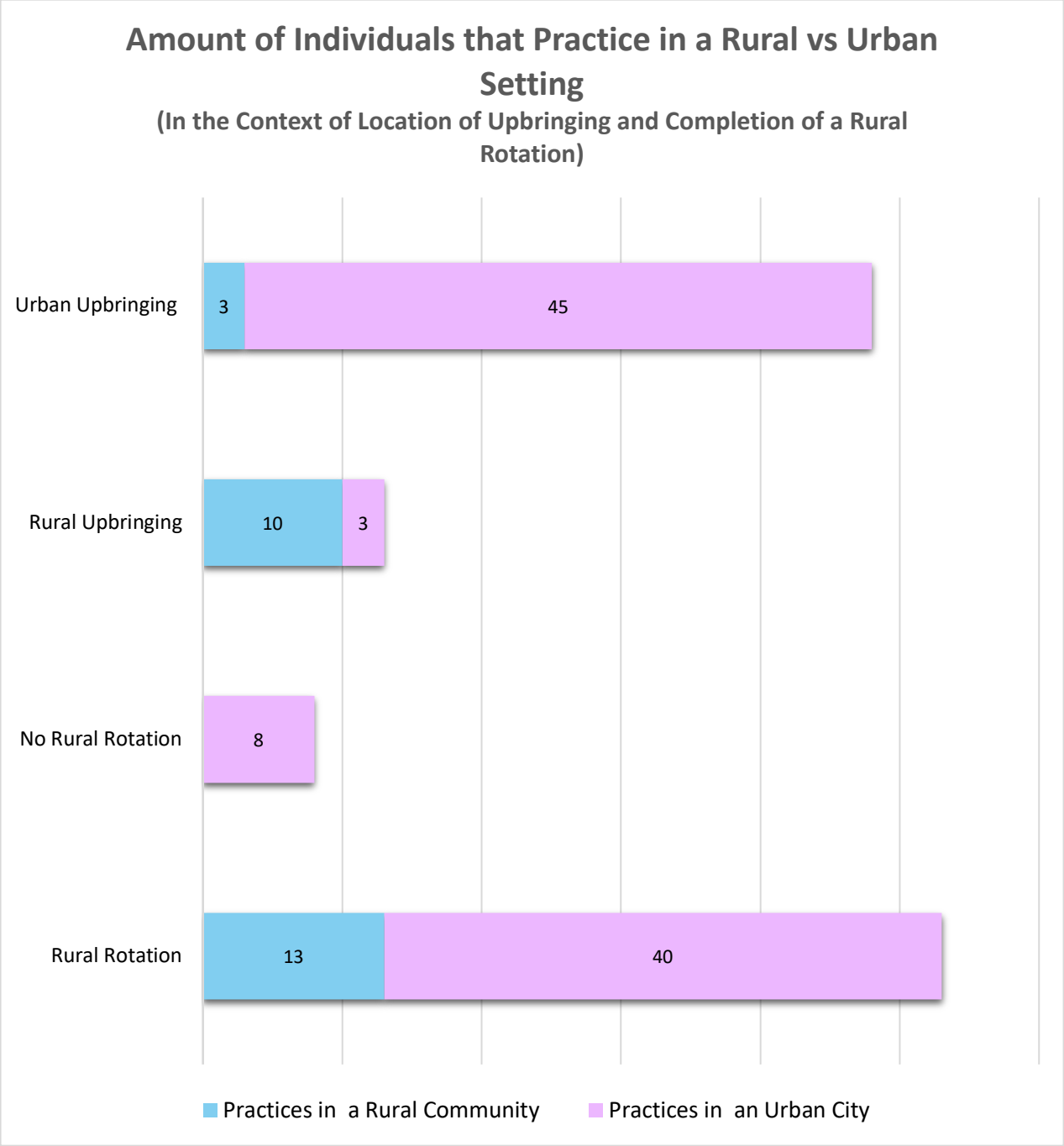
This figure illustrates the number of individuals that completed a rural rotation (53) vs the number of individuals that did not participate in a rural rotation (8)

Figure 3:



This figure illustrates that there are 13 practicing rural PAs vs 48 practicing urban PAs in Canada

Figure 4:



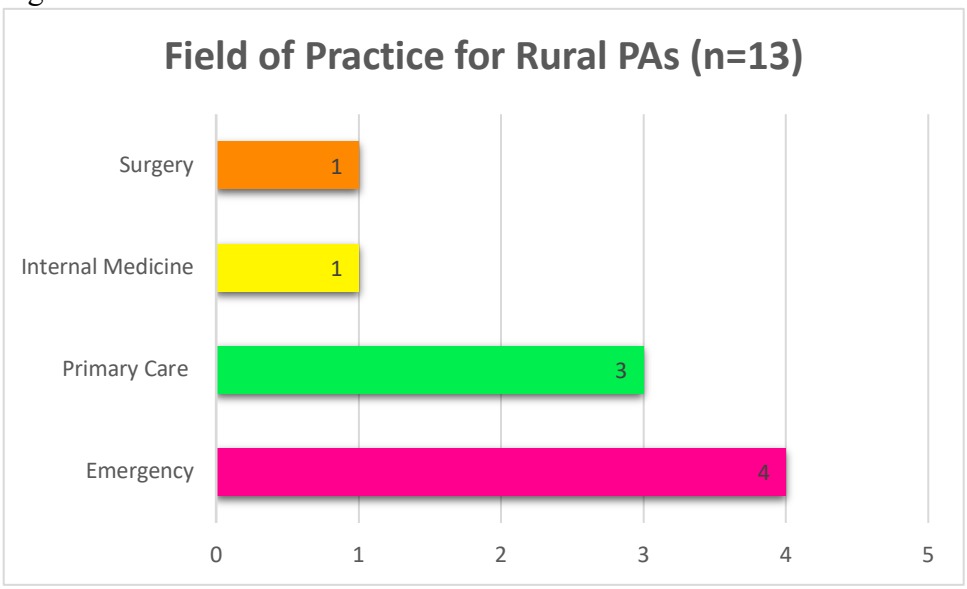
The above figure demonstrates that of the individuals who identified with having an urban upbringing, 3 are rural PAs and 45 are urban PAs. Contrarily, of those who identified as having a rural upbringing, 10 are rural PAs and 3 are urban PAs. Of those who completed a rural rotation, 13 work as rural PAs and 40 work as urban PAs. One hundred percent of indiviudals who did not complete a rural rotation work in an urban setting.

Table 1:

Field of Practice:	Number of PAs:
Primary Care	13
Subspecialty	11
Surgery	10
Emergency	10
Internal Med	8
Pediatrics	3
Psychiatry	3
Hematology/Oncology	2
Addictions	1

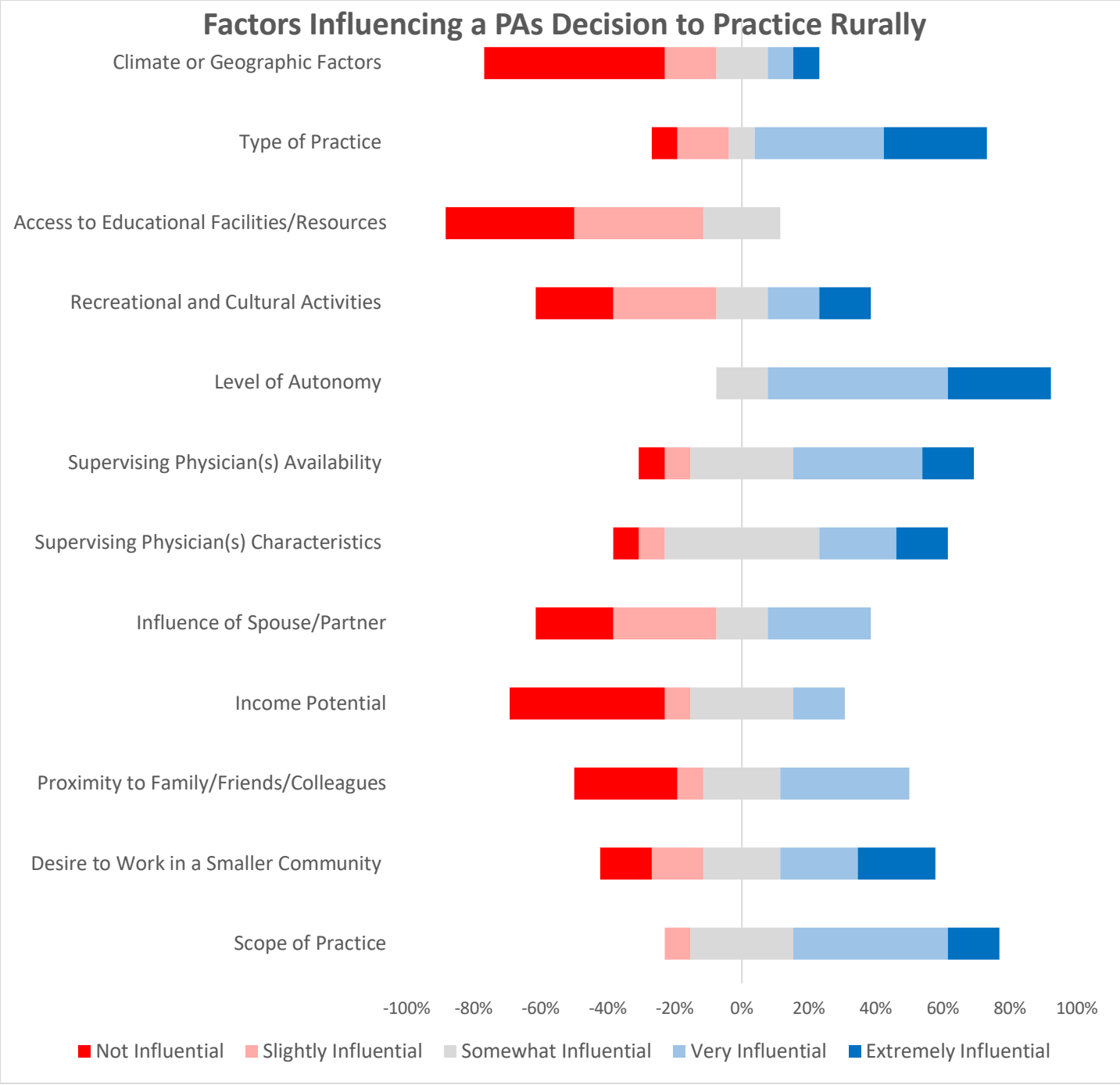
The above table illustrates that the most popular field of medicine of Canadian PAs is primary care, followed by subspecialty, surgery and emergency medicine.

Figure 5:



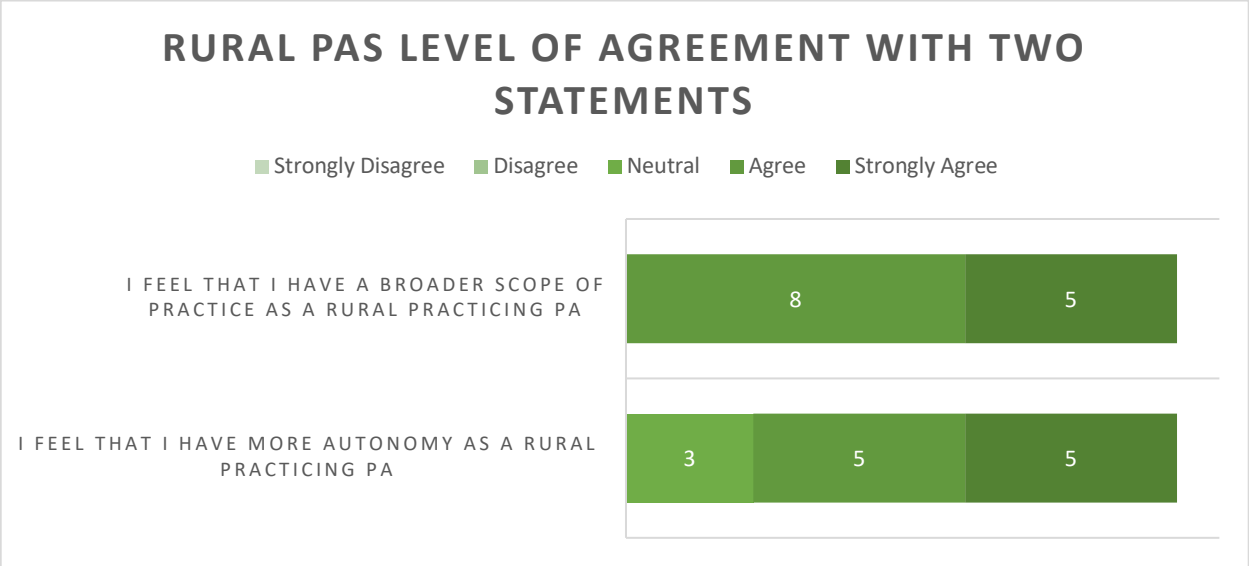
The above figure illustrates the type of practice for rural practicing PAs. 38.5% practice in emergency medicine, 30.8% practice in family medicine, 15.4% practice in internal medicine, and 15.4% practice in surgery.

Figure 6:



The above figure demonstrates that the most important factors that influence rural PAs include level of autonomy, type of practice and scope of practice. The factors that had the least influence on rural PAs were climate and geographic factors, income potential and access to educational facilities. Currently, there are no documented rural incentives offered to rural PAs.

Figure 7:



The above figure reveals that for the first statement, rural PAs having a broader scope of practice, 8 (76.9%) individuals agreed and 5 (23.1%) individuals strongly agreed with the statement. The second statement, 3 (23.1%) individuals had a neutral opinion, 5 (38.5%) agreed and 5 (38.5%) strongly agreed