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Letter to the Editor

Broadening the lens on rural practice affinity: integrating systems, context, and longitudinal support

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Dear Editor

We read with interest the recent article by Orrantia et al (2025), who propose a rural practice affinity model in which emergency medicine (EM) competency mediates the relationship between general self-efficacy and intentions to practise in rural settings[1]. We congratulate the authors for a rigorous, focused analysis that demonstrates how EM competence – tested while controlling for relationships, financial and personal aspects, and social desirability – contributes to rural practice self-efficacy and intentions.

Our letter offers complementary perspectives to aid the translation of this focused model into policy and program design. Importantly, we do not reinterpret the Orrantia model as broadly multidimensional; rather, we view it as a valuable, deliberately narrow test of one critical competency domain, the effects of which occur within broader contextual and system environments.

Longitudinal mentorship and identity formation

Orrantia et al controlled for static personal factors but their cross-sectional design limits insights into how professional identity develops over time. Evidence from longitudinal studies shows that continuous mentorship and social integration during training enhance rural commitment; therefore, embedding EM competency training within sustained mentoring relationships and longitudinal rural placements may strengthen the pathway from competence to long-term retention[2-4].

Health system alignment as an enabling dimension

System factors – remuneration frameworks, infrastructure and team composition, and regional referral networks – shape whether competency converts into feasible, sustainable practice[5]. In resource-constrained settings, perceived system-level support moderates burnout and professional belonging; aligning EM-focused curricula with health system strengthening is therefore essential.

Community integration and non-clinical fit

Beyond technical skills, social connectedness, cultural fit, and community engagement exert durable effects on retention; these psychosocial dimensions should be measured alongside competency outcomes during pilot evaluations[6,7].

Practical next steps

We recommend pilot studies that embed the rural practice affinity model within longitudinal curricular pathways (eg longitudinal integrated clerkships, mentorship cohorts), include system-level interventions (eg tele-support, referral linkages), and incorporate mixed-methods evaluations capturing community perspectives and objective workforce outcomes. Such implementation science approaches will show whether strengthening EM competence indeed yields sustained rural appointments when the enabling context is present.

Conclusion

Orrantia et al make an important contribution by isolating EM competency as a testable mediator in rural practice affinity[1]. Extending their work through longitudinal, system-aware, and community-embedded programs will better inform actionable strategies to recruit and retain rural physicians.

Conflicts of interest

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