REBUILDING COMMUNITY AND COMMUNITY HEALTH DEVELOPMENT IN RURAL MANITOBA: MEETING THE PROBLEM OF RECRUITING AND RETAINING PHYSICIANS

by

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A Thesis Submitted to the Faculty of Graduate Studies in Partial Fulfillment of the Requirements for the Degree of:

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To my daughter Mikale for being herself.

ABSTRACT

This thesis examines the problems Manitoba rural communities have recruiting and retaining physicians. It addresses two central questions: How can Manitoba rural communities recruit and retain physicians? and, What role does the community play in the process? Three contexts formed the framework for analysis: the rural setting and its economic and social vitality; the physicians' professional and personal perspective, and; community strength and power, rights and responsibilities.

Seven rural communities were visited and discussions were held with a number of residents. The methodology used was community research, which involves community residents in the identification and analysis of their community's problems, as well as in the formulation of solutions to their problems.

Community people consulted in this thesis believe that primary care is an appropriate form of health care for the rural setting; not the tertiary, high technology sort our doctors are trained to practice. Provincial and public health resources, team work, community involvement in decision-making and combined services with other towns are all preferred directions. Health care and facilities are tied closely with other aspects of rural life. Communities have a right and a responsibility to make decisions regarding their own health care. This thesis concludes that rural Manitoba is oppressed by economic decline, by a dominating urban mentality and by government paternalism. It is also oppressed by the dependency communities have on the presence of physicians they are unable to attract.

A community rebuilding process is recommended. The process identifies the issues and places the community in a position of power, rather than submission. A health development committee would be formed out of the process to create a rural health care system of holisticly inclined, community-based health services within a primary care network.

CONTENTS

CHAPTER ONE

INTRODUCTION

The central questions of this thesis are: How can Manitoba rural communities recruit and retain physicians? and, What role does the community play in the process?

This thesis is about health care, the role of community in health care and the revival of community. It is about rural communities and:

- their health care services and facilities;
- recruitment and retainment of physicians;
- improving the health care system for the rural population;
- self reliance, and;
- community involvement and participation.

Problems associated with the above include;

- a declining rural population;
- an aging population;
- economic stress;
- an urban bias in state intervention;
- alienation from decision-making;
- inequities in allocation and distribution of resources, and;
- inability to attract and keep doctors.

My philosophy of health care is about;

- the rights of the individual in decisions regarding her own health;[1]

- the rights of the community to be involved in their health care, and;
- active participation of consumers in health care decisions.

As a planner, I am interested in health care because of the inherent complexities of the field. Health is more than the curing of disease or the elimination of sickness. Health must be viewed holisticly because it involves many aspects of life.

The Subject of This Thesis

Without any specific knowledge on the subject of manpower planning[2], I sensed that the manpower issue encompassed many, if not all, of the elements of the health and medical care system. It would, therefore, provide a field of study that would be an excellent learning experience[3].

The factors that the issue of medical manpower encompass include;

- the various medical professions and their occupational structures;
- health and medical facilities, in terms of their composition, size, location and function;

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[1] An excellent book on this subject is, For Her Own Good: 150 Years of The Experts' Advice To Women, by Barbara Ehrenreich and Deirdre English [1978] Double Day, New York.

[2] The specific idea for this topic originated from Dr. Brian Postl, Department Head of Community Medicine in the Faculty of Medicine, University of Manitoba, and Co-Chairman of the Provincial Standing Committee on Medical Manpower (SCOMM). He suggested that medical manpower was a possible area of study appropriate to a thesis inquiry. SCOMM has been particularly interested in doctor shortages in rural Manitoba and so Dr. Postl suggested I focus this study on the actual recruitment and retainment question.

[3] Medical manpower is concerned with the numbers, specialties and distribution of physicians. Observers of Canada's changing patient / physician ratios generally conclude that "ideally, physician manpower requirements should be determined by needs, not necessarily patient demands, for physician services in the community. Nor should physician supply or availability determine utilization of medical services" (ed. Watanabe, 1988).

- population distribution, density and characteristics;
- the community;
- concepts of health and medicine, and;
- the philosophical and legislative development of the health care system into its current form[4].

I had minimal knowledge of the rural situation, but was drawn to the overall medical manpower subject. The further I looked at the topic, the implications for a planning thesis became more apparent.

Dr. Postl informed me that there is a maldistribution of physicians by specialty and by urban / rural location in this province, resulting in chronic shortages in many rural and remote communities[5]. SCOMM has been trying to remedy the shortages through recruitment campaigns which are designed to attract doctors to rural locations. Dr. Postl was instrumental in initiating a very progressive and successful model of health care, including a recruitment and retainment program in Northern Manitoba. He saw a substantive role for SCOMM in communities of the South.

The Effect of the Problem on Rural Communities

The essential reason that doctor shortages is a problem for rural communities is this: the

[4] According to Dr. Mamoru Watanabe of the Faculty of Medicine , University of Calgary; "There are many issues which surround and affect manpower planning, especially since the bottom line of this discussion is provision of health care services to Canadians, and inevitably, the cost of providing those required services. Issues such as geographic distribution or maldistribution of physicians, appropriate mix of primary care physicians and specialists, cooperation and coordination with other health care providers, universal accessibility of high tech services, etc. require discussion and resolution"(1988).

[5] This thesis focuses on communities located in the southern portion of the province and does not deal specifically with predominantly Native communities. It also does not attempt to address the maldistribution of physicians as it affects urban medical care delivery.

prairie landscape is dotted with hospitals. The facilities depend on the presence of a physician to be open and can be closed down if there is not a doctor working there[6]. Doctors are coaxed and begged to take positions in these communities, and some do relocate. However, in many communities, they do not stay for more than a year, and the community is once more faced with finding a replacement. If no doctor is found, the community must seek medical help from a physician in another town. The local hospital is underused, if not actually shut down. Community residents feel that their safety is jeopardized in an emergency and their health is compromised daily, without a doctor living and working there to provide on-going medical services. Furthermore, the presence of an active hospital contributes to a town's identity and pride and the facility is a source of economic activity and employment.

This is the problem to be addressed in this thesis. Understanding both the causes of the problem and the consequences of the problem on rural communities are the challenges of this thesis.

What is Community?

The word 'community' carries two meanings in this research. The first is community as a place, with people living there, sharing common interests and purpose. During this research, communities (towns and villages) were visited and discussions were held with some of the residents.

The second meaning of the word 'community' is as an abstract concept implying a spirit or force within a group of people that can be strengthened or weakened by societal

[6]Think about driving through small towns and villages in the prairies and how you inevitably see a green highway sign, indicating a hospital, and a blue sign, indicating a school. At first glance, one might conclude that this town is well serviced. What we do not see is the constant struggle those communities have in maintaining the facilities with personnel, programs and materials.

processes. The conclusions drawn from this research indicate a need for a deliberate attempt to revitalize community. This will strengthen communities' autonomy, their economic health and their overall community well-being. It will also help to improve rural health care.

An approach directed at involving the community begins with getting to know how a community functions in terms of its relationship with the formal health care delivery services and specifically, with its physician(s). This thesis is about finding out what influences a community's feeling towards community health and toward attracting a doctor to their town and keeping her there for a 'reasonable' length of time. It is about the picture communities present, deliberately or accidentally, to prospective doctors. It is about how community members interact with, relate to, or treat their doctor once he or she has moved in. It is about how physicians fit in to a new place; how they get along with the residents, how happy their personal lives are and how satisfied they are professionally. This thesis is also about understanding some subtle strengths and weaknesses communities have in their abilities to co-operate with neighboring towns, in their adaptability to new circumstances, and in their sense of cohesiveness in common values that allows for community decisions and action.

During the summer of 1989, several communities were visited and community people interviewed. The communities selected have had varying degrees of success in recruitment and retainment in recent years. Some communities have had troubles off and on. Some are generally interesting in the kinds of experiences they have had. Some communities' doctors are paid by salary, and some doctors are paid by fee-for-service[7]. Some communities are simply a mystery in terms of reasons for their success or failure in attracting and keeping doctors.

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[7]In Manitoba there are two types of payment for physicians. One is salary with office overhead costs paid by the hospital. The other is fee-for-service. The fee-for-service doctor bills the Manitoba Health Services Commission per patient visit or procedure, according to a pre-set schedule, negotiated between the Commission and the Medical Association. Overhead costs are paid by the doctor.

People interviewed included; hospital board members, municipality and town or village councillors, physicians, nurses, administrators, a church minister, and people on the street. Successful implementation of the recommended course of action presented at the conclusion of this thesis is dependent on a planner reaching as diverse a circle of residents as possible. The research, the analysis and the suggested future directions encircle the community in terms of its physical presence, its processes and its people. Community is a fundamental point of reference of this thesis.

The opinions and insights gained during the visits and interviews, a review of the literature, and recent newspaper articles on the physician shortages' problem (see Appendix One), have revealed the factors that influence this complex situation. The research led to the creation of a number of suggestions that communities, the provincial government, and the medical profession can follow to improve the rural situation. Implicitly and explicitly, these suggestions indicate a need for change in some fundamental underpinnings of the health care system.

A Closer Look at Community

Community is the common ground that planning and medicine serve and, hence, connects planning with medicine. As stated earlier, the research, the analysis and the suggested future directions of this thesis encircle the community in terms of its physical presence, its processes and its people. Understanding different applications of the meanings of community is vital to this thesis.

A) Community Health

Within a community live individuals, each with their own health beliefs and health

values. If the individuals are relatively healthy, they feel they have a sense of control or impact on their environment. Those beliefs, values, and feelings of control will contribute to the kind of interaction an individual has with the medical care system. For example, values and beliefs influence decisions concerning when to seek medical help, or when to talk to a neighbor; whether or not to confide in a doctor (perhaps fearing a breach in confidentiality in a small community). Those beliefs and values are reflected in how the community functions and how the group reacts to the formal health care system.

B) Community Needs

Rural communities have come to depend on the presence of a hospital for a sense of pride and identity. Hospitals are often the major single employer in small towns. Residents feel secure with a doctor living in the town, but that feeling of security is not founded in actual medical need. Research presented in this thesis shows that rural residents feel strongly about the need for doctors in their communities. Given the strength of that feeling, I must wonder why communities have not actively involved themselves more in the formal health and medical care system, in the recruitment process, and in doing what they can to keep a doctor there once he or she has arrived. Do rural communities feel so dispossessed of their town's infrastructures, lines of communication and internal and external interaction, that they have stopped taking care of their essential foundations for self-survival?

C) Community Strength

Interdependent with community health and community needs, is community strength. What are the processes that weaken a community's strength to direct its economic, political and social destiny? Can a community deliberately and consciously turn itself around and change its direction? How can community planning contribute to a revitalization process?

These issues are fundamental to this thesis.

Background of this Thesis Subject

The historical development of Canada and Manitoba's health care system must be examined for specific contributions to the problem addressed in this inquiry. Changes to and within the medical profession have played a part as have certain pieces of legislation encouraging the building of hospitals and training and paying of doctors (the Hospitals and Diagnostics Act of 1957, the Health Resources Fund Act of 1965, and the Medical Care Act of 1966, for example).

Medical technology increased in sophistication and in specialized knowledge. Medicine expanded and demanded expensive equipment and personnel, typically located in major urban centers. The dependency on equipment and technology deepened until we reached a stage where acute care, curative, high-tech medicine is all that we know, all that our schools teach, all that we fund, all that we trust. Rural people have not escaped this mentality. They too have come to think of health care as something that happens in an acute care facility with a physician present.

The creation of a heavy infrastructure of rural hospitals in this province meant that beds had to be filled to justify the buildings themselves. The landscape is dotted with hospital beds that are viewed as critical to a community's survival and identity. Free medical services meant that patients had nothing impeding them from seeking medical advice and treatment. People expect to get medical aid from a doctor in a hospital. They expect that they will receive the best care and if takes place in a hospital, they assume that the hospital is a necessary part of the treatment.

The system can not ultimately afford this tertiary care system[8] and it does not fit what

[8]According to Duhl (1986 78)," Primary care includes the delivery of services at first point of

we need. Most of the care administered for most of life's normal ailments does not require a physician in a hospital. Furthermore, we have hospitals that doctors, for some reason, do not want to work in, and towns they do not want to live in.

Tracing the evolution of our current dependency on the medical model[9] is relatively easy, or at least it is a well documented field of study. What is more mysterious is, when and why did doctors decide that rural practice is so completely undesirable and urban practice so irresistible? Is it connected to the dominance of urban culture over rural culture that has permeated this society? This dominance has contributed to a change in the kind of economy we now have, and to a change in the types of social organization found in the two worlds. Are the problems rural communities have in recruiting and retaining physicians an indication of the pressure urbanization has on human settlement patterns and behaviours?

In this thesis I will attempt to address these issues by examining the contextual frameworks of;

1) the medical professional and institutional structures;

2) the countryside in crisis, and;

3) the essence of community in a society that devalues rural values and idolizes the urban state of being.[10]

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contact: family doctor or community clinic. Secondary care includes specialists, routine surgery, ambulatory care in a hospital setting, and laboratory and X-ray tests. Tertiary care includes care by "superspecialists" and such care as open-heart surgery, renal dialysis, and long-term psychiatric care."

[9]Dulh distinguishes between the medical model of care and the health model in this way: "medical care focuses on a defined and limited set of difficulties, symptoms or illnesses that require prevention, treatment, rehabilitation, maintenance, or some combination of these. Health, on the other hand, encompasses the normal processes of growth, development and decline. It is made up of interdependent biological, psychological, social and spiritual foci in human development" (1986 35).

[10]R. Alex Sim goes so far as to term the phenomenon, "urban imperialism". He thinks that this imperialism "provides silent justification for the imposition of regional government on small communities, as well as the closing of rural schools, churches, and hospitals. Thus, too, the plight of the isolated, poor, and aged can be disregarded and the democratic right of small communities to plan and direct their own

The Contexts of this Thesis

In trying to come to some understanding of what is behind the problem of recruiting and retaining doctors, it became clear to me that looking at the problem too narrowly, limited the potential for understanding. In the beginning, it was almost irresistible to think of the problem in small terms;

- personality conflicts;
- living conditions;
- day-to-day relationships between doctor and patient and doctor and community.

Some people (many within the profession itself), thought that the only solution would be to force doctors with legislation or licensing requirements, to practice in selected areas. I came to realize that these were symptoms of a much more serious malaise, but the source elluded me until the inquiry opened up and my perspective and viewpoint began to change. One of my thesis committee members suggested I try to look from the rural outwards to the urban; not from the city to the country. Once that repositioning occurred, three frames of reference or contexts emerged as the basis of analysis and of understanding. Therefore, this thesis places the specific problem in the following contexts;

1) *rural Manitoba*, with its problems of alienation and decline in an over-urbanizing society;

2) *the structure of the medical and health care system* and the position doctors have in

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development can be snatched away." Sim worries that the labels assigned to parts of the landscape, such as, hinterland and fringe, are disparaging and "have the effect of extinguishing rural community life, for they offer an ideological justification for administrative arrangements that do violence to creative citizenship and local autonomy. The result, as in any imperialist system, is the legitimization of power falling into fewer and fewer hands. It also fosters a relation of dependency that is inefficient and costly. It depletes the human spirit. It destroys community" (Sim 1988 22 27).

the system, and;

3) *the role of the community* in terms of its capacity for change and growth and its rights and responsibilities relating to its survival, its health and its sense of self-reliance.

Chapter Two describes the first and second contexts in detail, and the concepts of community are discussed in Chapter Four, but the thematic concepts are explained below.

1) The Rural Setting

In this thesis, it is important to examine life in contemporary rural Manitoba and to consider how the realities of rural life determine communities' success and failure in, among other things, recruiting and retaining doctors.

Rural populations continue to decrease and communities face economic decline as the family farm becomes a ghost of the past. The traditional ways of life become lost in the demands of the changing landscape. Communities continue to struggle for survival while rural young people and urban professionals, in their quest for the meaning of life, think that their only hope for satisfaction is to settle in cities. The dichotomy between rural and urban lifestyles and values is aggravated by misunderstanding, misinformation and conflicting aspirations: one does not know the other.

Our economic system separates the consumer from the producer and alienates us from the real essence of economics - an exchange of goods and services. Hence, urbanites do not know what a farm economy has to do with them and farmers are dependent on products manufactured in another part of the world to harvest their produce for markets in places they have never been.

Government policy in this province tends to feed the urban centers and not the rural areas, even though 40% of the population live outside of Brandon and Winnipeg. There have not been enough serious attempts made to improve the lot of rural residents by

increasing their independence and promoting community strength.

2) The Medical and Health Care System

This thesis will also address the problem of recruiting and retaining physicians in terms of the kind of health care that is delivered and practiced here. It is my contention that the structure of the health care system contributes to the recruitment and retainment problem and therefore, changes to the system are necessary.

Our health care system is based on a linear medical model of physician-dependent, curative treatment, and requires acute care facilities to function. It does not include very much input or involvement from community members and it forces people to 'take what they can get' in terms of medical services. Medical students are encouraged to specialize and learn to depend on high technology to practice their trade. The billing system of fee-for-service creates an atmosphere of entrepreneurship while the state guarantees payment through insured hospital and medical services. All of this is in contrast to the old image of the country doctor; someone who shared in the life of the community, who helped generations enter the world and cared for them while they departed it and who were paid for their troubles with eggs and vegetables.

The way medicine is practiced and taught in this society is incompatible with rural circumstances and the way health services are organized and delivered is incompatible with rural life. Dispersed populations, rural values, as well as the necessity for non-acute health care and social services, demand alternative systems to the urban medical model of health care.

Rural living is threatened by the changing times and we have to choose our path. We can either sit back and watch decades of human existence deteriorate in the wake of

corporate farms, large-scale industry and urban domination, or we can take steps to revive and restore the qualities of rural living that will form a new economic system and, similarly, a new approach to social organization.

3) The Role of the Community

This thesis will concentrate on understanding what is happening in rural communities today; how they have changed over the years and what their current situation is. It must also concentrate on what community is, in its general and abstract sense, what its role is in terms of health care responsibility, and what community means as a context for living.

The community is the frame of reference of health and a context for living because health is, in part, determined and certainly influenced by social relationships among members of a community. Health is a relative and dynamic state of being. It is relative to one's age, geographic location and cultural standards. Health is determined by living conditions from the pre-natal environment onwards; by the amount of love a child receives; by the encouragement she had as she grew and matured; by the access she had to nutritious food, education, physical comforts; by the quality of her relationships with other humans and the emotional and intellectual support she felt from them and was able to give in return. The state of being healthy is a state of being able to cope with problems, including knowing when to ask for help. It is having resources available and an awareness of those resources on which to draw that allow us to function with a minimal amount of negative stress and a maximal amount of satisfaction, confidence, contentment and fulfillment.

A healthy community is all those things but with the added dimension and challenge of the presence of many individuals and many jobs to do. Community functioning is more complicated than individual functioning. Community health has a strong impact on the

health of the individuals who are its membership. Urban environments are more anonymous than small, rural communties are, and so troubled relationships within the community are more acutely felt in a compact community. Fortunately, the opportunities for rebuilding are similarly more intense because of the size and conditions and uniqueness found in rural communities.

This thesis takes a community-directed approach in the analysis of the situation and strategies for solutions in the problem of recruiting and retaining physicians for rural practice. A community-directed approach is not one that expects communities to provide services that the state was once responsible for but, because of cutbacks and ideological shifts, discontinued the practice. A community-directed approach, unlike current paternalistic government decision-making, assumes that the community viewpoint has been so far overlooked in the discussions and attempts to solve the problem. This approach assumes that the place the community has in the problem is critical to both understanding the nature of the problem and in considering ways to solve the problem. The perspective taken in the past reflects the interests of some of the people involved; medical practitioners and educators and government bureaucrats. That perspective has resulted in unsuccessful outcomes. They are unsuccessful because it omits a whole interest group - the community itself.

Where is the community in this problem of getting doctors to live and practice in rural communities? Are the people living in the areas described as 'underdoctored' involved in anyway in the discussions? What do the people care about? How are their lives affected by this? If a town's hospital is important to its sense of identity and a source of employment, then surely the residents have opinions about the state of that hospital. Surely they care if the facility is open or closed. If they want a facility in their town where they can seek medical attention, knowing that medical personnel other than doctors are not

allowed to service many of their needs, they must have thought about the problem of getting doctors. They must have a great deal to offer in terms of figuring out the problem and seeing some solutions. It is the people themselves who are most affected by doctor shortages and live with the repercussions every day, not the Winnipeg authorities. It follows, then, that it is the people themselves who are in a good position to analyze the problem and come up with solutions.

The Standing Committee on Medical Manpower

This thesis is about finding ways to help rural Manitoba communities recruit and retain physicians. The Standing Committee on Medical Manpower was established in 1979 to address the maldistribution of physician specialities and location; "for the purpose of review, analysis, evaluation and recommendations with respect to all matters bearing on the supply, category of practice and geographic distribution of physicians in Manitoba" (Annual Report, 1989).

Programs implemented by the Provincial Standing Committee on Medical Manpower (SCOMM) to remedy what is seen as a maldistribution of physician specialties and location, have not resulted in a satisfactory solution. The current recruitment method consists of SCOMM preparing a list of communities that are actively recruiting, and making those lists available to professional organizations etc.. Potential candidates can then contact the advertisers directly or go through SCOMM. Beyond acting as an introduction agency, SCOMM's role is fairly limited, and the communities have not been aggressive in their self-marketing. Other programs of SCOMM's offer;

a) financial incentives to medical students to consider rural practice;

b) start-up loans and grants to doctors willing to practice in rural areas, and;

c) coordination of specialty training with actual need.

SCOMM acknowledges that in spite of these programs, the problem of attracting doctors to rural practice persists[11]. The Committee funded the primary research of this thesis in an attempt to develop an approach to the problem from a community perspective.

Why this is a Planning Thesis

Health care planning has not yet joined the more traditional planning issues such as housing, land use policy, and design, as a typical field of study. The words have not been put together often enough in Canadian planning to spark discussions on the concept of health care planning or on the connection between planning and health. Therefore, an explanation is required. I am certain, however, that in a few more years, an explanation will be unnecessary.

1) Planning and Health

Planning and health have an historical association that forms part of the rationale for the subject matter of this thesis.

Early city planning efforts were often directed at combating ill effects resulting from unhygienic waste treatment, water provision, traffic routes etc.. Physical planning dealt with those problems by arranging settlements according to land use and population requirements.

11"The Committee (SCOMM) perceives that one important solution to the problems of both rural and urban manpower supply lies with the re-organization of the health care delivery systems, i.e., shared services arrangements and resources between the regions" (Standing Committee on Medical Manpower, Annual Report 1988-89 1).

More recently, planners have joined forces with health practitioners in, for example, the Healthy Communities movement. This movement recognizes the interconnected, intersectoral nature of health and planning. Planning can be the formulation of public policy based on sound principles and exercised by diverse groups of people. Public policy can consider health aspects and the effect it can have on the environmental, physical, social and mental well-being of a community. Furthermore, community forms the link between the practice of medicine and the subject of planning, specifically community planning. This connection will be further explored and established later in this section.

Formal health and medical care services can benefit from input from planning in many ways. For example, there is an unfortunate antagonism between the medical practitioners and government officials. Community members often get caught in the middle. Typically decisions are made either by physicians who are not trained in public policy or administration, or by government officials untrained in epidemiology. The two sides may have the community's best interests at heart but they are inexperienced in the ways of planners. We can be impartial without losing appreciation of human values.

Decisions in the medical and health care fields affect whole populations and account for huge expenditures of money, yet they are often made by less than qualified people. Medical care decisions are not generally made in consideration of the resources they will use in a societal sense nor the effects they can have on subsequent social developments. Health care decisions are removed from social concerns too and disregard the deep, cultural, historical and spiritual dimensions of health attitudes and beliefs. It is necessary for a philosophical and ideological change in decision-making that promotes human scale in all aspects of social, economic and political development. Medical care and health care should be considered in the context of life, and as such, be thought of as a dynamic, interrelated wave of influence and creation.

I believe that planning, free of the vested interests that medical practitioners and bureaucrats have, is in a position to see the kaleidoscope of viewpoints, needs, visions and

aspirations. Planning must be able to make linkages: connect the dots to form a complete picture.

2) Community Planning

This thesis will identify the scope and effect of the problem communities have in recruiting and retaining physicians. It will devise solutions that will maximize a community's objectives. Residents of rural communities feel they need a physician available at all times: inability to have one is a perceived community problem.

Community planning responds to community problems, including those problems that are perceived, and to a community's aspirations or notion of an ideal. According to Gerald Hodge (1986), community planning is an activity. It is a process of identifying the scope and effect of current and anticipated problems and devising solutions that will maximize the community's objectives.

Hodge (1986), refers to community planning as a social activity, that, by its nature, needs human interaction and community involvement in the planning, not just planner involvement. It is a process of decision-making, made up of a diverse company of characters, unlike "business planning and military planning".

Hodge talks about the formal and informal steps to define responsibilities, rights and interests as a part of the municipal planning process in Canada. The formal steps deal with procedure and the informal steps deal with the "substance" of the plan: "There are steps concerned with development of a community consensus about the need for a plan, the articulation of community goals from community concerns, the survey of community conditions, and the design and evaluation of alternative plans." Even though these steps are least visible, they require delicate handling by the planners and politicians. Their

involvement risks accusations of cynical, crass politics.

The planner must be highly skilled in guiding the public consultation phase. Hodge calls this period "a complex process of gathering information and giving advice. The information provided by individual specialists, agencies, and the public must be compounded until workable planning propositions are reached. This requires a high degree of social cooperation among the participants. *Moreover, each participant brings to the consultations his or her own values, knowledge, motivations, and criteria for judgement. Further, these perspectives may be personal, professional, or group views, or some combination of the three. Achieving a consensus on planning proposals is a delicate task that falls mostly to the planner.* Suffice to say at this point, the planner not only requires an acute awareness of the social relations inherent in the planning process, but also must adopt a personal frame of reference regarding the social intervention inherent in plan making" (Hodge 1986 320, emphasis by the author).

Hodge distinguishes between corporate planning and reconciliatory planning. He dismisses the corporate model for community planning because it does not employ democratic input, and instead uses top down direction and decision-making. It also "assumes a hierarchy of responsibilities between participants, but such a division of labour does not exist within community planning" (1986 332).

The other traditional model, the reconciliatory one, has a place for community planning as a mediator between economic and political interests. However, the diversity of interests inherent in community planning decision-making, or "plural political choices", as Hodge puts it, complicates its reconciliatory capacities.

Community planning is more long-term in its goals and objectives than either of the two traditional models and it recognizes a variety of interests from which a consensus must be reached. It also requires a "cooperative spirit".

In Chapter Four of this thesis, this classic planning approach will be supplemented and

updated with approaches that are complementary to the challenge of this inquiry. Hodge's work lays the foundation for some innovative community research and planning that is more sensitive to the problems facing communities today and more sensitive to involvement of people, rather than only professionals.

Thesis Research

The research for this thesis is mainly based on interviews and meetings with community residents as well as a review of relevant literature. The interviews and meetings are highlighted in the analysis of the circumstances in Chapter Three and in directions for the future in Chapter Five. In Chapter Three, the methodology of community research is explained in detail and it is fundamental to the philosophy and ethics of community planning and community health development.

The communities were chosen in a selective sampling and are not meant to be representative in a traditional scientific way. They were chosen for their various successes and failures in recruiting and retaining physicians, for their different economic bases and for their location in relation to Winnipeg and Brandon.

Informal interviews, meetings and discussions were held in seven rural communities: Russell, Rossburn, Birtle, Shoal Lake and Hamiota in the western region, and; Pine Falls and Beausejour in the eastern region of Manitoba. A brief description of these communities follows.

1) The Village of Rossburn has a population of 664 and the R.M. has a population of 715. The Rossburn District Health Center has 10 beds and the Rossburn Personal Care Home has 20 beds. In the listing for recruitment, Rossburn refers to the "excellent potential for further development of a regional team programme."

Rossburn has had problems in recruiting and retaining doctors. The longest a doctor stayed there is about one year. Their troubles started in 1985 when the doctor did not get along with the Board and was fired. In September 1986, another doctor arrived and stayed until February 1988. The community was without a doctor and the hospital closed until September 1988 when a wife-husband team arrived.

2) The Town of Birtle has a population of 850 and the R.M. of Birtle has a population of 1015. The Birtle Health Services District Hospital has 19 beds and the Personal Care Home has 20 beds.

This community has gone through periods of hospital closures because they have been unable to attract physicians. At the time of my visit, however, they did have a physician and the facility was nearly at full occupancy.

3) Hamiota is a village, located approximately 260 kilometers west of Winnipeg, with a population of 816. The R. M. of Hamiota has a population of 680. The Hamiota District Health Center services five municipal areas, with a total approximate population of 7000. About 10-12% of the population are 65 years of age or over.

The physicians in Hamiota are on salary. The Center handles surgery, outreach programs, and special programs. The Center has 21 beds and the PCH has 30 beds. It is a stable hospital but they are recruiting to replace one of their doctors.

4) The Town of Russell has a population of 1669, and is in the R.M. of Russell with a population of 634. The Russell District Hospital has 38 beds.

One physician has been there for a long time. His wife also used to practice there. Some people think the doctor has been an obstacle in recruiting because he is a workaholic and does not want to share his practice. The Board wants 3 doctors but the physician

claimed there was no room at the clinic. Pressure was placed on the physician and another doctor was recruited.

5) The village of Shoal Lake, located about 120 kilometers northwest of Brandon, has a population of 832, and the hospital serves approximately 3,000 people. The R.M. has a population of 795.

The Shoal Lake - Stathclair Health Center has 23 beds and the PCH has 40 beds.

The physician situation has been unstable and there has been considerable turn-over. There may be three week periods when they have no coverage at all. There was one doctor at the time of my visit but it is too hard for only one because they do not get a break often enough. Locums are sometimes available for only a few weeks at a time. The hospital was trying to make an arrangement with Hamiota for an on-call rotation; for example, 1 weekend on-call in 7. Since my visit, I have learned that Shoal Lake changed from fee-for-service to salary. They were also able to attract a physician, although I do not know if the salary helped them in the recruitment or not.

6) Pine Falls is located 120 kilometers northeast of Winnipeg and has a population of 950. The Pine Falls General Hospital has 35 beds. It is a three physician group practice providing acute care services to a catchment area of approximately 9,000.

7) The town of Beausejour has a population of 2547 and is about a forty five minute drive northeast of Winnipeg. The Beausejour District Hospital is a 30 bed facility. It usually has four physicians, although last August, one had recently left and they were hoping to recruit another.

In order to protect the confidentiality of the participants, the communities are referred to

by letter in Chapters Three and Five. This is so I can refer to my transcripts of the taped discussions and not reveal the source of the comments.

Contact was made initially through hospital administrators and the first meetings held in each town were usually with hospital board members, administrators and hospital personnel. Those meetings were taped, as were interviews with physicians and other community people.

The discussions were meant to be spontaneous and unstructured so that ideas would emerge unfettered by planning language and interpretation. There were typically expressions of defensive anger and hostility at the outset of the meetings and interviews. The sessions were extremely lively and sometimes explosive in the strength of emotions. I had requested that physicians not be present at the meetings with the board members so that the participants would not be intimidated with the presence of a person the community is desperately trying to keep. With one exception, my request was honored and doctors saw me separately, either at their clinics or elsewhere in the hospital.

The people showed a deep caring and concern for their communities and a deep anger at what they described as 'inside the perimeter politics'. They feel manipulated, ignored, misunderstood, maligned and out of control of their destinies. They also feel hotly determined to survive and show signs of desperation in their struggle for a way out of their problems. The people also showed a keen sensitivity to the complexities of the situation, of what is at stake and where their future lies.

I also spoke with long-time residents of the community, some directly associated with the hospital at one time; others who were involved in local politics or social service delivery. I talked with hardware store owners, pharmacists, housewives, retired mayors, farmers and business people. They told me about the stages their communities have

experienced in the changing tides of rural life and where they think their towns are headed.

I interviewed the wife of one of the doctors and the wife of an R.C.M.P. officer, and heard their stories of trying to settle in to a community that thought it extended neighborly courtesies, but actually did little to help soften the early months of loneliness and isolation.

In conducting this community research, it was vitally important that the work was justifiable, academically and ethically. Interference with the community from outsiders (whether they are planners or social workers et al) will be destructive if it does not appreciate the organic and natural dimension of community life. Discovering that dimension, recognizing it and knowing how to speak to it is a challenge of this research and a goal of this researcher. Helping the community to recognize it and nurture it is the route to solving their problems. It must be done by the people themselves, not because they are to blame for the problems, but because the people must be able to carry the sense of control and direction to keep it alive.

Understanding how a community lives and breathes is a major objective and critical step of this thesis. Just as health is, to a large degree, comprised of the nature of the social relationships in an individual's life, so too does the community's life and health reflect the quality of its social relationships. A community that works well, probably functions in an atmosphere of relative honesty and acceptance that may be missing in a community suffering from some dysfunction. Families that are oh-so-polite or horribly hostile are covering the real issues with a blanket of behavioral patterns. The blanket smothers conflict and turmoil as well as sentiment and respect. Healthy families have periods of unhappiness and fighting but they are able to accept the differences of their members and move on. Individual family members can accept a family decision that is not their first choice but believe that it is best for the family, or in some cases, best for certain family members at that particular time. Communities can do that too, but the nature and level of oppression under which they exist will contribute to their experiences.

It is important that we do not think of rural communities as homogeneous entities, sharing identical qualities, attributes, characteristics. Sorting out their similarities is only worthwhile to a point. For example, the characteristic of smallness is perhaps the most significant one because it relates strongly to all other factors in a community's functioning. It must also, therefore, affect the individuals living there. Smallness explains many things or accounts for many peculiarities of a community and can not be ignored. Beyond the issue of smallness, however, there will not be an attempt in this work to categorize, classify or otherwise blend community characteristics: each community will be considered on its own. This is also the approach taken in interviews with community people: individual opinions will carry equal weight.

Limits of this Thesis

There are a number of issues relevant to the problem rural communities have recruiting and retaining physicians that will have to be identified and discussed briefly. These are not to be confused with the main body of this thesis.

1) The question, for instance, of assessing whether or not a community is 'underdoctored' will not be addressed - I accept a community's perspective that they are in need, that they do indeed have a problem.

2) Health status indicators or other indicators of medical need, levels of care and levels of services will not be examined; nor will patient - doctor ratios be considered. Again, the perception of the community will be accepted.

3) The curriculum of our medical education will not be analyzed, nor will the programs currently in place through SCOMM to entice rural placements.

4) The issue of regionalization, hospital closures and support staff requirements will

not be investigated specifically, although like the aforementioned matters, these will be discussed and will arise often.

These are all important issues but this thesis must be confined to reasonable boundaries, not only because of time and resources. It must be confined to that which is centrally a planning issue - the community's place in recruitment and retainment of physicians.

Organization of the Thesis

The thesis is divided into six chapters.

I) *Chapter One* sets the stage for the inquiry. The purpose of the thesis is explained and its contexts are described. This will shape the perspective from which the thesis is written. It is my intention to approach this work from the perspective of the rural community, as compared to the perspective of urban policy-makers.

An explanation of why this is a planning thesis is given and includes a section on the connection between planning and health as well as a discussion of community planning.

The methodology of the thesis research is described and the notion of community research is explored.

II) In *Chapter Two*, the structure of the health care system is laid out to show the place physicians have had and how that position both hinders and supports the health care system as we know it. The medical profession is in a strong position to exert their influence and expertise in the search for solutions to this and other problems that plague our health care system. They will also benefit from a shift in some responsibilities to the community and an elevation in importance of the family practitioner. The growth in

dominance of physicians has resulted in the profession being alienated from society and removed from everyday community activities; they have been placed on a pedestal and must stand very still to not fall off.

Rural health care is discussed to show how inappropriate current delivery systems are for the context. Rural communities have grown to depend on the presence of a hospital for a sense of community identity and as a source of economic activity. Visiting a doctor is seen as a natural event. However it has been perverted by the resentment community people feel towards a profession that no longer wants to participate in the life and work of their hometown. The intensity of small town life exacerbates the loss of personal contact between doctor and fellow community members.

The realities of rural life are explored in an attempt to understand what the situation is today in rural Manitoba. The decline in the farm population, economic hardship, the increase in the numbers of elderly and their changing needs and the dichotomy between urban and rural people contribute to what some people refer to as a 'crisis' in rural Canada.

III) *Chapter Three* presents a commentary on the community research as it unfolded during the various discussions.

IV) In *Chapter Four*, concepts of community are discussed. The abstract notions of community and community building of several writers are compared.

The distinction between medicine and health is clarified to show that the current reliance on specialized, curative and intrusive medical technology is denying humans their whole shape and texture.

Eco-philosophy is described briefly to illustrate another way of looking at the world that is truly holistic and refuses to compartmentalize life into areas of specialties or bland similarities.

V) *Chapter Five* offers some new directions for the future of rural Manitoba. Ideas from community people are presented regarding solutions to the problems related to the recruitment and retainment question. A new approach to the problems communities have in the recruitment and retainment experiences will be suggested that will also have strong implications for overall development in social, economic and health-related areas.

Community-based health care is promoted as an alternative to the present structure. I suggest that a health committee be formed from a community rebuilding process to oversee the continuing responsibilities of health care delivery.

Vl) *Chapter Six* summarizes some of the outstanding lessons gleaned from writing this thesis and offers a vision of a new kind of health care system for rural Manitoba: one that draws on those lessons and is more appropriate to the setting and the needs of its people.

CHAPTER TWO

THE STRUCTURE OF THE MEDICAL CARE SYSTEM IN THE RURAL SETTING

Introduction

This thesis is about finding ways to help rural Manitoba communities recruit and retain physicians.

In Chapter One, I stated that changes to and within the medical profession have played a part in the development of our current medical care system. Medical technology has increased in sophistication and in specialized knowledge. Medicine has expanded and demands expensive equipment and personnel that are typically located in major urban centers.

Certain pieces of legislation have encouraged the building of hospitals and the training and paying of doctors. The creation of a heavy infrastructure of relatively small (35 beds for example) rural hospitals in this province meant that beds had to be filled to justify the buildings themselves. The landscape is dotted with hospital beds that are viewed as critical to a community's survival and identity. Free medical services meant that patients had nothing impeding them from seeking medical advice and treatment. People expect to get medical aid from a doctor in a hospital. They expect that they will receive the best care and if takes place in a hospital, they assume that the hospital is a necessary part of the treatment.

Rural people have not escaped this mentality. They too have come to think of health care as something that happens in an acute care facility with a physician present.

Traditionally, rural people looked to each other and to themselves for health advice. There were country doctors who were a part of the community and dispensed health care from the clinic attached to their home. A trip to the hospital was a major undertaking. Today's country doctor usually works out of the local hospital or a private clinic so that even the most mundane visit consumes expensive space, personnel and equipment. Meanwhile, there may be no support groups or resources in the community for social problems that plague us but that are not treatable in a strict medical sense.

In this Chapter I try to understand what the medical care system is in rural Manitoba. I also try to understand rural circumstances. The point of this examination is to determine if the medical care system fits rural life.

Part One examines the background of the health care system to show how it has evolved into its present state, and the position physicians and facilities have in it. The development of the medical profession as an important force in the health care system and in associated political decisions is explored. The profession has grown into a powerful self-governing body. Physicians have become removed from community life because of the type of medicine they are trained to practice. Medicine has become removed from the intimacy that personalizes health. The nature of medical education and its emphasis on curative care and specialization has contributed to the dependency doctors and the facilities have on technical and curative, rather than holistic[12] health care.

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[12]Holistic care sees the person in her entirety. That is: in her relationships with herself and with others; in her everyday living and in her responses to stress and crisis. Holistic health care sees the person as a being with physical, emotional, intellectual, psychological, spiritual and social dimensions. One does not exist separate from the others. This view is in contrast to specialized care that splits the person into parts and treats one without considering the others. Holistic care includes prevention of disease and promotion of well-being. It does not, in my view, allow for victim blaming. Holistic health care targets the root causes of suffering and ill health.

Part Two looks at the conditions of life in rural Manitoba and reveals the incompatibility of the medical system with the setting. Characteristics of small communities and rural life are discussed in an attempt to understand the essential structures of rural communities and how they are organized in terms of the communities' ability to change and grow.

Rural Canada is threatened by several conditions and influences:

- government decisions that ignore rural circumstances and needs;
- declining farm populations;
- economic instability, and;
- externally determined monetary policies, to name a few.

There is a crisis in rural Canada. Romantic notions of country living must be discarded and replaced with a clear assessment of the realities of rural life.

This assessment is central to understanding the hostility, alienation, animosity, resentment, powerlessness, despair and anger that rural people feel towards urbanites in general. Understanding those feelings also helps explain the resentment and anger rural people feel towards doctors who refuse to locate in their towns. Finally, an understanding of rural hostility helps to clarify the alienation rural people feel from politicians who, in their view, promote the dichotomy between rural and urban living. These feelings have grown from experiences particular to rural communities. They are feelings that can be used to help the people living there solve the maldistribution problem (as well as the concerned medical professionals mandated to solve the problem).

Government policies have contributed to the maldistribution problem and the dependency on hospitals in several ways. One of which has been to encourage the construction of hospitals in every town, village, and hamlet throughout the province. This has established an infrastructure that requires personnel to function and is expensive to maintain. The residents have developed an economic dependency on the institutions for

employment, and a psychological dependency for the community's sense of pride and identity.

The inappropriateness of curative over holistic health care becomes clearer when the social and economic processes of rural communities is described. The health care delivery system does not fit the needs of the people living in rural Manitoba. This mismatch results in an unhappy professional group resisting a style of life and practice that they are simply not suited for, and a population that is further alienated from the governance of their lives.

PART ONE

Background of the Health Care System

In this section, the link between the scientific paradigm and specialized medicine is shown to affect the organization of health and medical care. The rise of professionalism is traced to see how it contributed to the structure of the medical system. These two phenomena, along with government ideology and programs, have created the Canadian medical care system. From my perspective, these factors have not made the best system possible.

Pasteur's germ theory of disease and Koch's discoveries in microbiology, had profound effects on medicine and contributed to a scientific foundation of knowledge. Medical people then tried to isolate bacterial connections to all ill health in a specific unicausal or linear pattern. This purely biological perspective helped lay the framework for the curative-based, treatment-oriented medical care we are still seeing today (Bolaria and Dickinson 1988).

This perspective ignores social and other causes of ill health and denigrates the human

body to a mechanistic entity, void of spirit and soul, as well as denying a basic human quality - that we are social animals, functioning in a social environment.

Add to the dominance of the scientific paradigm, the appeal that kind of specialized knowledge holds for a class of practitioners and the power potential for the holders of the knowledge is vivid and strong. Medical practioners, particularly physicians, hold knowledge that they are not always willing to share, even when that knowledge is about personal health. It is knowledge that they can not own because it is knowledge about our own health. The profession has ended up with too much power over individuals and over governments. This power has allowed them to make decisions in health that further their own interests and not necessarily societal interests.

The Medical Profession Gains Ground

The rise of the medical profession has been, and continues to be, a major force in the evolution of our health care system.

The professionalization of medicine has been under careful study by sociologists and political theorists as a significant development in the occupational structure of the 20th century. Writers, such as Ivan Illich and Vincent Navarro, recognize the role of professions in an industrial society as a class issue and one that is dictated by, and part of industrialization and capitalism. Eliot Freidson, a sociologist, stresses the autonomy of the medical profession that it is legitimized by the state, and is largely responsible for inadequacies in health services. Historian Malcolm Taylor sees the immense power that the medical profession has had in this country and sees the profession's role as critical in the organization and implementation of health services. He refers to the medical profession as a "private government."

"The success of organized medicine in achieving its objectives can be attributed to a number of factors: the prestige of the members of the profession and the deference accorded their pronouncements even outside the scope of medicine; previous (and continuing) identity of the profession with other matters in the public interest; the profession's privileged access to the focal points of decision-making in federal and provincial legislatures, cabinets, and government departments; and, not unimportantly, the degree of cohesion within its membership and the resulting unanimity and consistency of the opinions and preferences expressed by the Association" (Taylor 1960 126).

Taylor contends that the provision of medical services is a matter of *public* interest and has recently become a major issue of public policy. In contrast, the medical profession thinks of itself as *private* group: "organized medicine's efforts to influence governments are thus clearly the typical reaction of any social group to any presumed threat to its control over its physical and social environment" (Taylor 1960 126).

Recognizing that patients were beginning to demand more from public policy on health services than the traditional relationship of physicians' assessment, patient pays - the medical profession responded. "The profession has moved to dominate, neutralize, or conciliate these pressures by; (a) strengthening its organization; (b) establishing prepayment plans to obviate the need for any revision of public policy; (c) influencing the course of such public policies as have been enunciated; and (d) seeking a participant role in the administration of such programmes as have been or may be established" (Taylor 1960 126).

Licensing of doctors began "with the founding of the American Medical Association in 1847 by doctors concerned about improving standards of medical training, but also about controlling competition from 'irregulars' who had not been trained in similar elite schools (Conrad and Schneider 1986). At the heart of the founding of medicine as a profession is

the control of markets, elimination of competition and the creation of a monopoly over health care (Conrad and Schneider 1986, and Friedson 1970)" (Susan A. McDaniels 1988 55-56).

The Canadian Medical Association was formed in 1867 under (Sir) Dr. Charles Tupper. It was made up of provincial divisions but also set out national policy. Its policies dealt with; 1) medical practices and standards, and; 2) the organizing and financing of medical services, through, for example, the Hospital Accreditation Committee and the 1930 Committee on Economics, which dealt with organized medical care programs, whether sponsored by government, insurance companies etc..

The BNA Act provided for 'one portal entry' to the profession with the subsequent Canada Medical Act of 1910 giving the medical profession the power to license themselves and administer the act to those to whom it applies and to achieve minimum standards of qualification.

During the depression and Bennett's Conservative administration (1930-35), more and more people could not pay their medical bills. Municipalities were facing bankruptcy and could not pay hospital deficits. Doctors' incomes were decreasing and poverty was increasing. The League for Social Reconstruction of 1937 had as its main proposal a plan for state health insurance as did the CCF and its Regina Manifesto.

By the end of the 1930's regional and class differences were glaringly obvious. WWII required a mobilization of resources and the debate over social reform abated. After the war, plans for post-war reconstruction were underway to avert economic depression and social unrest. The Heagerty Commission recommended a universal, comprehensive government administered system of health insurance to be financed jointly by the federal and provincial governments.

The medical profession and the CMA were growing in prestige as medical knowledge became more sophisticated. The CMA wanted a voluntary health insurance program and

without government intervention.

In the doctors' strikes of 1962 in Saskatchewan, and in 1986 in Ontario, professional perspective conflicted with governmental responsibilities. One analyst thought the reasons for the strikes were based on five themes:

"Who knows best, control, ideology, power and focus. The question of who knows best was central to the 1962 (Saskatchewan doctors') *dispute. Government took its mandate on this from its constituents and from expert analysts of the health care system. Medical professionals claimed their expertise from a combination of acquired knowledge through medical school education and their state-sanctioned monopoly over the provision of health care. In terms of control, doctors saw themselves in charge of health care and resented what they saw as interference from the state. Government, on the other hand, saw itself as in control of public costs of health care and as being in control over public access to health care as a right.*

In ideological terms, doctors saw themselves as a high status group with a moral obligation to protect the rights of individuals against incursions by the state. That this ideology was firmly supported by medical 'refugees' from the British NHS is clear. Government, in contrast, saw itself as protecting person's rights to health care regardless of their paying capacity. The medical profession felt they had the power in Saskatchewan even two years after the people had voted against them on the medicare issues, to get the government to back down. The government felt it has the power to force the doctors into line without much consultation or compromise. In terms of focus of attention, doctors in 1962 in Saskatchewan seemed more attentive to their own needs than to those of their patients or the people they served.... The government's attention was focused on the election and on public opinion to the exclusion of attention to the powerful group of doctors" (McDaniels 1988 55-56).

Conflict between the professional perspective and governmental responsibilities was manifest in the two strikes cited. Doctors saw themselves as holding more than medical knowledge. They saw themselves as having knowledge about government policy as it related to health care. One does not necessarily lead to another. Government and the medical profession have different interests and different responsibilities. They also have different agendas: doctors want to maintain their high status position, and; governments want to be re-elected. Unfortunately, those agendas are not often spoken about openly in discussions between the profession and government. The issues of power and responsibility are obscured behind talk of freedom from government intervention on the one hand, and public control over resources on the other.

In this section, I have tried to show how the medical profession established its self as a self-governing group with considerable power over government decisions and policy. Our medicare system and many other social programs have been deeply affected by the medical profession's influence. The profession has been intrusive in matters that far exceed their specific body of knowledge.

In the next section, the association between the medical profession and government policy is further explored. From the 1930's onwards, governments have acquiesced to pressure from the profession. I think decisions were made without enough thought to future affects of those decisions. As a result, our health care system has been closed to significant change.

Professional Dominance Takes Hold

By looking at the historical development of Canada and Manitoba's health care system, I hope to give the reader some understanding of where the problem of recruiting and retaining physicians originated. I can not see a problem existing without its historical background and I need to view the problem from back to front. Only then, can I recognize the contributing factors to a problem.

This section looks at two of those factors. The first is certain pieces of legislation, namely;

1) the Hospitals Insurance and Diagnostic Services Act of 1957;

2) the Health Resources Fund Act of 1965, and;

3) the Medical Care Act of 1966.

The second is changes to and within the medical profession.

A) Legislation

1) The Federal Hospital Insurance and Diagnostic Services Act was passed in 1957. It provided for public hospital insurance and cost-sharing for the operating costs of hospitals between the provinces and the Federal government. This legislation served to encourage the practice of high spending on hospitals and low spending on other kinds of health care delivery, such as community health centers. "By 1961, all provinces were operating hospital insurance programmes under this act. This development, which contributed to a general emphasis during this period (1950's and 1960's) on hospital construction, led to an increasing dependence upon a type of health care which was excessively costly, and also unnecessary and inappropriate for many purposes" (White Paper on Health Policy, Appendix Volume One, Manitoba Cabinet, 1972 9).

2) This act and the Medical Care Act of 1966-67 "have been chiefly responsible for the kind of health care 'infrastructure' that has been developed. It is an infrastructure in which

the acute-treatment hospital is dominant, and the kind of health care 'service' that has been promoted is principally the individual patient-single doctor relationship" (Peter Aucoin 1980 245).

The Federal Medical Care Act of 1966-67, because it insures only physicians and surgeons, has reinforced the dependency on that kind of health care and increased the use of those kinds of services. Other less expensive health care using other personnel have not been as developed. "The Act, in short, promotes the use of the the most expensive personnel in the health care professions" (Aucoin 1980 250).

3) The Health Resources Fund Act of 1965 provided funding to teaching facilities and medical schools. Again, money went to physician's education and to hospitals, further contributing to the prominance of physicians in the overall health care scheme.

B) Medical Profession

Changes to and within the medical profession have contributed to the present state of affairs. In a paper by Jonathan Lomas and Morris L. Barer, the power of the primary health professions is traced in this country from the pre-World War II structure that was "consistent with the individualistic ethic of the times" (Lomas and Barer in Evans 1986 244).

This point is important because it shows the ideology of the day reflected in the relationship between the profession and government, each with their own agendas.

Government kept out of the doctor-patient relationship except in an attempt to regulate quality of practice. This was difficult to do because no one but the practitioners themselves had enough knowledge to assess competence; so the doctors did it themselves:

Thus, the professions themselves were given the power to define the standards of practice expected within their service monopoly and the power to enforce those standards. Governments did not have the capability of maintaining standards. They had neither the

funds nor the knowledge to monitor the scattered practice settings and, in any case, enforcement by peers would be considered more acceptable. Thus emerged self-regulation with the informational asymmetry between government and practitioners resulting in the profession acting as agent of the state in protecting the individual public interest.

The authors note that while this policy may have made sense at the time, "it is possible to see in retrospect a number of difficulties attributable to this form of professional governance" (Lomas and Barer 1986 245).

Once this hands-off approach had been established, government could not instigate change without arousing the ire of the professions. Government removed itself from a position of influence and passed it on to the professions in a neat package of self-regulating monopoly.

Private fee-for-service practice also contributed to the detached position government assumed, although the significance of financial arrangements was not realized by government at the time. Fee-for-service private practice "resulted in governments granting the self-regulatory right to set practice standards not only for the content of care but also for the conditions within which that care would be delivered" (Lomas and Barer in Evans 1986 246).

Ultimately, the state controls medicine. It is the state that creates legislation that defines and regulates the medical profession. Further, the state funds the university medical schools, the hospitals, and the health-care insurance system. However, the state delegates its authority to the medical profession itself. In this fashion, the medical profession gains control over admissions to professional schools and over membership in the profession through licensing and through disciplinary mechanisms. This delegation of authority from the state to the profession allows for professional "autonomy"; further, most physicians engage in "private practice" and bill the health-insurance commission on a "fee-for-service" basis. All of these practices support the notion of the physician as a

private entrepreneur in a free-enterprise marketplace. Of course, this model ignores the fact that the medical profession enjoys a state-endorsed monopoly with severely curtailed competition and price-fixing in the form of negotiated fee schedules. Nevertheless, the free-enterprise rhetoric is regularly employed in order to protect the notion and image of professional autonomy" (Herbert C. Northcott in Singh and Dickinson 1988 42, underlining mine).

Physicians are "the principal providers of medical care in Canada", and they "are usually the first point of contact for those seeking care, they are also the 'gatekeepers' to hospitals, most health-care institutions, and many professional services. It has been estimated, for example, that physicians directly control approximately 80 percent of total health-care costs, even though their incomes account for only 15 percent of these costs (Chappell 1986 100). Thus, doctors' decisions concerning who will be admitted to hospital, how long they stay, and the type and number of tests and treatments provided to a considerable extent dictate the cost of health-care delivery" (Dickinson and Hay 1988 53).

Lomas and Barer identify three policy phases in Canada's manpower planning, all of which are mainly physician oriented.

Phase 1 The first came in the 1950's and 1960's and was in response to an anticipated increase of service utilization following the introduction of insured services. Attempts were made to increase domestic output of physicians with the opening of a number of new medical schools and increased admissions. The resulting increase in medical graduates did occur but it took a few years for the students to actually go through the school system. Immigration was also on the rise with the combined effect of an "annual average growth in the physician supply between 1957 and 1967 (that) exceeded average annual population growth by .82%, but between 1968 and 1975 the average annual excess was 3.4%" (Evans 1986 251). Between 1969 and 1975, the average number of graduates increased by

more than 50%.

Evans has pointed to two factors related to the increase in supply of physicians; a) the expected increase in demand from insured services did not occur, and; b) the resulting increase in utilization of services led to a dramatic increase in costs to the system.

Phase 2 The second phase in policy formulation of the 1970's was directed to containing the burgeoning supply of doctors. The snag for the federal government was that it could not 'interfere' directly with the profession or the profession would hold back support of medicare. The only thing the government could do was to control physician immigration, but by then the domestic production of doctors was in full swing and little was done to limit medical school entrances because of perceived distributional and specialty imbalances between areas.

Phase 3 By 1980, the third phase in policy-making began with a recognition of an over-supply of doctors and subsequent cuts to admissions to medical schools, particularly in Manitoba and Quebec. At the same time, a Provincial Committee was established here to seek solutions: but it too was, and continues to be physician dominated in its perspective; its analysis of the causes of the problem, and; in its efforts to alleviate the ill-effects of physician shortages in rural areas.

In the meantime, tight budgets forced cutbacks in manpower dollars to medical personnel other than physicians, with accompanying decreases in hospital beds. The mistake made was to equate need with utilization (i.e. days in hospital): "the forecasts of physician requirements were not based on epidemiologic studies of health needs translated (directly or indirectly) into physician service requirements, but rather on acceptance of the physician expenditure or utilization data of the studies' base years as a proxy for 'need'.

This utilization approach to requirements estimation is based on the key assumption that requirements are equivalent to utilization, that is what is provided is what is needed" (Lomas and Barer in Evans 1986 257).

Effectiveness does not enter in to the equation and the physicians benefit from increased utilization through increased income. Furthermore, utilization is then used to justify physician numbers and so on - the circle continues. Forecasts are also made dependent on a status quo in services: that is, physician dominance.

By the time national health insurance was in place, professional dominance, particularly by physicians, was safely ensconced as the controllers of the system. Manpower policies continued to favor professionals[13], even when alternate personnel would be less costly but as effective. Lomas and Barer consider the passing of medical insurance as a "missed opportunity to impose organizational change and reformed health manpower roles. Instead, it has been merely a mechanism that solidified the pre-existing dominance of professional governance by the primary professions. Government responsibility for a large segment of health care expenditures did emphasize the need for consideration of the collective public interest, but the historical forms of governance, which provided no mechanisms for this to occur, were left unchanged....All too often the existing regulatory structure and the number and mix of existing health manpower have been the primary determinants of by whom and how a particular health care service will be delivered" (1986 250).

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[13]An additional problem with physician dominance of the health care system is related to the relationship that exists between doctors and other medical professional groups: "the largely independent practice domains of the complementary primary professions (despite the broad scope of each) meant that there was no particular reason to establish effective mechanisms for inter-professional communication and control: each operated independently under an individualistic ethic and with its own view of the public interest" (Lomas and Barer in Evans 1986 246).

A dilemma exists concerning the concept of collective interest and efficient allocation of resources and to what extent professional groups should be responsible or held accountable. The dilemma centers around the conflicting concepts that are held by different interests. The interests are expressed in different ways. Public interest can be expressed in terms of regulating resource allocation and standards of practice. This public interest is not always easily reconciled with individual interest of the best care possible, nor with the interest of the professions themselves. "A governance system based on the individual public interest (quality assurance without resource constraints) became a powerful determinant of manpower policies because government had, where self-regulation had been granted, no obvious or painless method of forcing consideration of this new collective public interest. The primary professions themselves have become remarkably adept at excluding consideration of this interest by expressing their own countervailing economic and social desires as imperatives for the protection of the individual public interest: we must do everything possible for our patients whatever the cost (to third parties / benefit to ourselves)!" (Lomas and Barer 1986 247).

Lomas and Barer refer to the "anachronistic nature of professional governance," and the effect that the increased reliance on high technology has had. "Increased reliance on technology has led to concentrations of health manpower where the technology is housed (e.g.hospitals), a proliferation of new categories of health manpower and increased specialization or fragmentation of existing professions". The authors wonder if the concentration of personnel in hospitals may indicate that the hospitals or the clinics themselves, are in a better position to regulate practice and may, through incentive, consider the public interest.

Professional dominance has become institutionalized and supported by governmental, economic, educational and social structures. It has become entrenched in the organizations that are responsible for the delivery of medical services and affects every aspect of the

network. The end result is a system that is planned around the absence or presence of physicians. It is not planned around consumer need.

The next section looks at how Manitoba responded to the maldistribution in physician specialists and location. Although the intent was there to address the problem logically and systematically, it appears that the Provincial Committee's efforts were misdirected and did not reach deep enough to the root causes of the problem. Their efforts did not address the effects of professional dominance nor the effects of legislation that built an over-abundance of acute care facilities. The Committee's efforts also missed the point by excluding (accidentally or purposefully) the issue of community involvement.

The Standing Committee on Medical Manpower

The Standing Committee on Medical Manpower (SCOMM), was formed in 1979 to address the problems of maldistribution in physician specialists and location. Many programs were initiated to entice doctors to rural and remote areas.

The problem is described in the SCOMM material as an inability to entice doctors to live and work in rural Manitoba communities. This inability results in a maldistribution across the province. The reasons cited have to do with the hardships physicians face in rural life and practice compared to urban practices. All efforts to treat this problem have been directed by and to the people involved in the medical establishment (loans to students; start up grants to doctors and so on). All efforts have been directed at the practitioners. Very little has been directed at the communities or the people who live in them.

The entire manpower planning process has been based on the success or failure of recruiting and retaining doctors. The whole medical care system, including the use of

facilities, hinged on whether or not SCOMM's programs would work (in an ad hoc way), to ease doctor shortages in rural Manitoba. Use of other personnel or alternative delivery methods was not considered. The primary goal has been to recruit and retain physicians.

According to SCOMM, the main obstacles to getting doctors away from city practices are the perceptions about the hardships of rural practice. Whether or not city doctors really know how good or bad the conditions of rural practice are, has not been determined.

Even though SCOMM and others (Horne 1988), do not equate the low physician / patient ratios found in rural Manitoba with compromised access to care or poor health, the perceived problem does exist. (Physician to patient ratios in 1981 were; Winnipeg - 1:422; Eastman - 1:1596; Norman - 1:1183 [Horne, 1988 and SCOMM 1986])

SCOMM is concerned with expanding its responsibilities "to provide an on-going mechanism for comprehensive province-wide medical manpower planning". Since 1979, the committee has concentrated its attention on shortages and maldistribution of physicians in rural and remote areas of Manitoba. In 1987, a working group on rural placement was formed to develop techniques to recruit and retain doctors in those areas. SCOMM has come to recognize that "recruitment to these areas will not improve until such time as the matter of regionalization or shared services arrangements are put in place as well as other innovative ideas are introduced" (SCOMM Annual Report 1987).

Many of the innovative ideas have been directed at enticing University of Manitoba graduates to rural and remote areas. Others are directed at guiding the composition of rural practices. For instance, some of the proposed changes to the system are;

- limit solo practices and encourage shared or group practices on a regional basis;
- better inform the students about rural life and needs;
- organize rural physician supply from the University with University of Manitoba graduates, and;
- use legislation to control the numbers and placement of physicians ("monetary

incentives / disincentives").

Programs currently in place include;

- literature and information provided to local high school students encouraging them to consider medical school;
- work experience for 1st and 2nd year students in the field;
- loans to 3rd and 4th year students if they practice in remote and rural areas;
- rural rotation in community and family medicine;
- post graduate courses in rural and northern practice for physicians, and;
- incentive grants for physicians to work in designated areas.

According to SCOMM's 1987 Annual Report, "the shortages of physicians in rural and remote Manitoba have not been lessened by all the efforts of SCOMM, e.g., the Placement Bureau, the Incentive Programs and until recently, the facilitation of immigration of foreign physicians. Despite enhanced communications with the Faculty of Medicine and the Residents of the University of Manitoba concerning the need for physicians in rural areas, recruitment of local graduates has been poor" (13).

It is generally acknowledged that there is an oversupply of physicians in urban centers but a sporadic undersupply in rural areas. Furthermore, even though the absolute numbers of required doctors are small (about 25 at any one time), the problem is relative because one physician serves a large catchment area and their presence or absence affects many people. "The problem in rural Manitoba is that one vacancy in a one, two or even three doctor town constitutes a 100%, 50% or 33% reduction in medical resources: this, together with the difficulty in recruiting a locum for vacation or continuing medical education creates an urgent situation which tends to snowball as the remaining overworked physician(s) tire of the overload and leave" (SCOMM, Annual Report 1987 13). Meanwhile, the oversupply in urban areas is an expensive burden on the whole system without contributing to an increase in standards.

More recently, SCOMM has decided that, although their recruitment procedures are well developed, the essential problem remains and calls for another angle. The Committee has turned its attention to the communities themselves and efforts are going towards devising ways of involving the community in the recruiting and retaining process. This is an indication of some holistic and futuristic thinking that spells the beginning of the end of urban dominated decision-making and its impact on health and social service delivery systems.

Conclusion of Part One

SCOMM has been trying to help ease doctor shortages in Manitoba. Although the intention is there to fix the imbalances, it is apparent that the approach is limited to directing efforts to the medical establishment. Therefore, it can not get to the source of the problem.

The physician recruitment and retainment problem is a sign of something pervasive and far-reaching. It is an indication of a philosophy dominated by urban values that has permeated our society and the ways we approach work and culture. Our society has learned to hero-worship specialists, experts, and the image of the urban professional. Urban values are separate from the hands-on contact with the actual means of production and face-to-face relating that is reminiscent of another time in a rural setting. Urban values allow us to absolve ourselves of some of the responsibility of surviving by not knowing how to grow food, how to keep our minds and bodies well, how to build shelter, and how to make decisions about public money and public institutions.

The next section looks at social and economic characteristics of small towns and villages generally, and then considers the situation of overall rural decline as another

context of the problem of recruiting and retaining doctors in rural Manitoba. The final section of this Chapter merges medicine with the setting to show how the two are incompatible.

PART TWO

Characteristics of Rural Manitoba

Rural Towns

In this section, the works of Gerald Hodge and Mohammad Qadeer are looked at because they are both well-known authorities on Canadian planning and rural social structures. Their book was one of the first I consulted in my research. Having spent my life in urban centers, I was not familiar with small town life and I needed some fundamental information about the rural way of life. These two authors gave me a place to start.

Hodge and Qadeer discuss how towns differ from cities and from each other. "Individually they (towns) are unique due to the variations in: 1) the mix of activities and institutions; 2) the variety of the modes of local integration of national institutions; 3) small size; and 4) the truncation of social structures" (1983 119). For my purposes, the two most important are; 1) the small size, and; 2) truncated social structures.

1) The smallness of towns and villages is very important for several reasons. It "contributes to the visibility and observability of its residents. This may not necessarily engender emotional closeness or friendships, but it does promote mutual acquaintances and personal dealings...pervasive mutual acquaintance...offer(s) greater opportunities for mutual empathy and face-to-face relations" (221).

"Because of their small size, towns and villages are unable to sustain many professional and commercial services.... To live in these places one has to learn to rely on another's help, so volunteerism and mutual help are functional necessities.... To render and expect such help is part of the ethos of small community living, and to the extent that it prevails it makes towns and villages self-reliant and participatory communities" (221, emphasis added).

2) Truncated social structures refers to "the absence of vigorous leadership, a sense of powerlessness, lack of entrepreneurship, narrow economic base, vulnerability to business cycles, and unfavorable public policies, and so on". Higher decisions of institutions and government agencies are made elsewhere with only the lower echelons represented in towns and villages. Some local people will hold more power than others because they will have access to outside power brokers. "In small communities, the decision-making process is highly personalized" (137). This is not always good; for instance, who decides who gets welfare?

Hodge and Qadeer refer to a community's historical and cultural context. Their point is that as similar as rural circumstances can be, each community has its own personality. That personality is important to a town's persistent attempts to survive.

"The historical, cultural and social circumstances of every small community differ. These, in turn, influence the disposition of individuals and groups in a community, indeed the community as a whole, to behave in unique ways. Thus, the patterns of shopping, commuting, of socializing, as well as the ways in which social concerns are handled, the degree of cooperation in the community, and care shown for the community are a reflection of the choices that individuals and groups feel inclined to make" (217).

In other words, individuals and communities affect each other. The two do not exist independent of each other. One is a product of the other. This supports my concept of health as a social phenomena and my belief that communities are more than simply places to

be.

Hodge and Qadeer see an insecurity among residents of small communities. It is caused partly by the alienation from higher decision-making levels and a feeling of being a branch plant of some larger entity. That sense of insecurity "finds expression both as adversarial sentiment and as local boosterism" (221). Communities will react by engaging in competitive behaviour with each other (adversarial) and they will try to sell themselves for the highest bid from the outside (boosterism).

Finally, Hodge and Qadeer note that issues such as health care, are not easily resolved in small towns.

"It is important to grasp that such concerns (social services and facilities, for e.g. health) tend to raise complex issues in small towns about community functioning, even more so than they might in urban areas. The reason is twofold: first, the usual meager array of services in rural areas means that few support services will be available; and second, the greater distances and lower densities of populations almost automatically call for transportation solutions as well.....Planning the provision of services in small communities is much more involved with the integral functioning of the entire community and the available resources" (226, underlining his).

Urbanites can afford to be unaware of health care services because there are so many options and choices. This is not the case in rural areas. There are few choices to make in terms of health services and often a choice will involve travelling out of one's community to another. Because of the small population that is dispersed over a large area and because of the limited choice of services, rural residents are compelled to deal with social services in a basic way and as a community. Urbanites are not.

This realization provided me with some clues to look for as I continued with my research. It reminded me that rural communities are very different than urban ones are and

that there are reasons for the differences. It also reminded me that communities must be considered in their diversity and individuality.

Rural Decline: The Crisis in Rural Canada

R. Alex Sim is a Canadian sociologist, activist, community development worker and farmer. His book (Land and Community: Crisis in Canada's Countryside, 1988) is written as "a personal testament rather than a sociological treatise" (1). In his words, he writes "as a rural person looking out on the world from inside the rural community. The language is subjective, intuitive, selective, and impressionistic. *We*, not *they*, are the rural people" (2).

His book appealed to me partly because of its style of writing. It is personalized, passionate and literary. The book helped me understand how intimately connected rural communities are to the land and how that intimacy affects the health of the rural community. Sim does not romanticize about rural life. His image is not a fuzzy, warm memory. His image is an etching of a troubled environment. Sim says:

"I see the rural community, not as a quiet haven to escape a turbulent world, but as a battered raft drifting downstream on a river of change. It hits a rock and part of it breaks off carrying away some of its occupants, while those that remain grapple with other bits of debris in a frantic effort to reconstruct the raft. As others try to scramble aboard this rural raft, those already onboard are undecided whether to welcome them or cast then adrift.

Land and community are two aspects of rural life that bring these issues together. Land is the foundation of all life; community is the focus of family activities - the place of coming together, the base from which people go to and return from the outer world. Land and community constitute the marriage of two opposites. It is really a matter of

circumstance and choice. It may be congenial, a marriage of convenience where the land is exploited and laid waste and the community a place of dissension and ill will. It may be a happy arrangement of good husbandry of resources, a place of caring and mutual aid, where human nature is in tune with the natural world" (16).

Sim talks about the crisis in Canadian rural communities as "a transformation of rural life (that) has resulted in the loss of intimate social relationships, the disappearance or decline of countless villages, and the growth of others caused by the influx of new residents, resulting in tension between them and the old timers" (Sim 1988 17).

Sim cites several reasons or causes for the transformation and compares the different style and values in living in the 'old days'. He does not wallow in nostalgic sentiment and he does not wish for a return to the past ways of life. He does try to figure out what happened and hopes for a revival of the values that were behind the vibrant pioneering spirit and strength of purpose of former times.

"...We are losing, or have already lost, the large measure of autonomy, the intimacy, the sharing of work, the visiting and caring of those former days. Few of us would want to go back, yet the important vestiges of the past remain. On that foundation we can build a new rural community shaped and controlled more and more by the people who live there" (18).

He thinks some of the reasons behind the changes are linked to technological innovations (the automobile and the telephone for example), bureaucratic decisions that eroded local government power, different employment patterns, the changes farming technologies have wrought, and so on[14].

One of Sim's real concerns is with the loss of autonomy in rural communities (he

[14]To this list can be added the effects of social movements such as feminism, because women have begun to see possible options for their lives that are not necessarily focused exclusively on their homes, families and surrounding community.

concentrates on agricultural communities in this book), and the "weakness and dependency of rural social institutions." He wants rural people to "recognize that they must exercise more control over their own lives" and "set our own priorities", not rely on bureaucratic decisions (21).

The tragedy of our times is the weakness of what I choose to call 'positive ruralization forces'. I refer to respect for nature, sensitivity to the presence of others and their needs, and an organic sense of total systems, in nature and social relationships, in pride of workmanship and in the artisans' skills. These positive humanizing and ecologically wise attitudes have been threatened in part by the negative rural attributes of narrowness, insularity and conservatism, which have deprived rural people of the capacity to counter the powerful forces of urbanization. Meanwhile the city, despite all its attributes of high culture, despite the richness of its resources, has not counterbalancing influence to restrain its own destructive and colonizing violence. Correcting the restorative impulses could come from ruralization. That is my faith and vision (23).

There are signs of resentment and alienation and consequent discontent in rural communities; the research conducted for this thesis and in other sources uncovers evidence of this. The time may be ripe for rural people to look to themselves for action and direction and not to outside authorities.

From what I have seen and heard, people living in rural Manitoba communities are oppressed by government decision-making procedures that ignore their needs and input, that deny their abilities to freely contribute to the economy, that exclude them from the "search for self-affirmation as responsible persons" (Freire 1987 20).

As the disparity between urban and rural populations widens, it has become increasingly difficult and expensive to maintain the infrastructure of rural life. Indeed, unless something is done to stem the tide of rural depopulation, the very structure of our

rural society will continue to erode and the costs of trying to provide a decent quality-of-life will escalate in both the depleted rural areas and in burgeoning urban communities (Westarc Group Inc. 1988 Vol.1 1).

This poignant observation succintly describes a situation that threatens the very survival of rural life and, with it, in a dialectic response, places a strain on the urban centers. As one struggles to hang on to its residents and provide essential services and meaningful lifestyle attributes, the other is overloaded and suffers from the ill effects of exceeding a population threshold that cannot be comfortably accommodated.

Westarc is a research group in Brandon that focuses its work on rural issues. They conducted a major study of western Manitoban rural residents to determine labor needs and assessment. The study consisted of a survey, with a number of questions on topics ranging from farming to health care.

The Westarc Report found that the primary 'want' that rural people have is "some tangible evidence that there is a 'will' to help rural Canada comparable to the help provided in urban areas..." (Westarc 1988 Vol 1 1). They need to know and see that their efforts to rebuild their economies and communities will not be thwarted by interference; rather they will be supported and encouraged.

The report made the following general conclusion:

If there is a public desire to have a viable rural Canada, the challenge is clear. We must help keep farm families on the land, we must increase and diversify the employment base of rural communities, and we must provide the training and labor market support services required to maintain economically and socially viable rural communities... Unless our concern for rural life is coupled with political will and action, we can expect to see more abandoned farm yards and vacant storefronts in rural Canada (23).

The report examined statistical data of farm and non-farm populations and concluded

that Manitoba's farm population is "showing a continuing decrease, that there is a trend for decreased non-farm rural population and that Manitoba's urban population continues to show a steady increase" (49). Where there have been increases in rural populations, they have occurred in communities close to urban centers. There have not been increases in farm based employment but more exurbia oriented employment.

The report recommended that all levels of government should develop rural policies directed at reversing the decline in the number of small farms and at reversing the trend of young people migrating from rural to urban areas. Easing the dependency on farming was also recommended by targeting small businesses and industries that are appropriate to the setting. The Report called for a new approach to assessing the economic and social health of communities. It suggested that indicators should be devised that would consider individual community conditions and would more clearly describe the realities of rural life.

Sim states that "the reconstruction of the rural community cannot be considered apart from the restructuring of agriculture." However, the approach taken must reflect a new perspective of social and economic priorities: "the restructuring of agriculture along humane, ecologically sensitive lines is essential to the revitalization of the rural community" (1988 165).

Sim doubts the suitability of a yardstick of success that measures accumulated material possessions. "Rather, we must look for initiatives that enhance human growth and creativity, that are gentle and restorative to the environment, and that result in a rebuilding of community values. These values are part of the rural tradition and are still present, though not readily apparent, in rural community life. They can be recognized and taken as models for the future without trying to turn back the clock" (145).

Commitment to ideas and ideals must be deep in order for people to participate in change and to be changed. "Desirable rural change must go through the same evolution:

from ideas to personal commitment to social action to redistribution of power" (182). Action springs from ideas and ideas grow out of crisis or chaos. Sim sees two different types of social ideas: "One is voiceless, formless, inchoate, unfocused, imitative, and chaotic; the other is innovative, focused and creative. The first is transmitted from person to person, though it is difficult to know how."

The second type is "more grounded and perhaps more rational. The two types are not unrelated, for order and beauty can be (and perhaps must be), formed out of chaos" (183). It is important that ideas, and not individuals or institutions, are at the center of ideological change and subsequent social action. This is not to deny the need for organization in exerting social change. Rather, as Sim says: "Ideas and initiatives for rejuvenating a community may originate with individuals, but find shape in organizations. It is important to see how community regeneration can be brought about through organizations and what obstacles will be encountered" (185). It is just that ideas and the value of them, can and should be strong enough to stand without individual charisma or power.

The kind of organization that is established to implement ideas is critical to democratic change and to the success of a plan. In Chapter Three, a way of organizing is discussed that strives to be non-hierarchical and wide-reaching throughout the community, involving many different individuals and groups.

Rural Health Care

Where does health and the medical care delivery system fit in this troubled rural environment? Does the problem of recruiting and retaining physicians reflect a larger problem of neglect, misunderstanding and tension between rural and urban mentalities that is in part manifested in the kinds of medicine and health care practiced? Does the solution lie with wider rural development strategies and significant alteration to the formal health

care delivery system?

Sim examined rural health services and saw that the political structure of health services are primarily preoccupied with curative care - not prevention. Specialization and high technology have contributed to the heavy consolidation of doctors in large and medium size medical centers. "The medical profession has removed itself from the rural community, its services now being concentrated in large towns and cities while some hospitals struggle to keep alive" (1988 123).

The Manitoba landscape is dotted with hospitals; there is one in almost every village and hamlet. The current physician-dominated medical system demands that hospitals require round-the-clock coverage by at least one doctor. The hospitals are often the major source of employment in a town and give a community a sense of identity and pride.

In the Westarc survey, "rural community respondents indicated that health care, providing services to the agricultural community, maintaining community schools, grocery stores, and the post office, were the services which were most important to community survival" (8). In other words, health care is seen as a natural part of daily life and should therefore be available and accessible to all citizens (just like the local repair shop or gas station). Health is an on-going dynamic of life. It is something that people deal with every day, consciously or not. Access to health or medical services is, particularly in a small community, also a part of daily life.[15]

[15]Although I maintain that the real dimension of personal well being lives separate from established service delivery systems, people can think of the presence of their doctor or hospital or clinic as a normal part of day-to-day life, especially in a rural community. Not having access to one removes some power from the individual and from the community and, therefore, damages self-esteem and self-confidence. Furthermore, the reasons for limited access are indicative of much deeper societal problems and intensify the negative feelings people have with restricted access to medical services. Moreover, urbanization forces us to the anonymous and faceless attachment of the doctor-patient contact characteristic of big city hospitals and the fact that we rarely run into our doctor in settings other than his office. In a small community, one is likely to bump into their doctor in the local hardware store. That is what personalizes the rural health care system and changes the formal delivery structure from something that is separate from daily life to something that is as much a part of regular life as is a trip to the grocery store.

The survey found that "the chronic shortage of physicians in rural Manitoba communities was perceived as a major need", and the residents "perceive existing employment potentials in health care services and project that the need for these services are likely to increase in the future" (11, underlining mine). Again, health services are viewed as normal and as a part of the local economy in terms of overall employment gains and losses.

The formal structure of medical care delivery has become an integral part of rural community life in a far more personal and intense way than what is found in urban centers. Sim places the issue of health care in the context of rural life and suggests a way to improve health services drawing on intrinsic rural values and rural power.

The rural community can take matters in its own collective hands by finding ways of improving health services. It can agitate for better training of medical and para-medical personnel for rural work, but above all it can address itself to the issue of health, which is essentially a family and community concern. It can also examine the menus in school cafeterias and take a hard look at school busing. It can investigate the risk of chemical farming to the producers as well as to remote consumers. It can discover the incidence of stress in family life and of the abuse of women and children. In fact, countless local innovations are possible to raise the level of health in the community by humanizing its goals and activities. This path can be followed by making proper use of the people and of the natural resources that are in its boundaries. Much can be accomplished without the beneficence of Treasury Board, and when appropriate, much can be done to persuade the Treasury Board and its political masters to listen (125).

Consistent with this holistic and natural approach to service organization and delivery methods, we must recognize the needs of an increasing population of elderly people,

especially in rural communities. There are more elderly living in rural areas than in urban centers in this province. These people have health-related needs that are not only treatment-oriented. They need services and supports that relate to lifestyle, to income, to housing, to human contact, to changing work responsibilities and accompanying changes in feelings of self-worth and usefulness. Their needs will not be met with admission to an acute care facility, simply because we have no alternative services. This is wasteful monetarily, and is tragically inadequate in terms of our responsibility to our fellow humans. Rural communities need to involve their elderly in developing strategies that will be holistic in considering entire life systems and draw on the spectrum of resources people require to live a meaningful and healthful existence. It is wrong to ignore the reality that seniors have invested their lifetime in their communities and have every right to continue living there, provided they have access to whatever they need to live well. It is wrong to deprive them of essential supports, forcing them to migrate to other centers, casting them aside like read newspapers. The elderly have knowledge and experience to share and must be included in plans concerning health, housing, and social services.

Conclusion of Chapter Two

In this Chapter, the development of the health and medical care system and the rural setting was explored.

The present day reliance on physicians, especially specialized physicians as opposed to general or family practitioners, was shown to have negatively contributed to a health system that is not meeting the needs of rural people (possibly not urbanites either).

We are left with hospital-based care that demands physicians to keep the doors open and an education program that trains young doctors to absolutely need sophisticated

equipment and consultation with other doctors to practice their trade.

Manitoba's rural population is dispersed over a huge expanse of land and almost every cluster of citizens has a medical facility that must be staffed. The staffing includes nurses, orderlies, possibly some technicians, food preparers, administrators and cleaners, to name just a sample. None of those people are legally allowed to practice medicine, even though the kind of medical help that is most often required could usually be handled by the nursing personnel. In short, the whole operation is entirely dependent on the presence of a physician to justify its existence and to keep it open.

In Chapter Three the difference between the medical model of care and a health model is further explained. The primacy of the curative, intrusive medical philosophy and style of practice demands expensive technology that is unnecessary for the everyday health of the nation. A concept of health that promotes well-being through preventive care and improvements to the way people live in terms of living conditions, social support and mental and spiritual fulfillment, does not need the same trappings that the medical model does. It is sensitive to the needs of the people and it invites participation from all people, not just professionals to make it work. It is also sensitive to the landscape in which it is located. Rural Manitoba has different requirements than does urban Manitoba (difference here is not to be equated with inferior).

In Chapter Three I present what some rural Manitobans said and thought about the kind of health care they want and what they expect from their government. It is my contention that they are not practiced with presenting their case so that their observations have been narrowed to a point that is too small to reveal the real targets and causes.

In Chapter Four I explore the abstract concepts of community and oppression and attempt to provide a means of understanding another layer of rural discontent. I suggest some ways of encouraging self-understanding among community members.

CHAPTER THREE

PRESENTATION OF THE DATA: HOW THE PEOPLE SEE THE ISSUES

"The first principle in community organization is to start with the people as they are, and with the community as it is."[16]

Introduction

The primary research component of this thesis is comprised of a number of interviews, conversations and meetings with a variety of people living in rural Manitoba communities. This kind of research is called community research. It requires a commitment to the communities studied in terms of;

- wanting to see how things work from the perspective of the people living there;
- helping them understand what those feelings mean, and;
- helping them form some plan of action to improve their position.

As I noted in Chapter One, this thesis looks at the physician recruitment and retainment problem as a challenge for community planning. Community planning responds to community problems, including those problems that are perceived, and to a community's aspirations or notion of an ideal. According to Gerald Hodge (1986), community planning is an activity. It is a process of identifying the scope and effect of current and anticipated problems and devising solutions that will maximize the community's objectives.

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[16]George Rosen (1954), 'The Community and the Health Officer - A Working Team', American Journal of Public Health,44: 14.

Hodge (1986), refers to community planning as a social activity, that, by its nature, needs human interaction and community involvement in the planning, not just planner involvement. It is a process of decision-making, made up of a diverse company of characters, unlike "business planning and military planning".

As I stated in Chapter One of this thesis, an approach directed at involving the community begins with getting to know how a community functions in terms of its relationship with the formal health care delivery services and specifically, with its physician. This thesis is about finding out what influences a community's feelings towards attracting a doctor to their town and keeping her there for a 'reasonable' length of time. It is about the picture communities present, deliberately or accidentally, to prospective doctors. It is about how community members interact with, relate to, or treat their doctor once he or she has moved in. It is about how physicians fit in to a new place; how they get along with the residents, how happy their personal lives are and how satisfied they are professionally. This thesis is also about understanding some subtle strengths and weaknesses communities have in their abilities to co-operate with neighboring towns, in their adaptability to new circumstances, and in their sense of cohesiveness in common values that allows for community decisions and action.

During the summer of 1989, several communities were visited and community people interviewed. The communities selected have had varying degrees of success in recruitment and retainment in recent years. Some communities have had troubles off and on. Some are generally interesting in the kinds of experiences they have had. Some communities' doctors are paid by salary, and some doctors are paid by fee-for-service. Some communities are simply a mystery in terms of reasons for their success or failure in attracting and keeping doctors.

People interviewed included; hospital board members, municipality, town and village

councillors, physicians, nurses, administrators, a church minister, and people on the street. Successful implementation of the recommended course of action presented at the conclusion of this thesis is dependent on a planner reaching as diverse a circle of residents as possible. The research, the analysis and the suggested future directions encircle the community in terms of its physical presence, its processes and its people. Community is a fundamental point of reference of this thesis.

The intention was to initiate discussion but not to direct it in anyway, so that topics would emerge spontaneously and naturally. The objective of this form of research is to understand the community and its problems from the perspective of the people living there; in their own language and at their own pace; that is, not according to a pre-set schedule of timed questions and expected responses.

At the conclusion of each meeting or discussion, a list of prepared questions (see Appendix Two) were scanned to see if any topic had not been raised by the people themselves. It turned out that all groups raised all of the same items and it was not necessary to ask specific ones, except for clarification. I made no effort to control the tone or the vocabulary of the discussions.

Hours of conversations were recorded. The presence of a tape recorder did not seem to intimidate or hamper the vitality of the discussions at all. Some people I spoke to in stores etc., suggested that if I was going to get anything out of this conversation, "you may as well turn that thing on!" The point is that people were eager to speak out, to be recorded, to be listened to. They have something to say and are willing to say it.

Procedure

The Standing Committee on Medical Manpower (SCOMM), supported this phase of the research, through funding and with encouragement and information. I identified myself

when making contacts, as a graduate student, able to do this kind of research because of SCOMM's funding.

Seven communities were visited. Five of them are located in the Westman region of Manitoba and two are in the Eastman region.

The five communities visited in Western Manitoba were; Russell; Rossburn; Shoal Lake; Hamiota, and; Birtle.

A trip to those communities was arranged by telephone and follow-up letters for the week of August 8-11th, 1989. Meetings with administrators, Board Members and nursing staff were scheduled in each town. The meetings with administrators and hospital related people were held in hospital Board rooms. The meetings were taped.

The administrators were asked to invite any community people whom they thought were interested in the recruitment and retainment problem. In some cases, they attended the meetings while in other towns, community people were contacted and interviewed separately. Interviews and conversations with community people took place in restaurants, stores, offices, on the streets, in private homes and over the telephone. Whenever it was convenient, conversations were taped.

Separate meetings were informally lined up with doctors: informally because the doctors were unable to commit to precise times. The meetings and interviews with doctors were held in conference rooms, offices and clinics. Most interviews were taped.

In Eastern Manitoba the communities of Beausejour and Pine Falls were chosen because they are close to Winnipeg and yet have not experienced continual success with recruiting and retaining physicians.

Beausejour and Pine Falls were visited on August 31, 1989.

I am indebted to the individual administrators for calling the Boards together. Without exception, I was warmly received and offered a great deal of information, insights, perceptions and opinions. All the administrators and hospital staff were extremely helpful in arranging meetings and all participants were generous with their input to this research.

The opening question to all participants after the value of community research was

explained, was; What, if any, is the role of the community in recruiting and retaining physicians? This question was intended to provoke thoughts that would place the community and the participants at the center of the discussion. I wanted to encourage them to think of themselves as valuable players in the overall issue of health care and the recruitment and retainment problem.

As the meetings progressed, I sometimes raised different topics for discussion. Sometimes different topics were initiated by the people themselves. A strict survey or list of questions was not followed.

Community Research

"A knowledge of the community and its people ...is just as important for successful public health work as is a knowledge of epidemiology or medicine."[17]

Community is the common ground that planning and medicine serve and, hence, connects planning with medicine. As stated earlier, the research, the analysis and the suggested future directions of this thesis encircle the community in terms of its physical presence, its processes and its people.

The purpose of this section is to explain the concept of community research. Community research is an appropriate method to the philosophy expressed in this work. I believe that rural communities are oppressed. The first step in their liberation is for the residents to begin analysing their problems. They must name what they see in their own terms. I can only listen to what they say and then help them understand what the implications may be.

The merits of community research can be contrasted with traditional scientific research,

[17] Ibid

and challenge the commonly held belief that only experts are capable of conducting real research, "because the myth that research can only be done by someone with a Ph.D is no more valid than the myth that health care can only be provided by someone with an M.D" (Warren 1989).

Warren points out that traditional scientific researchers tend to feel stronger loyalties to the research itself than to the community they are researching. Their reports are written in language that only other researchers can understand, and appear in professional journals that only other researchers read. Community research requires much more than a working knowledge of research methodologies and traditional techniques based on the scientific model, standard sampling procedures, and so on:

It (community research) requires knowledge about the community as well, and is reflected by:

* *a desire or need to know something about the health of the community;*

* *a sense of accountability to the community;*

* *knowledge about the community - history, culture, environment, health needs and resources;*

* *knowledge of community-based health programs, particularly their development and implementation;*

* *access to the community itself;*

* *the ability to draw on community expertise;*

* *a willingness to place the needs of the community above the dictates of scientific dogma, where necessary, and;*

* *the commitment and capacity to ensure that the information is used to promote community health* (Warren 1989).

Finally, Warren states that effective community research can and should be done by members of the community as well as community health workers in recognition that

"expertise and information resides within the community and not solely within the halls of academe."

The concept of community research has an ecological component that is entirely compatible with the philosophical basis of this thesis as it was explained in Chapter One. Eco-philosophy, described in Chapter Four, sees the interconnected relationships in a setting and demands an appreciation of value-laden principles. Community research can be defined in terms of its potential contribution to community development and places itself in the heart of the community with a commitment over time to positively influence the progress a community can make.

The spirit of ecological inquiry rests on several values.

1) The first asserts that cultural diversity and pluralism (underlining theirs) are valid and defining qualities of community life. When there is more than one example of competence which is recognized and accessible, the community is expected to have more available resources, adapt more easily to external change, and promote more opportunities for the development of individuals and the community at large.

2) The second value favors the adoption of a resource perspective as a defining mindset when engaging in community research. Resources can generally be defined as those skills, qualities, structures or occurrences which can be mobilized in a specific community at a particular time in solving the community's problems or enhancing its development. A resource perspective orients the research staff toward the setting's potential promise rather than its problems, the proactive rather than the reactive, and the adaptive rather than the maladaptive.

3) The third value commits the research staff to the long haul -- to the belief that community research goes beyond the gathering of data in a one-shot hit-and-run operation. It involves the development of a reciprocal relationship with the host community which

builds on and extends beyond the initial gathering of data. Thus, the spirit of ecological inquiry is the spirit of commitment to a place over time. That commitment is concretized in actions which demonstrate that community research, by being responsive and responsible, can be a participating force in community development (Trickett, Kelly and Vincent in Susskind 1985 284).

These value statements lead to the perspective that community research is "an intervention into the ongoing flow of community life and should be approached as such. While community inquiry - like all research - is designed to generate knowledge, it also can serve as a primary vehicle for the development of a setting. By its very nature, it cannot help but have impact on the place where it occurs." (284)

The authors offer ten principles that "embody the spirit of ecological inquiry":

Cycling of Resources

1. Persons, settings, and events are resources for the development of the community and the research relationship.

2. The ecological paradigm advocated the conservation, management, and creation of resources.

3. The activating qualities of persons, settings and events are emphasized.

Adaptation

4. Coping and adaptation are the dominant means of growth and change.

5. The search for systematic events illuminates the process of adaptation.

Interdependence

6. Persons and settings are in dynamic interaction.

Succession

7. Persons, settings, and events are assessed over time.

Research Relationship

8. Community research and the research relationship are designed to be coupled with the host environment.

9. Attending to the side effects of community research is a priority.

10. Ecological inquiry is a flexible, improvisational process" (287).

Community Discussions

What follows is a report on the issues raised during the meetings and interviews: firstly, with the administrators and hospital board members; secondly, with some community residents not on the board, and; thirdly, with physicians.

The quotes presented here were chosen from my transcripts because they are representative of the feelings, emotions, ideas and opinions expressed in all communities visited.

1) The seven meetings with administrators and board members were consistently topical in nature and content in that the same issues were raised with the same degree of importance associated with each. Eight major areas were identified as significantly part of the recruitment and retainment problem and / or connected in some way. They have been categorized into areas for discussion purposes and do not represent any ordering in importance. Those eight issues are;

a) the medical profession's influence, power and place in the system;

b) rural decline and small town rivalries;

c) fee-for-service vs salary;

d) resentment of government and urban paternalism;

e) education, specialization and rural health care;

f) expectations;

g) regionalization and shared services, and;

h) physicians' personal and professional isolation.

ll) The community residents' interviews presented in this section include two long term residents of two different villages, the wife of a physician and the wife of a R.C.M.P. officer.

The senior residents revealed a keen understanding and sensitivity to the 'outsiders' perceptions and lifestyles that, in some ways, are in opposition to to classic rural lifestyles.

The wives are important contributors to this research because the personal environment in which one lives will naturally affect one's professional performance and the decision to stay or leave a place. Also, it is likely that the wives interact with the community on a much more human, everyday level than do their spouses. The wives are separate or distinct from wives of 'home-grown' residents, because of their spouses' occupations and the fact that they are from the outside, but the wives must also contend with the people and the daily activities within the community.

lll) Many of the physicians interviewed come from countries other than Canada. One doctor interviewed is a graduate of the University of Manitoba and one was a University of Manitoba medical student, doing a summer rotation at a rural community health center.

All of the doctors at the community health center see a strong role for the community in health care-related matters. Those physicians appeared to me to be more relaxed than the the doctors in other communities who worked in solo or two doctor practices. The community health center doctors are paid by salary. The other doctors are on a fee-for-service payment schedule. The community health center doctors are on a rotation schedule so that they get regular time off. The fee-for-service doctors are on call most of the time and do not get much time off.

1) Administrators' and Hospital Board Members' Analysis of the Problem

Hospital boards usually consist of the administrator, the director of nursing, the chief of medical staff (a physician), at least one official from the R.M. and one from the town council (such as the Reeve and the Mayor or a R.M. councillor and a town councillor), as well as community representatives (for example, local business persons, farmers, homemakers, teachers). The exact terms of membership, including the length of service, are established by the individual hospitals. Some boards allow for consecutive terms (three years per term, for example), favoring the continuity in involvement. Others opt for non-consecutive terms because the frequent change in membership is thought to result in fresh ideas and input as well as a shared appreciation of the difficulties hospital boards have in executing their responsibilities.

The eight issues listed earlier were raised as being central to the problems communities have in recruiting and retaining physicians. Some participants pointed to one or more as the reason for the doctor shortages, while others made reference to the issue but saw it as a part of something wider.

The language is strong and often emotional, especially in the first section that addresses a perceived overly powerful position of doctors in the delivery of health services.

A) The Medical Profession's Influence, Power and Place in the System

The profession as self-governing:

The most outstanding feature about the people who attended the meetings is their anger. They experience a sensation of being held hostage by strangers and are angry about it..

"We are hostages. The physicians work for the province, for the taxpayer and we can't tell them nothing: where they should go work, where they are most needed. They

are their own worst enemies because if they don't have back up in the rurals then they suffer....They (the doctors) *hold all the power"* ('D' 1).

They are angry that just a few human beings hold enough power over their town that the hospital can close down when the two doctors in town go on holiday, or a new recruit can not be enticed to move and replace the departing one or help ease the work load of the existing doctor. In one town, interested recruits were discouraged from coming by the Chief of Staff who did the screening. "The doctors should contribute to the growth, not prevent it" ('B' 4).

"It's so hard to get physicians that you do almost anything for your physicians" ('E' 3).

The continual loss of doctors is a humiliating and belittling experience that affects community confidence and their individual and community self-esteem. They wonder what is so wrong with them that they stay in a place where no one else wants to go to. They wonder why their community, in which they have invested so much of their lives and energy, is unfit for a group of professionals to work and live in; a group whom they perceive a need for.

They are angry that, although doctors receive an education that is partially subsidized by tax dollars, they refuse to practice where they are needed. Worse, the state sanctions that freedom of choice. The state goes a step further and defends the doctors' right to practice wherever they want. The state offers financial incentives to locate in rural areas but not in a binding contract. The people feel let down by the government and angry at what they describe as 'inside the perimeter highway' politics.

They are angry that the doctors they do have, control the recruitment process by discouraging potential candidates because they do not want to share the billing market. The people have virtually no say in the ways and means of medical care delivery in their own town but they suffer from the resulting underservice.

"We blame the Commission (M.H.S.C.). *They do nothing. SCOMM wonders,*

what can we do? Not with volunteers (i.e the state expecting volunteers to fill gaps in the system left by government cutbacks etc.) *and not without spending money and pilot projects"* ('D' 1).

"Historically, the bottom-line for the Commission and SCOMM and other government agencies is the dollar and they don't really care what you're doing as long as the bottom-line matches what they're prepared to pay for" ('D' 2).

They are angry at a profession that is "self-governing" ('B' 1), and that *"can control the number of doctors. They can do it because we have state medicine, the government is paying for it. It's not as if medical practitioners are going around setting up businesses. They are not. The are plugging into a state medicine.... If they want the benefits of state medicine, and there are benefits, high salaries and you don't have to hire a bookkeeper or chase bad debts. We do have state medicine and they have to live with that"* ('B' 2).

"If a doctor or lawyer does a bad thing on their job, they are disciplined by their own. If I do a bad thing in my job, I am disciplined by the laws of Canada. Where did this all come from and why is this so? Who has put the doctors and lawyers on a pedestal? And determining how many doctors there will be. It's crazy, they've become too powerful" ('A' 3).

"The doctors know they're in demand, even if you are crummy at your work."

"It does something to your ego to be wanted."

"The MMA and the College sets the rules" ('D' 5).

"They (the doctors) *are too greedy to take the necessary steps to get more people. It is a totally mercenary situation... We are captives to the College of Physicians and Surgeons because they control the number of people practicing. And they are guaranteed money by the government. They have no bad debts. They don't ever have to collect bills"* ('B' 3).

The doctors' working relationship with nurses and administrators:

Hospital people complain that the doctors do not take the time to familiarize themselves

with the facility and the personnel. Care is then compromised by a doctor not knowing what equipment is available. Professional relations are strained by the feeling that the doctors are parachuted in and do not care for their co-workers. There is also a problem with poor communication between doctors and staff and administration.

"The doctors won't take the time to talk to us. They just up and quit. They won't even fill out the forms."

The fast turnover also affects the nursing staff: "The nurses have a hard time too because of the constant changes" ('D' 5).

Staff nurses are angry at a medical system that prevents them from delivering health care which they are perfectly well qualified to deliver. Instead they have to sit back and witness physician dominated medicine that is not guaranteeing better care and is a burden to the system in terms of wasting time and financial resources. The nurses were adamant in making their case for expanded roles for para-professional and practitioners and midwives etc. They were very critical of doctors resistance to using them better.

The role of the hospital board:

The position that the hospital boards are in has an impact on the relationship between doctor and community. Boards are often caught in a squeeze between the two because, although the community demands certain things from the medical people and hospital, the Board has to keep the interests of the facility and staff and physicians in mind too. It is often a case of conflicting interests.

"I think we've (the Board) *tended to protect our doctors through the hospital Board from the community when they could have felt the full force of community fury.... If you don't have public confidence in your medical people then everyone suffers. You can soon have half the people in town running off to Yorkton to see a doctor, so your medical community has to work together"* ('B' 5).

"We have a very good Board and the community appreciates it but doesn't understand

how difficult the position is that we're in" ('D' 5).

Deciding to whom the Board should be responsible is a decision each town struggles with. *"The doctors should be responsible to the Board and the Board to the people..."* Commenting on the relationship in another town, one person said, "The (other) Board doesn't really have much power. The doctors have the power" ('A' on 'E' 3).

(The Community Health Center's Board, on the other hand, feel they are very representative of the community and that is part of the Community Health Center concept.)

Summary:

The issue of the medical profession's power emerged as the most dominant one in all discussions with community people, Board members and hospital staff, although it was one that was not specifically mentioned or asked about. Without exception, the perceived arrogance, attitude and power of the profession is the major reason for doctor shortages, maldistribution and high turnover rates. It is also seen as the primary obstacle to recruitment in some places. This issue overlaps with other issues, such as a perceived government inaction and neglect from the decision-makers and is seen in a very personal way. There is a paradoxical feeling of inferiority of living in an undesirable place and an aggressive defensiveness that condemns those who think their communities are undesirable.

B) About Rural Decline and Small Town Rivalries

The people are terribly worried about the general decline of rural communities. Their worries are tied up with infamous inter-community rivalries. *"Every community that starts to see their services disappear one by one feels threatened that eventually they are going to be next. And it happens to the very small communities."*

"Small towns are fighting to stay alive these days. We have an economic development

committee... and one of the things is to sell the community and entice businesses to come in: small business add up and it makes a difference. The more that's there, the more it entices."

"Small towns want to keep their own identities" ('E' 1).

"Other communities feel towards us like we feel towards Winnipeg because we're a growth community" ('B' 6).

"But it's a horrible thing to see your community do that (decline) *and you see your children going."*

"They can't make a living here. We're agriculturally based and it's tough times these days" ('B' 5).

"We need more than a healthy agricultural economy to reverse the decline in rural life. The population is declining" ('A' 6).

"The agricultural base must be stable or the rest of the economy and society won't get anything. The machine dealerships close down and the repair shops close down, the grocery stores don't get their revenue and it keeps on rolling" ('D' 2).

This feeling of vulnerability is aggravated by the rejection felt when they can not entice new doctors; *"This has a bearing on this because if a farmer is having a tough time and some kid comes out of Winnipeg looking like Don Johnson and says he'll come for $150,000 a year and you feel like spanking him. It's not a nice thing to happen to you"* ('B' 5).

Summary:

Health care is not viewed removed from the wider context of life in rural Manitoba: rather it is seen as an interdependent part of the entire society. They see that the weak position their communities are in is somehow connected to the reactions the people have to being rejected by urban professionals (it is a sense of being kicked when you're down). The board members see their hospitals as important centers of community activity but also

recognize that the facility does not and can not function in isolation from the rest of the community and its environment. The people seem to realize that they are sensitive to rejection from outsiders and do not hesitate to personalize the emotions that are aroused. The extra insult is they feel they have to be exceedingly nice and polite and grovel to the outside world in order to keep their communities alive.

C) Fee-For-Service vs Salary?

One group identified money as the issue. The debate over fee-for-service vs salaried concluded that salary is the preferred choice in 6 out of the 7 communities.

"As long as there is fee-for-service there won't be expansion and cooperation."

"It doesn't pay a doctor to do surgery. He can see more patients in his office visits than in the time he can do the surgery. The whole system is out of whack, the priorities are not met by the financial interests" ('B' 2). That group felt that a salaried position would increase the appeal of living and practicing there because "they would know they wouldn't have to run their legs off to make the kind of living they want to make."

However, they pointed out that the doctors currently working there are making far more money on fee-for-service than if they were salaried. *"Two fee-for-service doctors work in this town and can run them through like a calf through a shoot. And they do. They're seeing fifty patients a day. That's unheard of. The medical system is going to collapse under something like that"* ('B' 3).

Only one community group saw it another way: *"I don't think it's* (salaried) *a very efficient system. If there are 23 acute beds and 5 doctors admitting to them, how busy are each of the doctors for the salary going to be"* ('A' 2).

This comment illustrates how people equate medicine with hospital beds. A health care model would put doctors to work in health promotion strategies, home visits etc., not just in an acute care facility. This person's observation supports my earlier suggestion that as

long as there are hospital beds, the medical system will find ways of filling them.

"Salary is no good. One guy works hard and the other slacks off. I've seen it in England" ('A' 2).

In a community health center where the doctors are salaried, the Board members are convinced of the merits of salary vs fee-for-service.

"In order for the CHC concept to work, the physicians have to be on salary, because otherwise they can't be billing for a lot of things they do."

"There's been a big change in the physicians' attitude towards salary too. When we first came on this, there was no way fee-for-service guys would look at us. We were outcasts in recruiting."

"Fee-for-service doctors are out to make as much money as possible. Here our docs transfer patients to social workers or mental health. Fee-for-service doctors lose money when they transfer" ('E' 3).

Summary:

Among those who prefer salaried remuneration, there is a belief that fee-for-service encourages a certain kind of medicine that is treatment-oriented and not geared to health promotion and prevention. In that context, health is seen as separate from life and not as an ongoing, ever-changing part of living. It does not recognize many community factors that contribute to ill-health and well-being and does not recognize the role that other values and institutions play in health, such as education.

D) Resentment of Government and Urban Paternalism

There is resentment towards centralized decision-making. Rural communities feel ignored by the powers-that-be in Winnipeg.

"The people who are providing the service - us - there is no question that decisions are made before we ever hear about them."

"Decisions are made in Winnipeg at the seats of power. The next election will be fought on the perimeter. If that perimeter is not removed there's going to be big trouble in rural Manitoba."

"Life exists within the perimeter... And if it's outside the perimeter, it's frivolous and forget it."

They are angry to be thought of as uncultured and non-professional.

"We're sort of a microcosm of Canada. We feel towards Winnipeg like the west feels towards Ottawa"

"It's a master-slave relationship. We have no income, no independence other than what we get from the government. So we're just an extension of government services" ('B' 5).

"Sometimes decisions are made in Winnipeg that won't work here and that is really frustrating and it's because they don't ask you and don't understand the situation in rural areas and it's top down."

"They can't be looking outside the perimeter."

"For example, obstetrics and heart attacks; we can't have the same standards here and we're willing to have lower standards rather than having the city standards imposed on us. Our people don't want to go to the city to have their babies. And heart attacks, we need to be able to stabilize here."

"We've had medical students see our facilities and be amazed at the services here and the sophistication. And decision-makers look at the map and assign a huge area to a health resource person and they burn out" ('E' 2).

"We are a small political voice" ('A' 5).

This feeling of alienation is echoed throughout the communities. Some expressed an almost hostile attitude to urban people for what they perceive as a refusal to consider a rural

environment as home.

"Why can't the city people come out here and see what it's like here?... Why can't city folks come here? They'll see that life is pretty good here" ('A' 1).

Summary:

Once again, the language is strong and emotional and highly personal - government policy becomes personalized to the people it affects. Urban attitudes towards government are less personalized because it is a faceless, nameless connection. This comparison illustrates the depth of feeling and reflects the oppression rural residents live under. The mood expressed here sounds very much like what we heard regarding the medical practitioners, rural decline and government paternalism. It is this sentiment that underlies all the issues identified in this section.

E) Education, Specialization and Rural Health Care

There is also a feeling that the entire education system is urban biased and that medical education encourages specialization.

"In high school here they're not offered the same sciences in grade twelve that the city kids are, so they go in a year behind."

"I have known rural young men who wanted to go into medicine and didn't make it. It's always been like that. Our kids aren't accepted there. Rural kids don't get the priorities that urban people do. And it's always been that way at the U of M" ('A' 2).

If doctors don't specialize, the attitude can be "what's the matter with you in this family practice, you could have specialized."

"A big problem is the pressure to specialize. And we don't have the equipment out here. So one thing the U of M should do is to train students to practice in rural medicine and be GP's" ('A' 1).

A physician from South Africa added: *"Most of the doctors are trained for specialists. This is a superb opportunity to see a variety of problems. Also in the city it is more curative care but here it is more primary. You've got to concentrate your emphasis on prevention and all that money that's going into coronary by-passes now may not be necessary thirty years from now"* ('A' 4).

"Medicine must face the fact of all the old people in rural communities. Education and medical training must realize the need for more geriatric and general practice" (A).

Rural people have a strong appreciation for the nature of medicine necessary for their environment: *"It doesn't have to be a high-priced doctor advising on the four food groups"* ('E' 3). In the community health center setting, the team approach is fundamental to the whole practice of health and medical care: *"I think it's fantastic to have a team of doctors working for me. Less competitive"* ('E' 3).

"There is too much emphasis on specialization and not enough on family practice. In the country you have to have a wide range of knowledge" ('E' 3).

"They aren't educated in medical and nursing schools about the work here. They should be taught what to expect here, be prepared for the first period of adjustment" ('D' 3).

In one community, real concern was expressed for the loans programs currently in place for medical students and whether the province is getting its money's worth: *"The interest free loans program doesn't work because the kids borrow the cash from the banks and pay it back that way. That shouldn't be acceptable. That isn't the deal! That needs review. It's the tax payers money"* ('D' 2).

Summary:

These people realize that health promotion and maintenance and disease prevention are not dependent on high technology and specialists. What they want is primary care and practitioners who are connected with the social services, can work in a team and who are

available and interested in them. There is no nostalgic yearning for a solo practice, country doctor. The people know better than that and they see the benefits from group primary care.

Medical education and the trend to specialize were recognized as contributors to the problem. Rural medical care requires training in family and general practice and a sensitivity to the special demands and opportunities of rural life and practice. The available equipment and the medical needs in rural communities are primary in nature and not the tertiary care that students are trained in and expect to practice. As a result, the physicians are frightened of being alone and without the back up of high-tech equipment and colleagual support they had in the teaching hospitals. They have not been exposed to the rigors of primary care medicine. They are also not ready for the demands that rural practice makes on their time.

F) Expectations

Questions regarding differing expectations among urban residents and physicians and rural community people and physicians were raised in each meeting. The responses were interesting.

"I wouldn't wait at all for the things urban people do."

"Depends on what you're used to."

"As long as people get about the same as everybody in their circle, or local environment is in the same circumstances, it's ok. But if you think you are the only one subjected to this...."

"We've all been subjected to closures of some kind and we adjust. I think they will at some time tell us that our expectations of having acute care in Birtle and in all the other places is too high an expectation and we won't have acute care here. We have to keep fighting for it and make them believe we're worth it but I really wonder that we're going to

have acute care here."

"We expect some standards and access across the province. A provincial system" ('A' 5).

"In the city you can go to another doctor if you don't like him. In the rurals, he's the only doctor in town so you put up with it. We have lower expectations" ('E' 3).

"Our people expect to get an appointment right away for non-emergencies. We're too dependent. They (expectations) *are too high. They won't wait 30 minutes in emergency for a non-emergency. In a small community the docs will see everyone on the street and will have to face the patients they kept waiting. In the city, they're anonymous"* ('D' 3).

Summary:

In a way, it seems that the presence of an acute care facility validates the community's existence and everyone who lives there. This is another symptom of the oppression they live under because the mere presence of the hospital is held up as a sign of life in the community. Government officials declare the town well-serviced just because there is a hospital.

The entire issue of expectations invites rigorous exploration because it is susceptible to immediate responses that do not always reflect real and honest thinking. There are many aspects of the issue of expectations, ranging from direct physician-community relations, to community-system interactions, and to expectations rural people have compared to those of urbanites and how that relates to putting something back into the community in which we live. In other words; Do we expect to be recipients from some external authority's hand-out or do we expect to have control from inside ourselves and our communities?

G) Regionalization and Shared Services

The subject of regionalization came up at each meeting. All participants had thought about it before and all had strong opinions about it. They also spoke of specialty centers and said they had considered that possibility, even to the point of requesting funds from M.H.S.C. and the provincial department.

"We did talk to the Ministry about the possibility of having specialized centers, for e.g., alcoholism treatment, and the staff would be more geared to chemical withdrawl or whatever. It was the Minister of Health that nixed it, saying the existing centers at HSC and others in the city would handle them instead of people getting treatment in their own areas. People must go to HSC etc. because those places are (supposed to have) *100% occupancy"* ('A' 5).

"So rather than reduce the beds there, the rural people are supposed to travel."

"Yes, for things that they consider to be specialities like chemical dependencies."

"Being in your environment is very important to recovery."

Summary:

Most, if not all participants, realized the threat to small communities regionalization poses and the dilemma of deciding which town will have a closure. They see that if one town is to be the regional center, another town will lose their hospital, at least for acute services.

"That's when you'll see real competition, a fight for facilities" ('E' 2).

"Small towns want their own but maybe they can't always get it" ('A' 5).

The possibility of sharing services with neighboring communities is appealing to rural residents. However, they fear that a plan to regionalize will be imposed on them by Winnipeg politicians with little consideration for their needs or opportunity for their input.

H) Physicians' Personal and Professional Isolation

Administrators and board members were sensitive to the negative aspects of rural, especially solo, practice on both the personal and the professional sides of life.

Partly because of the kind of education University of Manitoba medical students receive, and because of the non-holistic approach to medicine that pervades this system, graduates are not prepared for the special demands and circumstances of rural practice if they do decide to locate in a small community.

Professionally, they feel alone and are afraid without the technical and colleagual support they grew accustomed to in the teaching hospitals. For example, if they are not presented with enough chances to perform a delivery assist, they lose their skills and the fear deepens.

"I feel that so many of them are trained to depend on technologies that are not readily accessible in rural areas, that they feel lost not having the expertise, not having someone to verify. There is nobody to talk with, no peer support" ('B' 1).

"Rural doctors tend to be on call 24 hours a day, seven days a week. And because they are members of a relatively small community, they are expected to be available" ('B' 2).

Personally, the doctors' private lives are open for small town scrutiny. They are high profile and so are their families. There is a tendency for people to hold their doctors in awe and, therefore, many will not socialize with the physicians or their families. Those who do socialize with them are often the subject of ridicule to other townspeople for being 'uppity', and 'who do they think they are, socializing with the doctor.'

Unhappy wives and the needs of children are cited as common reasons for physicians leaving. Again, in some meetings, there was resentment expressed toward physicians' families: at the wives for not being perfectly adept at fitting in, whether or not that is a realistic expectation, and at the families for not being completely satisfied with facilities for their children - "if it's good enough for our kids, it's good enough for theirs."

Summary:

Doctors and other urban professionals have a place in society that is different from hardware store owners, restauranteurs or farmers. It is a subtle caste system that elevates some and submerges others. It is based on the amount of education required, income, the professional association's rules, regulations and power, and because of some vague assignment of status and lifestyle trappings that ostracizes some occupations from some others. Assumptions are then made about the likes and dislikes of individuals in everything from choices in a new car, to choices in a new mate and childrens' names.

Physicians have been particularly segregated in this occupational societal process. Sadly, this has contributed to the expropriation of health from the normal, human level in which it belongs to an inaccessible strata.

ll) Community Residents' Analysis of the Problem

In this section, the observations of four community residents are presented. These are;

1) a man who had been on the original Board of the village's community health center;
2) in another town, the Mayor and owner of the local hardware store;
3) the wife of a physician, and;
4) the wife of a R.C.M.P. officer.

The first two people succinctly articulated some fundamental facets of our medical and health care system, the crisis in the countryside and the nature of provincial decision-making. The next two gave personal testimony of their experiences as high profile newcomers and how the townspeople's perceptions affected their settling in experiences.

1) The opening question to the elderly gentleman who had been involved in the

establishment of the community health center, was; Do you think communities have a role to play in health care and in recruiting and retaining physicians?

He replied, *"Yes, the community has to involve itself. They have to develop the system. But it's hard for people to accept different ways of doing things. You have to have what works in your own community, but you can learn from other's experiences. For example, community health centers are all based on the same principles but they develop individually."*

He thought the education doctors receive sets them up for an environment not found in rural settings: *"Their training emphasizes access to peer support and certain facilities but it's a different medical world here. Doctors can't function on their own these days."*

The problem with over specializing in health care is that it leads to self-diagnosing. The person must decide which kind of doctor to see depending on what they think their problem is. He thought that this is what medical care is like in urban centers. There is also a moral decision for society to make regarding spending money on specialist surgery or on research and prevention etc..

He pointed to the advantages of the community health center system over regular hospital and clinic systems. He noted that the entry point to the health care system with community health centers is wide open: *"Here you are in at any point. In other communities, for example Winnipeg, it is segregated and you must find the services you need."*

Another advantage of community health centers is the payment method. Salaried positions at the community health center have meant better care and a more caring type of practice, he thought.

Regarding small town rivalries and government decision-making, he referred to what he calls "turf protection". By that he meant a tendency for groups, associations or organizations to do things that serve their interests. They may not be the wisest choices and they may not serve societal interests, but the group will jealously protect what they see as their territory. He applied 'turf protection' to a town's identity and how each place

wants their own services etc.. *"At some point you have to give up something. For example, Hamiota is too small to do it on its own."*

Turf protection also applied to government decision-making. Ministerial departments suffer from 'turf protection' tendencies. It affects their ability to work for the people. Instead they work for themselves. It also shows in the way government limits itself to 'inside the perimeter' in its thinking and decision-making.

Finally, he spoke of rural economic development to combat economic decline. Development needs smaller units and numbers to fit the needs of the people. It also needs real involvement by the people and not the patronizing lip service they currently receive. He said "don't tell people what they want - ask them!"

2) I asked the Mayor of a small village about the nature of the problem that his and other small towns have in recruiting and retaining physicians. His thoughts were well organized, as if he had considered this issue many times. He identified six main issues.

a) *If I had a professional degree and my wife did too and wanted to work, it is very hard in a small community to place two professionals. One or the other and the other is languishing in her kitchen.*

b) *If I was in a life and death situation, I would want back-up. It must be very difficult to work in that situation. Not just financial but also moral.*

c) *24 hours a day 7 days a week. I would be tired of hearing people's problems in social scenes. Small towns, they know everybody. I blame the people - how many of us take the time to invite the newcomer over. If the doc makes one little mistake, every one talks about him. And it's usually bad talk, not praise.*

d) *The doctor's family is changing. People think differently, a greater recognition that to make the bread earner happy, we have to make the other welcome and happy. She must be able to call on neighbor's help to watch her kids for a minute. That's the community's role. The doctor's wife is an isolated person, and the town watches her. Like the*

R.C.M.P. and families.

e) *Housing. Where will they live? What are the standards? It's a big thing. Not castles but good housing.*

f) *I blame the medical society for this; in many ways the doc is a businessman like I am. When I came here* (he is the owner of a hardware store), *I borrowed to set up. Medical equipment is expensive but they should teach the business aspect as well as the fancy million dollar equipment that they are not likely to use. I bet doctors can't use the real small x-ray machines in their offices anymore. Let's train them for general practice more. I know the specialists make more money but we need GP's too so you might have to consult with students and teach more business. The teaching is getting ahead of itself, it isn't appropriate to the situation here. Over qualified for the situation, in a way.*

Politically, to achieve all this professional achievement and advancement for their children and themselves, the politicians can't assist every little village. We can't have highly equipped hospitals in every village. Centralize with Birtle, Shoal Lake and Hamiota; maybe we can get enough people for one good hospital.

He said that as long as the situation continues as it is, everyone suffers: *"A sick person here has to go to Winnipeg. But if there was a center closer, she could go there. Politicians have to bite the bullet and quit being politicians and say okay, it's time. We can't support all the towns but we would end up with better sports facilities, recreational facilities for our kids. We have nothing now.*

Again, these observations capture the significant aspects of the problem. He shows the need to look at the issues at a human scale. His expectations are realistic and he recognizes, without judging, changing ways of living and basic human needs and fears.

3) I spoke to the wife of a physician. She is a highly trained professional, unable to find a good job in the community she lives. She sees the lack of decent housing as a real problem; not knowing if there is a house available makes the prospect of moving that much more unappealing.

She also said that although the townspeople think they are welcoming the wife to the town, they really do not do anything to make her feel at home. *"Everyone knew who I was but no one went out of their way to approach me."*

She thinks some doctors encourage and promote the lofty image physicians traditionally have had and that image hurts people like her and her husband who do not consider themselves to be above the crowd. *"Lots of people think the doctor is different, in another class....At least with us they see we're different."*

The customs of rural society are very different from urban ones and she found that adjustments must be made to accept them. For example, invitations were extended that she, as an urbanite, simply could not understand: "Come out to the farm sometime.; or "Drop in anytime." As a city person, she was unaccustomed to the casualness of the invitation and was used to established times set and an idea of what would happen once she got there (Come for dinner, or come for the afternoon).

4) The R.C.M.P. officer's wife found a similar gap in the rural-urban customs. She thought the townspeople could be a little more empathetic with the spot she and her children were in, every time her husband was posted to a new community. She is alone a lot and knows no one at first. Her children are friendless newcomers, and she is lonely and bored. She does not know what resources are available to her and is not drawn into the community circle. The onus is always on her and that is a lot to expect from anyone.

The message from both women is consistent. These women live in different towns and are in different socio-economic situations. Their stories are virtually the same.

The hospital board in the town where the physician's wife lives said they "roll out the red carpet" to the physicians' families and yet, the woman specifically complained that she felt ignored. The one visit from a board member with a pie in hand, did not a welcome make.

The wife of the R.C.M.P. officer felt ostracized from the community because of her husband's job. So did the physician's wife. They both felt different from other community people because of customs, values and ways of life.

lll) Physicians' Analysis of the Problem

Except for the physicians in Hamiota, none of the doctors interviewed prefer or support salary over fee-for-service. One physician said he would leave the town he was in if the Board went to salary. He said this because he is at the time of his life when he should be making money. Another doctor prefers fee-for-service because he thinks it provides an incentive and he can watch his practice grow.

On the other hand, one doctor said; *"The question has to be asked; is that a good system of seeing patients? A system where you are dependent on a certain number of patients, where you can generate a follow-up which may or may not be necessary. With salary, you can see a patient based on their need, whether or not they need to come back. We look after the same number of patients per physician that fee-for-service doctors do but when you look at the number of patients that come into our office, that number is smaller. But we still maintain health for the same total patient population so our argument is that we do the same amount of work, probably with less office visits but we do it in different ways."*

I asked; How do you do it?

"Dealing with a number of the public health aspects, making use of ancillary services and making proper use of them, using nurse practitioners, public health nurses, home care... We're willing to cooperate with them and work as a group, not as adversaries."

Doctors who are on fee-for-service complain about the frustration of getting calls during off hours for non-emergencies. Salaried doctors did not find this to be a problem, in part because they work in a group practice and have set time off with rotation on

weekends.

Many of the doctors practicing in Western Manitoba are from South Africa. The doctors I spoke with made some interesting observations about their educational experience being more directed to general and rural practice than Canadian schools. All of them cited housing as a problem for incoming doctors and their families. They complained that the move is difficult enough without not knowing whether there is a house waiting for them when they arrive.

They also consistently noted the reception from the community was not overly welcoming. Part of it is the different ways of rural life that city people do not understand: casual invitations to visit a farm or just drop in any time, are not commonly extended in urban environments.

One South African physician likes small town medicine very much although he does miss professional support. He also complained about not having back up so that he and his wife could get away for vacations, weekends and conferences. He works fee-for-service and is adamant that although he is on call most nights and weekends, he does not need a third doctor to share the patient load with. When he is able to go to a conference, he makes no income while away but the office expenses continue. He would like to see a locum pool and the government pay office expenses while he is away. He called for a system that guaranteed time off.

The community health center in Hamiota represents a different way of delivering care. Doctors are paid a salary and see a much stronger role for the community in health care and in recruiting and retaining physicians, than do fee-for-service doctors.

"The communities need to be involved; it can't be left up to the medical profession. The whole community needs to become organized in conjunction with the medical profession to try and attract." To do that, the community should learn to point out its positive aspects.

They felt that the community can and should help the physicians settle in and feel welcome and can see how different life must be to outsiders settling in a small community.

A medical student working in Hamiota for the summer thought that his urban classmates are *"not wanting to to do even a rotation in the country or outside the city at all. They feel they won't enjoy themselves in the country, they've grown up in the city and are used to the amenities and their leisure time to go to night clubs etc.."*

The fact that only a small number of all applicants to the University of Manitoba medical school are from rural Manitoba came up at the meeting with the Hamiota doctors. One physician, originally from rural Manitoba said; *"There's going to be a lot of pressure to do that* (encourage rural applicants through changes in admissions procedures) *from the 40% of the population that live in rural Manitoba. They're paying taxes to put people through medical school and with a fair representation of rural people in cabinet right now, there's going to be a lot of pressure to do that very thing, and I'm sure they can do that."*

As suggested earlier, physicians are in the unenviable position of being excluded from the natural flow of community life, especially if they are newcomers and if they had to be cajoled into locating in a rural community. They are trained to practice treatment-oriented medicine in a physician-dominated system. Rural practice and rural living calls for different approaches that doctors are not prepared for.

Conclusion

The impression received in the towns in Western Manitoba is that life is lived very close to the edge; close to the land. It has to do with the fragility of the agriculturally based economy and a sense that everyone is peering up at the sky all the time, waiting for something to happen that will determine their future. There is an immediacy and an urgency in the people's perceptions of the future but there is also a sense of continuity and intergenerational permanency. It is as if they innately think in terms of seasons following

seasons in a constant and natural order of life, but this constancy is threatened by some pressure. The source of the pressure is what interests me. I hope this research finds it.

The general impression received in Eastern Manitoba was different from that in the western communities. For one thing, the communities are very close to Winnipeg: everyone refers to 'escaping' to Winnipeg for 'sanity breaks'. In the western towns, such an act or inkling seemed to be viewed as disloyal or cowardly.

Pine Falls and Beausejour residents appear to have a more urban attitude. The people were not as personally offended by physicians' reticence to move there. The Westman people seemed insular in their thinking and far more angry and resentful.

One reason for the difference may be that the agriculturally based economy in Western Manitoba creates a more tenuous and vulnerable existence than the more diverse economy of Eastern Manitoba. Beausejour, for instance, has a stable economy and is closely linked to Winnipeg; almost a satellite community. It is only about a 45 minute drive from Winnipeg and it is not uncommon for residents to drive in for an evening or to shop. Yet they too have had problems recruiting and retaining doctors although, at this time they are well covered.

Pine Falls is a single resource community, dependent on the Abitibi-Price pulp and paper mill, but established nonetheless. There too, participants in the meeting spoke of going into Winnipeg for entertainment and services. Both towns, unlike the Western towns, are not fighting for their communities' very survival. The people do, however, show the signs of insecurity and inferiority that mark the rural dilemma and distinguish a rural mentality from an urban one. Size, declining population, an increasing senior population, the family farm in jeopardy, economic slowdown and problems recruiting and retaining physicians, are all characteristics shared by rural communities throughout the Canadian prairies. Each characteristic relates strongly to another. In Chapter Four, the notion of community as a setting and as a place to initiate action and change is explored and provides us with a link that connects these characteristics.

This Chapter presented the views of the people.

In all communities visited, both the analysis of the problem and the solutions came very early on in the discussion. Many issues were raised and the analysis of the problem was very similar in each community. The following is a summary of those issues.

1) The central issue was that doctors have too much power over the small communities and the doctors will have to be controlled. The power behind the doctors was identified as a self-governing profession, protected and maintained by government policy that disregards the needs of the people and bows to pressures from the profession.

2) Doctors resist working in teams. They insist on doing everything themselves to the detriment of the patient and to the expense of the system in duplication of services. They do not refer patients to social services provided through the provincial health department or to other social services. The people suggested that it was because doctors want to do all the billing and not surrender their client base. They accuse doctors on fee-for-service of being "too greedy" to accept another doctor, even though the doctors complain of too heavy a workload and the people feel that they are not well served.

3) Doctors are not seen as wanting to 'fit in' or 'belong' to the community, and the community then feels exploited and used by the doctors. This is a personal and intimate level of emotion. The collective or community level of emotion is that this is their town and their facility and they want to protect and maintain it, not leave it to the whims of outsiders.

4) Primary care, perhaps in a community health center, is seen as an appropriate form of health care for the rural setting; not the tertiary, high technology sort our doctors are trained to practice. Provincial and public health resources, team work, community

involvement in decision-making and combined services with other towns are all preferred directions. Community people want a doctor with a "wide range of knowledge", and question the suitability of fee-for-service payment schedules that encourge a capitalistic, free enterprise style of practice, with incomes practically guaranteed by the state.

5) There is an urgent need for rural economic development schemes to revive declining rural communities. Many people want to see more small scale, locally controlled businesses. They see the need to reduce the dependency on government hand-outs and top-down decision-making. They believe that they have a right to be involved in decisions that affect their communities economically.

6) Health care and facilities are tied closely with other aspects of rural life. Community people think their communities have a role in the recruiting and retaining process. They believe they have a right and a responsibility to make decisions regarding their own health care.

Community research is best done in a long-term relationship between the people and the researcher. In this particular case, the level of anger and resentment was so high that opinions and feelings were easily expressed. The people had thought about the problem for a long time. It cut close to their lives and was not something they suddenly turned their attention to because I was there asking them about it. However, the situation begs for a community worker to commit herself to develop a long-term relationship with communites in a community research context. In that way, further analysis of the problem could be accomplished with the impetus coming from the people themselves. There would also be the opportunity for action strategies to be formulated, with the community worker acting as a helper, a facilitator and a guide for the community.

This research, then, can be seen as just a beginning; making an initial contact that adopts a positive attitude with the people. Their viewpoints are respected. The researcher

assumes that a solution does exist; or certainly the seed of a new process for change exists with the will to progress.

CHAPTER FOUR

PLANNING, COMMUNITY, MEDICINE AND HEALTH

Introduction

In this Chapter, I try to clarify the relationship between health and community by explaining a concept of health that distinguishes it from medicine and opens it up to the holistic influences of community well-being upon the individual and vice versa. Health takes place in a community setting because we are social creatures and the quality of our social relationships has an impact on our individual and community health and well-being. Rural society is different from urban society in its intensity of experience and its closeness to the land. It is different because community is obvious in rural culture: that too will become clearer in this Chapter. The distinction between medicine and health is more appparent in a rural setting and hence, the inappropriateness of a medical model in a rural context is transparently visible.

In Chapter Two, the problem with our medical system and the rural setting was briefly explored to show how a system with a heavy infrastructure of hospitals that requires physicians, is in conflict with the social, physical and economic environment of the rural community. In Chapter Three, the residents' anger, resentment, insecurity and feelings of inferiority, were revealed; they signify oppression and a divided community.

From my perspective, a distinct image is beginning to show as the contours of the

problem take shape. I can see a medical care system that has based itself on fallacious assumptions and inappropriate principles that see the human form as a fixable set of parts. These assumptions and principles have removed the very intimate and personal aspect from health, and placed it in an untouchable, unreachable corner. The medical model separates the body from the mind, spirit and social environment. It does not connect people with their surroundings in a relaxed, natural way. I think that individuals and communities can instinctively think of health as an integral part of daily living. It is human nature.

Yet, rural residents too, have abandoned the natural and independent self-healing and community action that marked the spirit of our prairie ancestors. Rural residents too have grown dependent on physicians, on hospitals, on equipment, and on government decision-making, instead of relying on shared values and community conflict resolution. In a way, the entrepreneurial, risk-taking spirit that was so vibrant at one time in both urban and rural development, seems to be what is lost in communities. That spirit requires a faith and confidence in one's self and in one's community. This faith seems to be at a low ebb today.

The data presented in Chapter Three revealed clear differences between urban and rural mentalities, attitudes and feelings as perceived by the rural people interviewed. In this Chapter, I attempt to understand what ails rural communities by considering what constitutes true community. It seems to me that contemporary rural Manitoba is weakened and is in tension with urban culture. Understanding the effect of that tension on the power of community will give me something to work with, something to strengthen.

In the summer of 1989, I visited a number of rural communities to talk with some residents about community involvement in health and in the recruitment and retainment problem. When I returned from my forays into the rurals, I was not quite sure what I was hearing from the people. That is, I knew I was hearing anger and hostility but I could not

figure out where it came from. I ventured out from this urban enclave that I think I am familiar with, not knowing what to expect from my rural experiences. I did not go to confirm some preconceived theory or picture. I came back a changed person. The depth of commitment to the land impressed me very much. The passion with which the people spoke, moved me. I drove back to the city wondering if I would ever understand the rural way of life and the source of their frustration, their commitment and their passion. The books outlined in this Chapter are ones I read after my trips to the rurals. They helped me to understand what is present in rural values and what is missing. I began to understand the anger I had seen.

There are reasons for community anger and resentment and the reasons originate in the reality of their situation. The reasons have to do with being oppressed by the paternalistic method of governing in this province; with the power doctors can wield over small towns and hospitals, and; by an economic system that strains the rural way of life.

Writers Consulted

The writers referred to in this section are from a range of disciplines and backgrounds. They believe in an integral strength of human beings and that people can be trusted to do what is best once they assume the responsibility. They reject an objective, scientific and prescriptive approach to understanding human conditions that I think is behind the medical model. Instead, they embrace a subjective, humanistic and normative philosophy that is consistent with my sense of health and community development. Finally, they offer a real direction that will start a process of reconstruction of community and perspective. This is why I chose to include them in this work.

The writers I refer to in this section are;

1) Robert Bellah et al;

2) R. Alex Sim;

3) Scott Peck;

4) Leonard Duhl;

5) Paulo Freire, and, later in this Chapter;

6) Henryk Skolimowski.

1) Robert Bellah and his co-writers, explore the moral values and traditions of American society and their connections with politics and community strength. They point to the American admiration for individualism as a hindrance to political and community commitment and seek to find individuality and freedom expressed in alternative forms of social and political organization.

In their book, Habits of the Heart: Individualism and Commitment in American Life (1985), the authors (mostly with sociology backgrounds), explain their attitude regarding specialization and professionalization.

"Let us consider how such a social science (one that is in part a public philosophy with an implication of social responsibility; a vocation) differs from much current work. It is of the nature of a narrowly professional social science that it is specialized and that each specialized discipline disavows knowledge of the whole or any part of the whole that lies beyond its strictly defined domain. It is the governing ideal of much specialized social science to abstract out single variables and, on the natural science model, try to figure out what their effects would be if everything else were held constant. Yet in the social world, single variables are seldom independent enough to be consistently predictive. It is only in the context of society as a whole, with its possibilities, its limitations, and its aspirations, that particular variables can be understood. Narrowly professional social science, particularly in its most reductionist form, may indeed deny that there is any whole. It may

push a radical nominalism to the point of seeing society as a heap of disparate individuals and groups lacking either a common culture or a coherent social organization. A philosophical social science involves not only a different focus of attention but a different understanding of society, one grounded, as we will see, in commitments to substantive traditions....For knowledge of society as a whole involves not merely the acqusition of useful insights from neighbouring disciplines but transcending disciplinary boundaries altogether" (300).

The research for their book is, like the research for this thesis, community-based, or to use their term, public. "Social science as public philosophy is public not just in the sense that its findings are publicly available or useful to some group or institution outside the scholarly world. It is public in that it seeks to engage the public in dialogue. It also seeks to engage the 'community of the competent', the specialists and the experts, in dialogue, but it does not seek to stay in the boundaries of the specialist community while studying the rest of society from outside" (303). For this philosophy and for their attitude toward the limits of specialization, they are included in this thesis.

Finally, the authors' philosophy of community is worth quoting: "Our experience together has confirmed for us one of the central arguments of our book, that the individual and society are not in a zero-sum situation; that a strong group that respects individual differences will strengthen autonomy as well as solidarity; that it is not in groups but in isolation that people are most apt to be homogenized" (307, emphasis mine).

2) R. Alex Sim is a sociologist, an activist, a farmer and a community development worker. He writes from personal observations and experiences about the "crisis in the countryside". He writes about the deterioration of rural values brought on by technological changes that erode the economic base of farmers, affect social conditions and alter political and social responsibility. His language reflects the compassion he feels for the countryside

and the deterioration he has witnessed. As he says, "the language (of his writings) is subjective, intuitive, selective and impressionistic"(1988 2). His knowledge is based on his experiences. He is included in this thesis because I like his writing style and because he writes perceptively from experience.

The other reason he is included here, is that he has a vision of a new rural society and a firm belief in its achievability. He urges local communities "to assert their independence and fight for more autonomy" (181). He sees it as a fight for freedom. "The denial of freedom is destructive, the root of our social malaise. What we must struggle for is freedom to participate. A denial of the right to participate, by whatever means, is a denial of the life-enforcing energy essential to a coherent society. If a citizen is cut off from access to power, the whole social organism becomes weak and ineffective" (181).

Sim wants the community, as a unit of society, to be "regenerated, reformed, reconstructed" and assures us that "the whole process will be a learning experience" (181).

3) Scott Peck is a Christian and a psychiatrist and has conducted several workshops on community building. His language is of a self-described "spiritual healer", and he strives to apply theory to practice in community-making as a means to global salvation.

Peck writes: *"I must write therefore, out of the particularity of my culture as a citizen of the United States and my faith as a Christian. Should some take offense at this, I ask them to remember that it is their responsibility to embrace my particularity, my uniqueness, just as it is my responsibility to embrace theirs. And that community, which includes all faiths and all cultures without obliterating them, is the cure for 'the core of our greatest contemporary trouble'"* (1987 20).

4) Leonard Duhl is a M.D. and an urban planner. He has written extensively about the Healthy Communities movement and is one of the early articulators of the concept. His

book, Health Planning and Social Change (1986), addresses the theoretical concepts of health compared to the medical model and shows the necessity for a truly holistic perspective of social processes and their relationship to individual and community well-being. He too, sees that power must be vested in the community, and must be recognized as such and acted upon in order for the value of participatory democracy to be realized and the benefits accrued to the community itself. I like his views on changing methods of governance because they would place power and confidence in the hands of the people.

5) Paulo Freire is an exiled Brazilian educator, who believes that all people are capable of learning to read and write through a dialectical process of naming objects through ideas, rather than forcing unfamiliar words that have little to do with one's environment. As the process unfolds, the person is changed from a passive entity to an awakened being. He becomes able to involve himself in overcoming his oppression and even freeing his oppressors. Conformity and unquestioning subservience and "fear of freedom" bind the oppressed of any society in a "culture of silence". Through "critical consciousness", the culture of silence is broken - that is the reawakening of the being, and the liberation of the oppressed and their oppressors is underway. The oppressed see a new reality by recognizing their own reality. Freire's ideas helped me to see that rural society is oppressed and the road to liberation must begin with the people analysing their situation themselves and owning the transformation process from the beginning.

Medicine and Health: an Important Distinction

The specific area of study of this thesis is related to the realm of our formal medical and health care system as it pertains to the problem of recruiting and retaining physicians in rural communities. However, the field of study involves many wider issues. Some are

matters directly related to the health and medical delivery systems and philosophies. It is important to clarify the distinction in meaning between medicine and health, because the distinction has implications for my framework of analysis.

Medicine is specific knowledge, acquired and applied in an organized fashion by an organized body of practitioners. For the purposes of this thesis, the field of medicine includes the facilities that train, educate, and provide support services for the practitioners. It also includes the private practices carried out in clinics and offices throughout the province, the dispensing of medications, the lab tests, and the sophisticated technology used in diagnostic and curative procedures. Medical practitioners are charged with curing sick people, but, with some exceptions, they are neither trained, instructed, nor expected, to practice the promotion of health nor community health.

The political structure of rural and urban health services is primarily preoccupied with curative care. Medical care has not taken a holistic approach to health and delivery systems. Disease prevention and health promotion have not occupied center stage in education programs for medical practitioners, resource allocation relevant to delivery systems, or to consumers' expectations from the medical care and consumers' responsibility for their own health.

Provincial efforts to standardize medical procedures throughout the province, regardless of local conditions, is dangerous to rural communities because the values imposed are urban values and "have difficulty in serving the variety of interest and needs of its scattered and diverse membership, especially those of rural or minority status.

Wherever power is vested at higher, more distant, increasingly urbanized centers of control, we can expect to find inappropriate programs directed to quiescent and often

frustrated local membership and leadership. Thus, *the alienation that prevails throughout modern life is felt sharply by those who are separated from urban centers where the ethos of power is expressed in program ideas that ignore ethnic, language, social class and cultural differences*" (Sim 1988 107, emphasis mine).

This is all part of the inappropriateness of the medical system to the rural setting. The two sides have different values. On the medical side is an urban value system that is characterized by anonymous human relationships, distance from the land, specialization and professionalization. Decisions that are made in the urban context for the rural context are misplaced and incorrect because they do not include considerations of rural values. On the rural side are values characterized by face-to-face contact among residents, a closeness to the land, generalized skills and adaptable applications of skills to tasks.

Urban values are reflected in the medical model. Specialization and high technology serve to concentrate doctors in medical centers, usually located in urban areas. This is why it is important to recognize the different value systems in rural versus urban life, and medical versus holistic models of health care. The recruitment and retainment problem for rural communities is connected to the different values and the two sides are in conflict with each other.

My concept of health reflects the broader perspective of rural values.

Health is a much wider concept than medicine and much harder to define. Health is a relative thing: it changes in time and in place according to one's cultural, and social milieu. It is relative to one's age, geographical location, and place in history. Good health depends on many factors and is influenced by many internal and external forces. Our mental state of health will strongly influence our perceptions of our physical health and overall condition of well-being. Health is not static; it is dynamic. Health is in part, determined by social relationships, because we are social beings living in a world occupied by other human

beings. "Health is embedded in a social context because people live in a social context" (Duhl 1986 141). Health, therefore, must be viewed in its social context because it is a function, a result, and a contributor to the quality of the environment - social and physical - and those environments affect and influence health. Human life and all other systems on the planet influence one another and must be seen in this interdependent contract.

Duhl suggests a "vision of the interconnectedness of systems", and to understand this, we need to differentiate between the medical model of change and a new health model of change: "medical care focuses on a defined and limited set of difficulties, symptoms or illnesses that require prevention, treatment, rehabilitation, maintenance, or some combination of these. Health, on the other hand, encompasses the normal processes of growth, development and decline. It is made up of interdependent biological, psychological, social and spiritual foci in human development" (1986 35).

Two factors of the social environment (and its impact on health) are "the effects of community politics and participation....The ways in which social settings foster or frustrate self esteem and confidence" (Duhl 1986 141). Included in community politics and participation, are the processes of health and social development. The levels of involvement by community people in decisions regarding health and social programs reflect the depth of political openness. It reflects the level of democratic vitality in a community. The more active the people are in the democratic process, the healthier the individuals can be because they feel their influence and they do not feel as powerless. The community is made healthier and stronger from the involvement.

People can not be coerced into doing something they do not want to do, or at least they *should* not be coerced in a democratic society. If people feel cut off or alienated from the decision-making processes that affect their lives, resentments build and contribute to a

resistence to the processes themselves. On the other hand, if people are involved in the processes, they are more likely to want to participate in change. Planning *for* people, especially in a matter as personal and unavoidable as health care, can not be ultimately successful. Planning *with* people gives them an honest sense of ownership; it also gives a truer picture of the issues, if the issues are revealed by the people themselves and the solutions are proposed by the people themselves. The expropriation of health by a system that does not involve its constituents, is running counter-productively to its purposes. The objective of this research and the final recommendations that arise from that research is to involve the people in all phases.

Health, then, is in a relationship with democractic processes and community. The next section looks at the meaning of community by reviewing several writers' perspectives of community. The languge changes from one to another and the message is slightly different in each interpretation, but a common theme courses through each one. The theme is that there is such a thing as *community,* and that it can be strengthened or weakened. The writers present different ideas as to the processes for building or strengthening community.

Understanding Community

In Habits of the Heart (1985), Robert Bellah et al, define community as "a group of people who are socially interdependent, who participate together in discussion and decision-making, and who share certain *practices* that both define the community and are nurtured by it. Such a community is not quickly formed. It almost always has a history and so is also a *community of memory* (italics his), defined in part by its past and its memory of its past" (333). Neighborhoods in America have, at times, been communities, but in "our restless and mobile society", community is hard to sustain. "Where history and hope are forgotten and community means only the gathering of the similar, community

degenerates into lifestyle enclave" (154).

Bellah's notions of history and memory comprising true community suggest the idea of community depth and spirit and a sense of always rebuilding. History and memory give a community soul: something that can exist throughout time and can flourish or wither depending on the nurturing it receives.

R. Alex Sim's interpretation of community is based on his intimate understanding of rural communities and rural values.

Community is both a place and a cluster of interests and relationships. Where people live in the same area but do not come together, there is no community. Likewise, a common interest, like a breed association, may provide people who seldom meet with a kind of association, but not with community. Community, therefore must have a spatial component: it must be somewhere; it also needs a tradition, a sense of belonging, a sheaf of common interests that binds people together. In modern times, community is both enriched and threatened by the influx of populations, and the influx of values, the absorption of values, styles and traits from outside. I emphasize the threat to community, the wider range of mobility provided by, among other influences, the automobile, and the incursion of the media into our homes, indeed into our brains. These have weakened bonds that are fused in face-to-face contact, resulting in change and stress to the family and community. Stress does not necessarily constitute a threat because the human capacity for adaptation is impressive. That is why the new rural community has so much promise (Sim 1988 61).

Sim refers to the importance of "group participation to personal growth and strengthening the democratic fabric of our country" but also sees the paradox of autonomy and social contact; "personal autonomy can be enhanced in groups or it can be diminished"

(Sim 1988 99). In groups where the individual has "little and has no control", community is destroyed, democracy is weakened and the individual is diminished (100).

There is a paradox or a contradiction at play in rural consciousness wherein the desirability of a world attitude - an awareness of international events, a sense of connecting globally - is in conflict with the loss of personal attachment to one's local community. Sim says it is a case of being "narrow but deeply rooted", "broad but shallow."

"The dilemma of rural life today is to find the means of rebuilding neighbourhood relations and restoring control of local interests without excluding the outside world" (101).

Scott Peck discusses characteristics of community and sums them up in a description of community as being "integrative". Community "includes people of different sexes, ages, religions, cultures, viewpoints, life styles, and stages of development by integrating them into a whole that is greater - better - than the sum of its parts. Integration is not a melting process; it does not result in a bland average. Rather, it has been compared to the creation of a salad in which the identity of the individual ingredients is preserved yet simultaneously transcended. Community does not solve the problem of pluralism by obliterating diversity. Instead it seeks out diversity, welcomes other points of view, embraces opposites, desires to see the other side of every issue. It is 'wholistic'. It integrates us human beings into a functioning mystical body" (Peck 1986 234).

Peck has conducted many workshops with people whom, for whatever reasons, have lost their sense of community and need or want to find it again. To that end, Peck emphasizes the importance of revealing conflict, rather than avoiding conflict. He describes four stages in community building that follow a "natural, usual order of things." The four stages are;

1) pseudocommunity;

2) chaos;

3) emptiness, and;

4) community.

1) *Pseudocommunity* is when the individuals are getting along on a superficial level by holding back and containing real feelings and concerns to avoid conflict. "Pseudocommunity is conflict-avoiding; true community is conflict-resolving." Individual differences are by-passed for fear of igniting an argument. Platitudes and generalizations obscure essential individual differences that should be expressed in order to get the real and true picture.

2) The period of *chaos* is one of bickering, leadership struggles, and general unpleasantness. It is productive in the sense that conflict is uncovered and the issues can be confronted (94). Organization and omnipotent leadership would end the disputes, but these are counter to community.

3) The solution to chaos is to experience the stage of *emptiness*: "the bridge between chaos and community" (95). Here, members are to 'empty' their minds of their "barriers to communication". By that, Peck means, "expectations and preconceptions; prejudice; ideology, theology and solutions; the need to heal, convert, fix, or solve, the need to control." Although there is a strong sense of individual therapy in this period of overcoming these barriers, Peck notes that "community is always something more than the sum total of the individuals present." The four stages are "not so much individual stages as group stages" (102).

4) After these three stages, *community* is reached. It is a time of peace and tranquility but maintaining true community is difficult, agonizing, and intense. However Peck goes so far as to describe the phenomenon of community as something "deeper than joy". He

hesitates, then names the sensation: he calls it "glory" (106). Later on in his book, Peck states the "avowed goals" of "genuine community": to "seek ways in which to live with ourselves and others in love and peace" (163).

Leonard Duhl contends that community is the frame of reference in health planning, even when the immediate health concern may be the individual or family.

He sees the community building process a little differently than does Peck. He thinks more in terms of non-dominating leadership. Duhl talks about creating a new 'governance' model that emphasizes wholeness and uniqueness: one that "conserves and preserves" while "moving towards openness and creativity." Leadership, rather than dominance and hierarchy, maximizes justice, health and "equality among unequals". Social change and social learning take place with or without a leader in simple daily tasks and in major life alterations. Like individual growth, social growth has great potential: "the society and its institutions have the capabilities and potentials to be alive, ever-changing and responsive to situations as they come up. This can happen only if the leadership is open to changing paradigms and perceptions and the leader performs an educational, steering role" (Duhl 1986 129).

"If our concern with organization for health (justice) shifts in part from the individual we must begin to focus on the relationship of people within a given community. Since each segment of the community has its own personal uniqueness and development they are as equal as anyone else to define their perceptions of and needs in health. By focusing only on special group needs, what we have wrought is a fragmentation and splitting apart rather than a health program for the larger community. Our goal is to get both: local uniqueness as part of a larger system" (125).

Governance of the community may be likened to Duhl's concept of health and the

organism: "governance of the whole body becomes a governance of unequals who are equal, who have to learn all about themselves, their potential, and the parts" (126). Sharing governance among a group, or tribe as Duhl calls it, relieves the individual of all the burden; a burden that can harm the organism. Through the tribe, intuitive knowledge, ritual and instinct encourages unconscious holistic experiencing.

Duhl argues that effective policy-making requires active and direct involvement of the community to which it is directed and to that end he calls for a "mechanism to assure community involvement within the process of decision-making." Differences in human preferences must be considered as well as those needs that are 'universal': *"the way to promote the meeting of underlying human needs is to foster the expression of individual preferences in meeting these needs.*

Involving the people in the planning of their own environmental health programs would serve a twofold purpose: it would assist them in gaining a meaningful connection to their government, which in itself is conducive to the health and well-being of the individual and government, and it would also help to assure that the decisions ultimately made would meet the universal needs of people as they are variously expressed" (131).

He argues for participatory democracy in community decision-making. *Participatory democracy rejects the traditional hierarchical structure and its values and instead embraces the decentralized power of dissimilar equals. Fundamentally, participatory democracy is a leaderless form of political organization since leadership is provisional and power is widely dispersed. Because it is leaderless, loyalty is transferred to the organization, idea, issue, or value. Thus, participation reflects allegiance to a cause which, in turn, fosters self-contained, closed societies. Because the supporting psychology is one of equality, horizontal movement becomes the new upward mobility. Within the democratic network or unit, a wide range of options are available which do not require the achievement of*

status but only the development of effectiveness or competence in new roles of equal status (264).

He counts on "interplays" between different interest and levels in society that will affect many people in many ways whenever any change occurs at one stage or level. Duhl recognizes elitism as an inherent danger of participatory democracy, but believes that wider based forms are possible and highly desirable because the "mutual influences of social change (can) branch out in many different areas." The solution is with networks that will maximize 'pluralistic responses'. Networking people must not be number crunchers but rather humanists in their orientation.

Paulo Freire's book looks at the condition of oppression and a process of liberation. He is included here because his writings made me see that the situation I was trying to understand in rural communities is indeed one of oppression.

In Pedagogy of the Oppressed (1987), Freire explains the domination that occurs in society and provides a method of liberation for both the oppressed and their oppressors.

He defines oppression as "any situation in which 'A' objectively exploits 'B' or hinders his pursuit of self-affirmation as a responsible person" (1987 40). Characteristics of the oppressed include; a desire to be like their oppressors; self-depreciation, "which derives from their internalization of the opinion the oppressors hold of them"; distrust of themselves; a lack of confidence in themselves, and; emotional dependency (49-50).

Dividing local communities breaks them down into non-dangerous units. It intensifies the alienation, keeps them isolated from other oppressed people. Oppressors will preach against class divisions but they really need the class struggle as long as it is all of them versus all of the oppressed. They are trying to get the people to look at each other as strangers, not as having everything in common. This exploits the basic insecurity of the

oppressed (139).

Unity and organization are transforming forces.

Through dialogue between teachers and students (leadership and people), an unveiling of reality occurs. Dialogue, common reflection and action, leads to re-creation of knowledge (56). It is important to come to know through dialogue, both their subjective situation and their awareness of that situation; their view of the world.

"The starting point for organizing...must be the present, existential, concrete situation, reflecting the aspirations of the people", and it must be at the level of action, not just intellectual (84-85).

How do people come to see their reality?

It involves "*the investigation of people's thinking - thinking which occurs only in and among men together seeking out reality. I cannot think for others or without others, nor can others think for me. Even if the people's thinking is superstitious or naive, it is only as they rethink their assumptions in action that they can change. Producing and acting upon their own ideas - not consuming those of others - must constitute that process*" (100).

People must learn to see the causes of their needs ; not only feel the needs. Freire calls it "a sense of totality" and an emergence to another level of consciousness; from 'real' to 'potential consciousness' (110). The causes, named and articulated, give the oppressed strength by showing a beginning to making important connections and thereby, drawing a map of progress[18]. During this process to the "sense of totality", it is important to maintain a multi-disciplinary, or multi-thematic perspective of analysis and that it be flexibly applied. Freire says: "In this way, the themes which characterize a totality will

[18]Sim says that people are not "a resource to be used, a market, or a means. Rather, people are the ends for which society exists....Participation is a pathway that leads to the autonomy through which new communities will grow....Participation not only requires a capability of working with others, but it also requires knowledge, which offers the key to power. People must know what is happening in the world, and what is happening to them. Things do not just happen. There is a system of cause and effect. If all people feel is the effect, without understanding the cause, they are powerless"(1988 188).

never be approached rigidly. It would indeed be a pity if the themes, after being investigated in the richness of their inner penetration with other aspects of reality, were subsequently to be handled in such a way as to sacrifice their richness (and hence their force) to the strictures of specialities" (113).

Freire's main tenet is that without true praxis, liberation is impossible. Praxis is "*reflection and action upon the world to transform it*" (36). This can be achieved without political power by the unveiling of the oppression by the oppressed themselves, and "through the praxis commit themselves to its transformation." That is the first stage.

"In the second stage, in which the reality of oppression has already been transformed, this pedagogy ceases to belong to the oppressed and becomes a pedagogy of all men in the process of permanent liberation" (40).

Decisions based on the "nuclei of the principal and secondary contradictions" (realized through dialogue), will be more successful than those that come from the top (105). "By stimulating 'perception of the previous perception' and 'knowledge of the previous knowledge', decoding stimulates the appearance of a new perception and the development of a new knowledge" (108).

The oppression that rural people live under can be recognized and overcome through a community building process. It would involve discussions and dialogue, conflict and confusion. It would require minimal involvement from outsiders except to encourage participants during the inevitable rough times. It would result in a long term change towards open and participatory democracy and strengthened community functioning. It would be owned by the people themselves.

A New Systems Perspective: A Theoretical Framework for Planners

Planners generally appreciate a systems perspective that strives to identify the players in a problem. We are not so simplistic that we miss the fact that several factors are generally at work in a situation. However, we are not used to really seeing the interdependencies of relationships that occur within a problem, nor the linkages within the global environment. Planning needs to construct frameworks that allow for applications of theory to practice so that those interdependencies are illuminated.

To do that, we must shake off the old 'rational, comprehensive' approach that cornered us into a compartmentalizing method of analysis. Our attempts at problem solving have been stifled as we have failed to see how one facet of a 'solution', or 'problem', can affect another facet.

Much has been written lately about the new paradigm and the paradigm shift, sustainable development and new economics. Alvin Toffler, Marilyn Ferguson, Fritjof Capra and others have presented us with a fresh perspective that is promising in its potential for planning. It gives us the foundation for facing today's planning challenges in a way that is grounded in practical thinking and flexible application.

In a spirit similar to Toffler, Ferguson and Capra, Henryk Skolimowski, author of Eco-Philosophy: Designing New Tactics for Living, gives us a perspective for viewing the world that lends itself very well to the subject of community participation and health development.

Skolimowski contends that compartmentalization is "unnatural", because it alienates knowledge from the human mind and from human values (Skolimowski 1981 15). He says that contemporary philosophy is guilty of compartmentalizing and of reducing intrinsic values to a "secondary, insignificant, or even non-existent" level, "in a world of cold facts,

clinical objectivity and scientific reason" (10).

Instead, he offers eco-philosophy as a liberating alternative. The characteristics of eco-philosophy are graphically represented in the diagram of the mandala shown below, and compared to the mandala of contemporary philosophy. The mandala is drawn in a way that illustrates how each component of eco-philosophy leads to and determines the next one.

"The essential message of eco-philosophy (is): we can affect every element of our social, individual, spiritual, ecological and political life, not separately, but by affecting them all at once. Moreover, unless we affect them all, none will be affected" (51).

Diagram I
MANDALA OF ECO-PHILOSOPHY

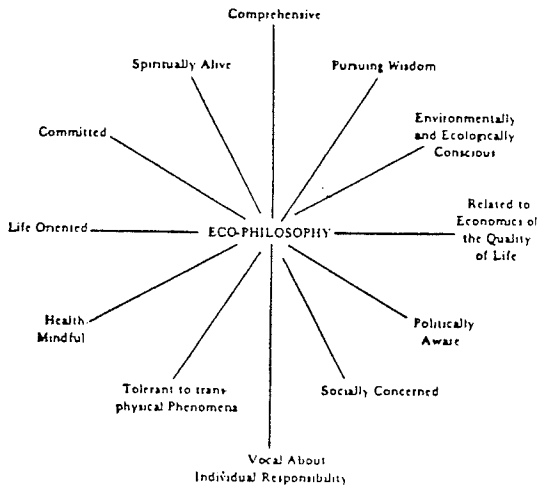
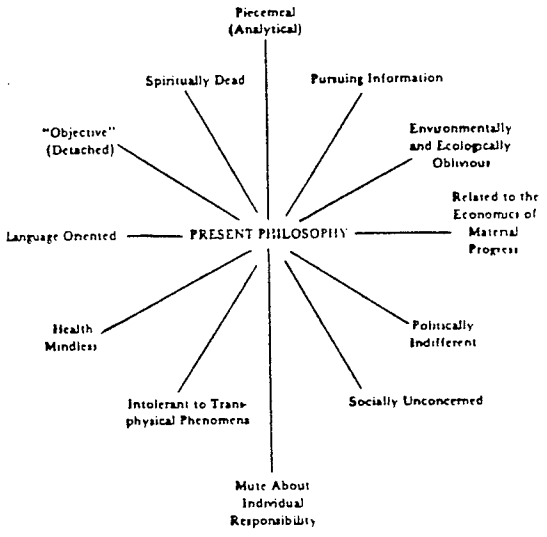


Diagram II
MANDALA OF PRESENT PHILOSOPHY



Source: Skolimowski, Henryk. 1981. Eco-Philosophy: Designing new tactics for living. London: Marion Boyars Publishers.

The characteristic of health consciousness reminds us that we are *"not machines to be mended when one part is broken or worn out: we are exquisitely, complex fields of forces. Within Eco-philosophy, taking care of one's health means taking care of the universe which is closest to one, expressing a reverence towards life through one's self; it is part of new tactics for living"* (47).

Eco-philosophy is vocal about individual responsibility; not to be interpreted as victim blaming, but as rights and responsibilities that we all have. Furthermore, it sees that people must be free to exercise those rights as well as their duties and obligations. This means that we can not expect individuals repressed by poverty, hunger, ignorance, despair or external power, to take their proper place in society and be responsible citizens. It means the oppressed must be liberated in order to be self-reliant.

Eco-philosophy is concerned with the well-being of society. This characteristic has strong implications for the health of rural residents and their involvement in formal health care services.

Society can neither be reduced to individuals (or considered as a mere sum total of particular individuals), nor can it be understood through its 'outward behaviour'. Society is the nexus and cradle of aspirations and visions which are certainly transindividual. Society is ultimately one of the modes of man's spiritual being. Society is certainly many other things too: an instrument for transacting business, an insensitive bureaucratic beast that frustrates our quest for meaning. But, ultimately it must be viewed as an instrument of man's perfectibility; thus, in the metaphysical sense, a mode of man's spiritual being (42).

Society is a 'cell' within the cosmos and we are therefore in a cooperative relationship with the other cells. One can not be disconnected from another.

Eco-philosophy is environmentally and ecologically conscious because we are an extension of nature and vice versa. We are not wardens of natural resources; we must have a reverence for nature.

Finally, and this is a real lesson for planners, eco-philosophy is comprehensive and global - not piecemeal and analytical. It is comprehensive, *"not because it is uncritically confident that it can grasp all and explain everything. Far from that. It is comprehensive*

of necessity, as a result of the realization that we have no choice but to look at the world in a comprehensive, connected and global way. Eco-philosophy, perceived as global and comprehensive, is a process philosophy which is integrative, hierarchical and normative - self-actualizing with regard to the individual, and symbiotic with regard to the cosmos" (36).

Planners need to rethink their notions of comprehensiveness and analysis. Eco-philosophy provides us with a place to start. Perhaps we could begin to look at the city and the community, as Leonard Duhl suggests, not only in terms of its 'hard' infrastructure, but also in terms of its 'soft' infrastructure: "that set of rules of behaviour, manifest in culture, laws, constitutions, regulations and procedures that make up both the formal and informal sides of life" (Duhl 1988).

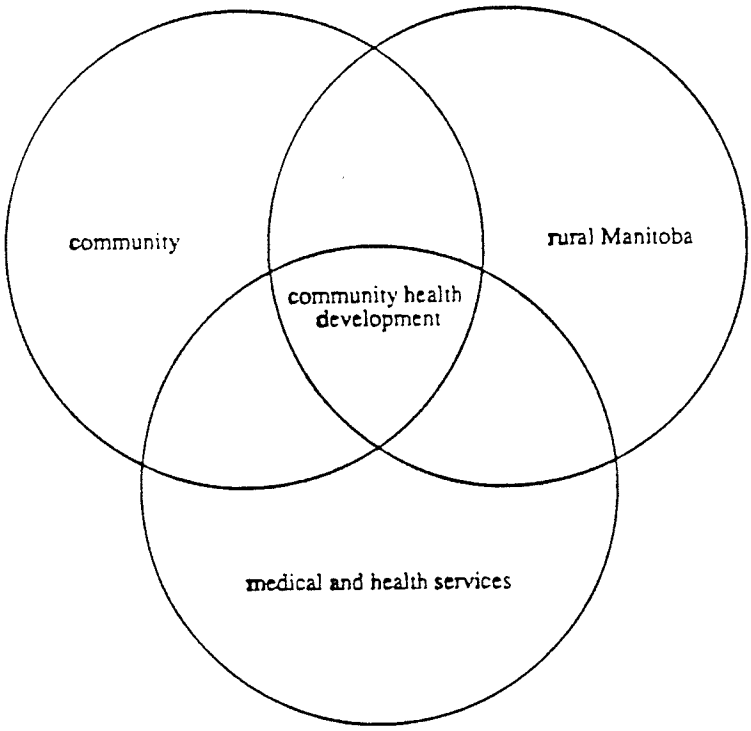
Conclusion

The essence of community is a difficult thing to grasp. Our society has neglected the importance of community partly because the community process involves facing some unpleasant revelations and accepting some philosophical tenets that may be unfamiliar in this post-industrial, predominantly masculine society. Social services and government policies serve to perpetuate the decline in community because they increase dependencies instead of bolstering independence. Community means nurturing a self-reliance within a place and a group of people who share common interests. Community members come to depend on themselves, on values and on each other instead of on outside forces, institutions, markets or initiatives.

We have seen that the conditions of life in rural Manitoba have changed against the grain of traditional values and ways of living. A sense of community remains in jeopardy and is starving from neglect, paternalism and a misunderstanding urban mentality that dominates our culture, government policies and societal structures.

The most striking feature of all the discussions with community people is their anger. I believe that the anger comes from a feeling of powerlessness and absence of control. When an individual feels that way, he or she cannot live with a sense of well-being, they cannot be truly productive and they will not live their life to its fullest potential. Feeling that we have an impact on our environment may be the single most important factor in our overall well-being. Similarly, communities must have a sense of control to function, to be productive, to thrive. When a community's control over its destiny, its survival, is diminished or taken away by outside forces, the community can not take care of itself. This is the most significant dimension of a community's personality when the survival of the community is threatened. If the community can regain its control and know it has a hand in its future, it can take appropriate action to heal itself.

Freire and Skolimoski argue for a perspective that purposefully looks for the obscure as well as the obvious and defies a reductionist's scrutiny. This method, this way of looking at things, sometimes requires turning around or inside out, pieces of the puzzle. The diagram below pulls together three contexts, overlaps them, and shows what emerges when they intersect. If it could be turned inside out or thought of three dimensionally, community health development would envelope the contexts. The lines should be dotted or fluid to represent flexibility and openness to many influences and temporal changes.



source: Sweatman 1990

Rural communities are in crisis. The people are oppressed and their values are in conflict with the kind of health care that is delivered there. If they are to be helped, we must appreciate how powerless rural communities feel and find ways to mirror their anger back at them. There must be a move to create strength within and among communities. The will to change must be present and the communities must be made aware of the amount of work there is ahead of them. It is this route that will lead to a more satisfactory outcome. The community must involve itself in the solution in an active, thoughtful, deliberate manner. That is what is meant by praxis; putting theory into action and reflecting on the process every step of the way.

The communities are oppressed by the conditions of economic decline. They are also oppressed by the arrogance of the urban mentality. They are further oppressed by the medical establishment. This is particularly noticable in their difficulty in recruiting and

retaining physicians. Government paternalism ignores and neglects the needs of the people.

The people's anger and frustration is the avenue to their freedom. Their recovery will be self-sustaining if they are helped to overcome their oppression.

The next step is to help communities overcome their oppression by affording them the opportunity to name their world and by assisting communities in the restoration and rebuilding process.

In the next Chapter, an attempt is made to set a course of community rebuilding. First, I present more opinions and observations of community people about ways of solving the recruitment and retainment problem. Some of their suggestions are quite radical. I think this reflects the severity of rural insecurity.

I will look at Sim's and others' notions of community organizing and rebuilding. There are ways to mobilize community action and provide some leadership to communities so that they may use their own solutions to reach a long-term, process of community regeneration. The objective is to help communities identify (name) their own circumstances (reality), and form an action plan to improve their community life.

I try to bring some order to the communities' ideas by grouping the suggestions into areas of responsibilities. This grouping will lead to recommendations that will be made in Chapter Six.

CHAPTER FIVE

FUTURE DIRECTIONS

Introduction

The first four chapters of this thesis have described the problem of recruiting and retaining physicians to practice in rural areas in terms of the rural setting, the community within the rural setting, and the kind of medical services that are delivered in those locations.

We know that the prairies are faced with a general decline in economic stability and in population that has led to damaged confidence and a weakened sense of direction. Rural areas have become dependent on government hand-outs, subsidies and agricultural policies that do not guarantee their livelihoods. These policies do leave them out of control of the present and the future and increase their dependency on outside forces.

Manitoba has a dispersed population distribution and an abundance of scattered small towns and villages. The urban population constitutes 60% of the provincial total. This makes the urban centralized power and decision-making especially apparent. The tension between urban and rural cultures and politics exacerbates the effects of economic decline and further divides rural Manitoba from urban, and divides rural communities from one another. Traditional small town rivalries that were once based on ethnic differences and competitive sports, are now based on a strange aberration of Darwinian natural selection. This is a 'survival of the fittest', in which a community's survival will be ensured if it is endowed with services, industries, schools and hospitals.

The networks of communities are linked with a web of highways, separated by expanses of farmland and punctuated with villages and hamlets. Each community is a unique settlement with its own history, its own social system and community dynamics. They are different, yet they share so many common problems, characteristics and threats to their existence. With notable exceptions, they resist forming united fronts to achieve common objectives. They are left splintered and unorganized in getting what they need and want from the paternalistic distributors of aid.

The people want to be able to live and work in their hometowns with some essential services available for daily living. One of those services is health care, which, according to the current application of the medical model, is translated into access to medical services, administered by a doctor, in a hospital. Again, according to the medical model, doctors are trained to depend on sophisticated equipment and colleagual support to administer medical aid, and are nervous to be on their own in a life threatening situation. Doctors, like other urban professionals of our time, expect to live their days in a city environment, with the amenities and lifestyle that accompany the urban setting. The combination of the two backgrounds and mentalities means that graduates from our medical school are not keen to move to a non-urban environment to practice medicine under conditions they have not been trained to work under.

The recipients of these hesitant urbanites are already in a fragile and oppressed state of mind and of being. They do not feel sympathetic to reticent outsiders, and are, therefore, not exactly expansive in their welcome.

This is a problem. Both perspectives are understandable and make sense, given the circumstances. The question is; what can be done about it?

In this Chapter, some ideas are explored with the hope that the most sensible, the most effective, and the most attainable solutions will become clear. Chapter Three presented

some of the problems as identified by community people. From their perspective, the primary problem behind rural communities' inability to recruit and retain physicians is the medical profession's power over the medical system. This power allows doctors to take advantage of a publicly supported education system with no means of guaranteeing provincial coverage for medical services. Doctors are free to practice wherever they choose and they usually choose to practice in an urban center.

The secondary reason community people identified for the recruitment and retainment difficulty, is that government does little to meet community needs. Government neglects rural Manitoba with provincial standards that are urban-biased, and policies that are decided upon within Winnipeg's perimeter.

Whether these perspectives are right or wrong is less important than the fact that they have been identified by the people most deeply affected by the current situation. It is my contention that rural Manitoba is in crisis. These perspectives reflect an oppressed population. The key to any solution will be to bring the people in on the solution formulating stage and thereby, encourage their liberation.

I begin with a return to the principles of community research and extend community involvement from the earlier analysis stage introduced in Chapter Three, to a directives or organizing stage. The value of community research as a tool to mobilize local initiative is emphasized and provides the beginning of a format for future action.

I go back to the community residents and present some of their thoughts and suggestions. I try and connect those ideas into a framework on which future directions can be based.

In Chapter Four, various writers argued for the possibilities of restoring and rebuilding community strength through a process that identifies the issues and places the community in a position of power, rather than submission.

Based on these concepts, and on what the people said in Chapter Three, there seems to emerge a route to follow that is promising in its positive impact on a deep and firmly set series of problems. Some ideas could be implemented fairly easily and soon. They should be the first set of objectives in a far reaching process of change. That process should have as its penultimate objective the initiation of a restorative process in rural communities that will help them identify their needs and expectations of the health care system, of their own communities and of neighboring communities. It will also identify their roles and responsibilities, and those of governmental and professional bodies. The ultimate objective is to redistribute the power and decision-making capabilities of rural Manitoba and end the crisis.

This will contribute to overall community well-being and the benefits should be felt in all spheres of community life. The process is meant to help communities liberate themselves so that they can exert maximum control in the goings on of their community.

In the conclusion of this Chapter, I propose the extension of a primary care model in rural Manitoba with community-based services forming a broad outreach of accessible care.

Looking for Places to Start : Back to the People

This section presents some of the ideas and suggestions community people had about remedying the problem of recruiting and retaining physicians as they perceived it (see Chapter Three for identification of the issues).

Community people, hospital board members and administrators talked about the role of the community in the organization of health care and their expectations from medical services. They spoke of regionalizing services and shared services as a cooperative effort between towns and not as a government inspired forced closure. There is a tone of desperation in their search for solutions in that they do not feel responsible for their

troubles. They do place the blame elsewhere and they feel they have suffered from a situation that is designed to serve the interests of every one but them. It appears to them that the medical care system is designed to promote doctors' monetary and social status and provide urbanites with a generous supply of medical options, all at the expense of rural residents' security, safety and peace of mind. Through this, they feel victimized and expected to sacrifice even more to solve the problem. I do not believe that this is entirely accurate. However, it is an understandable viewpoint and indicates an oppressed mentality.

During discussions with community people, a number of areas were identified as important to solving the medical-related problems in rural Manitoba. Both community people and physicians offered insight in this solution phase of the inquiry. Some areas were identified for their value in easing tensions between communities and medical professionals. Others were deemed valuable to the improvement of the delivery of health and medical care. At the conclusion of this section, the beginnings of a system that is more appropriate to the needs of the people and the environment will become recognizable. Included are some community responsibilities for changing the way the community makes decisions and thinks of themselves.

There will also be some suggestions that point to possible changes the medical profession and government may have to make to support community initiatives. These include preparing medical graduates for rural life, altering physicians' payment schedules, etc..

After hearing the various opinions from doctors and community people, an important comparison can be made. Comparing the community reactions with the physician reactions, we can see that the two viewpoints do not converge except in a community with

a community health center and salaried physicians. It appears that the community health care concept, coupled with salaried positions, serves to neutralize the antagonism between physicians and communities that is found in other situations. The community health center philosophy incorporates the facility and the community with other social and health services. It does this by placing them under the umbrella of the community health center, and by empowering the board to oversee all aspects of health care delivery. In a community health center, salaried doctors practice as team members, in cooperation and consultation with other team members. Conversely, fee-for-service doctors in a solo or two physician practice, work in a piecemeal fashion, and need to earn enough income to cover their overhead as well as maintain a profit margin. It does not make very good business sense to refer patients to another agency if the doctor thinks he can treat a patient and receive money for it.

A medical student working for the summer at a community health center, says: *"I've seen the pressure that fee-for-service doctors in the city are under to get the patients in and out the door. Here* (in a salaried hospital), *the doctors seem to have a lot more time to spend with their patients.* (The community) *is getting a lot better health care because of it as a community as a whole. And it can reduce the physicians' workload and they can feel a lot better about their practice too.*

As for the entrepreneurial spirit, (among) *my classmates, I see it too. They feel they've spent seven years at university and it's expensive, and they want to make money. They are willing to work hard and they want to make as much money as they can to make up for the time they've invested, so the spirit really exists. There will be a time when you want to settle down and have a family and time off will be more important and money isn't so important, and that will be a turning point.*

You won't find a lot of professions where you have to invest so much time for the education. And there's a lot of stress too. The feeling around school is that it's time to get

something back from the time invested and hard work for the last eight years" ('E').

Generally, the communities visited favor salary over fee-for-service. In areas that have had real problems, the people want their community and the surrounding ones to go salaried. That option seems to offer the best chance for the most coverage.

In this section I want to discuss the following issues as they were expressed by community people, hospital people and physicians. The issues are;

A) Limits to the Medical Profession's Power and Influence;

B) Education;

C) Physicians' Responsibilities;

D) Regionalization and Shared Services;

E) Housing, and;

F) Community Responsibilities.

These were areas that came up consistently in all discussions. As in Chapter Three, I will provide some commentary as to the significance of these observations as the section proceeds.

A) Limits to the Medical Profession's Power and Influence

A commonly stated argument among community and hospital people is that because the education doctors receive is subsidized by taxpayers and their incomes are guaranteed (in terms of billing the Manitoba Health Services Commission for services rendered), the government should be empowered to dictate where doctors will practice. Furthermore, the argument goes, because community people pay taxes, they should have a say in the type and quality of health care they receive. Medical services are almost a hybrid of free

enterprise and state-supplied programs. People are not free to choose their doctor or facility in rural areas. The doctors have freedom of choice as to where to practice. The state picks up the tab for a kind of health care that may or may not meet the needs of the residents.

Not surprisingly, most of the physicians have a different perspective on this issue. Although most physicians I spoke with saw monetary incentives to practice in rural areas as the direction to take, a few doctors interviewed did suggest limits to their professional powers as necessary to solving the maldistribution problem. Specific limits suggested included licensing requirements dependent on location of practice.

One physician sees the solution to the problem as having two possibilities: 1) either offer a financial incentive to practice in a rural area that can not be matched in a city, or, 2) legislate doctors so they have to work in one area and not another. He suggested it be a federal law and likened it to compulsory military of some other countries.

"We need to have some laws so everyone does some time in rural areas" ('A' 3).

A board member offered this viewpoint; *"The only answer will be; when someone can tell the doctors where to practice. Not wherever they want.... We'll pay you to work here and not there. It's so frustrating! We go over the same thing again and again. The problem will remain as long as you are my employee but I can't tell you where to work"* ('D' 1).

"As long as physicians continue in this enviable way it won't change. You have to say to doctors - No. Go to Saskatchewan. So go; what's the difference? The hospital is closed now!" ('D' 2).

One suggestion from a community member was that more doctors should be trained to increase the supply to meet the demand.

Another issue relates to the fact that some doctors maintain private clinics in town as

well as hospital privileges and responsibilities. If doctors keep a clinic in another part of town from the hospital, as well as working out of the hospital, services equipment etc. are duplicated and the doctors have a commercial interest in their practice. This interferes with the Board's influence over the terms of practice. It further removes the doctors from the town's health services generally.

"When doctors work out of the hospital and not a separate clinic, then a hospital is to a degree, subsidizing the doctors. And the hospital has some say over the activities and who to grant privileges to; so control is an issue" ('B' 6).

Small communities seem best suited for group practices because of the strain solo practice places on a physician. One reason to insist on group practices is that the setting is then there for a rotating on-call and time off. One hospital, for example, arranges a rotation of one weekend on for four or five off. Similarly, physicians are on call two nights out of seven.

"You have to develop a system that the guy gets time off because he gets burned out. A sole doctor in a small town is kind of difficult when he's on call 24 hours a day. So you need a system like the one in Hamiota where there is a call system. But then many doctors who are fee-for-service aren't going to want that" (physician, 'A' 2).

A doctor who favors incentives to entice physicians to rural areas, made this suggestion: *"A lot of it is word of mouth, what towns are good to work in. For a long term proposal, you could get a guy to sign a four year contract with a substantial establishment grant. I guarantee it. Then he would be attracted to something else in a rural community and believe me, there are a lot of guys who think finances above everything else. A guy would put up with a hell of a lot if it was worth while to him. In the rural areas, a fee differential or a tax break or something. He'll think it's a hell of a lot better for me to work 100 km this way and not that way and they'll do it"* (physician 'A'

6). A Board member added; "We approve of rural doctors being paid more per visit than city doctors."

The role of hospital Boards is a significant factor in the relationships among community people and the hospital staff and physicians. Hospital Boards should initiate frank and open discussions with other community people regarding the strength the Board should have and to whom the Board is responsible. Some Boards think they are responsible to the community first. Some see themselves as accountable primarily to the hospital as a free-standing, fiscal entity. While others feel mostly responsible to the physicians and maintaining a stable medical contingent.

In a community where the medical staff is particularly unstable, the Board seems especially willing to support doctors' expectations for the sake of community expectations. It appears that, although the Board would like to be firm in their dealings with the doctor(s) and not forsake community wants, it also feels compelled to compromise in favor of the doctors. That signifies the extent of the fear of losing doctors and the price communities will pay to keep a physician present.

B) Education

Earlier in this section, I quoted a medical student discussing his colleagues' views on financial and lifestyle expectations following graduation. The medical student's comments have important implications for the kind of messages students receive while at medical school. The entire area of education should be open to change as the identification of the problem section showed (see Chapter Three for observations regarding the need to increase emphasis in medical school on primary care, rural health and community medicine etc.).

On the subject of encouraging rural students into medical school by easing up admissions procedures, that medical student said; "you can't very well say to admissions' committees to let in more rural kids...."

To which a long time country doctor exuberantly replied; "Sure you can!"

The student was not convinced. He equated the notion of encouragement with a lowering of standards. This opinion was voiced in another town where a doctor suggested that any program to encourage rural students would diminish the quality of doctors. "If you're going to be biased in your selection, then you might not get the calibre of doctor you're looking for if you sway the process."

The whole trend to specialize must be examined more closely, in part because of its effect on rural shortages and the kind of medicine required in rural areas: *"There is too much emphasis on specialization and not enough on family practice. In the country you have to have a wide range of knowledge"* ('E' 3).

"They aren't educated in medical and nursing schools about the work here. They should be taught about what to expect here. Be prepared for that first period of adjustment" ('D' 3).

Students should also be taught basic information regarding hospital administration, provincial regulations, business methods, clinical management and general health care system knowledge, according to community people. I think that this suggestion has merit. Physicians might acquire a broader appreciation for health care and societal resources if their education extended beyond the specifics of scientific medicine. Perhaps then they might also broaden their perspective on holistic influences on health, influences on health by health care delivery systems, and other non-scientific matters. Doctors would also be able to make a stronger impact on health care if they understood how systems work in a socio-political context.

C) Physicians' Responsibilities

Both community people and physicians recognize the very important role physicians command in the medical care system. Our present medical system requires doctors to function. They are the ones who admit patients to hospitals, who administer most medications (or at least order them for nurses to administer), discharge patients, decide on a course of treatment, etc.. The Manitoba Health Services Commission allocates what amounts to approximately 95% of this province's overall health care budget. M.H.S.C. allocates those monies to hospitals directly and to doctors directly in fee-for-service arrangements. That places a tremendous responsibility on our hospitals and physicians as the primary consumers of health care dollars. Manitobans have little choice but to turn to their community and teaching hospitals and the physicians they staff for most of the medical services we use. That kind of expectation sets groups up for hostility because one side can not possibly meet all the expectations of another. As well, the traditional reverence people have for holders of specialized knowledge leads to intimidation and insecurity towards the revered. Physicians provide a classic example as subjects of such reverence.

There is tension and antagonism from some community people towards doctors. This is in addition to the intimidation they feel from this powerful group who, they think, is beyond their control or influence or even the possibility of developing a relationship with. The physician is someone who 'doctors'. He is temporary and peripheral to the community. He is not someone to talk with, to reason with or relate to. Communities depend on him through two sources:

1) community dependence on hospitals as a source of identity and economic activity; and,

2) individual dependence on professionals for information regarding their own bodies.

Community people think that physicians should spend time when they first arrive in a community to get to know the facility, the staff, and the town. *"They don't want to take the time to get to know the facility and staff. It pays off in the long term when they take the time to learn procedures etc.. When they don't, we pay. But, who will pay them to spend the necessary time to get to know the hospital?"* (D' 4)

One group suggested that if it is a salaried position, an orientation period should be part of the job. Fee-for-service doctors will not spend the time because they want to start billing right away. Therefore, where it is fee-for-service, M.H.S.C. should provide a minimum allowance for new doctors for perhaps a two-day period of familiarization with the community and the hospital.

There was a feeling that physicians should try to get to know people in the community and not wait for them to always take the first step. They should remember that the people may have had unhappy experiences with doctors coming and going and should adopt an attitude that they are going to settle in. Community people are hurt when they feel their community is always a stepping stone to other places. They want physicians to appreciate how insulting that attitude is and try to see the situation from the community's perspective.

I conclude from these sentiments that doctors should spell out their expectations clearly to the community right away, regarding expected time off, judging emergencies and non-emergencies, use of social and government services and so on and listen to what their expectations are in turn. Chapter Six will address physicians' responsibilities more specifically in recommendations directed to each interest group.

D) Regionalization and Shared Services

The topic of regionalizing health services has been around this province since the early

1970's. Without going into too much detail here, suffice it to say that the topic is being revived as difficulties in rural health issues remain. In SCOMM's Annual Reports of the last few years, the Committee notes that without some kind of shared service arrangements taking place in rural Manitoba, the chances of overcoming doctor shortages and uneven distribution are slim.

The issue of regionalization connotes a heavy handed, government inspired take-over of health and social services because the tactics of past governments were not very sensitive to community input or diversity of circumstances. However, the concept of small communities combining and rationalizing some services and personnel does have appeal. It may close some of the gaps in the system and ease the strain of 'going it alone': a strain that can push a fragile community into oblivion.

The possibility of regionalization of health facilities and services is on the minds of community people. They see the merits of combining many small hospitals into fewer larger ones and see the benefits as improved medical care for all. They do not like the idea that their town might be the one to close. They are ready for it if it is done with some planning and consultation with the people to be affected.

Changing facility use was discussed as a possible step to take. Some people suggested turning some acute beds into convalescent beds so that recovering patients do not take up space elsewhere and so that they may recuperate near their families and friends. Staffing of convalescent beds would not be as expensive as acute beds demand. There is also the continuing and increasing needs of an aging population for personal care home beds.

Community people see a need for cooperation among communities although they realize how difficult that can be. *"We have to get out of this feeling of parochialism; remain each to your own and forget about your neighbor. Fear of that ghastly word regionalization. But I see a co-operative effort coming. For example, the Group of Five* (Russell, Rossburn, Birtle, Shoal Lake and Hamiota). *We must do something collectively. We*

have to meet provincial standards but can't with the number of doctors so we have to do it with the Group" ('D' 1).

What the people are so tired of and frustrated with is the lack of political will and courage from provincial leaders. *"Group the facilities and the doctors and pay for it! Get good physicians and pay for it!"* ('D' 1). One person lamented that health care is in the political arena at all: *"Health care is not* (should not be) *a political issue. It is a right just like education. But there are far too many political philosophies that come into play in delivering health care. Everyone writes reports and gets on the bandwagon, the government changes and a new philosophy and it starts all over again. It is hampering the delivery of health care"* ('D'2).

Community people do not expect the same level of services available in urban centers. Indeed, provincial standardization tends to hinder rural health care and the people recognize the inappropriateness of those urban values. They want their doctors to care for them, they want their doctors to be a part of their lives, and they want them to be a part of the lives of their communities. This feeling is not surprising given the intensity of small town life and the absence of anonymity. Rural residents are very sensitive to the attitudes expressed by urban professionals who ridicule rural lifestyles and customs.

Naturally, rural people do not want their town to be adversely affected by any move to share services. They have a sophisticated understanding of the issue. They are willing to participate in discussions. They will entertain the idea of giving up something in return for alternative methods of delivering care, such as shared service arrangements with other towns.

E) Housing

Community people talked about providing housing to physicians' families. They thought that perhaps having a house designated for the doctors would mitigate the difficulties of moving to a new place. Some of the physicians I spoke with and the wife of one of the doctor's said that knowing a house was available to live in would make it easier to relocate. The point from the doctors' perspective is that they do not want to invest a lot of money in a town they may or may not stay long in. They would like to know that at the end of the journey to a new community, there would be a house ready to move in to. Opinions of community people on housing varied from community to community.

"We're working on it. We did have a house once but eventually it became something around our necks so we don't now. But we are looking into something. We are prepared to do something".

"The problem is that everyone wants a different kind of housing. So to have a manse-like thing is difficult. But to provide through leasing or something, a house that will be commercially attractive, and not sitting empty if the doctor decides to live in another house (might be a viable plan). *It's there for the doctor until they decide what to do. As a practical investment, it's there"* ('A' 4).

In another community, housing has been addressed but the Board claims that there is lots of housing available. They object to paying for a house for a doctor who is earning much more than anyone else in town.

The problem with communities attempting to provide housing is twofold. First, it is difficult for a community that may be struggling financially to justify providing a house for a physician who they know will make a very good income. This contributes to the resentment the community already feels and to the sense of selling themselves for the slim chance that a doctor will stay in their town.

The second negative aspect is that quality of housing is a subjective assessment. If the community did decide to make a home available, the questions would be: 1) how much

should the physician pay ? 2) should he own it or rent it ? 3) in what condition should the house be in for occupancy ? 4) what should be done if the house is unacceptable to the doctor ? etc..

I think that communities should include the housing issue in their discussions. Imagining what a new doctor faces when they enter a new town would likely be a useful experience for the community to go through. It may help to humanize the doctor and his family in the eyes of the community, and be a uniting influence for the community.

F) Community Responsibilities

Community people talked specifically about what they could or could not do to entice and keep doctors living and working in their community. This angle is different than the broader ones of community involvement in health care delivery or empowerment to local decision-making. Here, they were speaking of how their community appears to outsiders and whether they present an accurate and / or attractive image.

A couple of community groups felt that there is much communities can do to market themselves. They referred to self-marketing not only as a means to attract potential physicians, but as a means of recognizing their communities' strengths. They talked of putting together a package describing their towns' services, schools, clubs, sports facilities etc. so that newcomers could know what is available. The process of putting such a package together would be of benefit to the community because the towns' virtues would be explored, recorded and promoted.

"I think when you come from a small community you tend to underestimate that community and the activities that are in it. You overlook what's available. The real advantage of living here" ('E' 1).

Communities thought they could host a party for the newcomers and invite the whole town to participate. If there is no Welcome Wagon in the town, a welcoming committee could be formed and assigned the responsibility of looking in on the newcomers regularly for the first month. The committee should be ready to help the spouse with settling in to a new home, enrolling children into school, introducing her / him to people in the community and providing information about services, repair people and so on.

I think that communities should also spell out their expectations clearly to a new doctor right away and listen to what the physicians' expectations are too. The experience of articulating their expectations will be a useful exercise for the community and will lead to a basis for educating the community as to appropriate and inappropriate demands on the physician. Communication between the community and the physicians would help demystify the physician's persona. It would also help establish some ground rules for both players to follow.

Summary

Changes in rural society can occur at various levels as the tasks and objectives are decided on and the most appropriate agent and method of change is identified. These discussions were centred on the problem of recruiting and retaining physicians and the wider issue of community responsibility in the delivery of health and medical services.

The tone of the discussions signify that rural communities are oppressed. Communities must strengthen themselves and increase their influence on the medical and health care they receive.

There are three levels of activity where change must occur.

The first and second levels are government and the medical profession. Governments and the medical profession must pay attention to the needs of rural Manitoba. The message

from rural Manitoba is that changes to the educational curriculum in public schools and in the medical school are necessary. The status quo in facility funding and physician individualism must be questioned. Those are two levels where change is required. More specific recommendations to these participants will be made in the last Chapter of this thesis.

The third level is the community level. Community-based change is the focus of this thesis and the remainder of this Chapter. There are processes communities can initiate that will strengthen their decision-making powers and abilities.

Community Regeneration and Community Building: Mobilizing a Community to Action

R. Alex Sim writes:

The new rural community cannot be fostered or created by governmental policies. Rather, the regeneration of meaningful community life requires a devolution of power to the local arena. Government agencies, big corporations and powerful cities are not going to surrender their power and influence readily. On the other hand, there is little evidence that rural people are ready to challenge the vested interests that dominate their economic and social lives. Yet if they do nothing, the present trends are likely to continue and crises will deepen and recur more frequently, making renewal and reconstruction more difficult. Rural people may not be ready to challenge head on present trends and arrangements, but there is evidence of discontent and a stirring toward action - small beginnings, social innovations that are, in effect, pioneer pathways that others may be encouraged to follow. The discontent about farm policies is a hopeful sign. A widespread cynicism toward political leadership and government policies may stimulate rural people to look to themselves for direction, rather than to distant authorities (1988 145).

Sim goes on to caution us about relying solely on political solutions to solve problems that are essentially social:

There are many reasons to be skeptical of political solutions to social problems. The first to consider is the structure of government itself. Policies are developed in particular ministries with limited jurisdiction for example, agriculture, education, or environment. Each agency responds to a general problem with a specific solution, yet its policy must be stated in broad general terms to cover a multitude of specific cases. In contrast, an individual, or indeed a community, is a totality, a holistic phenomenon. The machinery of government is massive, slow moving, insensate, and amoral. Its response can be too little and too late, too soon and too much, too much and too late, or even too little and too soon. That is not to say that government is ineffective in all instances; but where unique, off-beat or swift responses are called for, then we see government at its most inept, a judgment that can be levelled at most large-scale non-government organizations as well. Too often we see a shotgun employed to kill a mosquito or a fly swatter used to drive off a skunk. This does not mean we can do without government intervention and big organizations, or to say big organizations are uniformly inept. It is in areas where ineptitude is most wantonly evident that we must be most critical. These areas have to do with minority groups representing natives, women, children, and medium and small-sized farmers. To this group I would add people living outside cities. As we already noted in looking at great associations, these massive structures with their ponderous programmes (even when they are well intended) are too heavy to meet or alleviate the subtle human problems that deprive people of their full potential. The human spirit has a light ephemeral quality, which must grow and flower in its own special environment (152).

Sim outlines three different kinds of political responses: 1) repressive; 2) palliative,

and; 3) positive.

1) Repressive responses are those that use power and wealth over underprivileged people. Rural people are susceptible to this as are minority groups.

2) Palliative responses include the sort of mid-range, short-term politically popular and easy policies. They do not solve anything in a fundamental way but they buy politicians time and usually votes. Sim advises that these may hold some potential for long-term effect and should not be discarded completely; but a caveat emptor may apply. An example of this kind of response is the common practice of building a hospital regardless of need or appropriateness in type of care and location.

3) The third kind is the positive response. This involves a transfer or sharing of knowledge and power and has specific importance in the issues of; professional power with its acquisition of knowledge; community involvement, and; access to government information (154).

This positive form of response is, of course, community-based. It means starting at the community level and going up and out. Conversely, government policies are created and implemented from the top down. Policies are often clumsily applied in non-appropriate measures.

Community-based decisions could be created sensitive to the people who are affected by them because they are devised by those people. The process by which community decisions are reached is itself a strengthening experience. Indeed, it is the process that matters more than the specific problem solving itself.

The Community Building Process

According to Scott Peck, the rule is; "Community-building first, problem-solving second (1987 104).

Peck says; "To achieve genuine community the designated leader must lead and control as little as possible in order to encourage others to lead. In so doing, she or he must often admit weakness and risk the accusation of failing to lead.... To be effective in community-making, designated leaders must keep their focus on the group as a whole" (164).

We know the rules of community; we know the healing effect of community in terms of individual lives. If we could somehow find a way across the bridge of our knowledge, would not these same rules have a healing effect upon our world? We human beings have often been referred to as social animals. But we are not yet community creatures. We are impelled to relate to each other for our survival. But we do not yet relate with the inclusivity, realism, self-awareness, vulnerability, commitment, openness, freedom, equality, and love of genuine community. It is clearly no longer enough to be simply social animals, babbling together at cocktail parties and brawling with each other in business and over boundaries. It is our task - our essential, central, crucial task - to transform ourselves from mere social creatures into community creatures. It is the only way that human evolution will be able to proceed (165).

Peck cautions us that individual personality conflicts or interferences in a group are not the leader's concern. If the group is not left to work out its own course, it will not become a community; "a group of all leaders" (119). "The general rule, therefore, is that leaders should restrict their interventions to interpretations of group rather than individual behavior. And the purpose of all such interventions is not to tell the group what to do or not to do but to awaken it to awareness of its behavior" (118).

In a preceding section of this Chapter, I related some of the views and opinions of community people and physicians. My role in that portion of this research was to deliberately not direct or manipulate participants' dialogue. A planner working with

communities in a community-based initiative towards developing a rural health care system, would have to have a feel for ways that will mobilize community action. The first stage would be to encourage discussion and inspire awareness. Other writers have provided me with directions to proceed with such an undertaking.

Community Action (1989) is a book written by three Quebecois. Two of the authors teach social work at the University of Montreal and the third is a writer. This book is almost a 'how-to' in community organizing, activism and implementing social change.

In Community Action, steps to mobilizing a community are outlined. General rules to follow in the process are; learn from others' experiences - know the history of the community and be aware of other groups to work with, and; share tasks with the maximum number of people (Lamoureaux, Mayer and Raymond 1989 121). The leader must "pass on your knowledge" about organizing, about the history of the community, and about any other information one gains about other groups that could be contacted and brought in to the fold.

Like Peck et al, the writers of Community Action see community building (or in their words, 'struggle'), as a process, and "each stage has its own objectives" (133). Determining and defining objectives is essential to each stage and they will be "either immediate or long term." Although objectives should be attainable, a level of objectives are "intrinsic to any struggle". For example; raising consciousness; empowerment; bringing in new members. The organizer should keep these 'across the board' objectives in mind throughout the process.

Once the objectives have been determined, appropriate strategies to achieve those objectives can be worked out and tactics to carry out the strategy can be devised.

"The tactics should be therefore consistent with the strategy - that is, they must be appropriate to the type of objectives being pursued, in both the short term and the long

term" (134).

Sim's 'positive response', with its transfer of power and knowledge, is the best course for the challenge in this inquiry and the procedure described above. A framework for a method of community health development can be formed by coupling Peck's et al notions of community building with the idea of transferring knowledge and building self-confidence in local decision-making. These goals are part of the rebuilding process itself. They are also part of the process of community organizing.

Community organizing is described in Community Action as having the following qualities:

1) "(it) *can be carried out only by bringing together people who, directly or indirectly, have common interests";*

2) "it is democratic, in the sense that the action has a democratic objective such as the affirmation or exercise of a right. The democratic aspect of community organizing should be reflected in the internal functioning of the group, in terms of both decision-making structures and the emphasis placed on the participation of all members";

3) "it is also an education process that validates people's existing knowledge and skills and enables them to acquire new ones. Finally, any strategy of community organizing should aim to bring about change, to reduce or eliminate exploitation, oppression, and alienation....Community organizing is an expression of people's faith in their own ability to defend their individual and collective rights and interests" (1989 7).

Community organizing is a form of praxis in that it is intended to win individual and collective power. The authors warn against the perversion of a 'community-approach' committed by the Quebec government that promoted volunteerism "to fill the gap in services left by the withdrawal of the state" (2). Community organizing should be truly democratic and attempt to exercise real power and not make people pawns for some other

purpose.

The research phase of community organizing is part of the process too. The authors of Community Action emphasize how essential research is to any community work and how important it is that the research binds the researcher with the community. Furthermore, the prospect of doing research need not intimidate people who want to acquire knowledge: "Research should be considered any activity that enables individuals to better understand their everyday social reality, on the job or in the community. Research is pointless if it remains in the hands of researchers instead of being used to serve the community. It should be used for education, information, and organization" (63). Similarly, it is important to remember that all phases of research are connected: "study (research and observation of facts), diagnosis (analysis), and treatment (action). *This also applies to community organizing, which usually involves the following stages: study of the community; identification and analysis of problems in terms of the classic questions of what, where, when, why, how; appraisal of the difficulties; planning and carrying out of action ; and, finally, assessment of experience*" (67 emphasis mine).

Community organizing is a version of community planning. The two contain essentially the same ingredients. In community organizing, the objective is to help the community liberate itself from its oppression. In traditional community planning, the objective is to respond to community problems, including those problems that are perceived, and to a community's aspirations or notion of an ideal.

Community planning is an activity. It is a process of identifying the scope and effect of current and anticipated problems and devising solutions that will maximize the community's objectives.

Community planning is a social activity, that, by its nature, needs human interaction and community involvement in the planning, not just planner involvement. It is a process

of decision-making.

Lessons from Community Economic Development

Community economic development (CED) is currently in practice in rural Manitoba through the Department of Industry, Trade and Commerce. CED is directed to turning around the very foundations of economic policy to make it more responsive to the needs of the community and more specific to the realities of the circumstances in rural Manitoba.[19]

The process of initiating and maintaining a CED program holds valuable lessons relevant to other aspects of community planning and community organizing (such as health care development). It is a holistic approach that places economic activity in the context of overall community functioning and well-being.

The local economic development process is essentially an approach towards the betterment of a community in all its facets, since the goals of local economic development are not simply economic in nature. In it, residents take an active part in deciding the future of their community, and the process is both educational and action oriented. It gives people a better idea of how their economy works and how they can have a major influence on their economic future (Nasewich 1989 75).

CED seeks to build self reliance and independence from outside decision-making. It seeks to liberate the oppressed through empowerment. Indeed, a fundamental point in initiating CED is that certain conditions must prevail before CED will succeed. The necessary condition is crisis. Workers in the community economic development field are

[19]Sim supports community economic development over mega-type projects because control is in the hands of the people themselves and the businesses are usually environmentally and socially beneficial to a community. They also tend to employ more people and generate more income to the residents in a long term venture (Sim 157).

convinced that there is no point in initiating that kind of effort until the community has experienced, or is in the middle of experiencing, a crisis.

Most often the essential driving force behind the initial commitment, participation, and start-up of local economic development and the search for alternative development is crisis. Lack of job opportunities, migration and declining population, lack of educational opportunities, deteriorated housing, decline and loss of business and retail activity, shrinking tax base, farm troubles, and the loss of primary resource industries or single industries, are often the generators of grass roots and self help initiatives towards economic development (Nasewich 1989 75-77).

The CED process can serve as a model for a community-based health development initiative because the principles are so similar. Those common principles are;

- communities must be ready to assume an involved position. To reach that point, the community is in crisis and the community is oppressed;

- self reliance and independence from outside decision-making is a primary objective, and;

- the benefits of community involvement will extend beyond the specific service targeted to reflect the holistic philosophy behind community development.

The next section describes the four stages in a CED process. Consider the applicability of these stages to community health development by translating some of the vocabulary from economics to health. At the conclusion of this Chapter, I will suggest a process for community health development, modeled on CED, that follows these four stages.

The four stages that have been identified in the community economic development process are;

1) start-up

2) community profile

3) identifying needs and setting goals, and

4) creating an Economic Development Strategy.

1) Start-up

In this phase, it is important to include as wide a range of participants as possible to ensure that a variety of interests are represented, that many opinions and viewpoints are available to draw on, that a base of interest and support is formed and, that the likelihood of the emergence of leadership is enhanced with a greater number of contributors.

It is a time to build community resources in terms of ideas, contacts and knowledge. The process is explained and a "basic statement of purpose" is formulated.

The "formats can include community meetings, business or other association meetings, local government and council meetings, futures workshops, or brainstorming meetings" (Nasewich 1989 76).

2) The Community Profile

Here, the community assesses itself in terms of its resources and its historical development and demographic data. The community's strengths and weaknesses, its problems and sources of stress are revealed, and this in itself provides the community with an invaluable learning experience. Again, leaders may emerge and widespread involvement can occur.

Resource identification can lead to the beginnings of strategy formulation and it helps illuminate a community's natural economic direction. The tendency to use this time as a bolstering of the town's marketable virtues in order to attract outside investors, should be recognized and avoided.

3) Identifying Objectives / Establishing Goals

Unlike regular economic strategies that are directed to job creation, CED also looks at

strategies such as; subsistence, welfare and migration and import substitution (Nasewich 1989 81).

A subsistence strategy focuses primarily on meeting and satisfying basic human needs (which are inadequately provided for) through the use of the existing resource base....It does not necessarily involve market exchange or monetary transactions and is not necessarily directed at either exports or the replacement of imports. Rather it is designed primarily to meet the basic needs of day to day living and has great appeal where resources are abundant but where the market economy is relatively limited or absent" (81).

A welfare and migration strategy addresses the outflow of young, skilled and educated people, due to restricted employment opportunities. It considers the future viability of the community as a place to live and work.

An import substitution strategy attempts to expand the local multiplier by increasing local production of needed goods and services' supplies. The message is self reliance, not isolationism, and includes quality of life considerations, improving educational opportunities, upgrading of skills, encouragement of non-traditional groups to invest and take risks, and other unconventional economic supports such as day care.

4) Economic Development Strategy

This is "essentially a written summary of the economic activities the community hopes to undertake and accomplish and how it intends to undertake them. It is an action plan outlining the achievement of the overall economic development goals and objectives of the community" (84).

Along with a general review of the first three stages, this summary also gives information about other existing plans and strategies of government agencies and departments and potential sources of funding so that action plans may hook up with ongoing projects where appropriate. It is an intelligent, well informed approach that

realistically tracks current happenings.

Community Health Development : A Program of Action

Community economic development is a strategy, based on a strong theoretical framework, to elicit the essence of a community into a practical, action-oriented, self-help initiative. Community health development is similar in that it is based on a philosophy that strives to place power and knowledge in community control in order that the needs of the community are met and the means of implementation are locally derived.

The steps in a community economic development plan can be modified and adapted to health development. Before that is done, some fundamental beliefs in health development should be established.

Guiding Principles and Philosophy

If a community-based health system is to be established, some general principles are necessary. These principles would provide a framework for discussion in the affected community. These principles would have to be accepted by both the medical profession and the government. This acceptance would establish the political will to succeed.

The following list of principles is certainly not exhaustive but should serve as a basis for further discussion.

1) An objective of community health development is to increase the people's ability to make informed decisions regarding medical treatment for when they are sick and designing health programs for everyday living. Physicians will benefit too from a decrease in responsibilities and a sharing of power and knowledge.

2) There must be a commitment to decentralizing health and medical services to expand accessibility to services and accountability for resource allocation. There should be a move to form cooperative shared services between and among communities. This will create stronger technical and consultative support for physicians as well as provide more complete medical services to communities. With accountable decision-making within communities, communities could decide whether to increase the number of personal care home beds, or change the use for hospital beds in concert with other communities' needs.

3) The role and responsibility of nurses in the primary care setting must be increased so that specialists do what they are trained to do, nurses included. This will likely involve an examination of legal assignments of duties among health professionals. A change in legislation dealing with, for example, nurse practitioners and midwives may also be required. Increased use of those personnel would result in; a reduced need for physicians in a primary care unit for many medical procedures; improved obstetrical care with personnel trained in natural childbirth techniques, and; an overall reduction in education and training costs.

4) Group practices should be considered the norm rather than the exception. Physicians should expect to be remunerated accordingly and to be respected as real people with ordinary human wants and needs. They are not extra-special creatures possessing unusual power and supernatural abilities.

5) Communities will have to decide on salaried or fee-for-service practices for their own situation. The disadvantages and advantages of the different payment schedules should be reviewed with communities so that a well informed decision could be made. Communities that have recently switched to salaried positions could be asked to give 'testimony' as to the factors influencing their decision and an evaluation of the effects of the decision. The testimony could include; the change in terms of retainment of physicians; overall delivery of health and medical care; cooperation among neighboring communities,

and; functioning of the hospital, to name a few topics.

6) Hospital and physician accountability may have to be examined for ways of assessing actual meeting of needs. Doctors could be in on hospital budget estimates and be held accountable for them. For example, patient days or treatments administered would indicate patterns of practice that may or may not be necessary. This would provide an incentive to look to community and social services to cover what physicians know the hospital cannot pay.[20]

Building a health delivery system from these principles should be done using as many existing structures and services as possible. Creation of more layers of bureaucracy and expenditures on capital projects should be avoided. Community people will most likely respond to a call for action if they know the objective is to work with what they are familiar with, rather than a complete dismantling of current organizations.

Community Health Development: Connecting Social Development at the Source

Like community economic development, community health development can follow stages in an ongoing process of change. Each stage has its set of objectives. As Community Action advised, objectives provide goals for a group to aspire to and they are a means of evaluating progress. Modeled on the four stages of community economic development described earlier in this Chapter, I will now outline a similar plan of action that communities could undertake to initiate a community health development process. It should be understood that this plan is based on the premise that the willingness to

[20]Some of thses ideas are derivative of those presented in Second Opinion: What's Wrong with Canada's Health Care System and How to Fix it, by Michael Rachlis and Carol Kushner, Collins, Toronto, 1989.

commence such a process begins with the community itself. There must not be any coercion from government. This process will be most successful when a community is in crisis. However, some variations of this plan is applicable to communities that are not in a general crisis but are unable to solve certain problems. Problems relating to establishing shared service arrangements with neighboring communities could be worked through with this approach, for example.

The four stages of community health development are;

1) Start-up

2) The Community Health Profile

3) Identifying Objectives / Establishing Goals

4) Health Development Strategy

In Appendix Three, a more detailed 'working' plan of action gives a preliminary step-by-step guide to initiating the process.

1) Start-up

In this phase, like the first in CED's, it is important to reach as wide a range of participants as possible. The venue for this meeting of minds could be a community health development workshop. All community members would be invited to attend. The principles of community health development would be discussed and gaps in the system would begin to emerge. Throughout this stage there will be conflict among participants as the different viewpoints, personalities and perceptions emerge. Diversity of opinion must be encouraged to ensure equitable participation and ownership of ideas. Peck would describe this stage in terms of pseudo-community leading to chaos.

2) The Community Health Profile

Here, the community learns to think of its health-related resources that are both

connected to formal health care as well as resources that are separate from the formal system. The community's strengths and weaknesses are revealed. Leaders may emerge from unlikely places and widespread involvement will spread. Strains from the preceding stage of chaos will linger, but the group will benefit from tangible signs of progress and naming their world and reality.

Comparable to an inventory list, a community's human, facility and service resources would be identified. These resources could include;

- under-employed teachers trained in special needs or gifted children;
- social workers;
- substance abuse programs;
- rape counselling and battered families shelters;
- child care information ;
- diagnostic equipment;
- number of acute care beds;
- number of long term beds;
- number of personal care home beds;
- specially trained nurses, and;
- provincial public health personnel and services.

3) Identifying Objectives / Establishing Goals

In this stage, the community makes decisions regarding its direction in health care. Rural communities have to think of themselves in relation with other communities. It may be time to initiate discussions with other communities. It is easier to have realistic expectations when one is aware of another's situation. Communication among communities is necessary because of the strength it gives individual communities when dealing with outside authorities and because cooperation in service delivery will result in more efficient and accessible delivery of care.

Communities will have to decide whether or not their members will support local health care services or use services in other centers. For example, some communities close to Winnipeg find their residents driving to the city for services (and goods) and not using their community's. Sometimes people want to have services in their community but do not use them enough to justify their presence.

The community may experience a period of what Peck would call 'emptiness' at this time. Members may feel let down by what seems to be either a futile mission or too big a job or responsibility. They may feel overwhelmed by the magnitude of the work ahead, not realizing that much of the hardest work has been done by this stage. This phase is the bridge to true community.

4) Health Development Strategy

Like the economic development strategy phase, this phase is both a summary of the first three stages and an action plan to implement goals and objectives. It also gives information of comparable work being done in other places.

By this time, the community will be ready to organize themselves and their ideas into a strategy. A process for reflection on action, or praxis, should be a fundamental part of the plan.

From the workshop settings of the three earlier stages, a working group, committed to health development could be formed. Currently in Manitoba, the only formal health-related body with representation from the community, is the hospital board and in some cases a health district board. There could be a community health committee that oversees hospital functions, perhaps in a subcommittee structure, but within the overall context of community health and related social services.

These community committees should be associated with other community committees to work out cooperative service arrangements. Both levels of committees could compile

and combine their inventories of available human, facility and service resources.

The salient point here is that communities must be able to identify their own health requirements. They should not be hampered by provincial standards. There should be a provincial recognition of diversity of circumstances and a realization that standards do sometimes draw down actual performance levels by imposing outside expectations and values that are impossible to aspire to or implement and efforts to do so only limit the development of appropriate ones.[21]

Conclusion

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[21]One of the difficulties in designing community-based health care programs is the problem of self-sustainability (Dennis G. Willms, 'Dilemnas, Trends, and Transformations in Community Health Worker Situations: Kenya's 'Nyamrerua of Saradidi', Environments, Vol.19, No.3, 1988.).

"These problems are attributed to the predominately clinical (curative) orientation of the health care infrastructure and the disease preventive and health promotive orientation of community-based health care programs. These tensions are emphasized in a number of structural relations: complex versus subsistence (peasant) economies; professional versus communal systems of accountability; modern versus traditional world-views; and biomedical versus holistic health system orientations" (101).

Those comments are directed at community-based programs in a developing country, but one could add to the list of contrasts, rural versus urban social and professional structures and the message would be the same.

In the Kenyan health program, informal leaders were identified in the community and were encouraged to represent their neighbours. The process of mobilizing a community was recognized as being very important to the outcome of the project and the informal leadership was seen as integral to that process. The author asks three questions for policy-makers and planners that have direct relevance to this thesis;

"1.How can programs be initiated in which community members will be self-reliant in their health care?

2. How can mutually supportive systems occur between the curative and clinically-oriented health care infrastructure, and programs that emphasize community action for disease prevention, health promotion, and family planning?

3. How should financial, administrative, and professional decisions be made which support the political will, intention, and abilities of local -level community leaders?" (102).

Willms refers to Paulo Freire's methods of uncovering knowledge through sharing and a consequent 'critical consciousness' as part of the process in identifying needs and procedures to meet those needs.

In this Chapter, the research findings are synthesized with the concepts of community and community building into some potential practical directions. Helping communities organize themselves to figure out the nature of their problems and channel their energies into self-determined directions, is a role planners can play.

The first section presented a summary of the thoughts and suggestions from some rural community people regarding solutions, or at least directions to take. It illustrates an astute awareness of the issues as well as possible changes to the system.

These ideas could be developed in a workshop setting with community residents, hospital administrators and board members as well as doctors, nurses and social services representatives. It could be the beginning of a process that identifies the problems, unites the entire community to a common goal and strengthens the community with a collective will to exert change and public activism.

R. Alex Sim offers some guidance on directions groups can take to achieve their purposes and makes a case for community originated development.

The recent community economic development movement has implications for local health care; some of its principles are altered and applied in recommendations for community health. The steps of a community health development process, modeled after community economic development methods, were described.

Although I reject the clamor that our entire health care system is in crisis, I do think that the situation in rural Manitoba is in a state of crisis. Economic decline, unstable social conditions, the aging population, the family farm in jeopardy, and the changes within the labor force, are evidence of what could be described as a crisis. Furthermore, the fact that the absence of a doctor in a small community can mean the closure of the local hospital and

the subsequent negative repercussions for the community, is a crisis situation. Community people feel alienated and angry that they have so little control or ownership in the day-to-day activities of their town.

A corrective response should not be a panicked one, however. This crisis presents us with an opportunity to begin a process of modifying the foundations of the medical and health care services and the rural way of life so that a real revival of community will start. It will not be a short term or quick-fix approach. It will be a systemic alteration and it will benefit many aspects of rural living and will work in concert with other efforts to resurrect community.

I have become convinced that the health care system should be restructured into some form of community-based services in a primary care model. This restructuring would occur after the community was mobilized into a rebuilding process. Community-based services are one "way of meeting the needs of people who are not well served by traditional health and social services or are not served at all. They are also a means of providing a reasonable level of accessible services in communities which would otherwise be underserved or served only by widely dispersed services necessitating travel over long distances" (Canadian Council on Social Development 1985 15).

Whereas traditional services are characterized by centralization, hierarchies and specialization, and oriented toward curing physical and social ills, community-based services are predicated on decentralized decision-making, public participation, team approaches, and self-help oriented toward prevention and health promotion....community-based services offer a perspective on social and health issues based on the premise that preventing problems by attacking their causes offers greater potential for improving well-being than curing problems once they have occurred. This approach does not obviate the

need for acute hospital beds or other types of illness-oriented and cure-based services, but it can reduce the need for them and allow a more effective use of resources (Canadian Council on Social Development 1985 17).

Taking care of one's health is a normal part of life: access to health care should also be a normal part of life. Most people will live and die without needing a CAT scan, or even an operation more complicated than a tooth extraction. Most people need to know how to eat nutritious food (and how to grow it, if they live in the right place), how to exercise properly and generally maintain a healthful lifestyle. They need to seek medical advise in emergencies, for chronic ailments, for pain, or when expecting a child. Parents need access to medical aid when their children are sick and when they are due for immunizations and other preventive care. This is, of course, over-simplifying the case, but it is to make the point that most of us will get through life requiring minimal help from the formal health sector and likely, very little tertiary care - mostly primary care.[22] Yet, this system, like the United States' one, has developed into a predominantly tertiary level system.

Primary health care addresses the main health problems in the community, providing promotive, preventive, curative, and rehabilitative services...(it) *includes at the very least education concerning prevailing health problems and the methods of preventing and controlling them, promotion of food supplies and proper nutrition, an adequate supply of safe water and basic sanitation, maternal and child health care, including family planning, immunization against the major infectious diseases, prevention and control of endemic diseases, appropriate treatment of common diseases and injuries, and provision of essential drugs.*[23]

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[22]According to Duhl (1986 78)," Primary care includes the delivery of services at first point of contact: family doctor or community clinic. Secondary care includes specialists, routine surgery, ambulatory care in a hospital setting, and laboratory and X-ray tests. Tertiary care includes care by "superspecialists" and such care as open-heart surgery, renal dialysis, and long-term psychiatric care."

[23]World Health Organization (1978) Report of the International Conference on Primary Health Care.

Many medical practitioners and facilities in this province already function in a primary care model. I am convinced of its value in the rural setting and encourage the extension of the goals and objectives of a primary care type of health system.

Alma-Ata, U.S.S.R. Geneva: World Health Organization.

CHAPTER SIX

SUMMARY AND CONCLUSION

The Problem and the Study

Reviewing the Problem

The central questions of this thesis are: How can Manitoba rural communities recruit and retain physicians? and What role does the community play in the process?

I did not commence this thesis knowing the answer to these questions. I thought I knew but I was mistaken, and the mistake became obvious when I realized that the narrow and traditional perspective with which I entered into this, was of no use in understanding the problem or developing solutions.

I thought the answer to the problem was to figure out ways of making communities more appealing to newcomers and of making doctors less intimidating and antagonizing to locals. I thought the medical system could remain essentially the same, but items such as licensing requirements for physicians might have to be meddled with to enforce a plan for provincial coverage. For many years I have worried about the treatment-oriented medical care system this culture is dependent on, but other than implementing some rather draconian measures to force physician involvement, I was unable to think of a way through the problems of our health care system and I certainly had no instinctive answers to the specific problem dealt with here.

Addressing the Problem

In this thesis, I have attempted to understand the problem rural communities have in recruiting and retaining physicians. I have suggested some possible direction for change that will have a long term, positive effect on rural Manitoba. I have approached the problem with a perspective that starts with the special needs and circumstances of rural communities and looks outwards. I have avoided an urban perspective that gazes romantically to the country. The difference is that by adopting this rural perspective, I hoped that there would be minimal interpretation of rural ways. I wanted instead to have a new and real appreciation of the viewpoints, opinions, sentiments and beliefs of rural residents.

Studying the Problem

To study the problem rural communities have recruiting and retaining physicians, I visited seven communities in Manitoba. Five of them are located in western Manitoba and two are in eastern Manitoba. I taped many hours of conversations, discussions and interviews with hospital people, community people and doctors. The discussions focused on;

- the role of communities in health care delivery;
- the perceived obstacles to access to medical care;
- the reasons physicians do not want to live and practice in rural communities;
- problems rural communities have generally, and;
- their attitudes towards government decision-making, among other topics.

(See Chapter Three for discussions regarding the analysis of the problem and Chapter Five for discussions regarding solutions to the problem from the communities' perspective.)

While this phase of the research was progressing, I was studying both the Canadian medical care system and the nature of community. The development of the medical care system in this country was traced in this thesis to show how it has grown to depend on physicians (practicing in state supported hospitals and protected by a very strong and influential professional organization), to function and to keep hospitals open and personnel working. Communities are dependent on hospitals (which, in turn, depend on physicians), not only for medical aid, but also for employment and community pride. (See Chapter Two.)

I had to understand what medicine and health have to do with planning and community. To that end, I read a number of books about holistic health planning, community planning and the wider subject of the regeneration of community. The literature taught me that there exists an inner sense of community in human beings and in social organizations that can be diminished by oppression but strengthened through a process of rebuilding. The rebuilding can occur through workshops or through community organizing. It is a long and arduous process but it can result in communities realizing their autonomy and their power. (See Chapter Four.)

The Findings

Discussions with community people revealed a deep resentment and anger towards urban dominated decisions that affect them in many different facets of life: economic

policies, health and medical care delivery and social services were three of the areas named.

The people expressed anger and resentment towards the medical profession, towards government decision-making and towards urban arrogance. They made some radical suggestions regarding controlling physicians' rights of where to practice. They think the medical care system trains doctors for a type of practice that is impossible in rural areas and that the entire system requires change. They believe the provincial government ignores rural circumstances and plans for them without any consultation or involvement from rural residents. It appeared that the communities are weakened and the people feel alienated from power over their lives.

The initial conclusions I drew from what I heard were;

- that the problem of recruiting and retaining physicians is widespread;

- that rural communities are at a real risk of dying. The people living there care very much about that;

- the recruiting and retaining problem is part of a wider phenomenon. It must be viewed holisticly and from a broad perspective to make sense of the nature of the problem, and;

- there is a need for a deliberate attempt to revitalize community. This will strengthen communities' autonomy, their economic health and their overall community well-being.

From what the people told me and from the literature I consulted, I concluded that the medical care system as it is currently organized in rural Manitoba is inappropriate for many reasons. Those reasons include;

- hospitals need doctors to stay open but doctors will not practice in rural areas because they are trained for consultative, high technology medicine and not the primary care required in the rural areas;

- small communities can not support a full service acute care hospital. They must share

services with neighboring communities;[24]

- hospital and health planning is currently dependent on the presence or absence of a few physicians. This leaves rural communities in a vulnerable state and adds to the alienation they already feel from decision-making and power, and;

- medical personnel other than physicians are necessary to the delivery of primary care but the current system does not make adequate use of them.[25]

Aside from the discoveries summarized above, I learned three fundamental lessons from this thesis. The first fundamental lesson is that democratic (community) processes are of the utmost importance in any social system; that they are in need of a boost, and; that without deliberate attention to them, this society easily slips into an undemocratic (technocratic / professional) way of doing things. Democracy is much more than one-person, one-vote. It is more than majority rule and it is more than representation by population.[26] Democracy is active participation by citizens from all strata, in every facet of their lives. This makes sense emotionally and intellectually, but it also makes sense psychologically if one accepts a basic premise that humans have an innate desire and ability to thrive and not merely survive, and can, therefore, take it upon themselves to think, to decide and to do for themselves. People will be more productive, more responsible and

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[24]Future Directions for Health Care in Saskatchewan recommended a ;"Restructuring of legislation and payment system to encourage the development and introduction of different medical practice models, including the encouragement of group practices, particularly in smaller communities" (1990 14).

[25]For example, the 1990 Report on Future Directions for Health Care in Saskatchewan recommended that; "Redefinition of the scope of nursing services to reflect increased professional responsibility and new circumstances which provide more opportunity for nurses to become more equal partners in the delivery of medical and hospital services. In certain settings, particularly rural Saskatchewan, nurses might become "gatekeepers" to a greater degree" (15).

[26]Many people suggest that our current federal system of representation-by-population is to blame for regional disparities because the two provinces with the highest populations are able to control federal pursestrings and policies. To correct the imbalance we need regional representation instead in either Parliament or the Senate. This was part of the Meech Lake debate.

ultimately, more healthy and happy, when they are involved with the means of production and the mechanics of governing.

Those human qualities are thwarted when power is in the hands of the few. The very essence of non-competitive cooperation is crippled and it becomes acceptable that decisions are made by a tiny minority without ever consulting the people whose lives are affected. This is passed off as democracy and those who challenge the intelligence and fairness of this, are dismissed as being naive.

The second fundamental conclusion is that when something is wrong with an institution (meaning institution in the abstract, not a building), it should be fixed. We sometimes keep trying to stuff a square peg into a round hole and even spend lots of money at it, until we finally must stop and decide to change the peg to fit the hole. In this case, it is clear that the medical system in rural Manitoba does not fit the needs of the people, the values, the landscape, the population distribution, nor the pocketbooks of the Ministry of Health. Since the lay of the land can not be changed, the structure and philosophy of the medical care system will have to change.

The third basic conclusion I draw is this. Every attempt must be made to reverse the tide of decline in rural Canada for the simple reason that it is worth saving. That is an interested urbanite's viewpoint: the viewpoint that matters belongs to the people who live in the country. While this thesis could not take on the challenge of rural recovery, it also could not avoid this larger context. The fate of rural Canada is an integral part of the problem.

A Vision for the Future

The purpose of this thesis does not include explorations into an idealized future. The problem of rural doctoring has expanded into holistic considerations. The fate of rural Manitoba, the organization of rural health care and the form of this health care have all come into focus as part of the problem. Along the way it has become useful to create a vision encompassing these elements. In Chapter Five: Future Directions, I presented some goals that this health care system could aspire to that would involve community rebuilding into a community-based health care system. I see a connection between overall community development and community health development that is vital to the survival and regeneration of rural life.

Rural Canada, particularly in the prairie provinces, is economically and spiritually depressed. Efforts must be made on all fronts to revive the traditional countryside values, while modernizing the methods of conducting business and farming techniques so that they emphasize principles of sustainable development and self reliance. As part of that regeneration, community-based health and social services, designed as part of a primary care outreach network, form a strategy that is conducive to adaptation to a land of diverse communities and peoples.

Community-based health services offer the kind of care for rural communities that best reflects the principles of autonomy, self direction and grassroot involvement espoused throughout this thesis. They could be developed in any number of ways and with a wide degree of variations. It will be the community people themselves who guide the evolution of the services with their active participation in researching and identifying needs, in planning and design, and in operating the services.

Community-based services, decided upon by the community, then, is the recommended course to work towards. To arrive there, communities will have to go through a rebuilding process first. That process, growing into the establishment of a different health care delivery system, will strengthen communities and serve to empower them. The benefits of

such an experience will be felt in the spectrum of community life and will contribute to an overall revival of rural living.

Community-based health services set up through a network of primary health care centers in rural areas could provide continuous care. A relationship could develop between the residents and the staff of the unit. These could be medium-sized centers strategically located among the towns and villages, with outreach units in other communities providing basic emergency and referral services. The acute care beds we have now, could be converted into convalescent beds for patients returning from, for example surgery or birthing, at a larger center. Recuperating near home is bound to be more successful than in a strange place, far from family and friends. A mother recovering from a difficult birth needs to be near her home, supported by her community, especially if she has other children to worry about.

Do we need expensively trained psychiatrists to fill every hole in the mental health care system in this province? We really need a network of, for example, child birth preparation classes, taught by community women who have been properly trained. This little adjunct will help women face childbirth less afraid, more knowledgeable, and better informed of all pre-natal issues, and would likely result in happier and healthier birthing experiences, with reduced incidences of postnatal depression. Community women, backed up by public health nurses, could also be trained to council new mothers. The atmosphere would be far more relaxed and normal and would decrease some of the stigma attached to seeking help. That stigma is what prevents many people from going for help. If this kind of support was routine, the healthful messages would be absorbed into the health beliefs, values, and practices of a community and its people.[27]

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[27]Independence, as opposed to dependence, is an indicator of well-being. However, knowing when to seek help is also a positive indicator and a sign of independence. Stoicism and stubborn individualism are not very different from each other, and do not contribute to living as a social creature. They tend to isolate and divide.

Training community people to perform some primary health care work also provides needed employment opportunities in rural areas (one of the concerns expressed in the Westarc Report), and directly involves them in the actual delivery of health care. Community health workers would form an essential part of the entire community effort to supply quality care and would be in a hands-on position to make informed decisions regarding a variety of health-related decisions in the context of a health committee.

The first stage in realizing this vision, is to begin the community rebuilding process. That will help the residents identify their goals and aspirations. It will help communities recognize their human and physical resources. It will help them choose the direction they want to take in the delivery and organization of health care to fit their community. The community building process is the vehicle, the mechanism, for connecting the community with its health and medical needs, strengths and weaknesses.

I envision a health care system in rural Manitoba that is a community-based, primary care network. It uses local health workers as a means of creating employment and of personalizing health information and support. The first stage in realizing this vision, is to begin the community rebuilding process. I have named this version of community building, community health development although, as the research found, health is an essential part of everyday living in rural communities. Rebuilding community can happen by concentrating on economic development or health development as effectively as other development targets.

The community economic development process can serve as a model for a community health development process because the principles are so similar. Those common principles are;

- communities must be ready to assume an involved position. To reach that point, the

community is in a crisis and the community is oppressed.

- self reliance and independence from outside decision-making is a primary objective;

- the benefits of community involvement will extend beyond the specific service targeted to reflect the holistic philosophy behind community development.

The four stages in a community health development process are;

1) Start-up; community people are urged to share ideas and problems with each other regarding health care delivery in their community;

2) The Community Health Profile; an inventory of community resources is compiled to indicate community weaknesses and strengths in human, facility and service resources;

3) Identifying Objectives / Establishing Goals; the community makes decisions regarding its direction in health care, and;

4) Health Development Strategy; a summary of the first three stages and an action plan to implement goals and objectives.

(These stages are described in more detail in Chapter Five.)

Recommendations

Returning to the two central questions of this thesis, which are: how can Manitoba rural communities recruit and retain physicians? and what role does the community play in the process? these wide ranging actions are suggested for three interest groups of the health care system. The groups are;

1) the provincial government as the source of fiscal support and policy determination;

2) the medical profession (through the Standing Committee on Medical Manpower) as the educators of physicians, the providers of medical and health expertise and a source of influence on the organization of facilities and services, and;

3) the community as consumers of health care and as participants in decisions affecting

their well-being.

1) The Provincial Government

I recommend that:

- policies be created to revitalize communities in rural Manitoba;

- the provincial government initiate a community support program that provides rural communities with facilitators or resource persons trained in community development;

- the facilitators work with communities, following the format suggested earlier or creating new ones as circumstances change, but with the objective of mobilizing communities to action;

- the government be prepared to implement decisions made by community development committees.

- the provincial government direct the Standing Committee on Medical Manpower to;

a) investigate affirmative action education policies on behalf of rural students particularly;

b) assist in community-based organization of health care (including recruiting and retaining physicians);

c) investigate fee-for-service versus salary arrangements in terms of effects on care and the community as well as effects on recruitment;

d) participate in coordinating and advancing the primary care model;

e) organize a newsletter for inter-community health care information;

f) develop a handbook on issues and options in initiating and maintaining a community health development process, and;

g) play a much more active role in stimulating direction in community revitalization through facilitating dialogue and encouraging and promoting networking among communities and between physicians and communities.

2) The Medical Profession

I recommend to the medical profession through the Standing Committee on Medical Manpower that;

- the education offered medical students be changed to encourage more general and community medicine;

- students should be taught general health administration and system delivery alternatives;

- students should be taught sociology, psychology and history to give them an appreciation of their work in relation to other aspects of society;

- students should learn to appreciate the background of financing medical care in this country and issues surrounding medicare to understand the hybrid nature of state supported medicine;

- students should learn to think about health in its dynamic, holistic sense;

- rural high school students must be encouraged to consider attending university but not only sciences and medical school;

- entrance requirements to university and medical school should be changed to correct the rural-urban imbalance;

- physicians who do relocate in rural communities should expend the energy and time required to become familiar with the hospital, the staff and the community. If doctors are on fee-for-service, then M.H.S.C. should cover physicians' costs while they have an orientation period;

- because rural customs are different from urban customs, physicians must appreciate the difference and try to see the world from the rural side;

- seminars, booklets etc. on physician responsibility to communities should be

provided to physicians', and;

- with a community health development resource person, conduct workshops with communities and physicians to help the two groups learn to communicate with one another.

3) The Community

I recommend to rural communities that;

- they initiate a community building process either on their own or by pressuring government for help in finding trained people to help them get started;

- communities should pressure government for funding to hire trained people;

- communities must decide on whether or not to provide housing to incoming doctors;

- rural communities must decide on the composition and mandate of hospital boards and to whom they are accountable;

- communities must decide on the level of involvement they want and need with other communities in shared services arrangements;

- rural communities must decide on how much they are willing to negotiate on health services in order to keep some level of primary care in their community, and;

- communities understand that without a great deal of commitment on their part and a lot of work in rebuilding, they may not survive.

Some Closing Observations

After approximately 15 months of intensive study on this topic, I would like to close with a few personal observations. These relate to health in general, to economics, to planning and to change.

In spite of the advances made due to self-help therapies and the women's movement in

the last few decades, and in spite of the sensible and inspired writings of Schumacher et al on human-scale economics, this society continues in a competitive and paternalistic, big-is-better mode. Economies of scale are taken to be the perfect model of industry, even when they are clearly inappropriate in some settings, such as rural Manitoba. That mentality carries over into health and medical care delivery. It is seen in the excitement over building expensive hospitals, even where there is homelessness, poverty, family violence, malnourishment and illiteracy. These indicators of poor health can not be cured within the confines of a hospital.

Is the objective of our health care system to improve the health of our citizens? Or is to cure illness? If we answer yes to the second question, then we will move along imitating the American approach, bankrupting our health care budgets, and aiming our sights at prolonging life because we are able to do it. If we could find ways of promoting healthy living and real control over one's life, in thirty years we will not need to perform quadruple by-passes to fix arteries clogged by a sickening lifestyle and stress. If we could reduce poverty and its accompanying ill effects, children in this country would not have to go to school hungry. They would be able to think of themselves as worthwhile persons. They could learn what they need to know and the cycle of poverty would grind down. If we could end the oppression that binds people to ignorance and despair we could build a truly democratic society and we would see greater productivity than we can now imagine.

One of the ways of achieving these goals is to strengthen community power and alter the decision-making procedures as they concern rural Manitoba.

We know that the current economic system fails rural Canada by leaving it vulnerable to externally set interest rates, subsidies, grain and oil prices, to name a few. What has been called 'western alienation' (originally an articulated response reflecting the resentment western Canadians felt towards the federal government and its obsession with central

Canada), should be looked at more carefully and critically because it collapses all four western provinces into a single-interest region. This is classic Canadiana politics and has done very little to adequately address the real problems that plague prairie economies. The answer lies in developing a new economics that is human scale, that is diversified and that is open to input from rural residents. The ideology behind this new economics is based on a belief that people do best when they have responsibility, duty and power.

Where A Planner Fits In

The central thesis of Sim's book is; "that the rural community suffers a unique disadvantage in a society dominated as it is by large-scale, hierarchical structures centred in cities" (1988 174). He agrees with Hodge that 'urban and city planners' are not equipped with a language or with the sensitivity needed to do the small-scale planning rural communities require. Planners typically apply the same techniques and the same vocabulary to rural situations as they would urban ones. Along with bureaucracies, planners meld small towns together into regions, rather than appreciating their uniqueness.

It is the responsibility of planners to adopt a sensitive value system towards rural development, and to learn how to speak with people and to encourage them to understand the nature of their problems. The bulk of responsibility in community rebuilding is, of course, with the community. Planners can help with gaining access to information; a critical step in the transferring of power. However, as Sim cautions, the initial need to know must start with the people themselves.

"The desire to realize the transfer of power to the community must grow spontaneously from a creative urge to know, a process that must be learned by doing....There is little possibility of rejuvenating community life until the habits of

dependency, of accepting the elitist tradition so strongly embedded in Canadian culture is broken" (1988 189).

Sim believes in a two-tiered approach to learning to participate. One is intellectual and involves asking questions and gaining knowledge. The other involves gaining experience from working with others. Planners can help with both spheres as soon as the community's spirit for participating is present. The evidence presented in this thesis supports my belief that that spirit exists. The question is: Does the commitment to revitalize rural Manitoba, including its health care services, exist in the halls of power of this province?

It is hoped that this thesis will contribute to the progressive social change that I am convinced we are capable of achieving and that the urgent need for change does not frighten us into inertia or reactive, misguided and desperate directions. The process of change matters as much as the objective itself. That lesson is perhaps the most important one of all.

APPENDIX ONE

Newspaper Articles Regarding Rural Manitoba and Problems Communities Have Recruiting and Retaining Physicians

Winnipeg Free Press. November 28, 1988.

Perimeter called Berlin Wall

Rural future looks gloomy, report says

By Randy Turner
Winnipeg Free Press

SOURIS — From the outside, the Perimeter Highway looks like more than just a stretch of pavement.

"It's sort of our own little Berlin Wall," said Souris businessman Dennis Tanguay. "It's creates too many problems.

"There's a lot of people who live inside (the perimeter) that can't look out, and a lot of people outside it who can't see in," Tanguay said.

'Perimeter vision' was a common theme drawn out in a federal report commissioned by the Department of Employment and Immigration, which casts a gloomy shadow over the future of rural Manitoba.

With the province's rural population shrinking and aging, business and community leaders in smaller towns are looking for answers in their quest to revitalize their communities.

However, they believe their efforts are hampered by misconceptions and a power structure that favors urban development, the study revealed.

"I think it's fair to say that rural people think city people get more than their fair share in terms of government money and services," said John Walker, senior research consultant for the report, compiled by Brandon's Westarc Group Inc.

"I think rural people are very sensitive about that."

Walker added that in some cases rural residents have reason to feel neglected.

Breakdowns of expenditures for federal and provincial economic development programs clearly indicate that the biggest share of the funds are allotted in Winnipeg, the report concluded.

That disparity may result from the report's finding that many residents in rural Manitoba have a limited knowledge of the programs or how best to take advantage of them.

"It's much more difficult to gain access to information concerning support services (outside of Winnipeg)," added Walker. "Information that's freely available in the city, they (rural residents) have to pay for."

Walker said that rural Manitobans feel shortchanged by Winnipeg much the same way that Winnipeggers feel shortchanged by Eastern political and financial powers.

That perception will not change unless governments reverse a growing trend to centralize public sector jobs in larger communities, said Miles Phillips, publisher of the *Boissevain Recorder*.

Phillips lead a delegation, which presented a brief to all three provincial parties, urging

Winnipeg Free Press. November 28, 1988.

Leaving the Land

Rural Manitoba is bleeding to death. Its young people are drawn to the bright lights and opportunities of the city, leaving a shrunken, aging population on the farms and in the small towns. Those who remain are trying to staunch the flow before it proves fatal to a way of life.

Second of a series

politicians to at least maintain the current levels of government and Crown operations outside Winnipeg city limits.

Even the loss of a few government employees can have a harsh impact on small towns, said Phillips.

"It seems silly in the city to worry about one lousy job," he said. "But one job in Boissevain (pop. 1,700) means the same as 300 jobs in Winnipeg."

"How do you expect business and private enterprise to invest in a community that the government is pulling out of?"

The provincial government recently closed the Land Titles Office in Boissevain, costing the town six jobs.

Political will is lacking

A vocal effort to keep the office in town failed, he said.

"Because we're small in size we don't have the political clout," Phillips added. "The political will is lacking because we don't have the people out here."

As the population base in rural Manitoba erodes, so too does the political power.

As late as 1978, rural ridings outnumbered urban in the Manitoba legislature. But the latest boundary commission has recommended that the number of urban ridings in the 57-seat legislature increase from 29 to 31, while rural Manitoba would be represented by 22 MLAs, down one from the current distribution.

The commission also recommends that the number of northern Manitoba seats be reduced from the existing five to four.

Phillips contends that people living in Winnipeg must realize that all Manitobans will be affected if the deterioration of the rural community continues.

"We have enough facilities here to serve a community twice our size," he said. "But if everybody moves into the city, they'll have to provide the same servies for people coming from small towns.

"Is this what Manitoba wants, to have everything in the city?"

Phillips acknowledged that the flow of residents from the rural to urban centres is a fact of life in today's society, like smaller streams flowing into a big river.

But current trends outlined in the Westarc report are simply not healthy, he said.

"If all those little streams dry up, the big river will dry up too," Phillips said. "And I don't think the people of Winnipeg realize that yet."

Winnipeg Free Press. December 1, 1988.

Rural communities told to shape up

Towns must take risks, official says

By Randy Turner

Here's the bottom line for rural Manitoba communities, a senior federal official says: only the fittest will survive and it will be up to the towns themselves to remain on the map.

That's the conclusion of Cal Stotyn, a senior Employment and Immigration official in charge of the federal department's regional and agriculture development programs.

"The idea that the government is going to solve the problem — it isn't going to happen," Stotyn said from Ottawa. "I'd be surprised if a lot more money would be put into rural development.

"They (community residents and farm operators) still have to make the decisions," he added. "They have to take the risks.

"If they don't do it, it won't happen."

Stotyn was responding to a recent report, commissioned by the department, which outlines the growing disparity between rural and urban populations.

The report, compiled by Brandon-based Westarc Group Inc., says governments must initiate long-term policy changes to establish industry in rural areas in order to reverse trends that put the rural way of life at risk.

Stotyn said there are already enough federal programs in place to help initiate rural development through regional offices. The $1.57-billion Canadian Jobs Strategy fund, for example, provides money and resources for rural job creation and development projects.

However, Stotyn admitted — as is underlined in the Westarc report — that rural areas have lagged in terms of access to such government programs because the programs are not promoted enough outside urban areas.

The department, he said, is already taking steps to raise the profile of training and industrial-development programs in rural regions.

Stotyn insisted that the future facing rural Manitoba — and Canada — is not all doom and gloom. He cited cases where residents have banded together to establish revenue-generating, job-creation projects suited to their regions; everything from enhancing potential tourist attractions to raising reindeer herds.

Farm operators can also take steps to subsidize their income by diversifying their operations, he said. For example, Stotyn noted that a group of farm operators in eastern Ontario identified more than 100 possible sources of extra income; everything from fish farms to farm vacations.

"While it's true that farm income is precarious at best, there are a lot of people who have found ways to deal with it."

Many of those income sources are agriculture-related, can be established on the farm site and do not require large sums of capital or government grants, he said.

Communities, he said, must take steps now to either reverse or capitalize on the

Winnipeg Free Press. December 1, 1988

trends outlined in the Westarc report.

Stotyn cited the increasing percentage of seniors in rural Manitoba, who are fast becoming the key component of many small towns, as potential for growth. And he disagreed with the notion that seniors will be a short-term industry.

Stotyn predicted the seniors' population in rural Canada will continue to increase.

"I think the smart communities and the smart business people will look at niches and ways to take advantage of that (aging trend)," he said.

The Westarc report noted that some Manitoba communites, especially Steinbach, are already promoting themselves as retirement communities.

Already, in small communities such as Hamiota, the personal care home and hospital have become the town's largest employers.

In fact, despite the list of danger signals identified in the Westarc report — the continuing trend to fewer and larger farms, the decided lack of small and large industries, the perceived lack of political will to address rural ills — optimism persists that rural Manitobans will outlast the problems they now face.

Souris businessman Dennis Tanguay echoed the sentiments of a number of the rural residents and community leaders interviewed for this series.

"My gut feeling is that Souris, and all the other Sourises in Manitoba, will survive," Tanguay said. "I think it's just the pioneer spirit of rural people. I think they will fight not to lose what they have."

Leaving the Land

Rural Manitoba is bleeding to death. Its young people are drawn to the bright lights and opportunities of the city, leaving a shrunken, aging population on the farms and in the small towns. Those who remain are trying to staunch the flow before it proves fatal to a way of life.

Last of a series

Winnipeg Free Press. December 1, 1988

Key recommendations from Employment and Immigration study of rural Manitoba

Key recommendations from a federal Employment and Immigration study of rural Manitoba conducted by Brandon-based Westarc Group last summer:

☐ Develop long-range government policies focusing on the establishment of industry outside of Winnipeg and slowing down trend for fewer and larger farms.

☐ Commission an in-depth study of development history of south-central Manitoba to explore the industrial success found there and determine if it can be duplicated in other rural areas.

☐ Improve accessibility in rural areas to any government programs designed to stimulate job creation and industrial growth.

☐ Develop policies and programs to address aging rural population bases, foreseeing implications related to health and social services and seniors housing.

☐ Change current criteria used to determine unemployment rates, as it may discriminate against residents of rural areas by underestimating rural unemployment. Also, develop a current and ongoing data base of economic and social indicators for individual communities and municipalities to facilitate regional development efforts.

☐ Stress recruitment of physicians to rural Manitoba. Shift emphasis to programs which will attract entry of young rural men and woman into medicine. Incentive programs dependent upon return of new physicians to rural area.

☐ Establish 'visions' for regions, to include possible development of natural resources or tourism potential distinct to region.

☐ Promote rural quality of life in order to preserve it.

☐ Curtail trends to centralize government services. Relocate government branch offices in rural communities, as has been done in Saskatchewan and Ontario.

Winnipeg Free Press. February 24, 1989

Rural growth key to strategy

FP FEB24/89

By Patrick McKinley

The province should use the departments of Health and Education as part of a new strategy to promote growth in selected rural communities, a report commissioned by the Filmon government says.

The Price Waterhouse management consultants report says the province must encourage development outside Winnipeg to provide greater economic stability.

But it says past rural development programs have been too thinly spread.

"We would recommend that resources be concentrated in those rural communities that demonstrate the capability to develop growth opportunities," it says.

Concentrating government services in designated communities is one of a series of recommendations in the 157-page report, one of seven consultants' studies released yesterday by Finance Minister Clayton Manness.

Sparse population

A summary of the studies was made public last month.

The report says that given their sparse population and lack of services, such as roads, not all communities can expect to be centres of growth.

Although it deals primarily with business development programs, the report says funding for health care, highways, education and other government programs should also be earmarked for communities that show the best potential.

But the president of the Union of Manitoba Municipalities said the government could run into severe political difficulties if it adopts the recommendation.

"It's maybe the right thing to do, but I think it would probably be dynamite out in the country if they tried it," Ray Sigurdson said.

"I imagine that would be quite all right with the communities that got picked, but there are a lot of others that wouldn't be happy with it."

Sigurdson said he hoped the province would not adopt the change without extensive consultation with rural residents.

The Price Waterhouse report says Manitoba's business development programs have

Winnipeg Free Press. February 24, 1989.

emphasized large and existing businesses when the greatest need is to create new job opportunities in rural areas.

Rural and northern areas now have to rely on government consulting and other services that are inconveniently located in Winnipeg, it says.

It says the province, already focusing on development of the health products and aerospace industries, should add energy-intensive industries and farm equipment to the areas singled out for special attention.

It notes Manitoba has abundant electrical energy and is already a centre for the manufacture of farm equipment.

The report does not say which rural communities should be singled out for growth.

But it says light manufacturing industries are poorly suited to the North, where manufacturers would have to compete with high wages paid by the forestry and mining sectors.

It says agricultural areas, such as the Pembina Valley, are better suited for manufacturing ventures.

It recommends streamlining delivery of business development programs in the North and rural Manitoba to eliminate overlapping responsibilities and excessive administrative costs.

The report proposes that cabinet set up a special committee to devote concentrated effort to an economic development strategy.

It says a central registry should be set up because the government now has no way of knowing if a company applying for aid is also getting funding through other programs.

The report also contains several references to the Canada-U.S. free-trade agreement, warning that Manitoba must develop plans to offset its negative effects and help businesses take advantage of free-trade opportunities.

Liberal business development critic Mark Minenko (Seven Oaks) said the Filmon government, which supported the free-trade agreement, has devoted too little attention to job training and other programs for those who are negatively affected.

NDP industry critic Len Evans (Brandon East) agreed, saying the government has done virtually nothing.

Meanwhile, a second audit report Manness released yesterday urges the government to avoid major expansion of social programs.

The report, prepared by a second consulting firm, calls for a prolonged period of consolidation in light of cost overruns in the Community Services Department over the past several years.

Among other things, it notes annual provincial spending on child welfare programs has increased to $45 million from $21 million since 1984.

Winnipeg Free Press. May 23, 1989.

First steps to better balance

The Filmon government has taken some helpful first steps toward slowing the growth of Winnipeg's dominance over Manitoba. The premier has put a minister, Jack Penner, in charge of rural development, opened cabinet office branches in Brandon and Thompson and assigned a task force to nominate government operations that could be established outside Winnipeg.

Because the departments and agencies tend to cluster close to the seat of power, government is especially hard to decentralize. They are, however, the only employers who work directly under orders from the provincial cabinet. Despite the difficulties, moving government offices is the quickest way to show concrete results from a decentralization and rural development policy.

Soon, however, Premier Filmon and Mr. Penner will have to lay down some principles and define some objectives for the decentralization and rural development effort. It can easily decay into a fruitless scattering of government goodies in rural districts which voted Conservative last year. It can lay new costs on government operations without noticeably improving the economy or the living conditions of rural Manitoba.

The Speech from the Throne provided a description of the problem to be solved: pressure on social services resulting from rural depopulation. The government's strategy to strengthen rural communities, the speech announced, includes decentralizing delivery of provincial government services. Mr. Filmon added a further explanation in his press conference: Winnipeg can and does grow on its own but government intervention is needed to ensure development for rural areas.

It seems likely, if the experience of other Canadian provinces and other countries is any guide, that young people will continue leaving rural districts and small towns, seeking work and starting their families in larger towns, in Winnipeg or outside Manitoba altogether. It is probably not in the power of the provincial government to prevent that slow but steady shift which has continued without interruption in Manitoba at least for the last forty years. The government can, however, notice the difficulties that result and try to minimize them.

One difficulty is that Manitoba has only one fully-equipped city for rural migrants to move to. Brandon and Thompson, attractive and pleasant communities for their size, cannot compete with the amusements, the labor market, the international transport links and the commercial services that are available in Winnipeg. As a result, urban drift in Manitoba means that one city keeps getting bigger and now accounts for more than half of the provincial population. That same city is also the provincial capital and a unified municipal jurisdiction. It elects more than half of the provincial legislature even though the electoral boundaries are skewed to the advantage of rural districts.

Part of the solution would be to focus provincial effort on Thompson and Brandon. The Filmon government intends to help renovate the Keystone Centre in Brandon, which is one place to start. It should also be improving the community colleges and the hospitals in those cities. It should be reviewing its own industrial development programs and those of the federal government to help ensure that those cities have strong and varied job markets. It should be pressing for improved rail and air service for Brandon and Thompson.

If the government scatters a land titles office for one electoral district, an agriculture department laboratory for another, simply to give every Conservative backbencher a ribbon to cut in the name of decentralization, then the dominance of Winnipeg will grow unchecked. The policy should aim to create more choices for the rural resident who does as a percentage of rural residents have been doing for years — upping stakes and moving to the city. It should aim to give them more cities to move to.

Winnipeg Free Press. August 28, 1989

Specialized nurses predict wider role

Law for paralegals seen as precedent

By Ruth Teichroeb

Midwives and nurse-practitioners are hoping the Filmon government's decision to expand the role of paralegals will be followed by a move to broaden the responsibilities of some health-care professionals.

Representatives of both groups say they are encouraged by Justice Minister Jim McCrae's recent announcement of forthcoming legislation to allow paralegals to operate despite opposition from lawyers.

Lynn McClure, a spokesman for the Manitoba Nurse Practitioner Association, said the government could cut health-care costs if it made better use of specialized nurses like midwives and nurse-practitioners.

"It means upsetting the status quo, which is what's happening to lawyers with the paralegal decision," said McClure, whose association represents about 18 nurse-practitioners.

Under review

"If the minister of health took an interest in it, that's where it would start."

Health Minister Don Orchard refused to say whether he will encourage a wider use of nurse-practitioners or legalize midwifery, saying through a spokesman that the issue is still under review.

The handful of nurse-practitioners now practising in Manitoba provide preventive health care and diagnose and treat patients in community health clinics as part of teams that include doctors, McClure said.

But nurses want the government to train more nurse-practitioners and amend legislation to allow them to bill medicare for services, like physicians.

"Nurses don't cost as much as doctors," said Vera Chernecki, president of the 10,000-member Manitoba Organization of Nurses Assocations. "We just have to convince those who control the purse-strings."

Access to health services is now controlled by physicians, Chernecki noted, adding: "We believe there is a place for an expanded role for nurses."

Midwives also are lobbying the province to legalize their services, which they say would improve medical care for expectant mothers both before and after delivery.

"I guess the government just has to make a decision that the health of mothers and babies is a priority," said Kris Robinson, who represents the newly formed Manitoba Nurse-Midwives Interest Group. "We're waiting for some response from the government, but I guess it's not on their list of priorities."

The province hasn't responded to a midwifery report submitted almost a year ago by the Manitoba Advisory Council on the Status of Women, she noted.

The report said that legalizing midwifery would cut health-care costs and give women of childbearing age a convenient and safe alternative to doctors.

Provinces now experimenting with midwifery in a hospital setting are finding it's a popular service, Robinson said.

For example, a midwifery program at Grace Hospital in Vancouver can't keep up with the demand, she noted.

"I think it would be a wonderful model for Manitoba," she said.

James Morison, registrar of the College of Physicians and Surgeons of Manitoba, said doctors aren't opposed to expanding the role of nurses.

"We support using nurses to their fullest potential," Morison said. "They've been expanding their roles in many ways already."

However, doctors would draw the line at nurse-practitioners being allowed to diagnose patients. "I think it is critical that the initial diagnosis is made by a trained person."

The college is also opposed to home-births, which are advocated by some midwives, Morison said.

Winnipeg Free Press. September 5, 1989

Incentive grants fail to keep doctors in rural Manitoba

By Alexandra Paul

About 25 per cent of the foreign-trained doctors eligible for incentive grants end up leaving their rural practices within two years, a provincial health official estimates.

"You pretty well have to go file by file to see where people have gone," Marcel Painchaud, executive secretary of the health department's medical manpower committee, said.

The precise numbers are buried in files and are not included in the committee's annual report, according to a copy provided by Painchaud.

The percentage appears significant but the numbers are small — only one or two eligible foreign-trained doctors leave their rural practice in any year, Painchaud said.

Critics, however, say the numbers show the government is wasting tax money on quick-licence doctors who leave rural Manitoba as soon as they can.

"They are getting all the incentives and educational leaves and it's costing Manitoba money just to be a stepping stone," Liberal health critic Dr. Gulzar Cheema said, adding he believes many of these doctors leave for other provinces after getting licensed in Manitoba.

They arrive on a work permit, are supported by the province to achieve landed immigrant status, then leave their rural practices.

Cheema said rural health officials are also out of pocket because they pay airfare and accommodation expenses to doctors who must be replaced later.

New Democratic critic Judy Wasylycia-Leis said, "Even if it's one doctor who is moved here and then leaves, it's a serious matter, given the shortage of doctors in rural and northern areas."

Both critics called on the government to open the program to landed immigrant doctors who want money to upgrade their training and qualify for medical licences.

A group of 16 immigrant doctors has promised to practise for five-year periods in rural and northern areas in return for educational funding.

Approximately 25 doctors are recruited annually into rural and northern Manitoba; about 12 are doctors trained in the United Kingdom, Ireland, Australia, New Zealand, South Africa and the United States, Painchaud said.

They receive medical licences without having to take extra training as long as they pass evaluation examinations, says the College of Physicians and Surgeons of Manitoba.

Six out of those 12 doctors must be left out of the

Winnipeg Free Press. September 5, 1989

equation entirely: they leave the province within six months and are not eligible for incentive grants and loans, Painchaud said.

They fill in for doctors on temporary leave for education or other reasons, so it is understood they will not stay.

It's the other six who are crucial to the rural doctors' program, funded out of a budget that was more than doubled to $700,000 in 1989.

These six doctors are on 12-month work permits and are eligible for grants and loans of up to $44,000 over four years to go north of the 53rd parallel, Painchaud said. South of the 53rd — which falls halfway between Swan River and The Pas — they can receive $33,000 over four years. Those settling in Brandon or Winnipeg are not eligible.

Twenty five per cent of these doctors leave within two years, after they receive landed immigrant status, Painchaud said.

He says the situation is not as bad as it is made to appear.

"We've been fortunate to retain a number of foreign medical graduates."

Half of the annual manpower committee budget is reserved for Manitoba medical students. The remainder goes to licensed doctors, including the foreign-trained.

The latest report, from 1987, said the committee spent $273,384 in total. It did not say how many foreign doctors received funding or give the amounts of the individual grants or loans.

Painchaud said foreign doctors were eligible for three separate programs, totalling $132,514.

"They are open to any qualified doctor no matter where they're from but definitely some (foreign ones) have taken advantage of them over the years."

The report said $20,945 in incentive grants was given to doctors accepting rural placements in 1987.

Another $67,934 was paid out in loans of $2,900 a month to rural doctors who enrolled in residency programs. A final $43,635 was paid to doctors upgrading their anesthesia qualifications.

Apart from $5,356 spent on administration, the rest of the 1987 budget — $135,514 — was handed out in loans and grants to University of Manitoba medical students.

The students can pay off the loans in cash or work them off in rural areas, Painchaud said.

Globe and Mail. October 3, 1989

The crippling of rural Canada

BY GERALD HODGE

Prof. Hodge teaches gerontology at Simon Fraser University and is the co-author of Towns And Villages In Canada (published by Butterworths, Toronto).

VANCOUVER

OTTAWA IS laying siege to rural life in Canada. It seems perverse, given the Conservatives' traditional suport by rural voters. But there's no other conclusion to reach after looking at the federal budget. Besides the burdens everyone will bear in a new sales tax and in income tax revisions, there are a host of budget items take direct aim at rural communities.

For example, most of the Canadian Forces establishments to be closed are not in urban areas. Small places such as Port Hardy, B.C., Portage La Prairie, Man., Summerside, P.E.I., Mont Apica, Que., and Sydney, N.S., are being forced to carry the burden of this deficit-cutting measure. In each case, the losses in jobs, local business and housing investment represent a huge share of the small local economies. Unlike cities, with other sources of new economic development, these gaps may never be filled.

Think, too, about where the crunch will be felt most with the dismantling of Via Rail. Transport Minister Benoit Bouchard will announce tomorrow what trains will be eliminated. The cuts will be in places such as Sackville, Sioux Lookout and Salmon Arm. These places, and thousands of others located on or near the main line, will lose one of the few major transportation links they have with other communities, both for their citizens and their visitors. An opulent express train to the Rockies or a high-speed rail line from Montreal to Toronto may serve urban vanities but they are meaningless to rural needs.

And the budget doesn't stop there. Large cuts are planned for the crop-insurance program. How can we ask farmers to produce precious foodstuffs for urban tables and bear all the burdens that nature visits on their crops?

Similar questions are raised by major cuts to regional-development programs. The places that need these programs are almost all rural, places that once stocked Central Canada's manufacturing and now find their resources depleted or outmoded. Also, these are the same places that need the unemployment-insurance program maintained, not cut.

This assault on rural Canada follows on the heels of that launched by the government's alter ego, Canada Post. To balance its budget, it has already begun to close 1,500 rural post offices.

So, it's no wonder that rural people are asking why should they bear the brunt of deficit reduction? Why no cuts in urban housing and transportation subsidies, or more reducing of urban military stations?

Is the Brian Mulroney government suggesting that rural Canada isn't worth saving? That it's dying anyway? The rural reality, not to mention geography, is quite different.

Even without the northern territories, 90 per cent of this country is rural. There are more than 9,000 small cities, towns and villages, compared to fewer than 70 urban areas, and they, along with the countryside, account for nearly one-third of the population.

This rural population has been growing steadily since 1961, requiring one million new housing units in the past 25 years. Statistically, there is little difference be-

Globe and Mail. October 3, 1989

tween rural people and city dwellers; their average household size, level of education, housing quality, income and participation in the labor force are about the same. One interesting difference is that small towns are becoming retirement havens — more than 3,000 have concentrations of senior citizens that are twice the national average.

Walk down almost any Main Street (or King Street) in smalltown Canada and you will be greeted by signs for supermarkets, fast-food franchises and real-estate companies familiar to urbanites. The TV dish on the front lawn confirms just how well rural people are plugged in to national, not to mention global, society.

This rural vitality springs from the cities' continuing demand for natural resources. Be it oil, wheat, lumber, minerals, hydro-electric power, gravel supplies or simple drinking water, city dwellers and their businesses have to obtain them outside the city limits. And where else would cities dispose of their leftovers? Vancouver sends its garbage to Cache Creek and Montreal's polychlorinated biphenyls go to Baie Comeau.

It's not just the cities that Canada's rural areas "help." Coal strip-mined in southeastern British Columbia fuels steel mills in Tokyo; large parts of northern Quebec have been flooded to light up New York. In short, when urban and rural fortunes are entwined, rural areas often get the dirty end of the stick.

GENERALLY SPEAKING, rural Canada is neither somnolent nor impoverished. But it is vulnerable. Rural economies tend to be one-sided. A single large industry — farming, forestry, fishing, mining, tourism or transportation — is usually juxtaposed against a gaggle of shops and a few public facilities.

To use a baseball phrase: there's not much depth on the bench. So if a local mill, mine or military base is closed, it's difficult to take up that slack. When the passenger rail service is pulled out, there may be no inter-city bus to replace it. When the local post office is closed, the new "super mailbox" is good only for letters; buying stamps or mailing a parcel means a long drive. (This especially hurts older people because as many as one-third them do not drive; taxis may be unavailable or unaffordable.)

Rural people are used to making do with less in their daily lives — they don't expect services and programs that equal urban ones. But they do want, and deserve, fairness and they want rural needs treated with respect.

It's worth remembering that rural people have long memories. The indignities suffered in the past at the hands of central governments and central institutions stick with them. Who's to say that the current barrage on their lives is different from Newfoundland's infamous resettlement program, the National Energy Policy or the shenanigans of the railway companies and banks in the early days of the West?

The twentieth was proclaimed "Canada's century," and when it began, this was mostly a rural country. Rural resources, natural and human, were essential to the burgeoning of urban Canada, and still are. (Why else do big-city corporations fight over mines in northern Ontario?) At best, it's paradoxical that the century should close with cities in the ascendancy. At worst, it's an inglorious end to have the federal government crippling rural Canada.

Winnipeg Free Press. January 31, 1990

Rivers loses MD, hospital

RIVERS (CP) — The departure of this town's only doctor has closed the hospital in this community of 1,300.

Since the weekend, the Riverdale health district's 16-bed hospital has stopped providing in-patient, out-patient or emergency services, administrator Glen Worthington said. "Basically, the hospital has been shut down."

Dr. James Lines left Friday and couldn't be reached for comment.

John Russell, chairman of the health district board, said even though Lines has been the town's only doctor for about 10 years, he complained his income was dropping.

"One of the things he always emphasized to the hospital is his income has been going down, down and down."

Finding another doctor may be difficult, he added.

Young doctors generally want to be where there are other physicians they can consult. Also, towns like Rivers have trouble competing with cities that can offer more in the way of leisure activities, he said.

Rivers is about 25 kilometres northwest of Brandon.

Brandon or Hamiota, about 25 kilometres northwest of Rivers, are the closest points with hospitals.

The only patient in the Rivers hospital when it was closed was taken to Hamiota.

Winnipeg Free Press. February 2, 1990

Shared clinics key to rural service

By Maureen Houston
Winnipeg Free Press

CARMAN — Medical practices with one or two doctors are disappearing in rural Manitoba, and banding together is the only hope for smaller communities that want to retain their health services.

That message surfaced here yesterday at the first hearing of the rural health-services task force.

It was also an emotional subject for many of the 40 health professionals who gathered to discuss the shortage of health care in their communities.

"I've been practising for 31 years and nobody has told me my practice is finished, " said Dr. George Mabon, the lone physician for Somerset and Swan Lake.

"I don't know where you heard this, but I don't think it's coming from the country."

Task force member Jim Westwood, a hospital administrator from Glenboro, said university studies have indicated that a practice with at least four doctors is the only viable option.

Rural Manitoba has 82 facilities with less than four doctors and only 30 with more than that.

"It upsets me to hear that this message is going out," Westwood said. "But linking together with other communities is still very viable."

Dr. Jim Menzies of Morden said the death of the one-MD practice is a reality rural areas will simply have to accept.

"It's very sad, but you're looking at evolution and you can't stop the tide from coming," he said.

But setting up a larger practice is no easy task in a time when many rural communities are struggling to keep even one doctor in town.

"My father and I used to be on call seven days a week and every weekend," Menzies said. "But a young doctor now doesn't want to do that and you're not going to make him."

Peter Elias, administrator of the Altona hospital, said that his town's problem in retaining doctors shows one- and two-man practices have to be kept alive.

"If you're going to provide health care to a community, then having those disappear would be the worst thing that could happen to rural Manitoba," he said.

Dr. Pat Doyle of Ste. Anne pointed the finger at disproportionate government funding to rural areas compared with facilities in Winnipeg.

"There has been an increase of

Winnipeg Free Press. February 2, 1990

only some 10 actively practising physicians in the rural areas in the 19-year period from 1971 to 1990," he said.

The solution, Doyle said, is to determine the various care needs of rural communities and allocate services appropriately.

"It is important to appreciate that not every town or hamlet should have a doctor," he told the task force.

But regionalization, he added, will not work because the idea of losing services to a neighboring town will discourage communities from co-operating.

Health-care professionals at the hearing were almost unanimous in their distaste for regionalization, preferring to use words such as "co-operation."

All agreed, however, that shared services are the only way to attract young doctors and keep rural health care alive.

The concept of shared services is distinct from regionalization, and implies that each community would retain existing health care.

Westwood, who acts as administrator for hospitals in Glenboro, Wawanesa, Baldur and Treherne, said the autonomy of each community board must be respected in any attempt to share services.

In Morden and Winkler, where plans are under way for a shared hospital to serve 30,000 people that combines specialty health services, has solved their recruitment problems, Winkler hospital board chairman Henry Neufeld said.

But professionals from smaller areas said that is easy for Morden and Winkler to say.

Joe Legault, reeve of the Rural Municipality of Cartier, said his area is struggling to find funds for an enlarged clinic in Elie to entice their doctor to come from Winnipeg more than three times a week.

The rural health services task force will hold five more hearings in rural Manitoba in the next six weeks.

Winnipeg Free Press. February 3, 1990

Neighbors get Carman twitchy

Plans for joint Morden-Winkler health centre raise fears about erosion of service

By Maureen Houston
Winnipeg Free Press

CARMAN — As Morden and Winkler go to bat for a joint health care facility, residents here watch anxiously from the sidelines, afraid their hospital may be the big loser in the regionalization game.

"There's an underlying concern about having a regional hospital and a very strong attachment to the local hospital," Carman Mayor Bob McKenzie told a rural health services task force here.

"If it (the future Morden-Winkler hospital) was perceived as an erosion of services here, I think it would be very easy to create great alarm in the community."

The most frustrating aspect for this town of 2,500, according to hospital board chairman Brian McGill, is a lack of communication with the two neighboring hospital boards.

Carman wants to know the score and help call the shots — especially if the new hospital is intended to serve Carman as well.

After the fact

"We're assured that we'll be informed, but we're a little concerned that we'll be informed after the fact," McGill said in an interview.

"That hospital is perceived as a threat here and our community is concerned, especially because health care is the biggest employer in the area."

Carman runs a 30-bed acute treatment centre that performs basic surgery and chemotherapy. Morden and Winkler, 40 kilometres away, have announced plans to dismantle their separate hospitals and create a shared 150-bed facility.

Winkler hospital board chairman Henry Neufeld said the plan is a first in Manitoba, a "futuristic" regional program.

It's mostly the word "regional" that has people worried, said Peter Elias, administrator of the hospital

Winnipeg Free Press. February 3, 1990

in Altona, 40 kilometres southeast of Winkler.

"It (the new hospital) is a very positive step for the area," he said yesterday.

"The only danger is that people get hung up on words — you talk about regionalization and the walls go up.

"We don't think of it as a regional centre. We look at it as decentralization of specialty services that are currently available only in Winnipeg."

The Morden-Winkler committee has consulted boards in Altona, Manitou and Crystal City-Rock Lake, but has yet to meet with representatives from Carman and Morris.

Morden hospital board chairman Jack Steedsman said it's just a matter of finding a mutually suitable date, adding he is well aware of Carman's fears.

"Their concerns and ours is that we don't take something of theirs that's viable," Steedsman said yesterday in an interview from Morden.

"That's not our intent. We want to provide something they don't have a chance of getting."

At the same time, however, he admitted there are no guarantees.

"We have to provide all kinds of services for our local people and we don't know that, five years from now, the Manitoba Health Services Commission won't say, 'Well, this or that is available in Winkler, so we might as well cut off the funding to Carman.' "

That's exactly what bothers Carman — regionalization in its truest sense. And that's why McGill is demanding some input.

"Regionalization without planning input from all affected groups within the region will lead to splintering of the area," he told the task force.

Steedsman said his group has to consult Carman, if only to ensure there is no duplication of specialty services.

"We want to make sure we dialogue with them. If we didn't, I could see the relationship breaking down.

"Carman is also a special case because it's being tugged by Winnipeg and by Portage (hospitals) and I guess they see themselves threatened by having to deal with another one."

But Steedsman also said he can't see Carman having as much use for the Morden-Winkler centre as other surrounding communities because of the town's proximity to Winnipeg.

Winnipeg Free Press. March 19, 1990

Shoal Lake economy swims against tide

By Maureen Houston
Winnipeg Free Press

SHOAL LAKE — For a small farming town in a province where the rural economy is slowly sliding downhill, this community seems to be holding on just fine.

The area boasts five major farm implement dealerships, a new curling rink, a hospital with three doctors, a high school, an RCMP detachment, and hydro and telephone offices.

Under the province's decentralization program, five positions were shifted here.

The town's population of 832 declined by only one person between 1971 and 1986.

Other Manitoba towns two and three times bigger should be doing so well.

However, community leaders are worried the much-publicized arrival of tough rural times will loosen their grip on prosperity.

Last year, the village and Rural Municipality of Shoal Lake formed a joint economic development board. This year, that board is participating in a community improvement experiment also under way in three other western Manitoba towns.

Westarc Group Inc., the applied-research division of Brandon University, is helping Shoal Lake, Boissevain, Melita, and Russell analyse themselves to develop a plan for the future.

"We want people to think about what they want their town to be like in the year 2000; what's their vision for the future," Westarc dirctor Bob Annis said.

A town hall meeting here March 1 kicked off a process of self-examination that will involve compiling a detailed community profile and identifying potential development strategies.

Mayor Mary Fiel said the meeting, with about 100 in attendance, was a resounding success.

"I was happy to see many people in their late teens out showing interest," she said, adding a survey on development ideas will be distributed to residents.

Although life hasn't changed much in Shoal Lake, its leaders say they can read the writing on the wall without glasses.

A few businesses have closed in the last year or so, including a large grocery store. Area farmers have escaped the worst of the recent drought, but aren't getting much richer. Local officials have been involved in an ongoing struggle to retain their high school, where enrolment is dropping.

"Our young people aren't staying and you have to have the young," Fiel said.

As easy transportation draws local shoppers and young residents to larger communities, opportunities for growth here are not clearly visible.

That's what the Westarc project wants to change.

"The restructuring (of the rural economy) has been a long, slow process and I think people are just now looking around their communities and realizing things have changed," said Annis.

Fiel insists the entire community must have input, rural and town dwellers alike.

"Everyone's concerned about what is happening," she said.

The Community Improvement Program grew from concerns that surfaced at rural development forums sponsored last year by Westarc and the Manitoba Community Newspapers Association.

Annis said the study is considered a pilot project because provincial rural development officials will be monitoring results in hopes of extending a similar program to other rural community.

The four communities currently involved have been chosen because they are spread out across western Manitoba, because of their "state of readiness," and willingness to be involved, Annis said.

"It will be a tool to work with when we go out and try to attract business," Dick Edmundson, former reeve of the Rural Municipality of Shoal Lake, said.

Winnipeg Free Press. May 6, 1990

Government needs to act on midwife controversy

Arlene Billinkoff
Under the Dome

As the chief medical examiner investigates the stillbirth of a baby at the Health Sciences Centre after a midwife was unable to perform a complicated delivery involving twins at a Winnipeg home, the spotlight has focused on the issue of midwifery.

On one side, opponents call for stronger penalties for unlicensed people who deliver babies, preferring the *status quo* where births can only be legally performed by doctors. On the other side, supporters urge the government to legalize midwifery and implement standards to ensure such people are adequately trained.

The conflicting views are not new. Neither is midwifery. It existed long before recorded history and even when doctors appeared on the scene they were not always available. Whether it was a matter of physical accessibility or financial impediments, many of our great-grandparents and grandparents were born at home with the help of friends, relatives and midwives.

With the passage of time, however, health facilities became more accessible and provinces passed laws which gradually phased out midwifery. At present, lay midwifery is illegal in every province. In contrast, Great Britain and the United States have legalized midwifery, as do most of the 210 countries which are members of the World Health Organization.

In Canada the practice has continued in remote areas and over the last few decades more people in urban centres have turned away from the formal hospital situation. In Ontario a task force conducted an extensive study which resulted in 70 recommendations, including recognition of midwifery as an autonomous self-regulating profession, which could be integrated into the health care system. Legislation was expected to be introduced this spring.

Interest has also been expressed in Manitoba. In the mid-1980s, when several pregnant women told Klinic Community Health Centre of their plan to have midwives deliver their babies, doctors at the centre knew it would mean home births — a practice opposed by most doctors. Therefore they were instrumental in developing a project at the St. Boniface General Hospital, where qualified nurse-midwives, who were trained in other countries, helped deliver babies in special birthing rooms. Doctors were available for back-up, if needed.

While that project was under way, the Manitoba Advisory Council on the Status of Women began work on what became a report and recommendations to the provincial government in regard to midwifery. Presented in September, 1988, it recommended legalization through a bill in which the scope would be defined consistently with the internationally-adopted definition of mid-

Winnipeg Free Press. May 6, 1990

wifery, implementation of standards and support for an independent governing body of midwives which would be responsible for self-regulation.

The government was urged to allocate funds for the establishment and operation of a midwifery training program, along with continuing education for renewal of registration to ensure continuing competency. The report also stressed the need for community-based health care centres throughout the province and the incorporation of midwifery services into the health care system.

Those services would be provided in approved settings such as community health clinics, birthing centres and private homes as well as institutional settings such as hospitals. All would be required to meet standards for safe and effective midwifery practice. Stressing the need for more options for women when they give birth, the report concluded that midwifery is a low-cost, convenient and safe alternative.

With sufficient safeguards, Liberal Leader Sharon Carstairs said her party would support the legalization, but Health Minister Don Orchard, who insisted he had no bias one way or another, said it would take several years — if at all — before the government gave midwives a legal right to practise. There definitely would not be any legislation until the next year at the earliest, he said, because several months were required to review the recommendations.

One year later, the issue remained in limbo, but hope for progress was expressed last August when the government decided to expand the role of paralegals. For supporters of midwifery, that seemed to be a parallel situation. The minister, however, said the report was still under review.

But for how long? The recent death of the unborn baby underlines the need for progress. Legalizing midwifery and setting standards would discourage such incidents.

Liberal critic Avis Gray accused the government of foot-dragging. When the minister received the advisory council's report 19 months ago, he promised to review the recommendations, she said. "We've heard nothing since." It seemed the report was just sitting on a shelf. She hoped the death would encourage him to dust off the report and assume some responsibility for establishing regulations for the practice of midwifery.

Orchard, however, insisted the province could not take a position on this controversial issue until it had more information about how it would fit into the health care system. It is necessary to assess issues such as training, liability, supervision and where midwives would practise, he said. The issue cannot be resolved easily.

That is correct, but the government appears to be stalling. If it is afraid of negative reaction to such trailbreaking, it should remember this would not be a new move and look at other countries where midwifery is already legal.

It fits into the health care systems because there was a willingness to do so. Is the Manitoba government willing?

Winnipeg Free Press. July 31, 1990

Smaller communities urged to unite against growing threat

By Bud Robertson

UNLESS they join forces to combat their crumbling economies, many of Manitoba's small communities may not survive, says the head of the province's rural economic development branch.

Many small towns and villages have few resources to begin with and it is these communities that must join forces to provide the kind of amenities that will attract new residents and keep those who are already there, said Leo Prince.

"They're going to have to start doing it, because what's going to happen is that none of them will ever be strong enough to attract (businesses) and what's going to happen is people are going to keep on going away from those communities for goods and services."

And as the farming community declines, the situation becomes even more critical.

Since the early 1940s, the number of Canadian farms has been cut by more than half, according to Statistics Canada figures, dropping to 300,000 from a peak of nearly 733,000 in 1941.

As the number of farms fall, so does the population.

In 1941, more than three million people, or 27 per cent of the total population, lived on farms. By 1986, the figures had dropped to four per cent, or only 930,000 people.

And as they leave the farms behind, many are forced to move to where the jobs are.

In fact, 1986 census figures show that 58 per cent of all Manitobans live in Winnipeg.

In order to help communities help themselves, the provincial government provides annual grants to each of the six rural development corporations in Manitoba.

Municipalities also pay membership fees to the local corporations, each of which has its own board of directors.

"Government should really be there in a position to facilitate, to assist but not to do it for them," said Prince.

Keeping up in rural Manitoba

Part 1

Faced with a crumbling rural economy, many Manitoba communities have been forced to take a long, hard look at themselves. In this three-part series, Free Press reporter Bud Robertson focuses on the issues and what some communities have done to try and keep up with the changing times.

Not only must communities work together to solve their own problems, so must those within each community.

Instead of pitting their energies against one another, urban and rural leaders must work together to address economic issues that threaten to destroy everyone's livelihood, he said.

That includes building the image of a strong community with ample health and recreational facilities and an infrastructure — such as good roads and sewage facilities — that can accommodate new industries.

Many communities don't have a plan of action to address the major issues, said Prince, adding they need to build upon their strengths and overcome their weaknesses.

"I think it's really important for communities to get those, what I call blueprints," he said, adding they don't have to be fixed in stone.

"They should be flexible documents that are created by the community, who is in the best position to know what its capacity is in fulfilling it."

In preparing their strategies, communities must also identify social, cultural and economic needs, he said.

"I think we've come to understand that there's certain things that people require in helping them define why it is good to be in a community."

Winnipeg Free Press. July 31, 1990

One of the first steps communities can take in building a strong economy is to expand or maintain the services they already have, said Prince.

Pride and spirit

Secondly, they can develop business enterprises within the community: "So that local people are investing in local enterprises, hiring local people.

"It has to do with that will and that community pride and spirit. . .where people say they believe in themselves and they believe in their community."

Surveys show that 80 per cent of all new job creation is a direct result of local entrepreneurship.

The third strategy for communities is to try to attract investors from outside.

But, competition for investors' dollars is fierce, said Prince, and bigger centres can commit large amounts of capital for prospecting.

"It's really become a fairly sophisticated thing," he said, "and the monies that are required to do it properly are really out of reach for smaller communities."

With a sagging rural economy, some communities have moved away from agricultural-based industries, said Prince, adding others simply don't have the infrastructure or the workforce for anything else.

Communities are encouraged to conduct labor market surveys, he said, to determine what kind of a workforce they do have.

The future labor force is also important, said Prince, and employment opportunities that interest local students should be explored.

Community leaders must find ways to attract these students back home, he said, "because if anybody's going to return to those communities, it's those that have actually lived in them."

But, he added, they are more likely to return to a healthy community.

"They know they can be reintegrated. There's opportunities for them, and that's the major concern."

There is hope for rural Manitoba, said Prince.

"It all depends on how people organize themselves to address those issues."

Everybody's business

There must be greater co-operation between all parts of society to define what can be done, he said.

Economic development "is everybody's business," said Prince. "It's not just the privy of the business community, it's everybody.

"Because everybody who's transacting in dollars is involved in economic development."

APPENDIX TWO

List of Example Questions for Community People and Physicians

COMMUNITY

- What constitutes community pride / spirit / identity?
- Where /how do community organizational structures fit in to the 'spirit'?
- What makes a town initiate its own Healthy Communities project or declare itself a Healthy Community?
- How important is a hospital to a town's identity?
- How important is a resident physician to a town's identity?
- What are the community's expectations in terms of availability of their doctor?
- How long does the community expect their doctor to stay?
- What kinds of facilities are there?
- What kind of support staff are there?
- What kinds of community events take place?
- Are they organized by an outside agency, like the government, or by local groups?
- Are the same people involved most of the time to the exclusion of many, or does everyone get into the act?
- What kinds of volunteer groups are there?
- How strong are the churches?
- Has the community ever experienced a catastrophe, natural or otherwise? How was it handled?
- Are there commercial businesses that provide services for just about everything, or is there a need for informal exchanges of services?

- How many people does the hospital employ?

- Does the hospital ever have to import workers or is the community able to provide the proper staffing?

- Where are they trained, if the job requires special training?

- How autonomous does the community feel in terms of, for eg. bureaucratic and governmental services?

- Why is your hospital important to your community?

- Why is it important to have a resident doctor?

- How important do you think it is to have a resident doctor?

- What kinds of services do you think are important for a resident doctor to provide?

- What do you think would be a reasonable work schedule and time-off schedule?

- Why do you think doctors don't seem to want to move here?

- Do you think doctors are paid enough? too much?

- Do you think doctors expect too much?

- What kinds of adjustments do you think doctors must make if they move here?

- Do you think it is better to pay doctors a salary or on a fee-for-service basis? why?

- What do you think doctors are good for?

- How does it make you feel when doctors won't come here to live?

- What should a community do to entice a doctor to come and stay?

- How involved should your community get in the process of recruiting and retaining doctors?

- Is it your responsibility or is it someone else's responsibility? who's is it and who would handle it best?

- What should families of physicians do to be happy here?

- What do you think it's like for them to come to a new place and settle in?

- Where do townspeople go for services?
- What do city people know about your life here?
- How do you feel about preventive health?
- How is information disseminated here?
- How close are community people to each other?
- What kind of relationship does your community have with other communities?
- How important is it that your doctor is a University of Manitoba grad?
- How much information do potential candidates ask for when considering a town?
- How much do they receive and from whom?

PHYSICIANS

- How important is it to a community that their MD is a University of Manitoba graduate, a local, a foreign grad?
- Does it factor into the success / failure of the process?
- Do townspeople relate differently depending on the MD's origins?
- How much information do potential candidates ask for when considering a town?
- How much do they receive and from whom?
- Does a physician think of her time there as 'paying her dues', professionally?

-Does she ever think of a community as a new home and then become disenchanted with the life or conditions and leave? ie, what is her attitude when she accepts the job?

- Does anyone interview departing doctors?

Here are some questions I would ask departing doctors;

- were you bored socially? culturally?
- what kind of living accomodation did you have?
- did you get any help finding a home?
- was your spouse / partner able to find something to do that they liked?

- if alone, did you find any romantic interests?
- were people nice to you?
- were you ever lonely?
- do you get along with your co-workers, or were there personality conflicts?
- were your children able to settle in? did they like their school? were they happy?
- did your patients trust in you? if so, did you like the feeling or was the responsibility a little overwhelming? if not, do you know why people didn't trust you?
- was the picture you received about the community accurate? or did someone neglect to tell you something?
- were you disappointed professionally? what was the nature of your disappointment?
- if yours was a group practice, did the other doctors provide you with the kind of support you needed? was the sharing of responsibilities fair and equitable, e.g. time off, on-call periods?
- what kind of medicine interests you?

Here are some questions I would ask incoming doctors;

- what kind of medicine interests you?
- what do you know about community medicine?
- what is your philosophy on primary care?
- where would you like to be professionally in five years?
-what are your favorite pastimes? interests?
- have you ever lived in a small community before?
- have you ever practiced in a small community before, and if so, under what conditions?
- what do you know about this part of the province in terms of geography, economic activity, history, people?
- what will your spouse / partner do in this community for work; will he / she

get involved in community affairs etc.?

- what do your children do for extra-curricular activities?

- are they happy with the prospect of living in a small community?

- how many days of holiday do you expect and want?

- how much time on-call do you feel is reasonable?

What are physician's perceptions according to SCOMM's records? Are they really the ones listed in the 1987 Annual Report [28] i.e. are those local graduates' perceptions or experienced physicians' reasons?

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[28] According to SCOMM's 1987 Annual Report, "Some of the barriers to rural practise have been perceived (by local graduates) as follows:

a) isolation from professional colleagues

b) overwork resulting from public demand for continuous service

c) lack of acceptable housing

d) limited social and cultural amenities

e) high cost of establishing a viable practice

f) high cost of living, particularly travel for vacations, business or professional meetings

g) difficulty of getting a temporary replacement to permit travel or attendance at meetings

h) lack of educational opportunities

i) constraint on fee income and its potential for growth due to limitations of population in the catchment area

j) lack of confidence or security to practise in a more isolated milieu, without ready access to sophisticated diagnostic and treatment resources, as well as consultation services, may reflect badly on the education and training of our graduates. Should more experience be gained during the internship and residency training in a community setting? This is particularly relevant at this time when the mandatory two year entry to practise is being considered: is the additional second year to be more of the same, e.g. tertiary care, or is it to be mainly in a community setting?" (13-14).

APPENDIX THREE

Procedure to Initiate Community Building Process

Based on the community economic development process, the following is a proposal for the commencement of a community health development program. A community health development process could begin with an organizer following these steps. They are not intended to be more than a guide, and would have to be adapted according to the setting, the groups already in place in a community, the severity of the situation and so on.

1. Choose clusters of communities that are located in different regions of the province for their locational diversity and associated economic and social circumstances. (For instance, the Group of Five {Rossburn, Russell, Birtle, Shoal Lake and Hamiota} in Western Manitoba could be one; Whitemouth, Lac du Bonnet and Pinawa in the East could be another, and; the Red River Valley Health District in the South, a third.)

2. Organize meetings in each community, giving as much advance notice as possible and with as much publicity as possible to improve the chance of attracting a wide range of people and interests. Announce it as a first of many workshops with the first one designed to relay the ideas of community health development and the possible directions the community can take. Regional Provincial public health representatives should be included as well as any known social service agency employees. The objective would be to go into the meeting with egalitarian positioning, openly recognizing special interests, training and talents but assuming even community interest: relate to and work with the community as a whole. In addition, the opportunity to participate must be clearly available to all so that

taking part will be seen as a normal, non-status and non-elitist experience. The purpose in community rebuilding is to mobilize the community and maintain it with informal leadership.

3. Contact the various groups of people, plan a community awareness program and organize the format and other details pertaining to the meeting. It will be critical that the bulk of the involvement, and hence, the initiation process, comes from the grassroots level, and not the top down, established community leadership. It is more likely that the people who typically are involved will certainly become involved if it is apparent that there is widespread community participation. It will also even out the competing interests and will lend credence to any conclusions drawn if the process has cross-societal support and input.

4. Coordinate and act as a facilitator at the first set of meetings. Begin with a brief explanation of the goals of the process and notes of caution about the inevitable troubles that the process of community action entail. Outline the need for an inventory of health and social services and ask for submissions from the participants for the planner to develop and maintain a list. Explain that if the community is not interested in meeting the challenge of building community and a community-based health care system, that is their choice and they are not being coerced in any way to take part.

5. Summarize the discussion of the meeting and make copies available to all participants in a follow-up newsletter. Ask for continued involvement and set out an agenda for continued workshops.

6. At subsequent meetings, help the community develop a set of priorities for action. Watch for potential leadership skills and interest and the foundations of a health committee.

7. Help the group develop networks within the community and with other communities as well as communiques to government authorities.

8. Submit a mid-term evaluation at six months, prepared with at least some members of the group.

9. Set out guidelines near the end of the term that a successor, or preferably the health committee if it is firmly established, could follow to continue the process.

10. Submit a full evaluation at one year, prepared with at least some members of the group.

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