Physician Retention in Rural Alberta: Key Community Factors

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ABSTRACT

Objectives: As part of a larger case study exploring physician retention factors and strategies employed by rural communities, the objective of this analysis was to explore the community factors that promoted physician retention.

Methods: A qualitative, collective case study design was employed to study four rural communities (cases) in Alberta that retained family physicians for four years or longer. Participants included physicians, staff members, spouses and community members (all were patients from the communities studied). Communities were selected through a retention-specific matrix; each quadrant represented a particular community typology. Case data collected from interviews, documents and observations were analyzed, and similarities and differences among cases were assessed.

Results: A range of community factors that could influence physicians' decisions to stay in a particular community were described by participants. Four themes, Appreciation, Connection, Active Support and Physical/Recreational Assets, were positively related to physician retention in the four communities studied. These community factors existed to different degrees but were present in all communities. Reciprocity was a fifth factor that emerged in three of the four communities studied.

Conclusion: Physicians, policy-makers, community members and health care professionals are encouraged to consider the community domain when planning and implementing strategies to retain rural physicians and other health care professionals. The four communities studied were able to promote retention of their primary care physicians by showing appreciation to them, building connections with them and their families, actively supporting their physicians and local health facilities, maintaining and improving local physical/recreational amenities, and nurturing reciprocal rapport with physicians.

Key words: Physician; retention; community; rural health services; case study

La traduction du résumé se trouve à la fin de l'article.

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The health and well-being of individuals in rural areas are in part dependent on access to health care resources.¹ Yet the availability of health care professionals, including physicians, is an ongoing issue for rural communities internationally²⁻⁴ and across Canada.^{1,5,6} Approximately 20% of Canada's population live in rural and remote Canada,⁷ defined as the population living outside the commuting zone of larger urban centres.⁸ Shortages of health care professionals, facilities and services make access difficult for many rural Canadians.^{1,5,6} Several studies have underscored current and projected insufficient physician coverage of rural areas.⁹⁻¹¹

Recruitment and retention strategies for rural areas may promote health care accessibility.¹² Although there is limited research in the area, physician job satisfaction, rural background, and workload have been found to be related to physician retention.¹³⁻¹⁵ Community factors or characteristics have been examined to an even lesser extent.^{2,16} Thus, despite the importance of this labour force issue for rural health, there is little conclusive evidence about retention factors and, in particular, information about community factors that influence physician retention.

OBJECTIVES

In response to this important health care issue for rural Canadians, successful community-based physician retention was examined in rural Alberta. As part of a larger case study exploring physician retention factors and strategies employed by rural communities,¹⁷ the objective of this analysis was to explore the community factors that promoted physician retention. Other factors (including professional and personal) are explored elsewhere. The research question addressed

in this study was: What factors within the community domain influenced physician retention in the selected rural communities?

METHODS

A multiple, or collective, case study methodology was employed.^{18,19} In this study, four rural communities in Alberta that had successfully retained primary care physicians were selected as cases through maximum variation sampling. Retention was defined as four years or longer, since previous research has suggested that rural physicians often migrate after approximately four years.^{20,21} Cases were first examined independently, and then comparative analysis was performed. This study was approved by the University of Calgary Conjoint Health Research Ethics Board, and there were agreements with each community's health region with respect to data collection, analysis and dissemination. Cases have been disguised and blinded in order to protect the confidentiality of participants.

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Sampling and recruitment

This study employed maximum variation sampling.²² From the literature and discussions with representatives from the Alberta Rural Physician Action Plan (RPAP), a typology of seven factors relevant to Alberta rural communities was developed, consisting of geographic proximity to an urban centre, access to health care resources, size of community, geographic location in Alberta, practice type, number of years for which at least one physician was retained, and resources available to the community. From this, a matrix with four cells evolved: Southern Farming, Urban-edge, Micro Community and Northern Resource-based.

Existing data from the RPAP database were used to identify communities that fit the study criteria, and the first author used e-mail or fax to contact eligible communities' physicians regarding participation. Once a contact physician from the community agreed to participate in the study, his or her corresponding health region was contacted. Community A was a small southern ranching community, Community B was situated in a busy western industrial area, Community C was a small eastern rural-remote community, and Community D was a northern community largely supported by oil and gas, agriculture and tourism. Participants in each community were either contacted by the initial physician contact or responded to newspaper or poster advertisements independently. Data were collected within a one-week period in each community.

Data collection

Individual interviews, document review and personal observation were data collection techniques employed. The first author conducted individual interviews with participants (including physicians, physician spouses, hospital/office staff, and community members) in the selected communities. A general interview guide approach was used²² consisting of approximately 20 questions for each participant type, relating to their community, physician recruitment and retention, and community actions.

A total of 41 participant interviews were conducted, ranging from 9 to 12 interviews per community. Of the 15 physician participants, 80% were male, with ages ranging from approximately 30 to 60 years and time in rural communities ranging from 4 to more than 30 years. Seven were Canadian born, and the remaining eight were from four other countries. Managerial, nursing, reception, x-ray, and nurses' aid staff were interviewed. Community members were all patients in their local communities and included business people, journalists, mayors and town councillors.

Data analysis

All interviews were tape recorded and transcribed, and individual transcripts were sent to interested participants for member checking. Verified transcripts were uploaded into ATLAS.ti 5.0 to be coded. A separate code list was built for each community. The lists were compared to create a final code list used for coding all interviews. The four cases were built individually, and the similarities and differences among cases were then examined using matrices based on Miles and Huberman's "stacking comparable cases" as well as cognitive mapping²³ to illustrate retention domains, the relations among the domains, and specific retention factors.

RESULTS

A range of community factors that could influence physicians' decisions to stay in a particular community were described by partici-

pants. Four themes related to community – Appreciation, Connection, Active Support, and Physical/Recreational Assets – were described by participants in all four communities as physician retention factors. These community factors existed to different degrees but were present in all communities. Reciprocity was a fifth factor that emerged in three of the four communities studied (it did not emerge in Community B). Each of the factors will be discussed in turn below.

Appreciation

Physicians in this study provided a number of informal and formal examples of how they felt appreciated by their communities. Physician participants cited verbal feedback, acknowledgements in the newspaper, and personal cards and gifts. According to two physicians, community members showed gratitude in creative ways: "I was just given a picture yesterday; it's just in my office there. There's a patient that painted." [Male physician] and "Personal thank yous, you know, cards" [Male physician]. One male physician talked about his community's response to physicians' initiatives: "I spoke to Rotary [Club] last week and people were very flattering [about] what we're doing." Staff members also recognized this retention factor:

All you have to do is just walk into a staff room on any given day and there's baskets and fruit and thank you cards from communities. The people do their bit all the time and they're continually thanking the physicians in the papers. [Female staff member]

Community members recognized appreciation as important. A male community member offered, "I hope that it's things like feeling valued, I hope it's things like people thanking them and appreciating them occasionally." Some specific ways in which community members demonstrated their appreciation were cited by one female community member:

I think the people that are aware of it do show their appreciation. I think they do tell the doctors and the hospital staff. I know I have always given my doctor a Christmas card and a bottle of wine or liqueur or something at Christmas just to say thank you for looking after our family for this year.

The sense of appreciation from the community was recognized as necessary by some respondents:

...the population has to recognize them in some ways or, bringing chocolates and whatever, you know? ... That happens here. I would say yeah, it does. And so that's a good thing. [Female physician]

Connection

Community connection, or a sense of belonging and integration into the community, was discussed by a number of participants in different ways. One female physician described this sense of belonging by describing her community as "... a very warm and friendly town... a very good place to bring up children". Connection to the community was directly linked to retention by a female physician, who explained, "You stay because you feel connected to the community. You stay because, yeah, you're part of it more so than anyone, than your urban counterpart can feel... you stay 'cause you're

integrated into a community that you like.” Likewise, a physician’s spouse commented,

We’re here because we really, really want to be here. We’re not here because this is the job that [Spouse] was offered and nothing else was available. Like it was a hundred percent conscious decision on our part to move to [Community] because of the practice, but because of the location, because of the community.

Within a small community, a female staff member speculated that physicians had the opportunity to “have some say in what happens in your community as well, and some of them have gotten involved in community activities.”

Active support

Participants provided concrete examples of how the community mobilized to assist and support physicians. For example, participants cited various actions, such as fundraising for medical facilities, volunteering, political advocacy for facilities, welcoming and befriending physicians and their families, and nominating physicians for community awards. A female physician explained that the active support from community members was constant:

No matter what we’ve done – being raising money, being, you know, going to bat with the [health] region, being, you know, offering transportation for our woman’s nights for marginalized populations – you know, just, they have been just overwhelmingly supportive.

Participants in two of the four communities also acknowledged successful attempts to mobilize local residents to retain their physicians and health care facilities. A female spouse explained:

The community put up a fabulous fight and won...they called in politicians and they had letters from different people, some of our school administrators. One in particular wrote a very passionate, powerful speech and I think it really did make a difference. And actually some of the politicians say that was one of the things that kept [Community] alive.

Physical/recreational assets

Physical, natural and recreational assets within communities were also a factor in retaining physicians. A male community member explained the appeal to newcomers and permanent residents: “That is a huge factor in retaining people and getting people to come here. Because when they come and look around and they go, ‘Wow, this is kind of a neat area, I could live here.’” A female staff member asked rhetorically, “Where else are people going to go that they’re going to find something like that, where you’re actually almost living like a holiday?” Recreational and physical assets were cited by two male physicians as important. One said, “There’s a lot of things in the community. I mean the extra-curricular things for kids and for adults if they want to do them too”, and the other physician said, “It’s those [recreational] sort of things that keep my wife happy, which therefore keeps me happy.”

Reciprocity

A clear perception of reciprocity, or mutual benefit, emerged in three of the four rural communities studied. In interviews in these

three communities, it was evident that participants perceived that physicians worked hard to care for patients, their practices and the hospital, and contributed to the community (e.g., involvement in municipal politics, donations to local sports clubs and facilities, volunteerism), while community members showed gratitude and respect through council initiatives, fundraising, personal acts of appreciation, and continuing support as patients. One male physician described the importance of this give-and-take relationship: “It is paying back to the community that has made us welcome... you cannot keep taking. As a physician your food on your table comes from your community.” A male community member provided a description of the community perspective about reciprocity:

...they [physicians] have a very high level of respect in our community and they’ve earned it, they’ve earned it. They have been innovative, they’ve been creative, they partnered well together. They’ve been cooperative, particularly with the health regions. They’ve been innovative. They’ve earned a level of respect but they give good health care and we know they do give health care, they care, and so we care as a community. We care about them. They are wonderful people, and we love them.

Limitations

As this study employed a case study method, its results may not be generalizable beyond the specific cases studied; reader or user generalization²⁴ is appropriate for this study. In addition, because of research ethics parameters, the first author was unable to approach individuals directly regarding participation and was therefore subject to the efforts of the local contact physician and word of mouth to enrol participants. This restriction may have excluded participants with insight into retention. Member checking did not occur beyond the initial transcript with participants who were interested, and thus there was no additional audit for clarity or confirmation. Another limitation was the finite time available to spend in each community, which did not allow for full immersion in local culture. Finally, threats to validity existed within each method employed; however, using data source and methods triangulation as a “corrective tactic”²³ enhanced the trustworthiness of the data.

CONCLUSION

There is little evidence in the literature about physician retention factors generally and community factors specifically. The present study helps to fill in the gap in the physician retention literature on community factors. Rather than researching what is lacking or troublesome within communities, this analysis built on the strengths of rural communities and illuminated the multifactorial nature of community retention. Our results are supported by the small existing literature on community retention factors. Physical aspects of the community have most often been recognized as a retention factor.^{16,25-27} Showing appreciation to physicians^{13,16} and community connection^{26,28} are also documented in the literature. In addition, while not as widely recognized, some researchers have cited active support as playing a role in retention.^{28,29} Although reciprocity has not been identified previously as a retention factor, the importance of community-physician interactions has been recognized.^{26,30}

Other retention factors related to characteristics of physicians – including physicians’ personal characteristics, training and workload issues – are also important considerations.³¹⁻³³ Although the

community domain is often regarded as less important in the physician retention literature, the results of this study support the community's relevance to retention. Physicians, policy-makers, community members and health care professionals are encouraged to consider the community domain when planning and implementing strategies to retain rural physicians and other health care professionals. Communities can act in specific ways to target retention and in general terms to improve and build the community as a whole. Retaining physicians will help to protect the public health of Canada's rural communities.

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RÉSUMÉ

Objectifs : Dans le cadre d'une vaste étude de cas sur les facteurs et les stratégies de fidélisation des médecins en milieu rural, nous avons voulu analyser les facteurs communautaires qui favorisent le maintien en poste de ces médecins.

Méthode : Nous avons mené une étude qualitative et collective dans quatre communautés rurales de l'Alberta (les « cas ») ayant conservé leurs médecins de famille quatre ans et plus. Les participants étaient des médecins, des membres du personnel, des conjoints et des résidents (tous des patients des communautés à l'étude). Les communautés ont été choisies selon une matrice portant spécifiquement sur la fidélisation; chaque quadrat représentait une typologie communautaire particulière. Nous avons recueilli les données au moyen d'entrevues, de documents et d'observations, analysé ces données, puis évalué les similitudes et les différences entre les cas.

Résultats : Les participants ont cité divers facteurs communautaires ayant pu influencer la décision des médecins de rester dans une communauté donnée. Quatre thèmes (appréciation, relations, soutien actif et équipements physiques/récréatifs) étaient positivement liés à la fidélisation des médecins dans les quatre communautés étudiées. Ces facteurs étaient présents à différents degrés dans toutes les communautés. Un cinquième facteur, la réciprocité, était présent dans trois des quatre communautés.

Conclusion : Nous encourageons les médecins, les stratèges, les résidents et les professionnels de la santé à tenir compte de l'aspect communautaire lorsqu'ils planifient et mettent en œuvre des stratégies pour fidéliser les médecins et autres professionnels de la santé en milieu rural. Les quatre communautés à l'étude ont réussi à fidéliser leurs médecins de premier recours en leur montrant leur appréciation, en tissant des relations avec eux et leurs familles, en appuyant activement leurs médecins et leurs établissements de santé locaux, en entretenant et en améliorant les équipements physiques et récréatifs locaux et en entretenant des rapports de réciprocité avec les médecins.

Mots clés : médecin; fidélisation; communauté; service santé milieu rural; études de cas