Elements of rural practitioner retention: a synthesis of four related research projects

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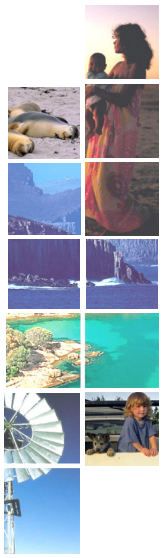


ABSTRACT

This paper is a synthesis of the results of four research projects conducted within the Rural Health and Workforce Research Unit at the School of Medicine at James Cook University (and the former North Queensland Clinical School). Each study was a separate endeavour, with separate staff, samples, findings and reports. The studies used similar sampling, data collection and analysis methods. Each was built on the broad mission to enhance understanding of the issues that influence rural practitioner retention. A secondary mission was to identify areas in which policy/strategies enacted during the 1990s influenced retention.

Aims

This paper has two aims, to:

- synthesise commonalities in terms of issues affecting retention arising in this series of studies;
- identify possible policy interventions.

Method

This is a qualitative research synthesis employing an inductive, comparative method of analysis. Initially, key common findings across the studies are identified, before comparing respondents' reported experiences within the context of each study.

Results

Certain recurring themes are evident across the studies regardless of perspective or personal experience.

- there is a need to engender a greater sense of support
- support initiatives need to be visible and access uncomplicated
- initiatives are needed to support network development
- preparing families for rural life/practice is as important as preparing practitioners
- support organisations are well-placed to recognise and act when GPs/families struggle
- retention needs to be recognised as ongoing—not an end-point
- relocation within rural areas should be seen as "retention".

Conclusions

The issues identified here are likely to be common to most rural health professionals.

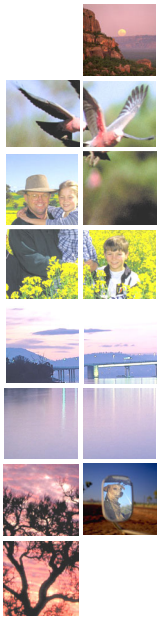
Keywords

Workforce, retention, professional support, family support, policy

INTRODUCTION

During much of the 1990s, the research and policy focus on the universal problem of insufficient medical practitioners in rural areas centred on recruitment and training. [1–5] The issue of retention of rural practitioners was often viewed and treated as a simple extension of the recruitment issue and the primary cause of workforce problems was thought to be insufficient numbers of graduates entering rural practice. [6–9] Hence, many of the rural workforce strategies in Australia targeted selection of medical students, medical curricula, postgraduate training and retraining experienced urban graduates. [10] Many of these are long-term strategies, the outcomes of which we are just beginning to see.

However, there has been increasing recognition in the literature that retention involves a different set of issues from recruitment. [12–15] This is because decisions to take up rural practice (ie. recruitment) are made outside of the contextual setting of rural practice, whereas decisions to remain (retention) occur within that setting and are based on experience there. [16–18] The decision to remain in rural practice appears to be a dynamic equilibrium of positive and negative factors, and issues such as overwork and poor adaptation to role changes easily upset this equilibrium. [15] Thus, retention can be challenged by "various contingencies of life that more or less require us to change locations". [16, p.28] Family issues are amongst the most important, along with workload and relief. [15, 16, 18, 19] Many of the triggers could be addressed at a policy level, potentially improving retention. Therefore, there is a need to understand better the issues that influence retention, particularly those that can inform policy.



This paper outlines a synthesis of the results of four research projects conducted within the Rural Health and Workforce Research Unit at the School of Medicine at James Cook University (and the former North Queensland Clinical School), with a particular focus on retention.

AIMS

The aims of this paper are twofold; to:

- synthesise commonalities in terms of issues affecting retention arising in this series of studies
- identify possible policy interventions.

METHOD

This is a qualitative research synthesis employing an inductive, comparative method of analysis. Initially, key common findings across the studies are identified, before comparing respondents' reported experiences within the context of each study. This latter process enables a broader understanding of the scope of influence and relative importance of each.

THE STUDIES

Table 1 outlines the four studies. Each study had a separate set of aims, with separate staff, samples, findings and reports. However, they all shared several common threads: similar sampling, data collection and analysis methods and building upon previous and contemporary work being undertaken within the Rural Health and Workforce Research Unit. The Unit is a small core group of researchers, headed by the author. The Unit began in 1995 at the North Queensland Clinical School (University of Queensland) in Townsville, and then moved to the newly created School of Medicine at James Cook University in 2000. A major advantage of maintaining a core group of researchers has been the development of a skill base and "corporate memory" that enables successive research projects to compliment or build upon earlier projects.

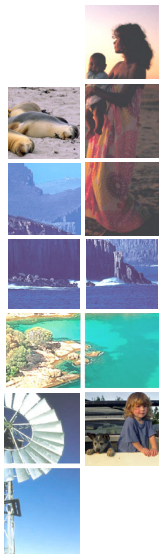


Table 2 outlines the key findings of each study.

RESULTS

Certain recurring themes are evident across the studies, regardless of perspective or personal experience. The recurrent themes are:

- a need to engender a greater sense of support
- support initiatives need to be visible and access uncomplicated
- initiatives are needed to support network development
- preparing families for rural life/practice is as important as preparing practitioners
- support organisations are well-placed to recognise and act when GPs/families struggle
- retention needs to be recognised as ongoing—not an end-point
- relocation within rural areas should be seen as "retention".

Need to engender a "sense" of support

Many participants indicated that they did not always feel that support was available to them. They were aware, for example, of various initiatives but did not always feel that these applied to them, or did not know how to access them. In studies 1 and 2, for example, the early emphasis of Rural Incentives Program (RIP) initiatives on supporting GPs relocating to rural areas caused some concern and resentment

amongst GPs already in rural areas, who often reported that their attempts to tap RIP funds were unsuccessful. The more recent "retention" payments should have alleviated some of this resentment. However, some respondents indicated that their earlier rejections made them disinclined to "try again".

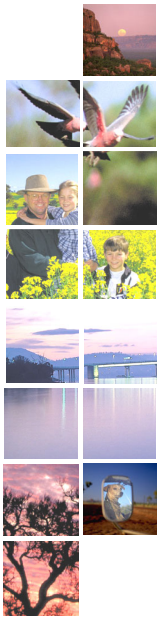
Nearly all GP participants in the studies reported at least occasional feelings of professional isolation, either currently or in the past. Despite the ability to develop support structures for themselves, the experiences of these rural GPs also highlights the ubiquity of a sense of professional isolation in rural practice. Difficult relationships with people that they were required to interact with for work purposes were also reasonably common. The development of networks and the extent to which the GPs find their supports adequate appear to be important issues in retention. Study 4, for example, indicated that those with established professional and personal networks had a higher level of satisfaction.

Support initiatives need to be visible and access uncomplicated

A common issue raised across the studies was the difficulty that many respondents encountered when attempting to access funds or support from various agencies and schemes. Respondents reported difficulties locating appropriate agency staff who could knowledgably outline the parameters and criteria relating to particular initiatives. Additionally, many reported that information materials and application processes were difficult to reconcile and complete, often within short timeframes. Others considered that eligibility criteria were too restrictive.

Initiatives are needed to support network development

Many respondents reported that establishing networks was a major early focus that could be assisted in quite pragmatic ways, such as being provided, upon arrival, with lists of key contacts, being introduced to local contacts, and linked to professional "buddies". Some form of "introduction to rural practice/life" program for practitioners and their families prior to moving into a rural setting was commonly raised, particularly in studies 3 and 4. Respondents believed that local divisions of general practice, hospitals and community members/groups were best placed to provide early support. Having said that, it was apparent that the establishment of longer term networks are dependent on the individual. Nonetheless, support organisations can assist in maintaining networks through strategies such as organising and funding meetings, seminars or workshops, and providing and/or organising relief.

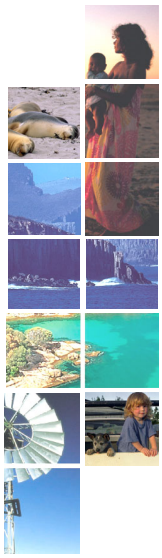


Preparing families for rural life/practice is as important as preparing practitioners

For too long organisations have focused on recruiting and supporting the practitioner without specific consideration of the practitioner's family. Fortunately, there is increasing realisation that family issues, such as schooling, employment and satisfaction, are important aspects of practitioner retention. Respondents in all four studies noted the important role and function of family in their professional and personal circumstances. In study 1, for example, family issues were commonly raised as key factors in the decision to move. In study 2, family issues were often the trigger

for considering to leave, but had been successfully, or at least acceptably, resolved. In studies 3 and 4, the broader roles of, and issues relating to, family were well demonstrated. Clearly, support organisations can play significant roles in preparing families for rural practice/life and assisting families to settle in. Equally, communities can also play significant roles in assisting families, particularly in the early days. That said, there is a need for such support to be co-ordinated, organised and timely. Recognition and appreciation that each family unit is different and will require/appreciate different levels of community support is also important, as this is an area which can quickly breed dissatisfaction or distress.

One issue, raised particularly in study 3 but also in others, was the propensity for specific family support strategies to be viewed negatively by community members. Some respondents noted that, as important as early support was to them, they were aware that the additional (obvious) support provided to medical families could cause distress or resentment within the community, particularly communities that are struggling. We have also found and reported this in other work. [21] This is not a case against providing support, but rather to note that support needs to provided in a way that is sensitive to community circumstances and perceptions.



Support for struggling practitioners and/or families

This is a particularly sensitive issue, but especially important, partly because of its sensitive nature. Respondents, when raising this issue, noted the important role that support organisations can play. Firstly, support organisations (eg. divisions of general practice, workforce agencies, professional colleges) can and should provide strong and appropriate support for newly arrived practitioners/families—respondents reported varying levels of satisfaction in this regard. Secondly, support organisations need to have, or have access to, personnel who can regularly and sensitively "touch base" with practitioners/families to keep a "watching brief"—this means developing a good, trusting relationship with practitioners and their families. Thirdly, organisations need to have, or have access to, appropriate and sensitive services, ideally to intervene before "difficulties" become "crises", but definitely at the crisis stage. There are specific strategies and services in place for crisis situations, but practitioners and their families need to know that sensitive and appropriate support is also available before that stage. Often, this is where strong networks come to the fore, but well-publicised formal support mechanisms also need to be available and known to be available.

Retention needs to recognised as ongoing—not an end-point

Too often, respondents reported early contact from a support organisation or community "group", followed by a deafening silence. Support organisations and communities need to recognise that "recruitment" does not equal "retention". Recruitment is a one-off activity, but retention is an ongoing activity because circumstances and situations change constantly. Respondents (and rural communities themselves) often reported that to be accepted as a "local" one needs to have lived in the community for a substantial period of time—often decades, sometimes only by birth. If this is so, then clearly communities and support organisations have a clear role to "support" "new-comers" for a very considerable length of time. However, as respondents indicated, the level and type of support will change with time. Support organisations and communities need to be aware of, and prepared for this.

Relocation within rural areas should be seen as "retention"

Study 1 provided a graphic demonstration of this—all but one of the respondents had moved to other, generally less "remote", rural locations. Equally, participants in study 2 who had relocated had generally moved to other rural settings. In these instances, these practitioners and their families were not "lost" to rural practice, although this is the common perception. In reality, they have been "retained". This should be recognised as such. Practitioners and their families who want, or need, to move to other "rural" settings should be supported and assisted in this process. There may well be a need for a sliding scale of support and assistance, particularly for "regular" movers.

CONCLUSIONS

Although the numbers of participants involved in each study are relatively small, the in-depth nature of the interviews and the high participation rates assure validity of the findings. The concurrence of the key findings with the national and international literature suggests that themes identified here are likely to have wider relevance than purely in terms of the participants. Clearly, for retention strategies to be effective, these key themes need to be addressed in a consistent, cumulative way. Several strategies in line with current initiatives have been raised.

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AUTHOR

Craig Veitch is Associate Professor in Rural Health at the School of Medicine, James Cook University. His career as a health professional and rural health researcher spans 30 years. During the past 15 years, he has been actively involved in rural health research and evaluation, particularly workforce, health services and community involvement. Craig is the Australian representative on the Board of the International Network.

Table 1 Outline of the four studies used

Study No	1	2	3	4
Title	A qualitative interview survey of Queensland GPs who left rural practice between January 1995 and March 1996	Nine year follow-up of rural general practitioners' retention, educational and professional support	Impacts of family support strategies on the retention of GPs in rural Queensland	Personal and professional support networks of rural general practitioners
Investigators	RB Hays, PC Veitch, B Cheers, LJ Crossland	RB Hays, PC Veitch, J Hollins, S Wynd, LJ Crossland	PC Veitch, LJ Crossland	PC Veitch, C Joyce,
Design	Cross-sectional qualitative survey of GPs who left rural practice during 15 month period	Longitudinal qualitative survey of GPs originally interviewed in 1991	Cross-sectional qualitative survey of rural medical families	Cross-sectional qualitative survey of rural GPs
Aims	- identify reasons for leaving rural practice- develop guidelines for improving retention	- identify changes in support needs - changes in practice - impact of formal strategies	- identify experiences and needs - personal strategies- impact of formal strategies	- identify types and benefits of networks - how networks developed and maintained- role in retention
Sampling	all GPs meeting criteria	GPs interviewed in 1991 study	locationally representative, random	all in one geographic area
Sample size	21	23	16	16
Participation	17 (81%)	15 (83%) of 18 located	15 (94%)	15 (94%)
Data collection	semi-structured telephone interviews	structured telephone interviews	semi-structured telephone or face-to-face interviews	semi-structured telephone or face-to-face interviews

Table 2 Key Findings of the four studies used

Study	A qualitative interview survey of Queensland GPs who left rural practice between January 1995 and March 1996	Nine year follow-up of rural general practitioners' retention, educational and professional support	Impacts of family support strategies on the retention of GPs in rural Queensland	Personal and professional support networks of rural general practitioners
Findings	**Influences to stay:**- Work variety- Professional support- Family lifestyle- Community relationships**Influences to leave:** - After hours workload- Long/short-term locum access- Management load- Remoteness from family**Triggers to leave:** - Difficulty coping with change- Children entering high school- Poor housing quality- Personality clashes	68% still in rural practice (48% in same practice) **Common characteristics** - Strong local community connections - Strong community commitment = "integration" - Supportive local and distant professional and personal networks - On-call relief remains major issue - Challenges to retention on-going **Changes over 10 years** - Few were eligible for GPRIP support = no impact - Improved quality of and access to CME - Decreased procedural work/increased non-procedural skills	- Family needs change with time - Greatest need around arrival - Initial needs around learning about/settling into community - Childcare and schooling issues important - Need for alternative GP - Need for spouse to maintain "own identity" - Importance of contact with others in same situation - Work opportunities, particularly for professionals - Later needs commonly around practice/business management training and support	**3 forms of network:** 1. Clinical: advice/consultation on management issues 2. Workforce: relief/cover 3. Social: meetings, conferences, collegiality - Need assistance early on to establish networks - Importance of face-to-face meetings early on to establish trust and rapport - Networks once established are self-maintaining
Policy issues	How to define retention; eg: - 5 years in 1 place - moved but still rural	Past initiatives have had little impact. Changed support needs.	Different strategies needed to address initial and later needs	Support organisations can assist early on to establish networks