Requiem for a One-Doctor Town

KERIDWEN CORNELIUS March 4, 2021
https://www.phoenixmag.com/2021/03/04/requiem-for-a-one-doctor-town/

An avid cyclist, Dr. Michael Druschel often commutes on his bike and performs everything from minor surgeries to routine check-ups at the North Country HealthCare center in Seligman.; Photo by Mirelle Inglefield

The solitary, satchel-carrying rural doctor is etched into our enduring fantasy about small-town Arizona. But such physicians are fading away. The doctors are gone, but the towns – and the medically underserved people who live in them – remain.

A few years ago, Dr. Molly Anderson – the only physician serving the verdant Southern Arizona village of Patagonia – was called for jury duty. As she sat in the small-town courtroom, each potential juror was asked if they knew anyone involved in the case. Anderson recalls looking around and thinking, “Well, the defendant is a patient. The victim is a patient. The witnesses are patients. The detective is a patient. And I can’t say this because of privacy laws.”

Fortunately, she didn’t need to breach confidentiality. One after the other, they all admitted to knowing her. The “everybody knows your name” phenomenon is one of the side effects of practicing in a one-doc town – a bucolic lifestyle immortalized in shows like Northern Exposure and Dr. Quinn, Medicine Woman.
But the solo family physician on the frontier is fast going the way of fiction. In 1983, 40 percent of the nation’s doctors practiced alone, according to the American Medical Association. By 2018, that number had fallen to less than 15 percent, underscoring a troubling fact: Arizona suffers from a huge shortage of primary care physicians (PCPs). To meet its needs, the state currently requires an extra 563 PCPs, plus an additional 1,941 by 2030, according to the Health Resources and Services Administration.

The scarcity is felt most acutely in rural areas, which struggle to recruit and retain physicians and are hemorrhaging hospitals and health clinics. According to an informal PHOENIX magazine study of Arizona Medical Board licenses and medical clinics statewide, only about a half-dozen true one-doctor towns remain. Most Arizona towns of 1,000 residents or less have no dedicated local physician – they’re zero-doctor towns.

That’s certainly a loss for people living in these “medical deserts” scattered around the state. And it may also be a loss for clinicians. Because some family docs in remote Arizona towns like Patagonia, Seligman and Safford say small-town medicine epitomizes the kind of personalized, caring experience that both doctors and patients desire. Unfortunately, that too is disappearing. But some country docs in Arizona are trying to keep the tradition alive.

It wasn’t blind fate that conspired to make Dr. Michael Druschel the lone physician serving the Route 66 outpost of Seligman. He grew up in a small town in Pennsylvania and has always gravitated to blink-and-you-miss-‘em burgs. That’s not unusual. A rural background is the strongest predictor that a doctor will choose to practice in a rural location, according to the American Academy of Family Physicians.

A year and a half ago, Druschel moved to Flagstaff, where his wife and two daughters can enjoy urban amenities and he can pursue his passions for skiing, biking and running. Three days a week, he works at the North Country HealthCare clinic in Williams. And once a week, he puts on a podcast or audiobook and drives a little over an hour to the smaller clinic in Seligman (population: 776).

Dr. Druschel examines a patient in his Seligman practice; Photo by Mirelle Inglefield

Again, that’s not unusual. In the past, solo country docs often hung their shingle in their hometown. But in today’s consolidated system, rural physicians are typically employed by a company that operates several full- or part-time satellite facilities. So practitioners may toggle between clinics in Green Valley, Arivaca and Amado, or Parker, Quartzsite and Bouse.

Rural populations skew older, and that’s certainly true in Seligman, which attracts retirees seeking an off-grid, nostalgic lifestyle. So Druschel, a family medicine M.D., does a lot of geriatric care. But in the absence of nearby specialists, he also has to be a sort of Swiss Army knife in scrubs, wielding a range of skills with aplomb. And that suits Druschel just fine. “I’m someone who likes variety,” he says.
“I’m someone who also likes procedures. So if I can do something safely in my clinic, I usually like to try to find a way to make it happen.”

On one recent patient, Druschel personally performed an echocardiogram, plus a lung and abdominal ultrasound, then inserted an IV and ran the fluid, drew blood, and finally sent the blood via courier to a lab. He’s conducted a sleep study in a patient’s home, provides basic counseling and prescribes psychiatric medicine. “I feel I make deeper connections with my patients,” he says, “because they really come to rely on me… since I’m the one managing the majority of their medical issues.”

Since many older patients can no longer drive long distances, and some lack the transportation or inclination to leave town, frontier family physicians sometimes have to treat conditions that push them to the limits of their comfort zones. In Patagonia, Anderson recalls a patient who came to her clinic with a severe laceration. She recommended heading to the hospital. But the patient gave her an ultimatum: “Either you do it, or it’s not gonna get done.”

Unlike Druschel, Anderson comes from an urban background. The family physician grew up in Phoenix, attended college in Los Angeles and went to the University of Arizona’s College of Medicine in Tucson. The first 12 years of her career, she logged 80-hour weeks in urgent care at a Tucson clinic. When her husband retired, she decided she wanted a lifestyle that made room for her hobbies: hiking, serving on Democratic Party committees, volunteering with the Unitarian Church and writing bawdy limericks.

Rural medical personnel at the Ganado Mission in Arizona in 1938; Photo courtesy Arizona State Library, Archives and Public Records, History and Archives division, Phoenix, #90-0101

The couple moved to Sonoita, and a few years later, Anderson began working at the Mariposa Community Health Center in Patagonia. “By the time I’d been here two weeks, it seemed like everybody in town knew who I was,” she says. “And I had no clue who they were.”

Inspired by these awkward encounters, she wrote a limerick called “Small Town Doc”: “In the best of all worlds, I suppose/ I should have recognized you by your woes./ But if you’re from Patagonia/ it’s more likely I’da known ya/ had you presented yourself without clothes.”

Despite having a population of about 772, Patagonia provides a varied clientele at Anderson’s clinic. The area is home to a quirky assortment of residents that seems ripe for a TV medical drama: vintners, artisans, birdwatchers, foodie retirees, low-income long-timers, Mexican American mining and ranching families, and cowboys. “Boy, they are a stoic group,” Anderson
Anderson says she enjoys rural medicine because she can form close, enduring bonds with her patients, plus generations of their families. “It’s nice to be able to sit and talk with people and their families and actually know something about their home situation,” she says, sitting in the clinic where she’s worked part-time for 25 years. “You run into people at the store and at restaurants all the time, and it just makes you feel more responsible for them.”

Despite having a population of about 772, Patagonia provides a varied clientele at Anderson’s clinic. The area is home to a quirky assortment of residents that seems ripe for a TV medical drama: vintners, artisans, birdwatchers, foodie retirees, low-income long-timers, Mexican American mining and ranching families, and cowboys. “Boy, they are a stoic group,” Anderson says of the wranglers. One man came to her with an achy arm after he’d endured a fractured humerus for two weeks while he finished his roundup.

For some PCPs, Druschel’s and Anderson’s experiences represent the old-fashioned ideal of family practice – a combination of independence and interpersonal connection. That’s what drew family physician Dr. Gail Guerrero-Tucker to practice at the Gila Valley Clinic in Safford, a town of roughly 10,000, located 60 miles east of Globe near the New Mexico border.
A native of Nogales, Arizona, Guerrero-Tucker did a rotation in Safford while she was at U of A’s College of Medicine, and she was excited that the clinic gave family physicians the chance to deliver babies — which almost never happens in cities. “I always remembered this clinic as being my favorite place to be and my whole ideal of what it should be like to be a rural doctor,” she says. “I’m glad I came, and I’ll probably retire here.”

But not everyone feels they can make the same choice. As a teaching facility, the Gila Valley Clinic sees lots of medical students and residents passionate about pursuing rural family medicine, Guerrero-Tucker notes. “Everybody says, ‘I love this. This is why I went to medical school.’ They’re so jazzed when they leave, and they’re so idealistic about the whole thing.” And then many of them choose instead to become specialists working at hospitals and urban centers.

Why? One reason, Guerrero-Tucker explains, is that the culture in medical school often discourages bright students from becoming family physicians and urges them into more lucrative and prestigious specialties. The other reason, she says, is money. The average medical student in Arizona graduates with nearly $200,000 in debt, according to U.S. News & World Report. And since specialists can earn two or more times the salary of a PCP, many students choose fields that can better help them pay off their loans.

Partly as a result, Arizona has only 42 percent of the PCPs it needs and ranks 44th in the nation in its number of PCPs, according to the U.S. Department of Health and Human Services. Combine that with the closure of four rural hospitals since 2007 — in Yuma, Kingman, Florence and Douglas — and the result is a rural health system on life support.

The dearth of small-town docs is especially problematic given Arizona’s vast geography and large population of seniors. For many elderly people, the prospect of driving two or three hours to see a physician and navigating an unfamiliar city is terrifying, Guerrero-Tucker says. “[If] they don’t have a family member or somebody who can take them, they just don’t cope. So I have a lot of people who need to go [to a specialist or hospital], but they won’t.”

On-the-ground specialty services can also be thin in rural Arizona, explains Dr. Daniel Derksen, director of the Arizona Center for Rural Health at U of A. For example, La Paz and Greenlee counties both lack labor and delivery capabilities. So if you’re a pregnant woman in Parker and your water breaks, you may have to beeline to Phoenix or Yuma to have your baby. “[I]f you’re in labor, you’ve already had a kid and your labor’s gonna be short,” Derksen says. “It’s a big deal as far as health outcomes if you don’t have ready access to those services when you need them.”
Derksen also points out that hospitals and health centers are economic pacemakers for their communities. The American Medical Association calculates that each physician supports an average of 17 jobs, from nurses to pharmacists to office managers and bookkeepers. So the arrival of a doctor or a clinic in a rural area can have a “multiplier effect,” Derksen says. “On the other hand, when you start to go into decline and you lose a physician or nurse practitioner and you can’t recruit, you start burning out the [other staff] who have to take on more and more work. The next thing you know, the hospital or the clinic closes, and you’re back to having no health infrastructure for many, many miles.”

Experts suggest several prescriptions to address the rural doctor shortage. One is to expand and strengthen training opportunities in remote areas. “Because if your education pipeline begins and ends in Phoenix and Tucson, that’s where all the people are going to go,” Derksen says.

Another remedy is to recruit and financially support medical students from underserved areas and diverse backgrounds, since these students are more likely to serve similar communities when they become doctors. The U of A’s College of Medicine – which has locations in Tucson and Phoenix – has launched programs to prepare students from tribal reservations, rural communities and inner-city areas to enter med school. These efforts have started to make ripples. In 2019, the U of A medical school graduated eight Native American students – the most in its history. In previous years, that number was typically zero or one.

Tuition reduction programs can also encourage medical students to practice where they are most needed. Arizona started an initiative in 2020 offering free tuition at the medical schools in Tucson or Phoenix for students who promise to practice primary care in federally designated Health Professional Shortage Areas for two to four years.

Derksen also suggests emulating a program in New Mexico that provides state income tax reductions of up to $5,000 for physicians, dentists, nurses and other health practitioners who practice in underserved locations. In addition, travel stipends can provide a financial booster shot for docs who commute between remote clinics. Druschel’s company pays him a small stipend that helps cover the cost of gas and vehicle wear-and-tear.

And even amidst a doctor shortage, there are relatively simple innovations that can improve health care for people who make their home on the range. One option is mobile services. In southeast Arizona, Chiricahua Community Health Centers’ medical “clinic on wheels” and “Molar Patroller” dental clinic serves residents around Willcox, Bowie and Douglas.

Druschel’s employer, North Country HealthCare, operates a pharmacy that transports medications to the Seligman clinic. “If I didn’t have the pharmacy delivering, I think it would be twice as hard to take care of people,” Druschel says. “Because many people only have P.O. boxes, Seligman doesn’t have a pharmacy, and it’s a hard drive for people sometimes to go to Williams or Kingman.”

Even more invaluable, Druschel says, is telehealth. “I think the rise of telehealth with the COVID pandemic really needs to become a permanent thing, because access to specialists is so difficult for [rural] people. Telehealth allows us to offer more resources for patients. And even if they don’t have internet or phone service, we let them come to our clinic and use our televideo services.”

Another potential upshot of the pandemic is being dubbed “The Fauci Effect,” after Dr. Anthony Fauci, currently chief medical adviser to President Joe Biden. In 2020, the number of students
nationwide applying to medical schools jumped by 18 percent over the previous year, according to the Association of American Medical Colleges. U of A’s medical school received around 1,000 more applications than it typically has in the past. So if more and more idealists are inspired by the current crisis to care for the hardest-hit communities, that’s promising news for Arizona’s doctor desert.

**Doctor Deserts** - Arizona’s rural health safety net is vast and intertwined, comprising dozens of federally qualified rural health centers and hospitals, plus no fewer than 50 tribe-operated clinics and hospitals managed by Indian Health Service. But gaps inevitably remain. The circles below represent areas in Arizona where no health centers or clinics exist. Since the lands in question are sparsely populated, the circles do not uniformly indicate medical neglect, but do show where populations and various towns are vulnerable.