

Rural Healthcare Specialty Priorities

Rural Physician Workforce Survey: Insights
rural healthcare administrators need on
physician recruitment and staffing decisions

A SPECIAL REPORT BY:

JACKSON
Physician Search®

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Contents

Executive Summary	3
The Rural Workforce Reality	4
The Clinicians Carrying the Load	5
Who Might Leave	6
When Vacancies Cascade	7
What a Vacancy Does to Those Who Remain	8
The Financial Blind Spot	9
Worksheet: Price Your Own Vacancy	10
The Rural Specialty Priority Map	11
What to Protect	14
What to Grow	15
What to Cover Differently	17
Three Specialties, Three Playbooks	18
The Comeback Window	20
Recommendations and Conclusion	21
About / Notes	22

About this study

In August 2026, Medical Group Management Association, Jackson Physician Search and LocumTenens.com commissioned an online survey to better understand rural healthcare organizations' priorities related to physician specialties and the effects on the physician workforce in those rural care settings.

Clinicians and administrators shared a core set of questions: name up to five high-impact specialties, assess current coverage, choose a workforce approach (Protect, Grow or Cover Differently), and — when a decision was needed within 12 months — rate 10 coverage models for short- and long-term viability.

Administrators then answered about searches, vacancies and succession; clinicians answered about coverage gaps and staying, leaving or returning.

The study included 227 qualified respondents with rural experience: 168 clinicians and 59 administrators. Among clinicians, 101 currently practice rurally and 67 did so in the past. Administrators represented hospitals, Critical Access Hospitals (CAHs), Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs) and medical groups. The survey took about 11 minutes.

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The rural specialty workforce is not gone, but it often is one key departure away from creating a serious gap.

In the specialties that rural clinicians and administrators say matter most, the physician is usually still there. But for rural health leaders who named family medicine a high-impact specialty, more than two out of three (68%) described its permanent local capacity as insufficient or fragile, with no margin for losing one more person. OB/GYN, general surgery, internal medicine and behavioral health show the same pattern: services that work today and would not survive the next retirement, resignation or reduction in hours.

The clinicians carrying those services make it clear that those conditions will not hold. **Two-thirds of current rural clinicians (65%) said they lack adequate specialist and colleague backup — a wider deficit than they reported on compensation or workload — and 59% said they are at least somewhat likely to leave their position within two years.** Among clinicians without adequate backup, that figure rose to 67%. The clinicians who have already left rural practice named inadequate backup as the second most common reason they went. And the 45% who would consider coming back named it, alongside compensation, as their price.

Rural organizations cannot put every priority into a search for a permanent hire at once: Among administrators with active physician searches, 81% named at least one high-impact specialty with no permanent search underway. Locum tenens, care teams, visiting specialists, telehealth and regional partnerships fill different roles by specialty and time horizon.

Coverage gaps, in other words, are not only an access problem. They are the mechanism that produces the next critical vacancy. When a consequential physician vacancy opens, it is usually sudden and covered from inside the building. The remaining clinicians absorb the call, the referrals and the work beyond their scope. Nearly one in four administrators (23%) said the vacancy made it harder to recruit anyone else.

Rural healthcare leaders face tough decisions on where to recruit first, which existing services cannot afford another physician departure and what clinical resource can safely carry access while a longer-term plan is built.

Findings at a glance

- 68% described their permanent local physician capacity in **family medicine as insufficient or fragile today.**
- 81% of administrators with active searches named **at least one high-impact specialty with no permanent search underway.**
- 65% of administrators' most consequential physician vacancies **were still active searches**, and **only 12% had been anticipated more than a year ahead.**
- **Only 25%** formally **estimated the financial effect** of their most consequential vacancy.
- 65% of current rural clinicians said they **lack adequate specialist and colleague backup**, and 59% said they **may leave within two years.**
- **45% of clinicians who left rural practice would consider returning** — for competitive compensation and real specialty backup, the same two changes current clinicians most want.

That process is what this report is all about, based on research into rural healthcare organizations during summer 2026 by Jackson Physician Search, LocumTenens.com and Medical Group Management Association (MGMA).

The findings are organized into the Rural Specialty Priority Map as a tool to better examine recruitment and physician succession clocks, vacancy economics and the conditions that determine whether rebuilt capacity holds in rural care.

One Departure Away

Rural leaders are making specialty staffing decisions amid three familiar pressures: a limited physician supply, persistent financial strain and growing competition for clinicians. National forecasts differ in scale but point in the same direction. The Association of American Medical Colleges (AAMC) projects a physician shortfall of up to 86,000 by 2036, while the latest projections from the Health Resources and Services Administration (HRSA) estimate a shortage of about 141,000 physicians by 2038. HRSA expects the gap to be much more severe outside metropolitan areas, where projected physician supply would meet only about 42% of need.^{1,2}

The rural workforce is showing that strain. Rural areas lost nearly 2,500 physicians, or about 5%, from 2019 to 2024, while the number of independent rural physicians fell 43%. By early 2024, about three in four rural physicians were employed by hospitals, health systems or corporate entities.³

As of 2026, more than 40% of rural hospitals were operating at a loss and 417 were vulnerable to closure. Rural communities have also continued to lose individual service lines: more than 300 rural hospitals have eliminated general surgery, more than 450 have eliminated chemotherapy, and behavioral-health access remains substantially more limited than in urban areas.⁴ Maternity care has contracted sharply as well: 146 rural hospitals have stopped delivering babies since the end of 2020 or announced plans to do so in 2026.⁵ For rural leaders, workforce planning is increasingly tied to whether an essential service can be maintained at all.

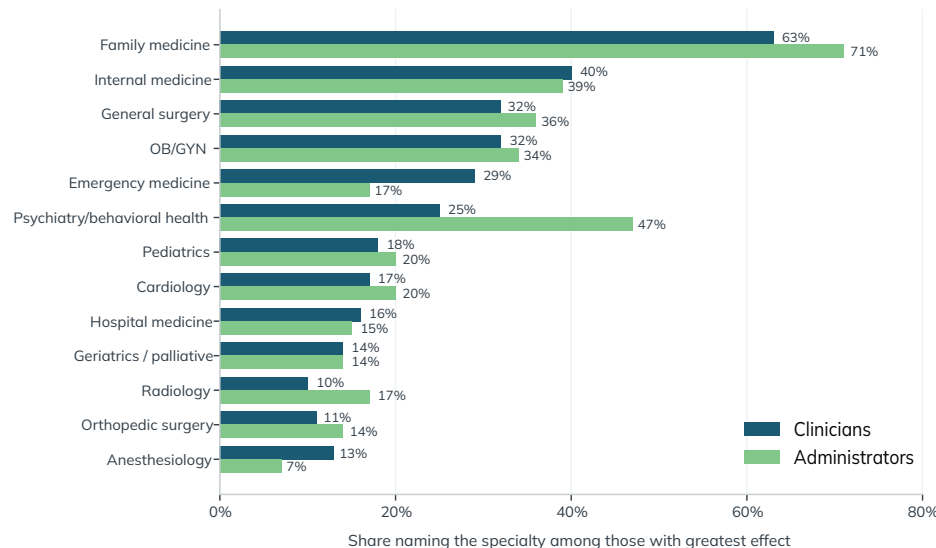
At the same time, rural organizations have more ways to provide coverage. Locum tenens, physician-plus-APP teams, visiting specialists, telehealth and regional partnerships can fill different needs, while APPs now account for about 40% of the provider workforce.⁶ Rural leaders therefore need to decide not only whom to recruit, but which staffing model fits each specialty, how quickly coverage is needed and how a temporary solution connects to the longer-term plan. **Those figures largely describe the services that have already been lost. This report examines the ones that have not — yet.**

Adequacy Is the Exception

Respondents named the specialties with the greatest effect on access, quality and sustainability in their rural markets, then described the current coverage situation for each. Those descriptions fall into three areas for this analysis:

1. **Adequate** means the community has enough permanent local physician capacity today.
2. **Local but thin** means permanent physicians are still there, but capacity is either insufficient or fragile enough that another departure or reduction in hours could create a serious gap.

Figure 1. Rural Specialties With the Most Impact on Access, Quality or Sustainability



3. **Alternative or absent** means access depends mainly on temporary, visiting or virtual coverage — or there is little to no meaningful local capacity at all.

Adequate permanent local coverage was the exception. Only 21% rated family medicine adequate; the shares were 13% for internal medicine, 18% for general surgery, 7% for OB/GYN and 9% for psychiatry. Orthopedics was highest at 38%. No respondent rated geriatrics, gastroenterology or urology adequately covered.

More important is what sits behind those low ratings. Family medicine is the clearest case: The physician is still there but the margin for losing one is not. Two-thirds of respondents (68%) called capacity local but thin, splitting nearly evenly between insufficient (35%) and fragile or at risk (33%). General surgery and OB/GYN show the same strain, each 61% local but thin; internal medicine is 76%; psychiatry is 50%, with another 35% already relying on alternative coverage or reporting no meaningful local capacity at all.

The stakes of those thin services are high. Majorities said losing local access would have significant consequences: 77% for pediatrics, 74% for emergency medicine, 70% for family medicine, 64% for OB/GYN and 63% for general surgery.

The Clinicians Carrying the Load

Behind each “local but thin” rating is a physician still practicing in that market. Current rural clinicians were asked to describe the conditions of that practice, and one statement drew more disagreement than any other: **65% said they do not have adequate specialist and colleague backup**, including 16% who strongly disagreed. By comparison, 42% said compensation did not fairly reflect their scope, call and workload, and 39% said their workload was not sustainable for the next two years.

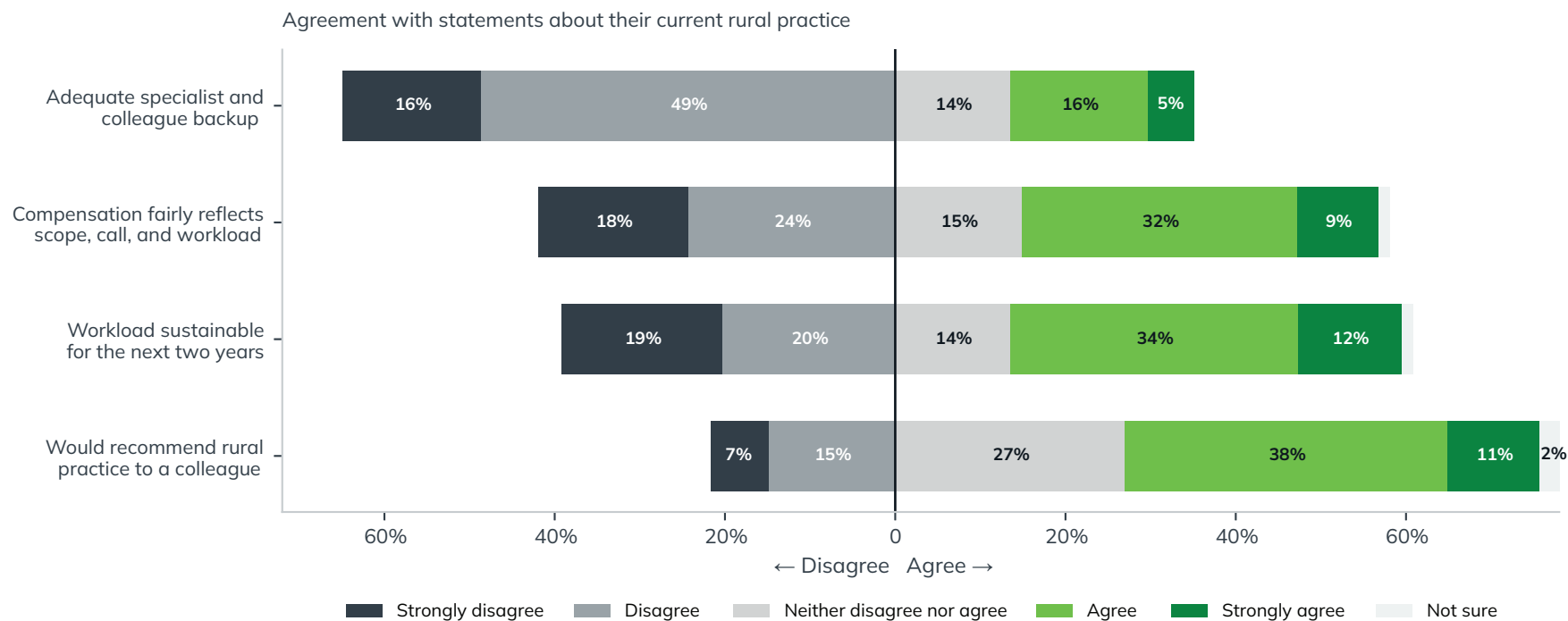
Backup, not pay, was the biggest reported deficit. It is also the one most directly created by the specialty gaps described above: When the local general surgeon, obstetrician or psychiatrist is absent or stretched thin, the family physician down the hall is the one without backup.

Even with those concerns, rural practice still has appeal. Nearly half of current rural clinicians (49%) would recommend it to another physician

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in their specialty, compared with 22% who would not. Asked what keeps them, they led with quality of life and connection to the community (53%), followed by compensation (41%), mission (32%) and scope of practice and autonomy (28%). The people carrying rural services are, for the most part, people who want to be there.

Figure 2. The Backup Deficit Is the Widest Gap Current Rural Clinicians Report



Who Might Leave

Wanting to be there is not the same as staying: **59% of current rural clinicians said they were at least somewhat likely to leave their current position within two years**, including 32% who were very likely. Excluding clinicians whose primary arrangement is locum tenens — for whom changing positions is routine — barely changed the result, to 57%.

The concern was not limited to physicians nearing retirement. Among physicians 11 to 20 years into practice, 78% said they might leave, although that group is small. Retirement also was not the main reason longer-tenured clinicians were considering a move.

The reasons they gave are the conditions this survey set out to measure. Workload or burnout (39%) and compensation (39%) led, followed by call burden (27%), organizational culture or leadership (26%), a better opportunity elsewhere (22%) and inadequate specialty support or colleague backup (18%). Only 3% said they were not considering leaving at all.

Likelihood of leaving within two years

59% said they are at least somewhat likely to leave

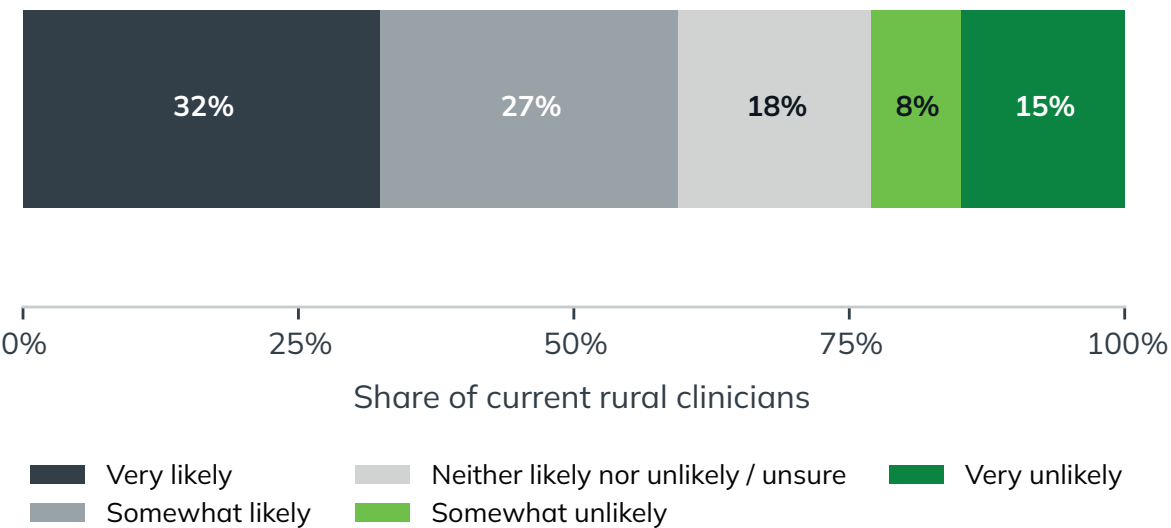
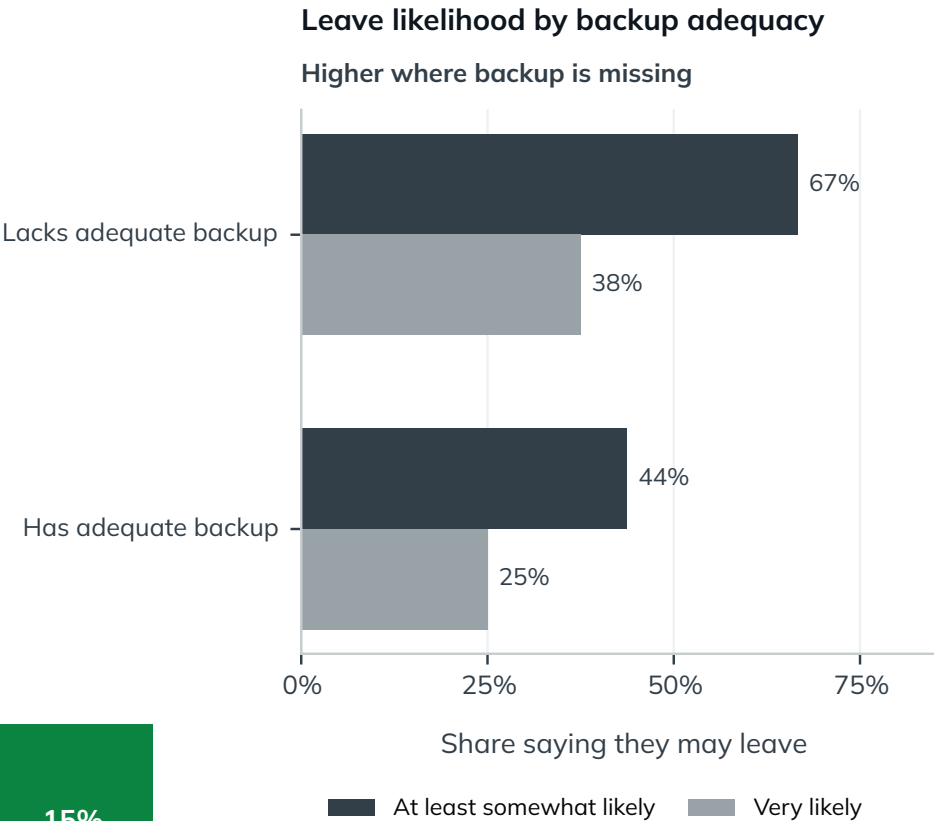


Figure 3. Most Current Rural Clinicians Say They May Leave Within Two Years — More Where Backup is Missing



The Vacancy Clock

Three-quarters of administrators reported a consequential physician vacancy in the past three years. Among the most consequential vacancies, 65% were still active searches. Of those reporting duration, 24% had been open six months or less, 42% had already lasted seven months or longer, 21% were described as ongoing and 12% were unsure.

Most vacancies were also identified late. Only 12% were anticipated more than a year ahead; 57% were anticipated less than six months before they occurred or not anticipated at all. Planning was just as thin. Asked how the interim arrangement came about, 19% of administrators said it was part of a contingency plan that already existed. Half said the arrangement was developed after the vacancy opened or had been discussed in advance without being fully worked out, and 16% said no interim approach was used at all. Asked separately to name the primary interim approach they actually used, a similar share (12%) selected none.

The Team Becomes the Bridge

What organizations actually did while the position sat open points to the same planning problem. The most common interim choices were physician-plus-APP models (21%), internal physician cross-coverage (18%) and APP-led access with physician oversight (15%). Locum tenens was fourth at 12%. Not one administrator named telehealth. That pattern matters because it runs against

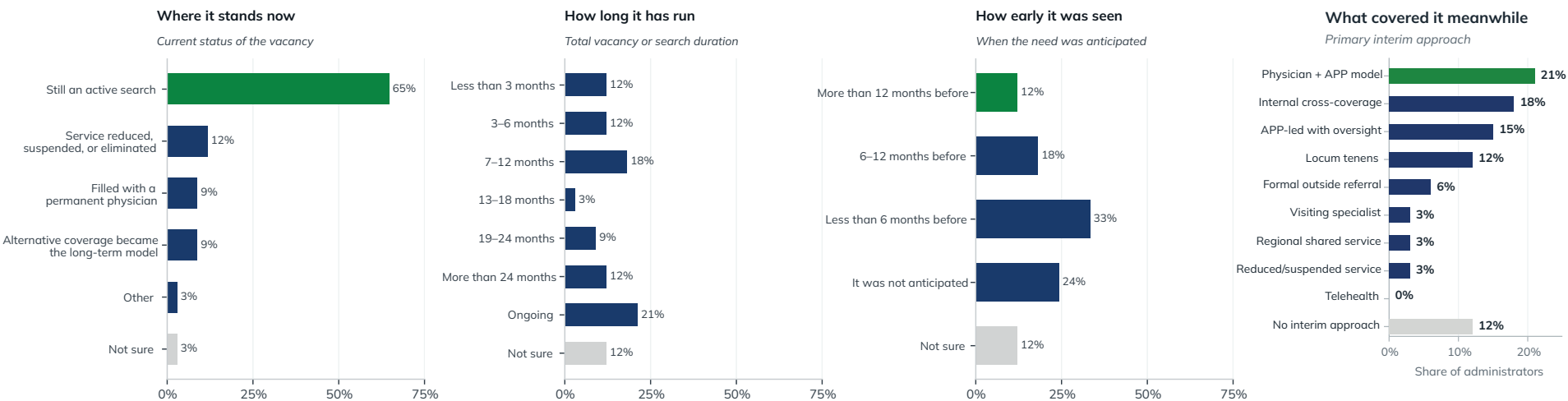
respondents' own judgment about what works. Locum tenens received the strongest short-term viability rating of any model (47%), while internal cross-coverage drew some of the most resistance: 32% rated it not viable. **When vacancies opened, organizations most often relied on capacity already inside the building — the same clinicians the survey shows are already short on backup.**

The Next Departure Is Already Visible

The next vacancy is usually already visible. Sixty-four percent of rural administrators expect at least one physician to retire or substantially reduce hours within five years. Among those answering the succession question, 26% had a formal plan for all or most expected departures and 15% had a formal plan for some. One-third had only informal plans, 15% knew of upcoming departures or had not fully assessed the risk and 11% were unsure. Family medicine was the specialty named most often.

Today's search and tomorrow's departure also frequently overlap. Of 13 administrators with both an active search and a known retirement or reduction in hours, 12 named at least one specialty on both lists. Among 17 with an active family medicine search, eight also expected a family medicine physician to retire or cut hours. **The organization is trying to close today's gap while the next one is already coming into view.**

Figure 4. The Vacancy Clock: Most Consequential Vacancies Are Still Open — and Few Were Seen a Year Out



Administrators describing their single most consequential vacancy of the past three years.

What a Vacancy Does to Those Who Remain

A major vacancy affects much more than the empty schedule. Rural administrators reported longer patient waits (57%), more physician workload or call (51%), more work for APPs and clinical staff (51%), burnout, morale or retention effects (46%), patients leaving the local system (43%) and reduced visits, procedures or surgical volume (43%). And 23% said the vacancy made it harder to recruit other physicians or clinicians.

Clinicians described the same cascade from the inside. When specialty coverage is unavailable or understaffed, 65% said their patients travel farther or leave the local system and 59% said patients wait longer. The effects then reach the clinicians themselves: 40% take on clinical work beyond their usual scope, 36% spend more time coordinating transfers or external referrals, 35% experience more stress or burnout, 23% carry additional call or cross-coverage, 20% feel less effective as a clinician — and 17% said the gap makes them consider leaving their current position.

The survey cannot prove that one effect causes the next, but the pattern is consistent from both vantage points: an open position adds strain to the same team a future recruit would be joining, and the strain becomes a reason to leave.

Closing the Cycle

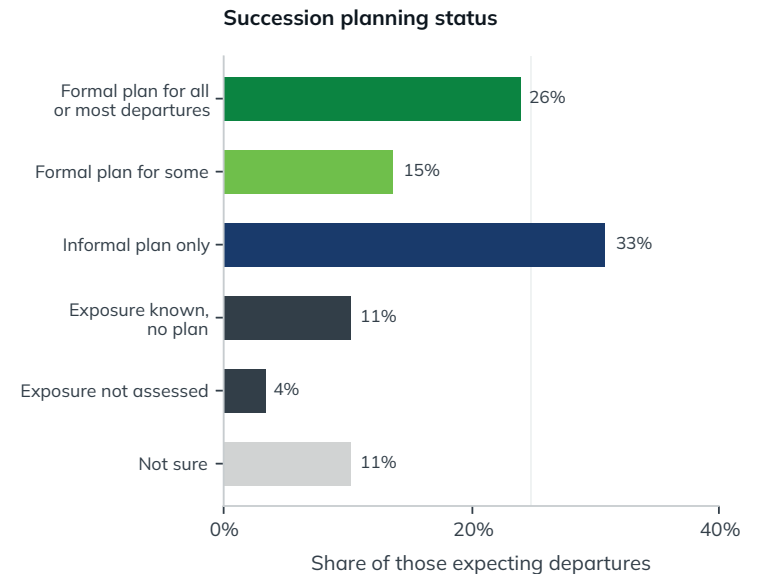
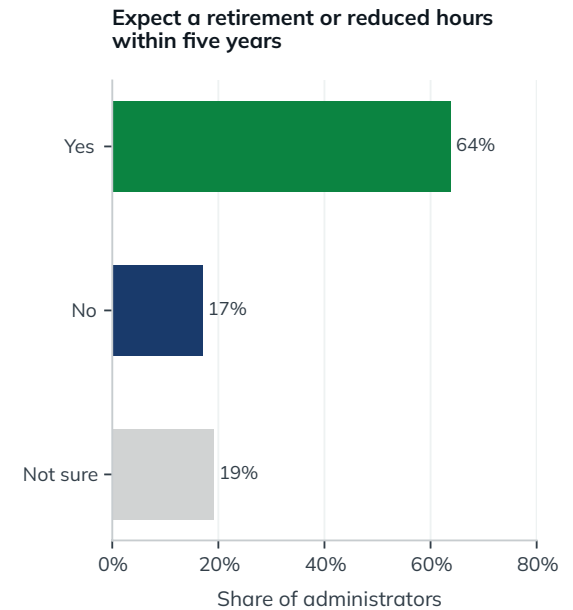
Backup and intent to leave were related in this sample. **Among current rural clinicians who said they lacked adequate backup, 67% said they might leave within two years and 38% said they were very likely to.** Among those who said backup was adequate, the figures were 44% and 25%. The clinicians who have already left tell the same story in the past tense.

Among former rural clinicians, the leading reasons they actually left were workload or burnout (33%), inadequate specialty support or colleague backup (31%), compensation (24%), call burden (22%) and organizational culture or leadership (20%). Among current clinicians, the leading reasons they might leave were workload or burnout (39%), compensation (39%), call (27%), culture or leadership (26%) and inadequate backup (18%).

These are different groups answering different questions. Even so, the same problems sit near the top of both lists — and inadequate backup ranks higher among clinicians who have already left than among those now considering it.

This is the point at which a specialty vacancy stops being one organization's staffing problem and becomes the source of the next one. A missing surgeon, obstetrician or psychiatrist removes the backup the remaining clinicians depend on; the remaining clinicians absorb the call and the out-of-scope work; some of them leave; the next search starts later and is harder than the last. **Protect, Grow and Cover Differently — covered later in this report — are the three points at which leaders can interrupt that sequence.**

Figure 5. The Clock Ticking on Another Vacancy



The Financial Blind Spot

The earlier cascade is mostly measured in people and rarely measured in dollars. Administrators trust their interim coverage to hold access and quality. More than half rate it good or excellent on both counts (52% access, 56% continuity). They don't trust it to hold up financially — only 19% rate it that well on sustainability beyond 12 months.

Few organizations had formally put a number on the vacancy itself. Only 25% had estimated its financial effect: 14% included downstream effects and 11% looked only at direct revenue. Another 14% made an informal estimate. By contrast, 43% made no estimate or evaluation and 17% were unsure.

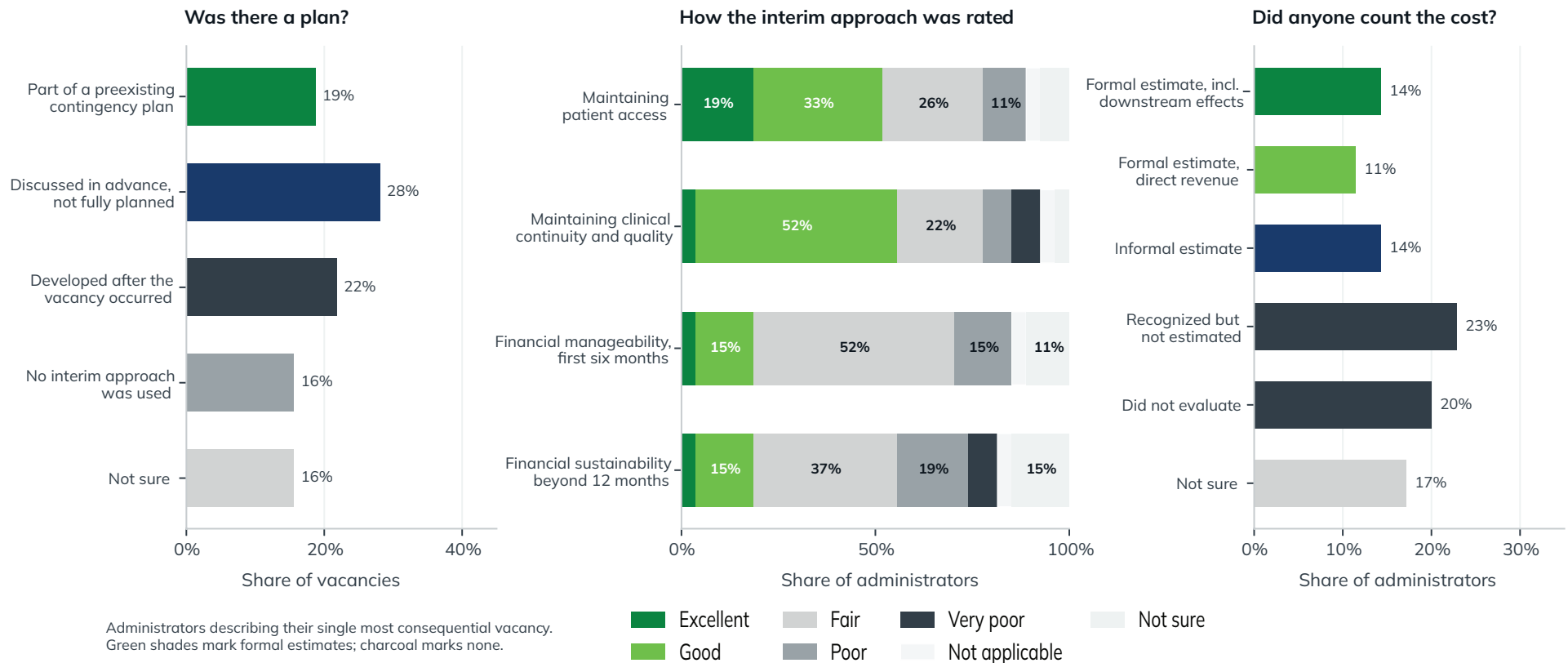
The published evidence suggests those numbers are large. The American College of Surgeons reports that a rural surgeon can contribute an

estimated \$1.05 million to \$2.7 million annually to a small hospital,⁷ and in one survey 12% of critical access hospital administrators said their hospital would close if surgical capacity were lost.⁸ At the far end of the scale, a revised analysis of California hospital closures found rural closures were associated with an **8.7% increase in inpatient mortality for time-sensitive conditions**, while urban closures showed no measurable effect.⁹

Without even a rough estimate, leaders have little basis for comparing the cost of recruiting earlier or arranging temporary coverage with the cost of leaving the position open — or with the cost of the departures that an open position helps cause.

Figure 6. Vacancy Planning and Cost Accounting

Rated better clinically than financially — and only a quarter formally counted the cost



Worksheet: Price Your Own Vacancy

Only one in four administrators in this survey had formally estimated what their most consequential vacancy cost. This worksheet lets any rural organization build a rough monthly estimate for a single position in under an hour. Use internal figures where you have them. The result is a planning estimate; its purpose is to give leaders a number to weigh against the cost of recruiting earlier or arranging coverage sooner.

STEP 1 Enter six monthly figures

A

Direct net revenue the position would generate

Net patient revenue per physician FTE, from your cost report or productivity data. MGMA DataDive compensation and productivity benchmarks can substitute where internal figures are unavailable.

\$

B

Downstream revenue tied to the position

Referrals, imaging, lab, procedural and surgical volume and admissions attributable to the specialty. In this survey, 43% of administrators reported reduced volume and 23% reduced ancillary use after a consequential vacancy.

\$

C

Revenue retained by interim coverage

The share of A + B the bridge actually preserves. Enter 0 if there is no interim approach — as was true for 12% of consequential vacancies.

\$

D

Cost of interim coverage

Locum tenens fees and travel, overtime, extra call and premium pay, contracted telehealth or visiting-specialist arrangements.

\$

E

Recruiting cost, spread across the search

Search fees, signing bonus and relocation, divided by the expected months to fill.

\$

F

Months the position is, or is expected to be, open

Your organization's recent searches; rural time-to-fill by specialty

months

STEP 2 Run the math

Monthly exposure

$$(A + B) - C + D + E$$

\$

Total exposure over the vacancy

$$\text{Monthly exposure} \times F$$

\$

Value of starting the search six months earlier

$$\text{Monthly exposure} \times 6$$

\$

Cost of the bridge versus no bridge

Compare D against the portion of A + B that C preserves

\$

A Rural Practice in Focus

Consider a rural leadership team reviewing three services at once. Family medicine still has local physicians, but capacity is thin and one physician may cut hours. OB/GYN relies partly on temporary coverage while permanent capacity is fragile. Behavioral health has limited local capacity, but more than one viable way to expand access.

The **Rural Specialty Priority Map** uses that kind of decision to organize the survey findings: what needs protection, where capacity should be added and where another coverage model may make more sense.

Where Physicians and Administrators Agree

Family medicine dominates the priority list, named by 63% of clinicians and 71% of administrators. Internal medicine follows at about 40% for both groups, with general surgery and OB/GYN close behind. Emergency medicine (EM), behavioral health, pediatrics and cardiology form the next tier.

Clinicians and administrators agreed on most specialties, which matters because these decisions usually require both groups to commit. The clearest split is behavioral health: 47% of administrators versus 25% of clinicians

named it a top-impact specialty. Clinicians placed somewhat more weight on emergency medicine and anesthesiology.

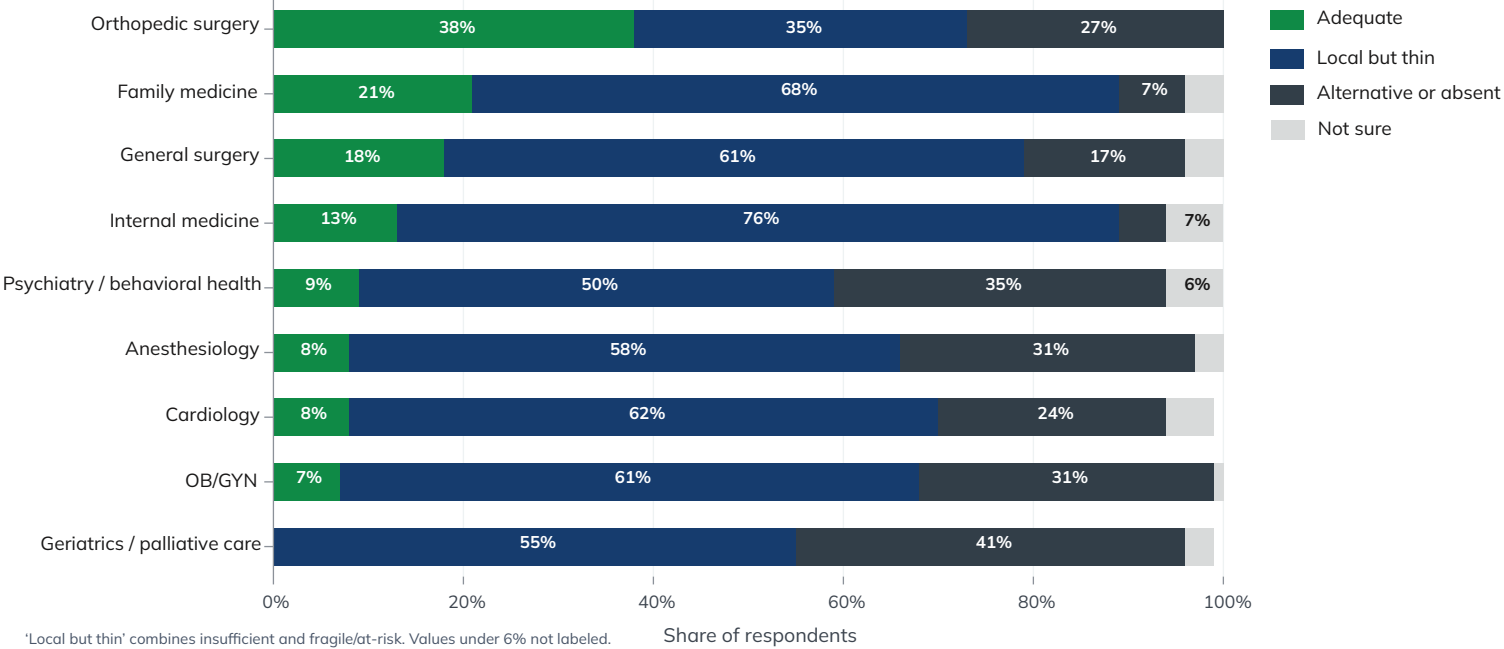
Three Kinds of Gaps

The three starting points introduced earlier — adequate, local but thin and alternative or absent — each raise a different management question:

Grouping the responses this way shows that the same broad “shortage” can mean very different things. Family medicine is mostly local but thin. OB/GYN combines very low adequacy with substantial reliance on alternative coverage. Psychiatry includes both thin local capacity and communities where coverage is alternative or absent. Those starting points call for different responses.

What rural respondents described	The question it raises
Adequate permanent capacity	Monitor — will stability be sustainable?
Capacity exists but is insufficient	A growth question
Capacity exists but is fragile or at risk	A protection and succession question
Coverage is primarily temporary, visiting, or virtual	A coverage-design question
No meaningful local capacity	A referral and partnership question

Figure 7. Three Kinds of Gaps
Most specialties still have local physicians — with too little slack



What Rural Care Leaders Would Do

Asked what to do, respondents chose **Grow** for most specialties: 50% for family medicine, 54% for internal medicine, 56% for geriatrics and 49% for OB/GYN and pediatrics; gastroenterology reached 74%. **Protect** led only in orthopedics and oncology, while general surgery nearly split between Grow and Protect. Service reduction drew little support.

Set against the capacity data, that ambition should be read carefully. **Grow usually means repair rather than expansion: moving an essential service from thin or fragile to workable.** And set against the retention results, growth has a precondition: The service being built should be one that the clinician already in it will stay for.

Figure 8. Ranking Workforce Approaches

Respondents chose building capacity — from a thin base

Most appropriate workforce approach for each priority specialty, sorted by share choosing Grow

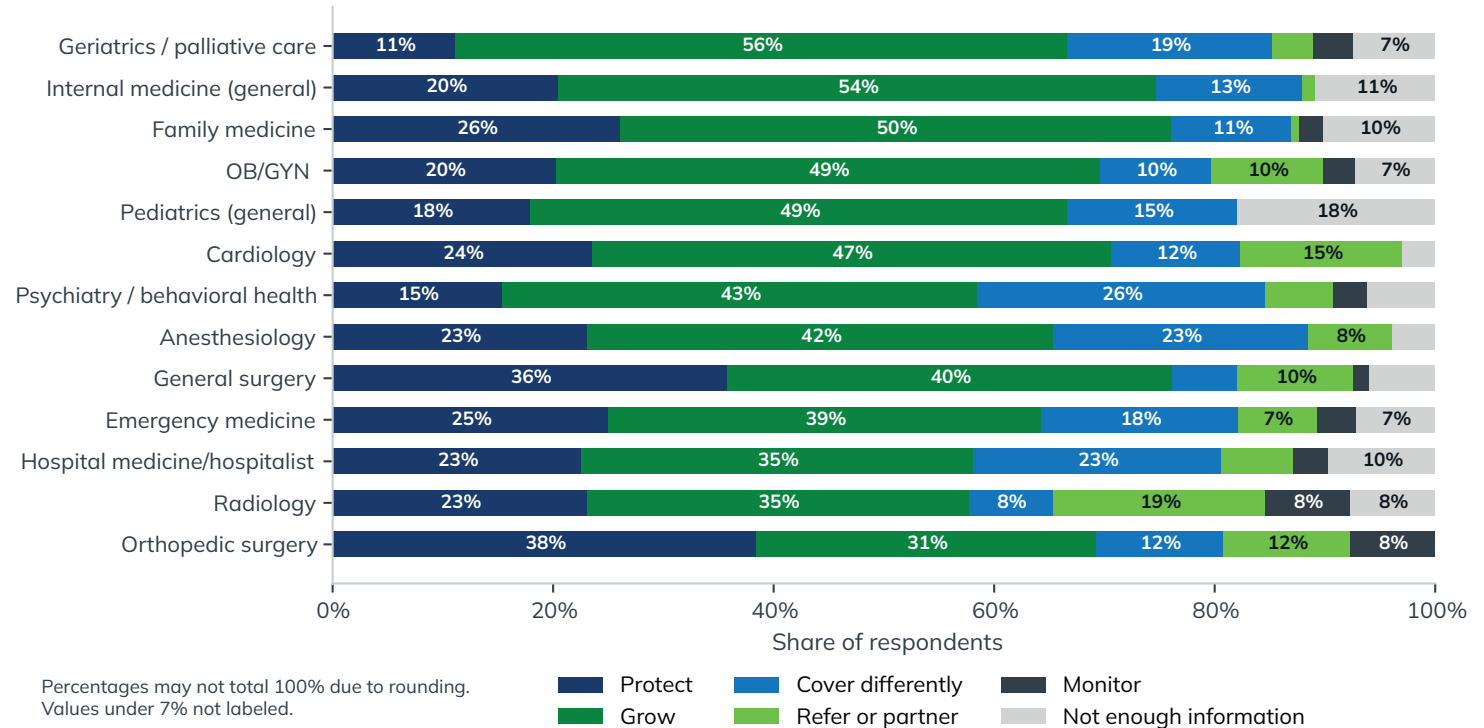
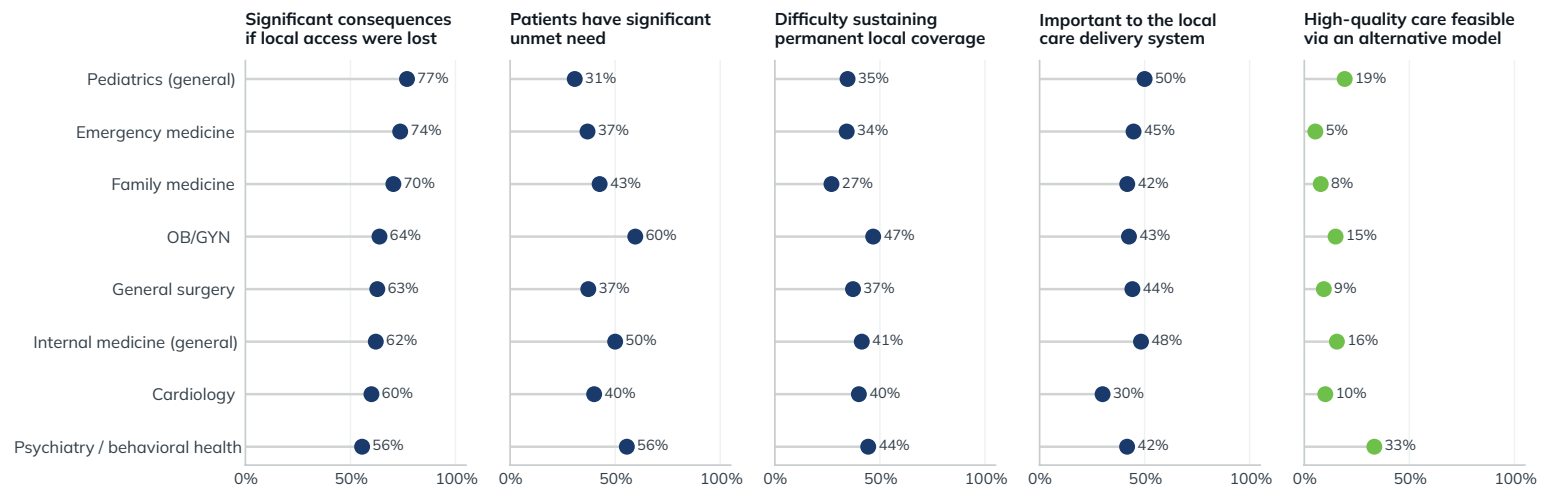


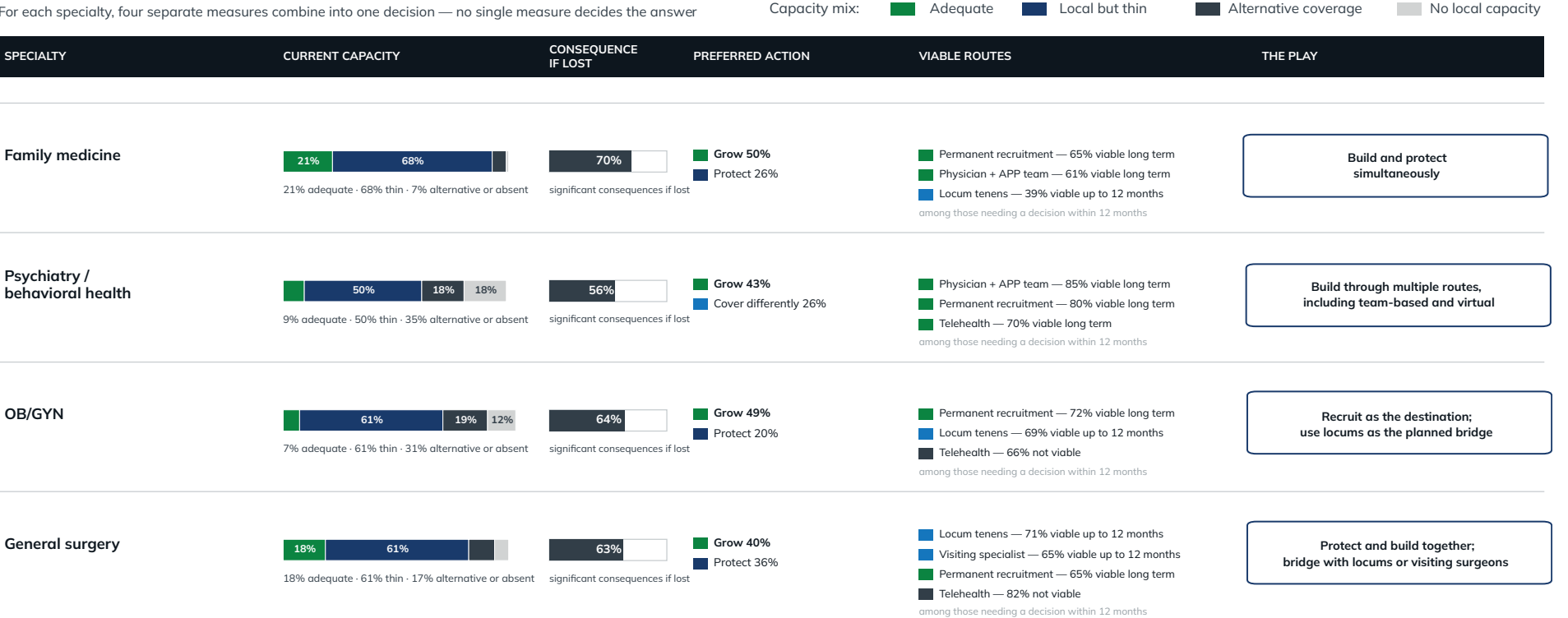
Figure 9. High Consequences, Hard-to-Sustain Coverage, Few Substitutes

Share of respondents saying each statement describes the specialty in their market



The Rural Specialty Priority Map

Figure 10. The Rural Specialty Priority Map



Capacity percentages computed from respondent counts and may not total 100 due to rounding. Consequence is the share saying there would be significant consequences if local access were lost. Preferred action shows 2-3 leading choices. Viable routes reflect only respondents saying a coverage-model decision is needed within 12 months.

Route colors: Viable as a short-term bridge Viable as a long-term model Rated not viable

Reading the Map

The Rural Specialty Priority Map combines current local capacity, the consequences if access is lost, what respondents said they would do next and which coverage models they considered workable in the short term or long term. It is not meant to replace the service-line analyses, pro formas or workforce plans rural leaders already use. Its value is in showing what those decisions need to account for: Two specialties can be equally important and equally thin, yet differ sharply in how much time leaders have, which coverage options are realistic and whether the immediate job is to protect, grow or cover differently. Consider the contrast between psychiatry and general surgery: Both have thin permanent capacity, but psychiatry offers several viable long-term routes — including telehealth — while general surgery has fewer substitutes and relies more heavily on permanent recruitment plus short-term locum or visiting coverage. Priority tells leaders where to focus; the coverage options show what may work.

This is not meant to replace the service-line analyses, pro formas or workforce plans rural leaders already use. Its value is in showing what those decisions need to account for: Two specialties can be equally important and equally thin, yet differ sharply in how much time leaders have, which coverage options are realistic and whether the immediate job is to protect, grow or cover differently.

What to Protect

Protect means maintaining important local physician capacity before it becomes a vacancy. The service still works; leadership's job is to see when thin or fragile coverage is one departure away from failure.

Consider One Rural Practice

At the practice introduced earlier, family medicine is still functioning. Local physicians remain, but capacity is thin and another reduction in hours would leave little margin. The Protect work starts before the problem becomes acute.

What Rural Care Leaders Said

Protect led only in orthopedic surgery (38%) and oncology (38%), with general surgery nearly split between Protect and Grow. Family medicine drew a sizable Protect share (26%) even while Grow led, showing that some anchor specialties require both jobs at once.

Orthopedics shows why Protect does not mean “already failing” — it had the study's highest adequate-capacity rating (38%) and the strongest Protect vote. Protection is not only for services already collapsing; it is also about preserving valuable capacity before it slips.

Rural Health's Fragility Watchlist

Fragility extends well beyond the Protect leaders. Figure 7's “local but thin” bar (page 11) combines two answers: capacity that is insufficient, and capacity that is fragile or at risk of loss. The fragile half is the Protect signal, and it's broad — from 39% of OB/GYN assessments down to 32% of emergency medicine, with anesthesiology, pediatrics, general surgery, internal medicine and family medicine in between. Majorities in all seven of those specialties said losing local access would have significant consequences. High consequences plus fragile capacity is the core signal for practices that need to Protect.

What the research shows: These ratings track documented outcomes. When rural counties lose hospital-based obstetric services, more births occur in hospitals without OB units, and a *JAMA* analysis of 4.9 million rural births found an associated increase in preterm birth.¹⁰ Rural areas also

Protection has two practical pieces. Start succession and recruiting earlier when a departure is visible — only 12% of consequential vacancies were anticipated more than a year ahead, while 64% of administrators can already name a likely retirement. And invest in the conditions that make clinicians stay, because the survey findings are specific about what those are.

experienced steeper declines in pediatric inpatient beds than urban areas, and nearly one-quarter of U.S. children saw the distance to their nearest pediatric inpatient unit increase over the decade studied.¹¹ For general surgery, the American College of Surgeons reports that a rural surgeon can contribute an estimated \$1.05 million to \$2.7 million annually to a small hospital;⁷ another study cites a survey in which 12% of critical access hospital administrators said their hospital would close if surgical capacity were lost.⁸

What Protection Looks Like

Protection has two practical pieces. Start succession and recruiting earlier when a departure is visible — only 12% of consequential vacancies were anticipated more than a year ahead, while 64% of administrators can already name a likely retirement. And invest in the conditions that make clinicians stay, because the survey findings are specific about what those are.

Only 25% of administrators formally estimated the financial effect of their most consequential vacancy. The ultimate cost of an uncovered service does not appear on any one ledger: A revised analysis of California hospital closures found rural closures were associated with an **8.7% increase in inpatient mortality for time-sensitive conditions**, while urban closures showed no measurable effect.⁹

What to Grow

Grow means adding physician or physician-led team capacity. In this survey, that usually means rebuilding thin services rather than expanding healthy ones, often while another gap is being managed at the same time.

The Mandate to Build

Rural leaders are choosing to grow, not retreat, in nearly every specialty: 50% for family medicine, 54% for internal medicine, 56% for geriatrics and 49% each for OB/GYN and pediatrics; gastroenterology reached 74%. Administrators' plans also lean toward building: 49% of active funded searches were new-growth positions, and for the most urgent specialty, 44% intended permanent recruitment and 22% a physician-plus-APP team.

What the research shows: The case for growing family medicine capacity is the best documented among this report's top specialties. A national county-level analysis found that each additional 10 primary care physicians per 100,000 residents was associated with lower cardiovascular, cancer and respiratory mortality. Primary care physician density also declined more sharply in rural than urban counties over the decade studied.¹² Thin family medicine capacity is both an access problem and a measurable population-health exposure.

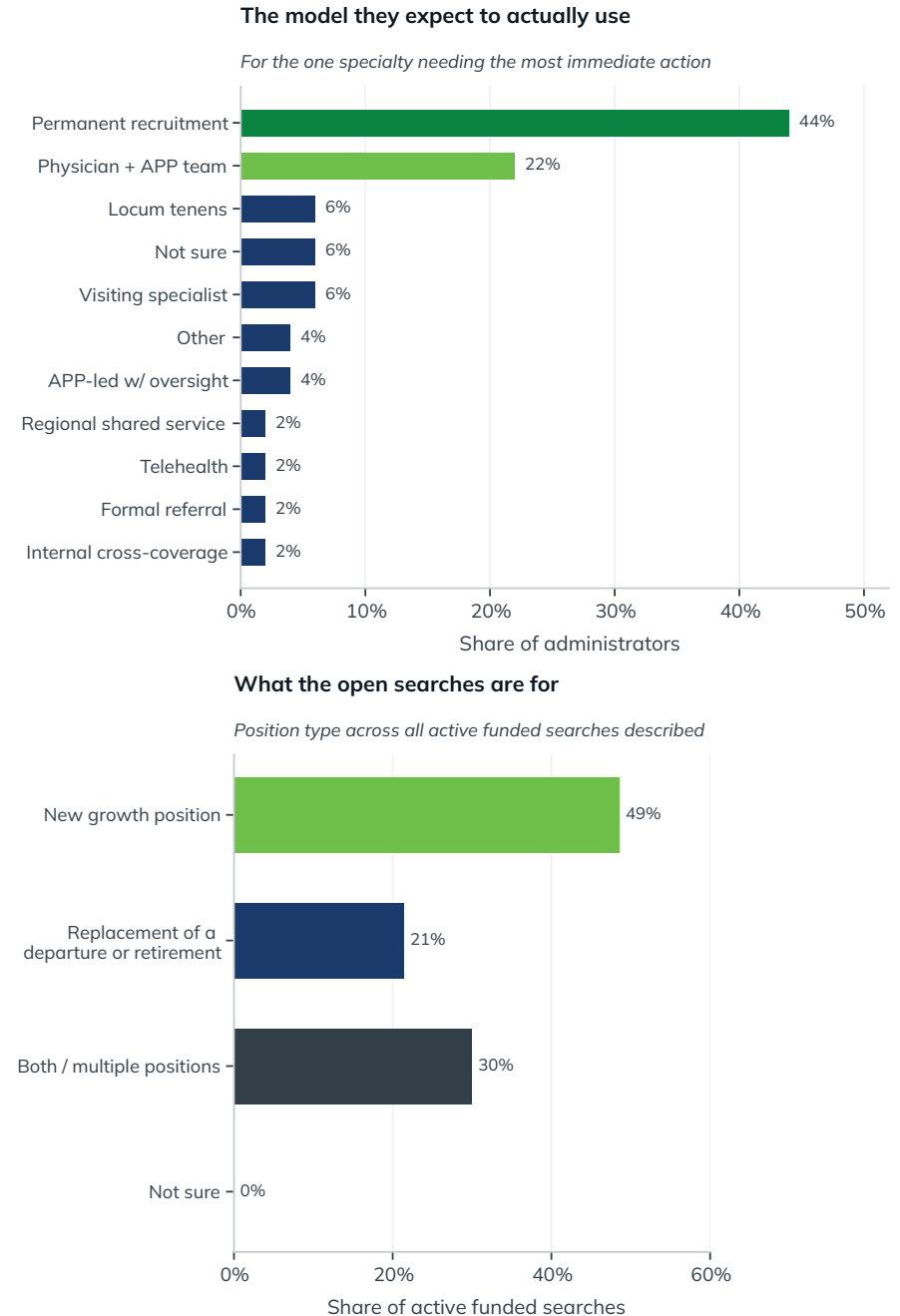
81% of administrators already recruiting named at least one high-impact specialty with no active funded permanent search

The Priority List Is Broader than the List of Searches

Among administrators already recruiting, 81% named at least one high-impact specialty with no active funded permanent search; across all administrators answering the search question, the figure was 90%. Among searching administrators with at least one Grow-designated specialty, 60% had a Grow priority without a permanent search; across all administrators with a Grow designation, 77%. Organizations cannot put every priority into a search at once.

Picture a rural care organization facing this choice. The same leadership team can see several valid needs at once: add family medicine capacity, strengthen behavioral health and keep OB/GYN from becoming more fragile. The hard part is deciding which need gets a permanent search now and which gets another response.

Figure 11. Administrators Intend to Build, but the Priority List Is Broad



Growing with Team-Based Care

Physician-plus-APP teams are the second major growth route: Across the specialty assessments, 55% rated physician-plus-APP teams viable long term, second only to permanent recruitment. The model was especially strong in psychiatry (85%) and reached majorities in family medicine (61%), internal medicine (60%) and emergency medicine (58%). With APPs comprising a growing share of the workforce, some rural growth will come from building teams around the physicians organizations can recruit and retain.

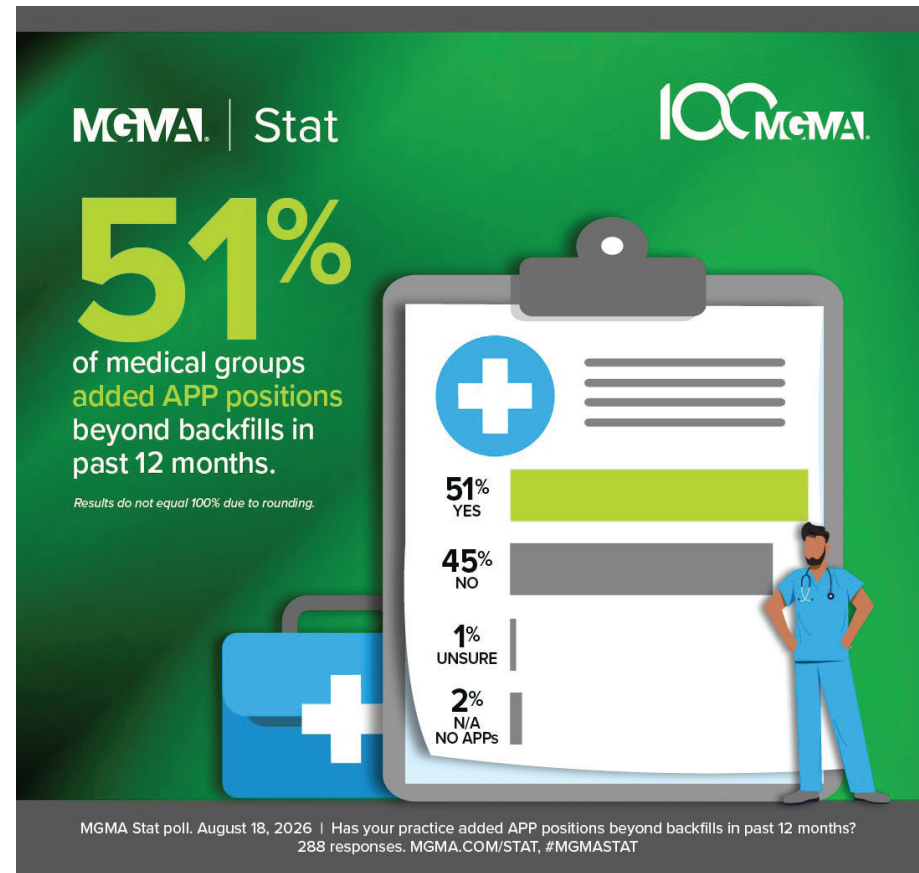
What the research shows: Behavioral health carries its own outcomes case for building through several routes at once. As of June 2026, about **31.7 million rural residents lived in federally designated mental-health professional shortage areas**.¹³ County-level research has linked mental-health shortage-area designation with higher suicide rates, with that association growing over time.¹⁴ CDC data also show that rural suicide rates increased faster than urban rates from 2000 through 2018.¹⁵

Team-based care is also already central to rural anesthesia. More than four in five rural counties had no anesthesiologist in one national analysis, while CRNAs played an important role in maintaining rural anesthesia services. The same study found emergency surgery and 24-hour obstetric coverage among the areas where rural hospitals faced the greatest anesthesia challenges.¹⁶

Rural respondents drew a different line around APP-led access without an on-site physician. It was viable long term for half of psychiatry respondents but rated not viable by majorities in emergency medicine, OB/GYN and general surgery.

Growth and Execution Risk

Growth is also the action most exposed to execution risk. Thin supply and recruiting in a competitive market mean the recruitment clock and clinician retention are part of the growth plan, not separate problems.



MGMA polling found more than half of medical groups added advanced practice provider (APP) positions beyond backfills in the past 12 months in August 2026. The primary driver was practice growth. Leaders linked additions to service-line expansion, increased patient volumes, new locations, extended hours, growing referrals and efforts to improve patient access.

What to Cover Differently

Some gaps cannot wait for permanent recruitment. Cover differently means using locums, care teams, telehealth, visiting specialists, regional sharing or referral either as bridge coverage or, where appropriate, as a durable model. The key finding is that the right model changes sharply by specialty and time horizon.

Permanent recruitment was the strongest long-term option overall, rated viable by 68% of respondents. Psychiatry was the exception, where respondents rated the physician-plus-APP model even higher.

Locum tenens received the highest short-term rating of any model: 47% of the specialty assessments rated it viable for up to 12 months, compared with 24% for long-term use. Support was especially strong for short-term use in OB/GYN (69%) and general surgery (71%). Emergency medicine

stood out because respondents were just as likely to see locums as workable long term as short term, at 47% each.

Visiting specialists were also viewed more often as a short-term option than a long-term one, 33% versus 19%. Internal cross-coverage was less appealing: 32% said it was not viable. Regional shared-service agreements drew the most uncertainty, with 27% saying they were not sure whether the model would work.

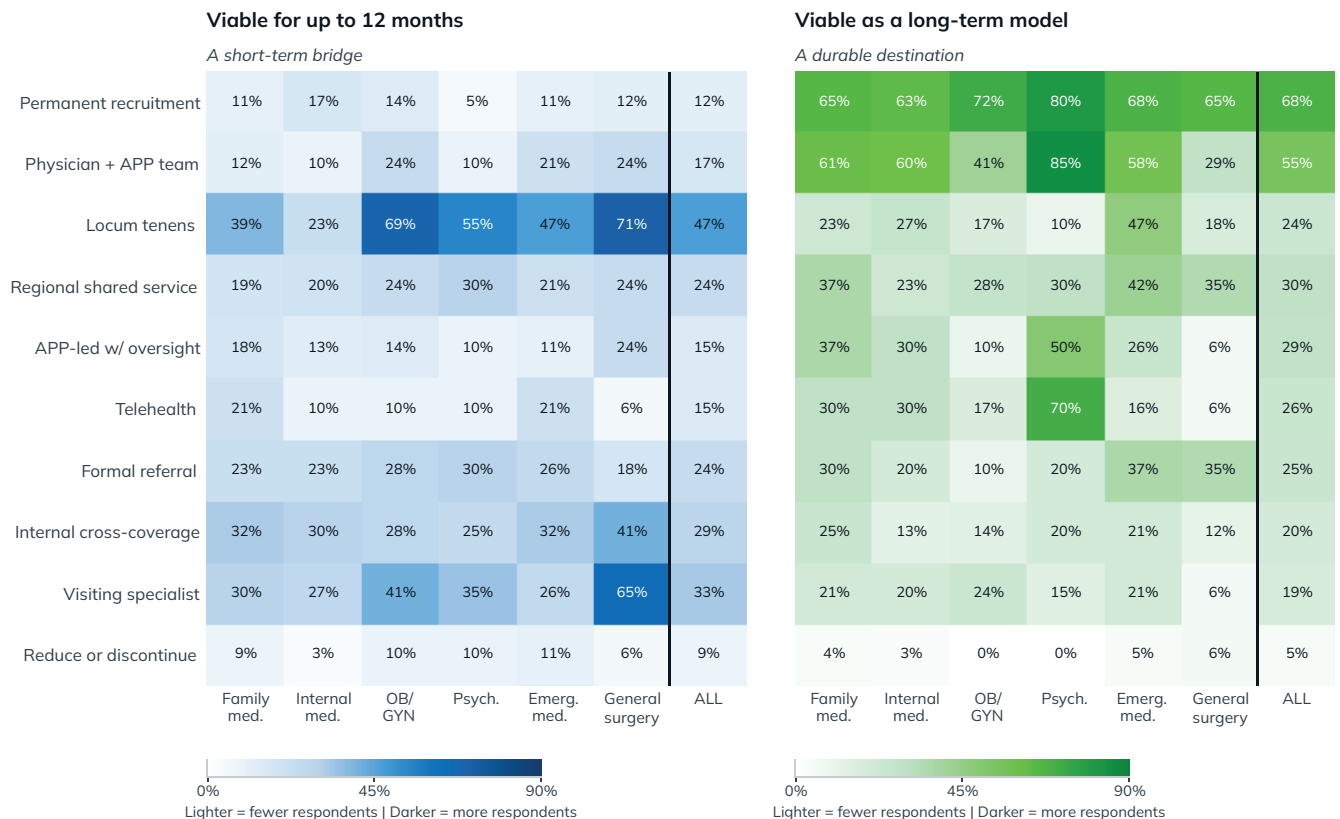
Telehealth was highly dependent on specialty. It was viewed as a strong long-term option for psychiatry, with 70% calling it viable. By contrast, majorities said telehealth was not viable for OB/GYN, emergency medicine and general surgery.

Bridges and Destinations

Across 255 specialty assessments from respondents facing a coverage decision within 12 months, the overall results were:

Model	Viable within 12 months	Viable long-term	Not viable	Not sure
Permanent local physician recruitment	12%	68%	9%	11%
Physician + APP care-team model	17%	55%	14%	14%
Locum tenens physician coverage	47%	24%	17%	12%
Regional shared-service agreement	24%	30%	19%	27%
APP-led access with physician oversight	15%	29%	39%	17%
Telehealth / virtual specialty coverage	15%	26%	42%	17%
Formal outside referral arrangement	24%	25%	27%	25%
Internal physician cross-coverage	29%	20%	32%	18%
Visiting or itinerant specialist	33%	19%	30%	18%
Reduce, suspend, or discontinue the service	9%	5%	75%	11%

Figure 12. Bridges and Destinations: Respondents Saying a Coverage-Model Decision Is Needed Within 12 Months



Three Specialties, Three Playbooks

OB/GYN: recruit as the destination; use locums as the planned bridge.

Nearly three-quarters of respondents (72%) said permanent recruitment could work as a long-term answer. Almost as many (69%) said locum tenens could work for up to 12 months. By contrast, most respondents did not see telehealth or APP-led care without an on-site physician as workable options.

Psychiatry / behavioral health: build through multiple routes. Respondents saw several workable long-term options: 85% supported physician-plus-APP teams, 80% permanent recruitment and 70% telehealth. Locum tenens was also seen as a workable short-term option. Unlike many other specialties in the study, behavioral health had several ways to expand access rather than one clear path.

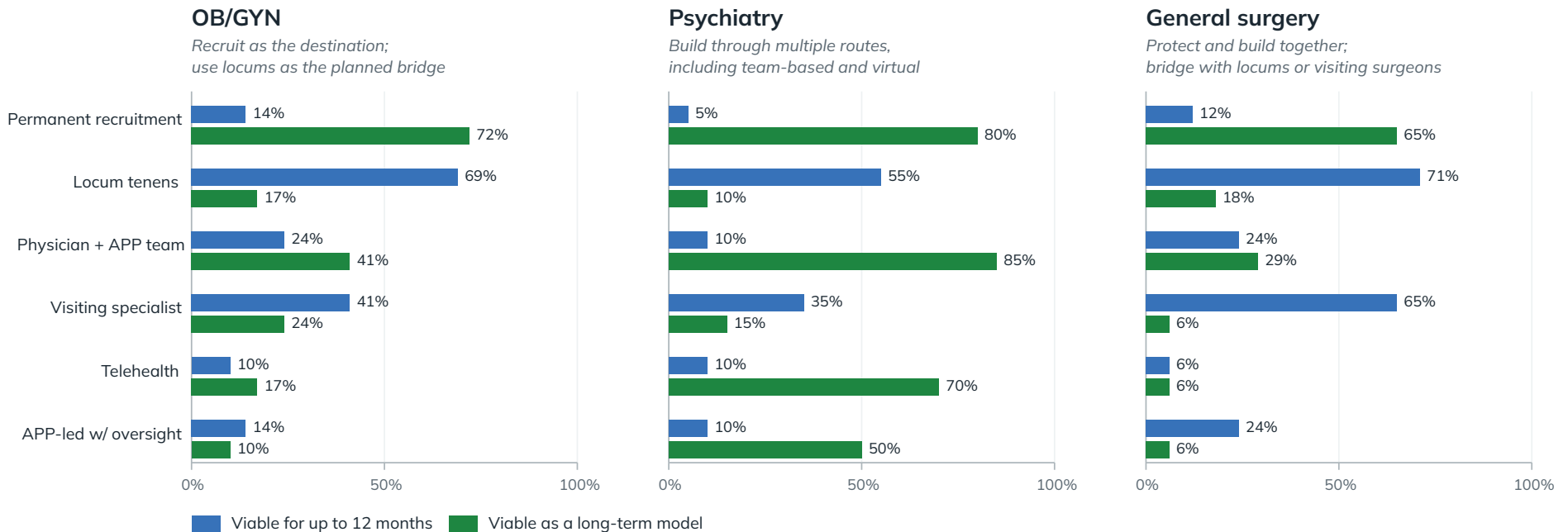
General surgery: protect and build together; bridge with locums or visiting surgeons.

Permanent recruitment was rated viable long term by 65% of respondents. For shorter-term coverage, 71% supported locums and 65% visiting surgeons. Other options drew much less support: 82% said telehealth was not viable, and 94% said reducing or discontinuing the service was not viable.

What This Can Look Like in Practice

One organization could be handling these specialties very differently at the same time. OB/GYN might need temporary physician coverage while a permanent search continues. Behavioral health might be able to expand sooner through a care team, telehealth or both. The right choice depends on the specialty, how long the arrangement needs to last and what comes next.

Figure 13. Three Specialties, Three Playbooks



What Comes After the Bridge

Among rural administrators for whom we could compare the coverage model they planned to use in the next 12 months and the model they had already rated for the same specialty, 72% chose an option they believed could work long term. Another 20% chose an option they believed could work for up to 12 months. None chose an option they had already said was unworkable.

Those short-term choices were spread across several coverage approaches, not concentrated in locum tenens.

That matters because choosing a short-term option is not necessarily a problem. The question asked what organizations planned to do in the next 12 months, so a temporary solution may be exactly what is needed.

For more on strategies to navigate physician transitions while ensuring coverage and investing in long-term team building, read this [February 2026 MGMA Insight Article](#).

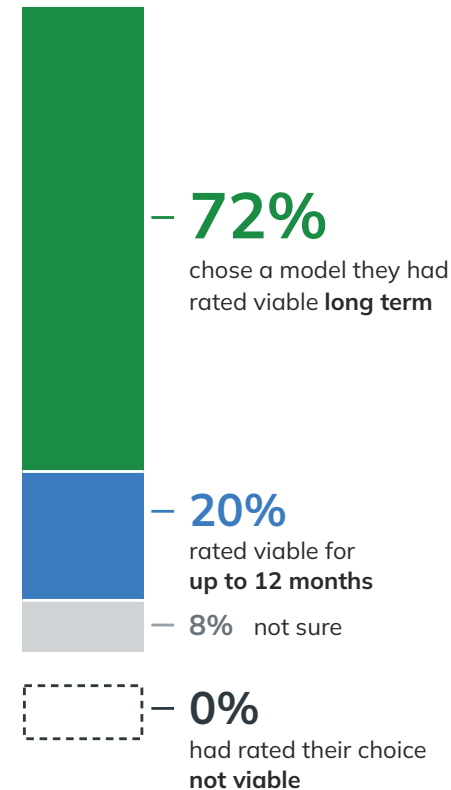
Covering Differently on Purpose

The practical lesson is straightforward: Choose the coverage model that fits the specialty, be clear about whether it is meant to last months or years and decide in advance when the organization will review it.

Permanent recruitment may still be the long-term goal. But the practice has to keep functioning while the search is underway. Temporary coverage can help protect patient access and reduce pressure on the clinicians who remain, especially when leaders are clear about why they are using it, how long they expect to need it and what should happen next.

Figure 14. The Next 12 Months: What Leaders Plan to Use

Each administrator's planned coverage model, by how they had rated that same model



Before any bridge starts

- ☐ Does the model fit the specialty?
- ☐ Is it meant to last months or years?
- ☐ When will we review it?

The Comeback Window

This report previously looked at the clinicians still working in rural settings. This section shifts to the ones who left and the evidence that many of them have not closed the door on a return.

Who Would Come Back

Forty-five percent of former rural clinicians said they would be very or somewhat likely to consider rural practice again; 30% said they were unlikely. The conditions for returning are specific: competitive compensation (47%) and better specialty coverage and colleague backup (45%) led, with reduced or redesigned call burden and more flexible scheduling or reduced-FTE options at 24% each.

Those are the same two levers current clinicians named. When asked what would most improve their experience, current rural clinicians put better specialty and colleague backup and more competitive compensation at the top, both at 49%.

Retention and re-recruitment run on the same fuel. The organization

that fixes backup and call for the physicians it has is, at the same time, building the conditions that would bring back the ones it lost.

There Is More Than One Door

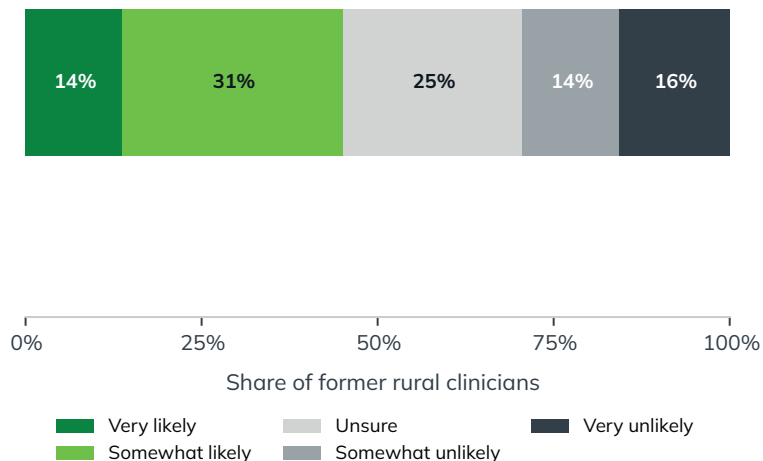
Nearly a quarter of former rural clinicians pointed to flexible or reduced-FTE options and redesigned call as conditions for return, which suggests **some former rural physicians may be open to returning through something other than a traditional full-time position.** Part-time roles, shared call arrangements and locum-to-permanent pathways are all plausible re-entry ramps — and the survey's own sample includes physicians (17%) whose primary arrangement is locum tenens.

These findings connect the workforce decisions detailed earlier. Protecting a service depends partly on keeping the clinicians already there. Growing capacity means recruiting people into the working conditions the survey describes. Changing the coverage model changes how workload, call and backup are shared across the team. The same conditions that keep clinicians in rural practice are the ones that would bring others back to it.

Figure 15. The Comeback Window: Nearly Half of Former Rural Clinicians Would Consider Returning

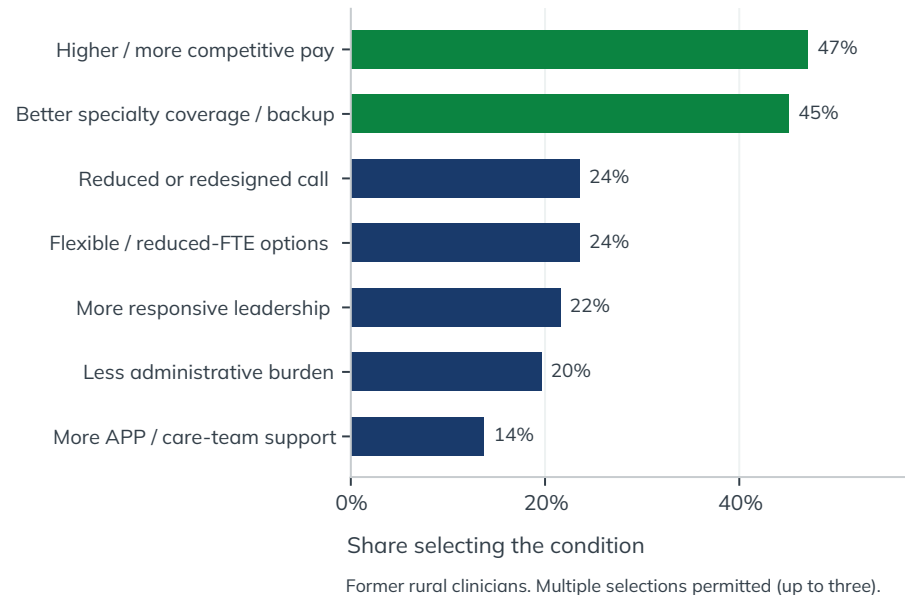
Would you consider rural practice again?

45% are very or somewhat likely to consider it



What would bring them back

Green marks the two conditions current clinicians also rank first



Recommendations

The rural practice introduced earlier does not have one workforce problem. It has a queue of decisions: what to protect first, where to add capacity, how to cover the gap in the meantime, when to act and what will keep the clinicians already carrying the load from leaving.

Protect

1 Treat Backup and Call as Part of the Coverage Plan.

Lack of specialist and colleague backup was the biggest deficit reported by current rural clinicians and was associated with greater likelihood of leaving. Protecting and growing a service therefore means more than filling a position. Call schedules, cross-coverage and access to specialist support need to be designed — and budgeted — alongside the staffing model.

2 Put the Workforce Question into Every Service-Line Review.

When a priority specialty comes up for budget, strategy or operational review, do not stop at demand, volume and financial performance. Ask whether current physician capacity is adequate or already thin, what happens if another physician leaves, whether the service needs protection or additional capacity and what coverage can realistically hold access in the meantime. Those questions belong alongside the pro forma, recruiting plan and succession discussion — not in a separate workforce exercise.

Grow

3 Start the Next Clock Before the Current One Runs Out.

Only 12% of consequential vacancies were anticipated more than a year ahead, yet 64% of administrators already expect a physician retirement or substantial reduction in hours within five years. Turn known departures into recruiting and succession timelines now, especially in specialties already running thin. Keep a contingency plan for the departures that arrive sooner than expected.

4 Recruit Back, Not Only Forward.

Almost half (45%) of former rural clinicians would consider returning. Their top conditions — better compensation and better specialty or colleague backup — are the same improvements current clinicians want most. Redesigned call, reduced-FTE roles and other flexible arrangements could create another entry point for clinicians who are willing to return to rural practice but not necessarily to the same job structure they left.

Cover Differently

5 Build the Model Before You Need It.

Coverage decisions made after a vacancy opens tend to default to whatever capacity is already in the building. Rural organizations that plan physician-plus-APP teams, telehealth or a locum bridge in advance, before a departure, keep more options and better terms than those improvising under pressure. Treat these models as designed infrastructure for a specialty, not an emergency substitute.

6 Give Every Bridge a Destination.

Temporary coverage works best when leaders are clear about what it is meant to accomplish and what comes after it. Match the model to the specialty, decide whether it is meant to last months or years and set a review date when the arrangement begins. A bridge should buy time for the next decision, not postpone it indefinitely.

Conclusion

Rural workforce strategy extends beyond filling open positions. It begins with the clinicians who are still there — most of whom want to stay, and many of whom say they may not — and with the recognition that a specialty gap left to the remaining team is often how the next gap gets made. The rural organizations best positioned to sustain access will see risk earlier, choose the right response for each specialty and protect the people carrying the service while that response takes shape. They will treat permanent recruitment, temporary coverage, team design, succession planning and retention as parts of one workforce plan — not separate problems handled one vacancy at a time.

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