

**REAP Sponsored Year 4 Rural Electives
(an early outcome study)**

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Background

The purpose of the Rural Education Action Plan (REAP) UBC Year 4 Undergraduate Medicine Program is to encourage UBC fourth year undergraduate medical students to spend additional time in rural medical practices in the hope that it will increase the likelihood that they become rural physicians. REAP has provided stipends and travel expense reimbursements to medical students completing rural electives since 2001.

Definitions

In this study 'Rural' is defined as any Rural Subsidiary Agreement Community (RSAC). ⁽¹⁾ Rural and RSAC are used interchangeably in this paper and mean the same thing. The terms 'rural elective' and 'rural rotation' are used interchangeably in this paper and mean the same thing. Rural rotations or rural electives refer to any UBC Medicine Undergraduate Program Year 4 rotation that occurs in any RSAC. Rural 'Hometown' is any RSAC 'Hometown' as provided by a UBC MD in a Graduation Program.

Objectives

This is the first study that attempts to measure whether or not, and to what extent, REAP's Year 4 (Y4) rural electives program correlates with an increased likelihood of rural practice. Prior evaluation studies have measured this program's usage but were unable to examine actual outcomes due to the length of time needed for a sufficiently large group of medical students to complete their training and enter clinical practice.

In addition to analyzing the programs overall success, this study attempts to answer the following questions about which rural electives REAP should support.

1. What, if any, correlation exists between the cumulative amount of rural elective time and the likelihood of rural practice?
Answer: There is a strong positive correlation between Y4 rural elective time and the likelihood of rural practice. Pages 6-8.
2. Should there be a maximum number of REAP funded rural elective weeks or rotations?
Answer: No. Pages 6-8.
3. Are students who only complete post-CaRMS match rural electives less likely to practice rurally?
Answer: No. Page 9-10.
4. Are students who only complete rural family practice electives more likely to practice rurally?
Answer: No. Pages 11.
5. CCFP's or RCPSC's – which group took more Y4 rural specialty electives?
Answer: CCFP's took more as an absolute number, but both groups took the same percentage of their rural electives as rural specialty electives (47%). Pages 13.
6. Are graduates who provided a rural 'Hometown' more likely to practice rurally?
Answer: Yes, CCFP's are 4.2 times more likely and RCPSC's are 6.3 times more likely to practice rurally. Pages 14-15.

Methods

Data selection

The original dataset started with 2,522 UBC Medical school graduates from the Classes of 2008-2017. From this dataset were removed: those who could not be located; those who had not completed their residency as of February 2022; and those who either did not provide a 'Hometown' or provide a 'Hometown' outside of British Columbia (BC). What remained was a dataset of 1,875 physicians who: graduated from UBC's Distributed Medical Program, had completed their residency, and were 'native' to BC. These 1,875 physicians were divided into two groups. The Canadian College of Family Physicians (CCFP's) dataset consisting of 833 physicians and the Royal College of Physicians and Surgeons of Canada (RCPSC's) dataset consisting of 1,042 physicians.

Reason for limiting the dataset to Class of 2008-2017

It was decided to limit the analysis to the Class of 2008 onwards so as to avoid the potential confounding variable of differing MD Undergraduate education systems. All physicians in this analysis were graduates of the Distributed Medical Program. The UBC Faculty of Medicine, MD Undergraduate Program website states *"The distributed medical undergraduate program aims to improve upon the low number of rural and Indigenous students seeking medical careers, while also allowing students to complete their training in rural and underserved communities, where, as studies suggest, they are more likely to return to practice once their training is complete."*⁽²⁾

Reason for limiting the dataset to BC 'Hometown' graduates.

Publically available UBC Graduation Programs from UBC Ceremonies and Events Office website were referenced for the years 2008-2017 to obtain the 'Hometown' of medical school graduates⁽³⁾. Only those graduates who provided a 'Hometown' native to BC were included in this analysis. It is assumed that 'Hometown' is a self-identification of one's background, and could therefore be used to identify graduates from both rural and non-rural BC. Those graduates who provided a 'Hometown' non-native to BC or who did not provide a 'Hometown' were excluded from this analysis.

The purpose was both to identify those graduates who self-identified as coming from Rural Subsidiary Agreement communities as well as to remove the possible confounding variable of out of province students who might never have intended on practicing in BC.

Reason for splitting CCFP's and RCPSP's into separate groups.

It was decided to analyze CCFP's and RCPSC's as separate groups because CCFP's are more likely to practice in rural communities compared to RCPSC's⁽⁴⁾. Family physicians constitute 73% of RSAC physicians. Family physicians constitute 47% of non-RSAC physicians. CCFP's also often have shorter residencies. There was concern that RCPSC's who completed longer residencies outside BC might be more likely to 'get settled' in those provinces and thus be less inclined to practice medicine in BC after completing their residencies.

Limitations

No adjustments were made for which medical schools the physicians completed their residency at or which residency streams they may have trained in. This was because there was insufficient data to identify at which medical schools many graduates completed their residencies. Removing physicians for whom the school of residency was not known would have greatly reduced the size of the dataset.

Rural retention was not examined. This analysis only looked at outcomes in terms of incidence (recruitment) to rural clinical practice. A physician was determined to be rural regardless of whether they practiced in a rural community for 1 year or 13 years. Rural retention was not examined in this analysis for two reasons. Firstly, the statistical complexity of the analysis exceeded the available skillset. Secondly, the limited number of years many physicians in this dataset have been in clinical practice since completing their residencies might lead to erroneous conclusions. Physicians are more likely to move about in their early years of clinical practice before settling in a long-term practice location ⁽⁵⁾⁽⁶⁾.

The CPSBC Medical Directories used to determine physician communities of practice are an annual snapshot. Changes to the physician demographics can and do occur between the dates at which the Medical Directories are produced.

Results

Rural Electives and the Likelihood of Rural Practice.

CCFP's

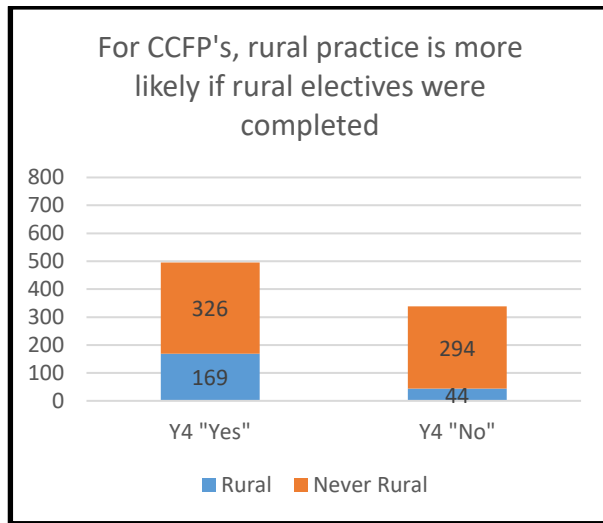


Figure (1) Comparison of the number of CCFP's who completed rural electives and practiced rurally with those who did not complete rural electives.

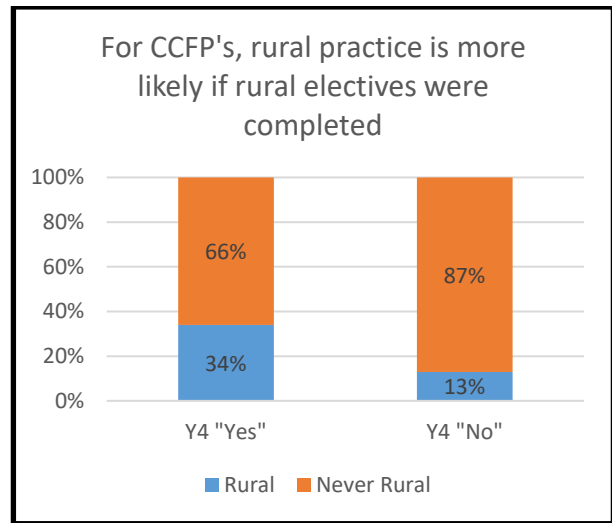


Figure (2) Comparison of the percentages of CCFP's who completed rural electives and practiced rurally with those who did not complete rural electives.

CCFP's who completed rural electives are just over two and a half times more likely to practice rurally at some point after graduation (Figures 1 and 2).

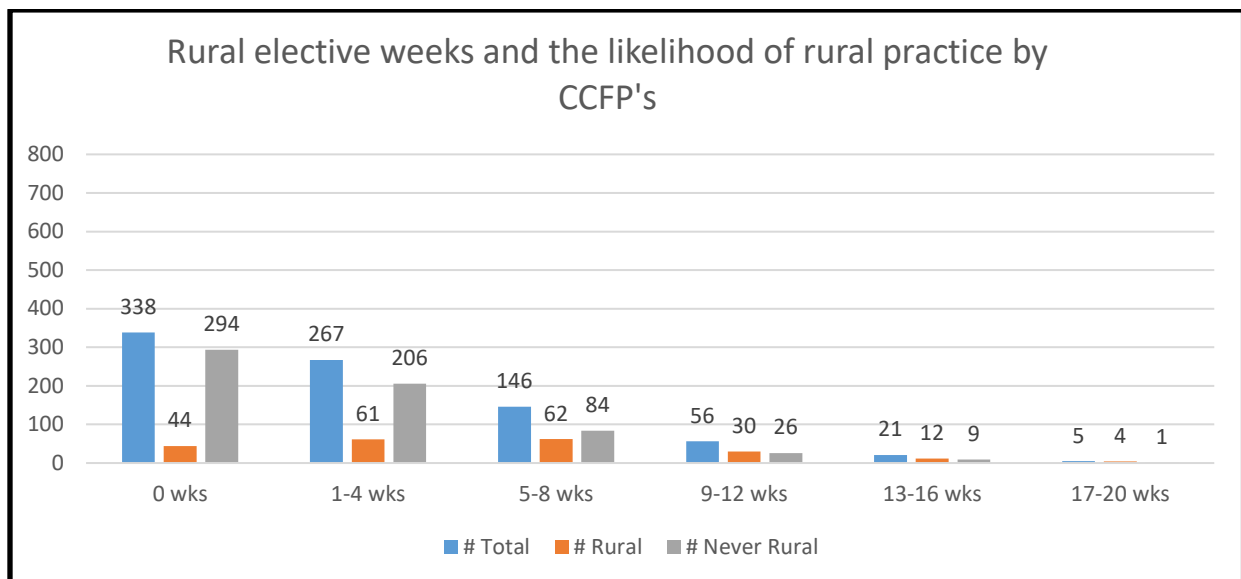


Figure (3) 41% of CCFP's had no rural exposure during Year 4.

The large number of CCFP's with little or no Y4 rural exposure means a large number (44) of rural physicians come from this group. Of the 213 rural CCFP's, 105 (49%) had four or less weeks in rural electives (Figure 3). The pattern for CCFP's and RCPSC's is similar with the exception that RCPSC's were less likely to have taken any rural electives. Of the 89 rural RCPSC's, 73 (82%) had four or less weeks in rural electives (Figure 7).

For CCFP's, 59% (495 out of 833) took rural electives. For RCPSC's, only 30% (313 out of 1,042) took rural electives.

The likelihood of a CCFP practicing rurally increases with the number of rural elective weeks they complete (Figure 4).

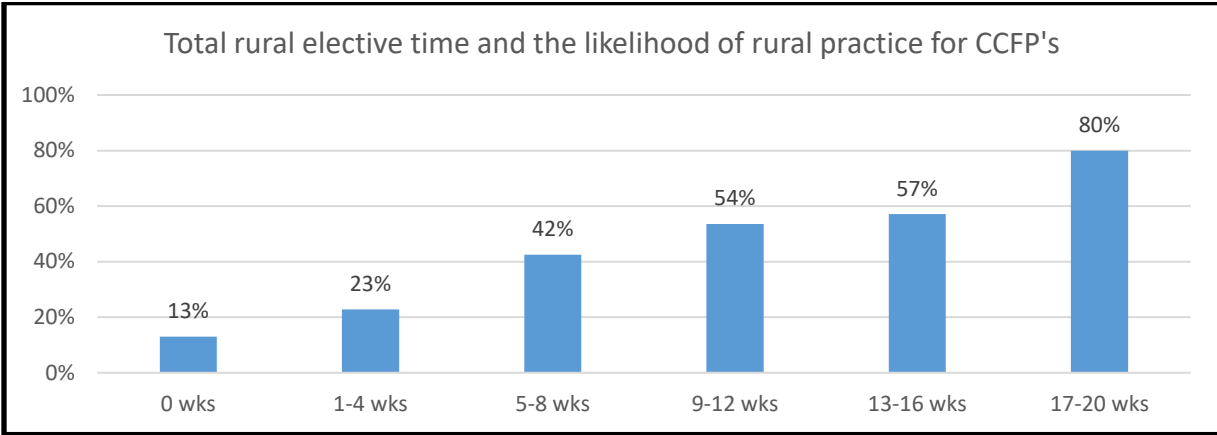


Figure (4) For CCFP's, the likelihood of rural practice increases with rural exposure.

In total 26% (213 out of 833) of the CCFP's in the dataset have practiced rurally at some point in time. For CCFP's, 34% (169 out of 495) of those who completed any rural electives eventually practiced rurally. It should be noted that the 80% success rate for the 17-20 weeks group is based on a total of only five people and should be interpreted with caution.

RCPSC's

RCPSC's who completed rural electives are just over three times more likely to practice rurally at some point after graduation (Figures 5 and 6).

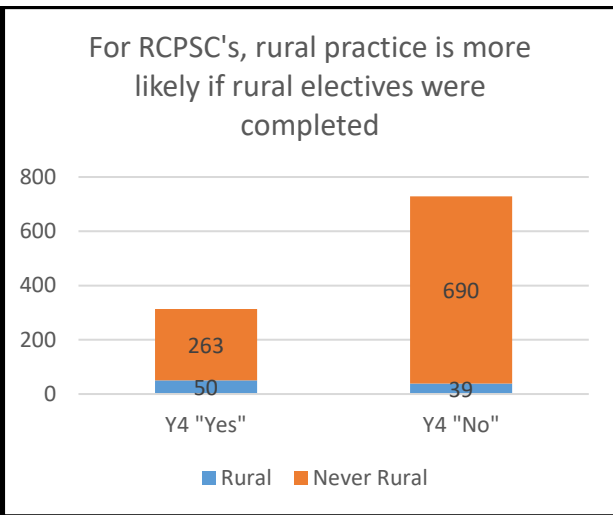


Figure (5) Comparison of the number of RCPSC's who completed rural electives and practiced rurally with those who did not complete rural electives.

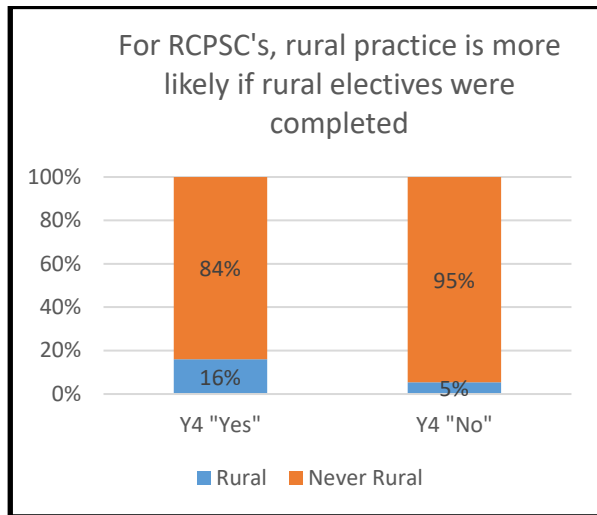


Figure (6) Comparison of the percentages of RCPSC's who completed rural electives and practiced rurally with those who did not complete rural electives.

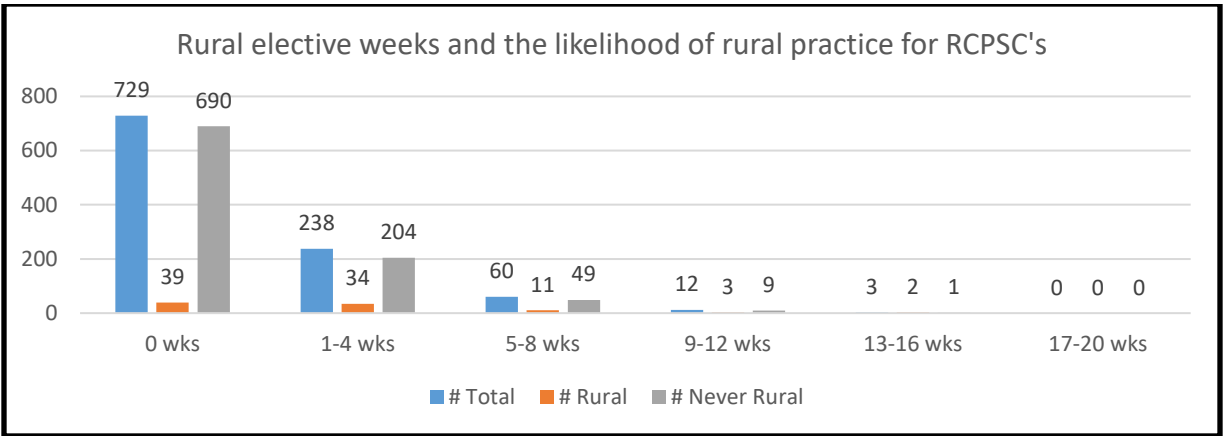


Figure (7) 70% of RCPSC's had no rural exposure during Year 4.

The likelihood of a RCPSC practicing rurally increases with the number of rural elective weeks they complete (Figure 8). However, the increase is far more modest than the increases for the CCFP's (Figure 4).

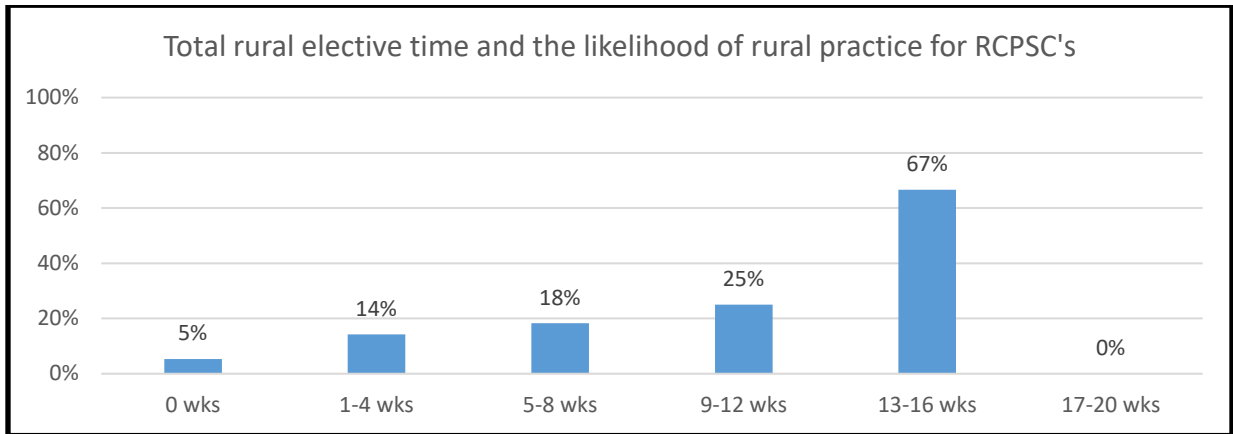


Figure (8) For RCPSC's the percentage likelihood of rural practice increases with rural exposure, but not as significantly as for CCFP's.

In total 9% (89 out of 1042) of all RCPSC's in the dataset have practiced rurally at some point in time. For RCPSC's, 16% (50 out of 313) of those who completed any rural electives eventually practiced rurally. It should be noted that the 67% success rate for the 13-16 weeks group is based on a total of only three individuals.

Timing of Rural Electives and the Likelihood of Rural Practice.

CCFP's

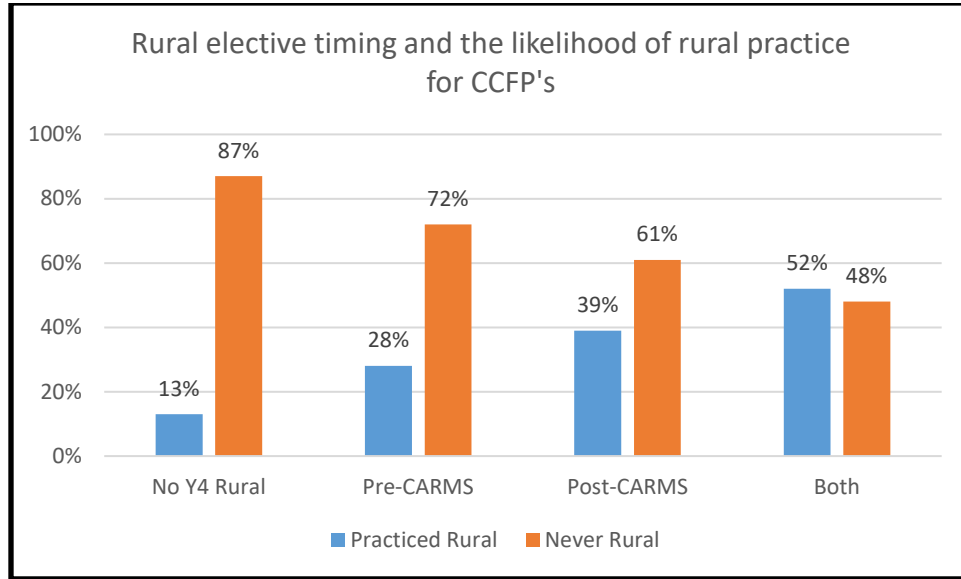


Figure (9) CCFP's who only took post-CaRMS rural electives were not wasting REAP resources.

CCFP's who had not taken any rural electives had a 13% chance of practicing rurally at any time since graduation (44 out of 338).

Those who took only fall (pre-CaRMS) rural electives had a 28% chance of practicing rurally at any time since graduation (94 out of 332).

Those who took only winter (post-CaRMS) Rural Electives had a 39% chance of practicing rurally at any time since graduation (29 out of 74). This suggests that students who only take post-CaRMS Rural Electives are truly interested in rural medicine and are not simply going rural for a lark in the period between CaRMS and the start of their residencies.

Those who took both fall and winter rural electives had a 52% chance of practicing rurally at any time since graduation (46 out of 89). This high percentage might be due in part to every student in this group having, of necessity, taken at least two rotations. The likelihood of rural practice increases as the number of rotations and number of weeks of rural electives increases.

There is considerable difference between the fall and winter periods in terms of the amount of time available to take rural electives. The fall (pre-CaRMS) period currently has 20 weeks of electives whereas the winter (post-CaRMS) period only has 4 weeks of electives.

RCPSC's

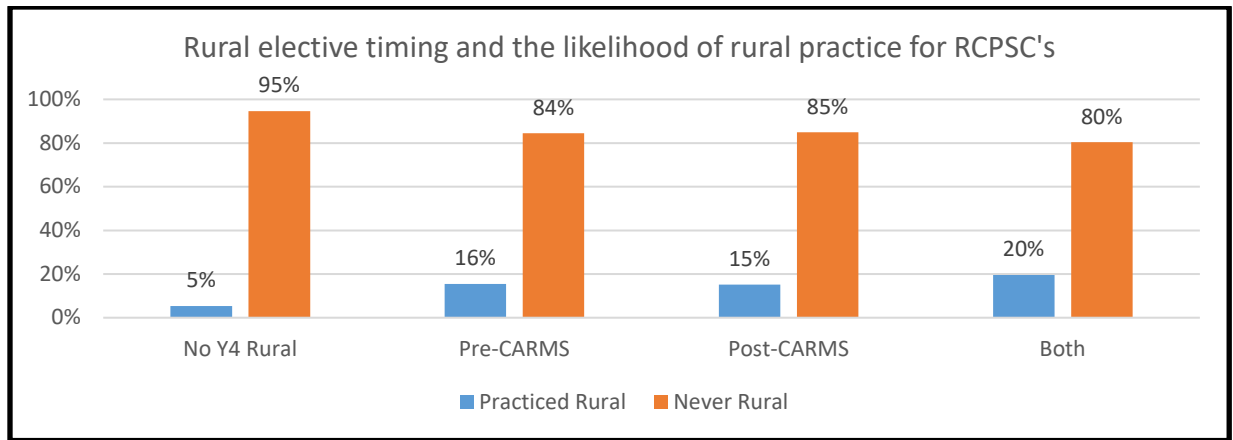


Figure (10) RCPSC's who only took post-CaRMS rural electives were not wasting REAP resources.

RCPSC's who had not complete any rural electives had a 5% chance of practicing rurally at any time since graduation. (39 out of 729).

Those who took only fall (pre-CaRMS) rural electives had a 16% chance of practicing rurally at any time since graduation. (25 out of 161).

Those who took only winter (post-CaRMS) rural electives had a 15% chance of practicing rurally at any time since graduation. (16 out of 106).

Those who had completed both fall and winter rural electives had a 20% chance of practicing rurally at any time since graduation. (9 out of 46). Although the absolute number of subjects in this calculation is quite small, the pattern is similar to that which appears for the CCFP's.

Rural Family Practice Electives versus Rural Specialty Electives.

CCFP's

CCFP's who took only rural specialty electives were more likely to practice rurally, as compared to those who took only rural family practice electives (Figure 11). Those who took both rural family practice electives and rural specialty electives were the most likely to practice rurally. As is the case for those who took both fall and winter electives, this high percentage for those who took both family practice and specialty electives might be due in part to every student in this group having, of necessity, taken at least two rotations. The likelihood of rural practice increases as the number of electives and number of weeks of rural electives increases.

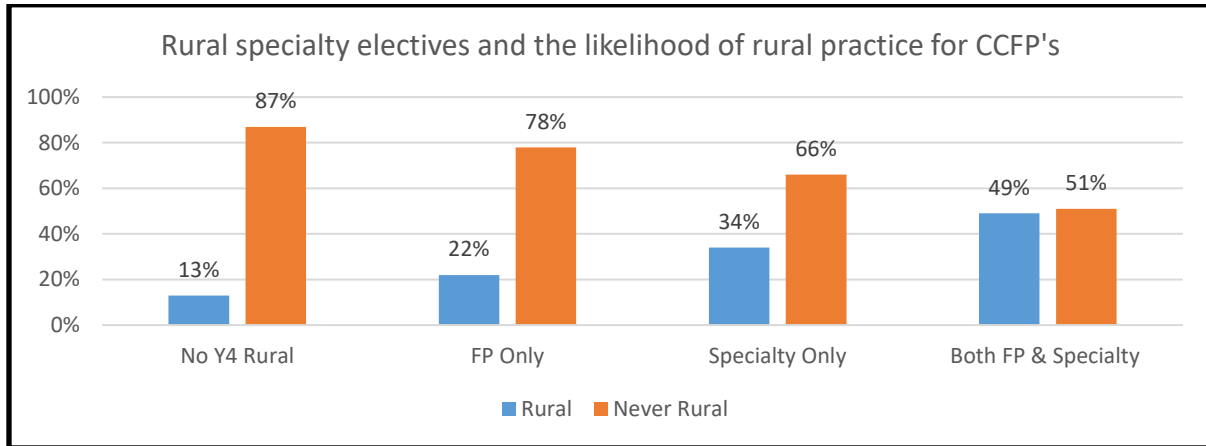


Figure (11) CCFP's who only took rural specialty electives were more likely to practice rurally than those who only took rural family practice electives.

RCPSC's

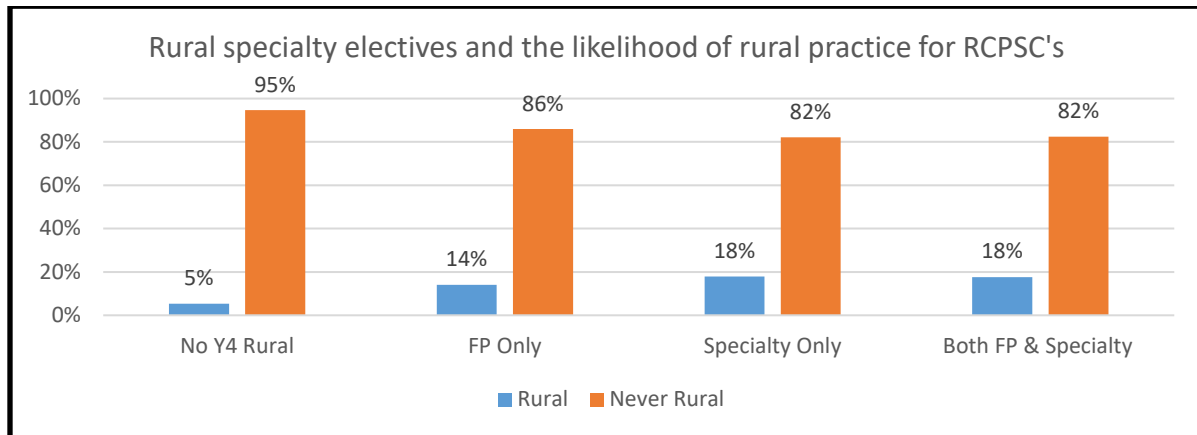


Figure (12) RCPSC's who only took rural specialty electives were slightly more likely to practice rurally than those who only took rural family practice electives.

There was little difference for RCPSC's who took rural electives, regardless of whether they took only family practice electives, only specialty electives, or both (Figure 12).

Timing of Rural Family Practice Electives.

CCFP's

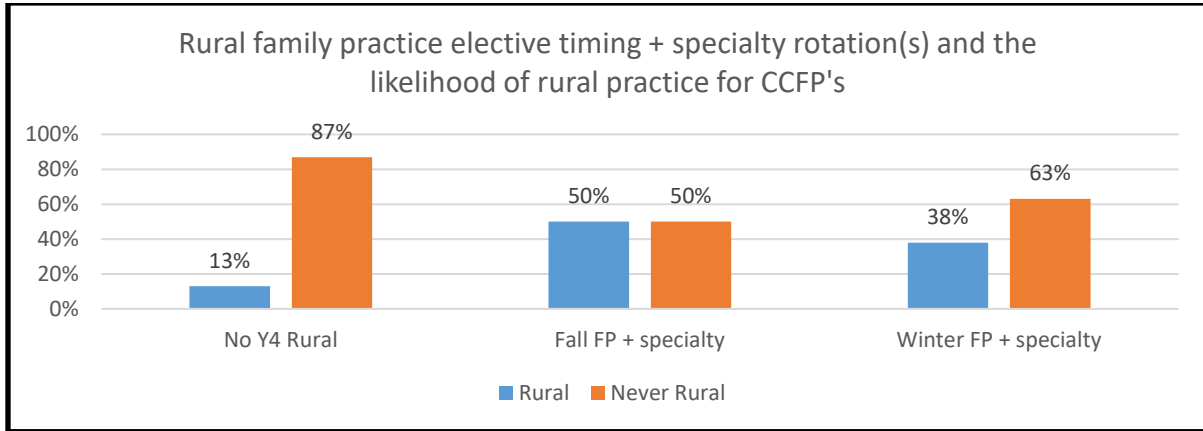


Figure (13) CCFP's who completed a combination of only a fall rural family practice elective and a rural specialty elective were more likely to practice rurally, compared to those who completed a combination of only a winter rural family practice elective with a rural specialty elective.

Those CCFP's who completed only a fall rural family practice elective(s) and rural specialty elective(s) at any time had a 50% likelihood of practicing rurally. Those who completed only a winter rural family practice elective and a specialty elective at any time had a 38% likelihood of practicing rurally. However, the numbers were small for the winter rural family practice group, with only 16 in the group.

RCPSC's

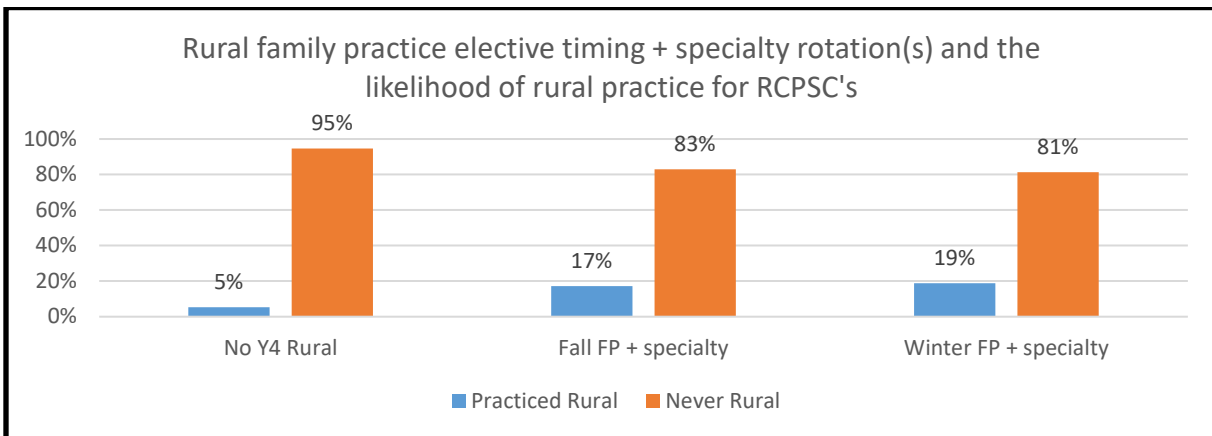


Figure (14) RCPSC's who completed a combination of only a fall rural family practice elective and a rural specialty elective were as likely to practice rurally, compared to those who completed a combination of only a winter rural family practice elective with a rural specialty elective.

Who Takes Rural Specialty Electives, CCFP's or RCPSC's?

Of the 495 CCFP's who completed rural electives, 282 (57%) completed one or more rural specialty electives. Rural specialty electives accounted for 47% of the rural electives taken by future CCFP's.

Of the 313 RCPSC's who completed rural electives, 157 (50%) completed one or more rural specialty electives. Rural specialty electives accounted for 47% of the rural electives taken by future RCPSC's.

As a group, of all the students who took Y4 rural electives, 47% took rural specialty electives. This holds true for CCFP's and RCPSC's. It might be that both groups saw the value of a broad scope of training but it seems more likely that this is the result of program regulations governing the selection of Y4 electives.

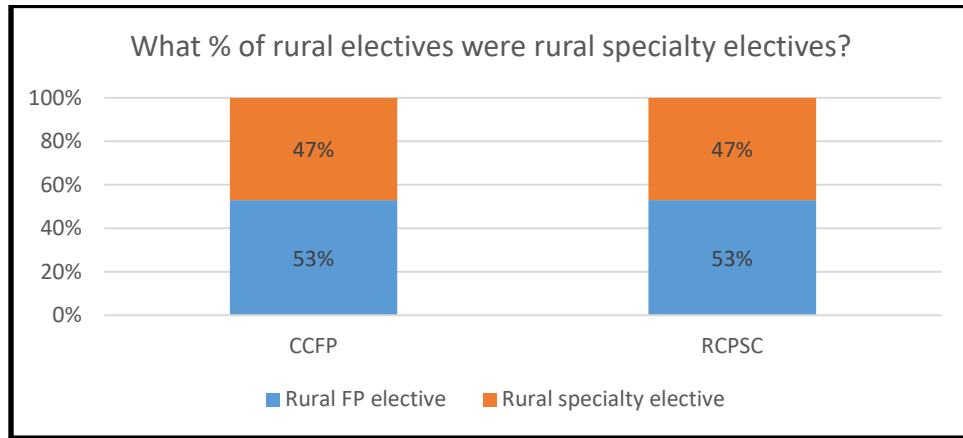


Figure (15) 47% of all rural electives were rural specialty electives.

	Physicians	Total Rotations	Specialist Rotations	% Specialty Rotations
CCFP's	495	900	419	47%
RCPSC's	313	420	196	47%
Totals =	808	1320	615	47%

Table (1) 47% of rural electives taken were rural specialty electives.

The ‘Hometown’ Effect.

CCFP’s

Examined independently of whether or not students took rural electives, there is clearly a positive relationship between self-identifying with a rural ‘Hometown’ at the time of graduation from UBC Medical School and the likelihood of clinical practice in a rural community at some point after completing residency.

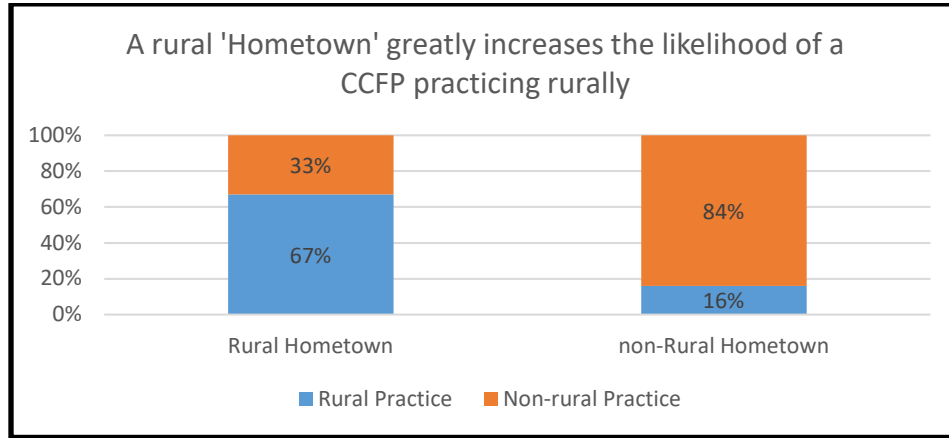


Figure (16) CCFP’s from a rural ‘Hometown’ are more than four times as likely to practice rurally.

One hundred and fifty-nine out of 833 (19%) of CCFP’s had a rural ‘Hometown’. Of those 159, 106 (67%) practiced in a rural community at some point after completing their residency (Figure 16). CCFP’s from a rural ‘Hometown’ accounted for 50% of the CCFP’s in this dataset who practiced in a rural community.

Six hundred and seventy-four out of 833 (81%) of CCFP’s had a non-rural ‘Hometown’. Of those 674, 107 (16%) practiced rurally (Figure 16).

	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	106	107	213	67%	16%	26%
Non-rural practice =	53	567	620	33%	84%	74%
Totals =	159	674	833	100%	100%	100%

Table (2) For CCFP’s, a rural ‘Hometown’ greatly increases the likelihood of rural practice.

In our study CCFP physicians with a rural ‘Hometown’ are 4.2 times as likely to practice rurally compared to those with a non-rural ‘Hometown’. However, in this dataset there are 4.2 times as many non-rural ‘Hometown’ CCFP’s as there are rural ‘Hometown’ CCFP’s. That is why half of the rurally practicing CCFP’s in our study come from non-rural ‘Hometowns’. Wade et al.⁽⁶⁾ found that graduates who came from non-metropolitan areas and became family physicians of Indiana University School of Medicines (IUSM); a school that uses a geographically distributed training model intended to foster primary care practice in non-metro areas; had a 4.4 times greater likelihood of practicing in non-metro locations. Wade et al.⁽⁶⁾, wrote “Review of these data show that although a greater absolute number of family physicians practicing in the more-rural counties come from the more-urban hometowns, as a proportion, the rural areas produce substantially more rural family physicians. In general, the non-family medicine graduates tend to set up practice in the large metro areas, regardless of the location of their hometown. However, those specializing in family medicine return to the type of location characterized by their hometown.” The same holds true for this study of UBC MD Undergraduate Program graduates.

RCPSC's

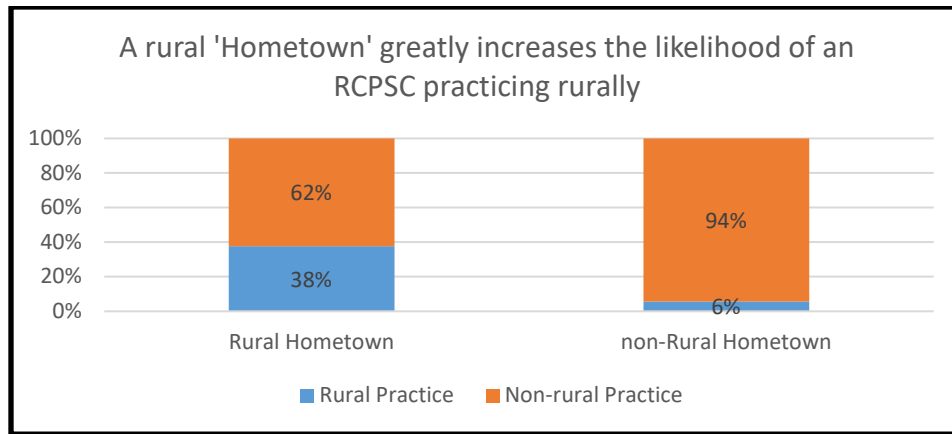


Figure (17) RCPSC's from a rural 'Hometown' are more than six times as likely to practice rurally.

	Hometown			Hometown		
	Rural	non-Rural	Totals	Rural	non-Rural	Totals
Rural practice =	35	54	89	38%	6%	9%
non-Rural practice =	58	895	953	62%	94%	91%
Totals =	93	949	1042	100%	100%	100%

Table (3) For RCPSC's, those with a rural 'Hometown' are much more likely to practice rurally, but still much less likely to do so than CCFP's with a rural 'Hometown'.

Ninety-three out of 1,042 (9%) of RCPSC's had a rural 'Hometown'. Of those 93, 35 (38%) practiced rurally. RCPSC's from a rural 'Hometown' accounted for 39% of the RCPSC's in this dataset who practiced in a rural community.

Nine hundred and forty-nine out of 1,042 RCPSC's had a non-rural 'Hometown'. Of those 949, 54 (6%) practiced rurally. RCPSC physicians with a rural 'Hometown' are more than six times as likely to practice rurally compared to those with a non-rural 'Hometown'. However, in this dataset there are 10 times as many non-rural 'Hometown' RCPSC's. The majority of rurally practicing RCPSC's come from non-rural 'Hometowns' (54 out of 89).

Conclusions

Students who complete Y4 rural electives are more likely to practice rural medicine.

At this time in their careers, it is too early to say that those who have not yet practiced in a rural community will never do so. The numbers could go up. In a study by Willke ⁽⁷⁾ “Among those with 5 years of practice, 34.7% had changed practices.”

The designers of REAP’s Year 4 Rural Elective Program were wise to include both family practice and specialty electives as well as both fall and winter electives. The results of this study suggest that those with only winter rural electives are more likely to practice rurally compared with those with only fall rural electives; and those with only specialty electives were more likely to practice rurally than those with only family practice electives.

Year 4 students who become RCPSC’s are much less likely to take rural electives or practice in rural communities.

UBC MD Undergraduate Program graduates who list a rural BC ‘Hometown’ at the time their MD’s are awarded are more likely to practice in a rural community at some point after residency. It has yet to be determined whether, and how, their rural retention rates might differ from those who list non-rural ‘Hometowns’.

Recommendations

Given the positive correlation between the amount of rural exposure and the likelihood of rural practice, it is recommended that any limit on the maximum number of rural elective weeks eligible for REAP reimbursement be removed.

REAP should continue to fund both Y4 rural family practice electives and rural specialty electives.

REAP should continue to fund Y4 rural electives regardless of whether or not a student completing a winter (post-CaRMS) rural elective has already completed a fall (pre-CaRMS) elective.

A second outcome study should be conducted in 4 or 5 years, at which time there should be nearly 1,000 additional graduates who will have completed their residencies. At that time, those individuals from the current dataset will have been in practice longer and will be more established. More advanced statistical analysis can then be performed on that expanded dataset to examine the question of rural physician retention.

It would be interesting to know how well rural ‘high school graduated from’ on admission applications compares to rural ‘Hometown’ on the Graduation Program when the MD is awarded. What percentage of those who graduate from a rural high school self-identify as rural upon being awarded their MD and which is a better predictor of rural practice?

The UBC MD Undergraduate Program should consider increasing the number of applicants from rural ‘Hometowns’ who are admitted into the program.

References

1. Rural Practice Subsidiary Agreement Communities & Rural Retention Program Point List. https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/rrp_points.pdf/ April 4, 2023.
2. The University of British Columbia (UBC), Faculty of Medicine, MD Undergraduate Program, <https://mdprogram.med.ubc.ca/about/distributed-program-sites/> March 29, 2023.
3. UBC Office of Ceremonies and Events, Graduation Programs <https://graduation.ubc.ca/event/about/graduation-programs/> March 29, 2023.
4. College of Physicians and Surgeons of British Columbia, Medical Directory, Sept. 28, 2022. There were 2,497 physicians listed with a primary address in an RSAC. Of those, 73% were family physicians and 27% were Royal College specialists. Of the 12,087 physicians listed with a primary address that was not in an RSAC, 47% were family physicians and 53% were Royal College specialists.
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6. Mou, H., Olfert, M.R. 2015. "Inter-Provincial Migration Intentions of Family Physicians in Canada: The Roles of Income and Community Characteristics. *Healthcare Policy* Vol. 11 No. 2. 58-71.
7. Willke, R.J. Practice mobility among young physicians. *Med. Care.* 1991, 29(10):977-988.

Appendix A

CCFP Correlation between a rural 'Hometown', rural exposure, and rural practice (categorized by weeks of rural elective exposure).

How to interpret: Example: 338 CCFP's did not complete any rural electives.

31 of those 338 had a rural 'Hometown'. Of those, 20 practiced rurally at some point, and 11 never practiced rurally. (20/31 = 65% with rural 'Hometown' practice rurally).

307 of those 338 had a non-rural 'Hometown'. Of those, 24 practiced rurally at some point, and 283 never practiced rurally.

Table (4) For CCFP's, the relationship between: rural 'Hometown', rural exposure and rural practice.

Y4 zero weeks Rural Electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	20	24	44	65%	8%	13%
non-Rural practice =	11	283	294	35%	92%	87%
Totals =	31	307	338	100%	100%	100%
Y4 1-4 weeks Rural Electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	27	34	61	68%	15%	23%
non-Rural practice =	13	193	206	33%	85%	77%
Totals =	40	227	267	100%	100%	100%
Y4 5-8 weeks Rural Electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	30	32	62	64%	32%	42%
non-Rural practice =	17	67	84	36%	68%	58%
Totals =	47	99	146	100%	100%	100%
Y4 9-12 weeks Rural Electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	21	9	30	72%	33%	54%
non-Rural practice =	8	18	26	28%	67%	46%
Totals =	29	27	56	100%	100%	100%
Y4 13-16 weeks Rural Electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	7	5	12	64%	50%	57%
non-Rural practice =	4	5	9	36%	50%	43%
Totals =	11	10	21	100%	100%	100%
Y4 17-20 weeks Rural Electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	1	3	4	50%	100%	80%
non-Rural practice =	1	0	1	50%	0%	20%
Totals =	2	3	5	100%	100%	100%

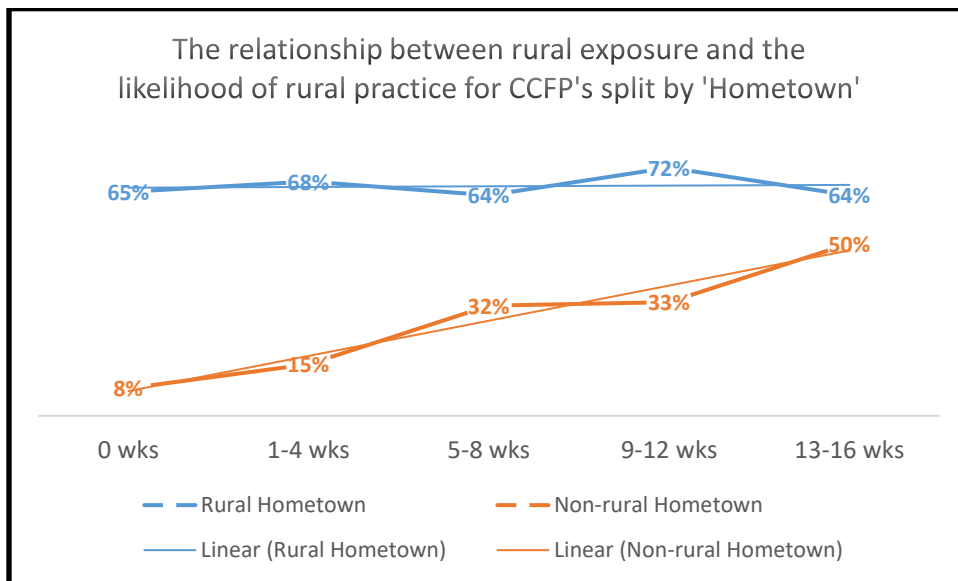


Figure (18) - for CCFP's from a non-rural 'Hometown', the likelihood of rural practice increased as rural exposure increased. For those from rural 'Hometowns', the likelihood of rural practice did not increase with increased rural exposure.

The data for Figure 18 was taken from Table 4. For CCFP's from a non-rural 'Hometown', the likelihood of rural practice increased as Year 4 rural elective time increased (Figure 18). This was not the case for CCFP's from rural 'Hometowns'. For CCFP's from rural 'Hometowns', the likelihood of rural practice did not increase with increased rural exposure. This may be due to this group having a high likelihood of practicing rurally at all levels of rural exposure.

Appendix B

RCPSC Correlation between a rural 'Hometown' and rural practice at any time; broken down by rural elective exposure.

How to interpret: Example: 729 RCPSC's did not complete any rural electives.

45 of those 729 had a rural 'Hometown'. Of those, 14 practiced rurally at some point, and 31 never practiced rurally. (14/45 = 31% with rural 'Hometown' practice rurally).

684 of those 729 had a non-rural 'Hometown'. Of those, 25 practiced rurally at some point, and 659 never practiced rurally. Only 5% (39 of 729) practiced rurally in this category.

Table (5) For RCPSC's, the relationship between: rural 'Hometown', rural exposure and rural practice.

Y4 zero weeks RSAC electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	14	25	39	31%	4%	5%
Non-rural practice =	31	659	690	69%	96%	95%
Totals =	45	684	729	100%	100%	100%
Y4 1-4 weeks RSAC electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	12	22	34	40%	11%	14%
Non-rural practice =	18	186	204	60%	89%	86%
Totals =	30	208	238	100%	100%	100%
Y4 5-8 weeks RSAC electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	5	6	11	42%	13%	18%
Non-rural practice =	7	42	49	58%	88%	82%
Totals =	12	48	60	100%	100%	100%
Y4 9-12 weeks RSAC electives						
	Hometown			Hometown		
	Rural	Non-rural	Totals	Rural	Non-rural	Totals
Rural practice =	3	0	3	75%	0%	25%
Non-rural practice =	1	8	9	25%	100%	75%
Totals =	4	8	12	100%	100%	100%
Y4 13-16 weeks RSAC electives						
	Hometown			Hometown		
	Rural	Non-Rural	Totals	Rural	Non-rural	Totals
Rural practice =	1	1	2	50%	100%	67%
Non-rural practice =	1	0	1	50%	0%	33%
Totals =	2	1	3	100%	100%	100%
Y4 17-20 weeks RSAC electives						
	Hometown			Hometown		
	Rural	Non-Rural	Totals	Rural	Non-rural	Totals
Rural practice =	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!
Non-rural practice =	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!
Totals =	0	0	0	#DIV/0!	#DIV/0!	#DIV/0!

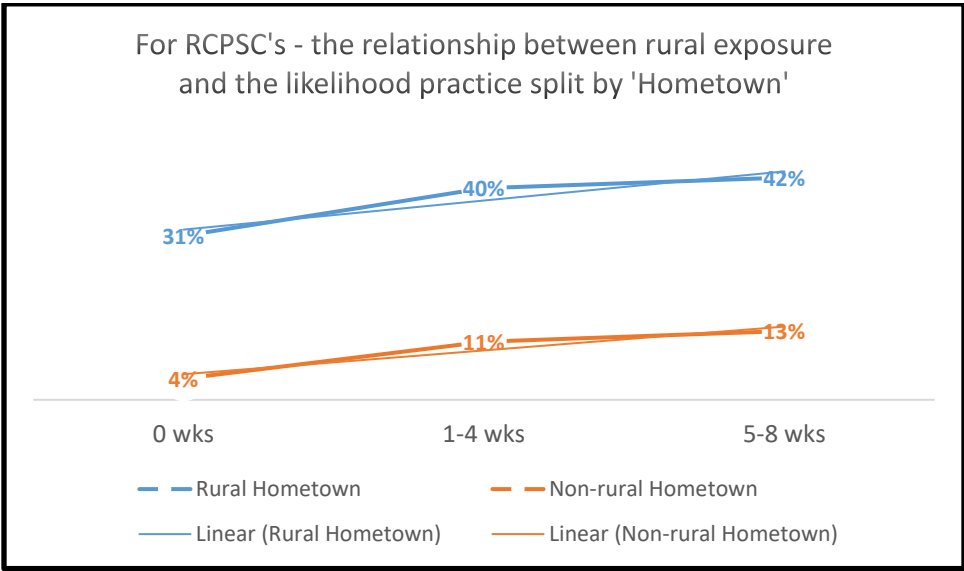


Figure (19) – unlike for CCFP's, for RCPSC's the likelihood of rural practice increased with rural exposure, regardless of whether they came from a rural or non-rural 'Hometown'.

The data for Figure 19 was taken from Table 5. Due to a dearth of data, only three categories were graphed.

For RCPSC's from either rural or non-rural 'Hometowns', the likelihood of rural practice increased as Year 4 rural elective time increased.