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Exploring indicators of experiential place integration in a sample of Queensland rural practitioners: A research note

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A B S T R A C T

Introduction: Until recently, the focus on the universal problem of insufficient medical practitioners in rural areas had been on training and recruitment. Many of the rural workforce strategies in Australia targeted selection of medical students, medical curricula, postgraduate training and retraining experienced urban graduates. To date, there is little consistent evidence that the rural workforce situation in Australia is improving. 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.

Aim: To perform a scoping exploratory post facto review of interview data with a view to establishing the potential for a dedicated prospective study of rural GP retention.

Methods: Theoretical construct of 'dimensions of integration' was used in a post facto review of in-depth interview transcripts of 17 medical practitioners who had left rural practice. The construct posited integration as an active developmental process based on three 'principles' - security, freedom and identity - which together form the basis of practitioner retention. A series of 'dimensions' (n = 27) exists within each of these principles.

Results: Many of the 27 dimensions were found to be absent, particularly for practitioners who left before they originally intended. In some cases, apparently well-established practitioners (in terms of numbers of dimensions present) left because of some external 'pulling factor'. Dimensions related to practitioner security were generally most often missing.

Conclusion: The potential for a dedicated prospective study was established.

Key words: experiental place integration, general practitioners, retention, rural practice.

Until recently, the focus on the universal problem of insufficient medical practitioners in rural areas had been on training and recruitment[1-5]. The issue of retention of rural practitioners was often seen as a simple extension of the recruitment issue and the primary cause of the 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. To date, there is little consistent evidence that the rural workforce situation in Australia is improving[11].

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 are made outside of the contextual setting of rural practice, whereas decisions to remain 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]. 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.

A study of long-standing rural physicians in eastern Kentucky demonstrated a relationship between integration and rural physician retention[16]. The author argued that integration into a community was a key element in retention, and that the process of integration is a 'type of progress that builds bonds with place … that in turn encourage retention'[16,p.28]. That said, integration and retention can be challenged by 'various contingencies of life that more or less require us to change locations'[16,p.28]. The resulting model of integration is an active developmental process based on three 'principles' - security, freedom and identity - which together form the basis of practitioner retention. A series of 'dimensions' exists within each of these principles (these dimensions form the basis of Table 2).

Our experience of rural practice suggested that many aspects of the US-based model appeared relevant to the Australian setting. We therefore decided to review (post facto) transcribed in-depth interviews with former rural practitioners, in Queensland Australia, as a first step in developing a prospective longitudinal study of newly recruited rural practitioners. In this paper, we use the model of integration to analyse the interview transcripts in an effort to identify consistent patterns of presence or absence of the dimensions and to guide future research activities. This is a scoping study rather than a critical analysis of the data. It was undertaken to assess the worthiness of undertaking a larger scale prospective study focusing on the 3 principles and their associated dimensions.

Rationale & Interpretation of principles

Many of the 27 dimensions can be considered to be universal indicators; eg. 'confidence in medical abilities'; 'career aspirations and goals'; 'desire to meet family needs'; 'on-call coverage'; 'social and cultural requirements'; and respect for, and of, the medical and at-large communities.

However, other dimensions are probably more system specific. As a specific example, the security dimension 'comfort with medical community and institutions' operates at two distinct levels in the Queensland setting. Firstly, at the local level, the medical community is usually quite small - commonly less than a handful of medical practitioners and not many more nursing and allied health professionals. Secondly, at the broader institutional level, the state-based public health system is a key provider of health services in rural and remote Queensland. Despite several restructurings during the past decade, ostensibly to give more local level autonomy, the system remains largely under the control and direction of the Head Office in the state capital (Brisbane). For private practitioners, the broader institution is the national universal health insurance scheme (Medicare),

which either directly (through payments to the practitioner, called direct-billing), or indirectly (through reimbursements to the patient) accounts for a considerable proportion of general practitioners' income. Medicare pays 85% of the 'scheduled fee' that is determined and agreed by the Health Insurance Commission and medical practitioner organizations. The remainder of whatever fee a practitioner charges is met by the patient, unless the practitioner direct-bills Medicare. One way, or another, most rural medical practitioners have to deal with the state-based public system - many as employees, others as referral agents to hospitals. In some small communities, the same practitioner (Medical Superintendent with Right to Private Practice [MSRPP]) fulfils both the public and private roles[19]. These and associated issues limit the role that Queensland practitioners can play in medical institution, health care resources and community development (ie. 'community & medical institution development' and 'ability to develop health care resources' dimensions).

Data and Method

The data used here were originally collected for an in-depth survey of practitioners' reasons for leaving rural practice. While in-depth, the interviews were reasonably open (ie. semi-structured) in terms of the topics covered.

We used Cutchin's model of experiential integration as the basis of the post facto review of the transcripts (see Table 2). Our experience of rural practitioner retention suggested that the model provided a reasonable summary of the types of issues raised by rural practitioners and therefore was a worthy starting point to explore the reported experiences of former rural practitioners.

In reviewing the individual transcripts, we assessed whether each dimension was raised either positively (present) or negatively (absent) and, in the event that no mention of a dimension was made, it was also coded as absent. Not all dimensions were applicable to all interviewed practitioners (eg. 'family' for an unmarried practitioner; and 'group' for a solo practitioner). Comparisons were made between each practitioner's early expectations and their later experiences in order to determine the strength and direction of the evidence for each dimension and in an attempt to nullify purely negative responses relating to the time of departure.

Results and discussion

Table 1 summarises the key characteristics of interviewees. The Rural Remote & Metropolitan Areas Classification (RRMA) was used to code both the sites where practitioners had previously worked and were currently working. The majority of interviewees were males, married and from metropolitan backgrounds, although seven of the 17 had lived in rural communities for all or most of their childhood. Interviewees had been in a wide variety of practice styles, including full-time Medical Superintendents of rural hospitals (MS), part-time Medical Superintendents with Right of Private Practice (MSRPP) and full-time private practitioners. Most had been in communities ranging from 1,000 to around 10,000 people. All, but one (a hospital-based general physician) were general practitioners and most had entered rural practice with some timeframe regarding how long they would remain in rural practice in mind. Three had no particular timeframe in mind, but had intended to stay indefinitely if they liked rural practice. Six of the 14 with a predetermined timeframe left before they had anticipated and three stayed longer than anticipated. Ten interviewees had prior knowledge and experience of life in their chosen community (a major reason for choosing that community), usually as a relieving practitioner. The majority of interviewees relocated to other rural settings - generally larger communities closer to the coast and southwards towards Brisbane (state capital). All remained positive about rural practice and, for the most part, the communities they had left.

Table 2 summarises the presence/absence of the 27 dimensions in each of the transcripts. Six dimensions (2, 5, 6, 15, 21, 27) were evident in no more than one-quarter of interviewees. A further seven dimensions (3, 4, 7, 17, 18, 19,

24) were exhibited by fewer than half of the interviewees. Just four dimensions (1, 9, 10, 26 - often noted by interviewees as key attractors to rural practice) were exhibited in more than 70% of cases. In terms of the three principles; only three (of 9) Security dimensions, six (of 10) Freedom dimensions; and five (of 8) Identity dimensions were evident in more than 50% of cases. It is important to remember that absence of a dimension may have been due to either a negative comment, or no comment at all, during the interview. It is thus possible that the absence of dimensions may be over-estimated. We, therefore, have been cautious in our interpretation of the results, focusing more on broad trends than on specific issues, in line with our aim of assessing the potential for a dedicated prospective study.

Table 1: Personal characteristics of participants

Interviewee	1	2	3	4	5	6	7	8	9
Area classification*	Remote other	Remote centre	Rural other	Remote other	Remote other	Remote other	Rural other	Remote other	Rural other
Gender	Male	Male	Male	Male	Male	Male	Male	Male	Male
Married?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Spouse employed?	Yes	Yes	Yes	Initially	No	No	Yes	Yes	No
Children	1	Adults	No	1	No	2	2	1	2
Rural background	Capital city	Capital city	Capital city	Capital city	Capital city	Large rural	Rural other	Capital city	Large rural
Previous practice	RFDS#	Remote NZ	Capital city	Capital city	Small rural	Large rural	Rural other	Other metro	Rural other
Years in place	8	4	2	10	2.5	3	5-10	2+	13
Intended time (years)	Life	Not fixed	2	6 months	2	10	5	3.5	Long time
Reasons for leaving**	Bureaucracy, no relief	Professional conflict, no support	Done time, did not want to burn out	Closer to relatives, childs educ.	Spouse comport, no relief	Poor housing, no support for spouse	No relief, profess. Isolation	Bureaucracy, conflict with matron	Children's edu, office conflict
Total years in rural practice	13	6	2	11	30	3	8	6+	19
Practice type	MSRPP+	MS++	MSRPP	Private GP	MSRPP	MSRPP	Private GP	MSRPP	Private GP
Current location	Remote centre	Large rural	Capital city	Large rural	Remote other	Rural other	Large rural	Rural other	Capital city

Table 1 continued

Interviewee	10	11	12	13	14	15	16	17
Area classification*	Remote other	Remote centre	Rural other	Remote other	Remote other	Remote other	Rural other	Remote other
Gender	Male	Male	Male	Male	Male	Male	Male	Male
Married?	No	Yes	No	Yes	Yes	Yes	Yes/ divorced	Yes
Spouse employed?	N/A	Yes	N/A	Initially	Yes	No	-	No
Children	-	2	-	2	3	No	3	2
Rural background	Large rural	Rural other	Overseas	Rural other	Capital city	Capital city	Rural other	Capital city
Previous practice	Large rural	Large rural	Rural other	Rural other	Small rural	Rural other	Small rural	Capital city
Years in place	5	1	1	4.5	1.5	4	2	9
Intended time (years)	5	1-2	Not fixed	Not fixed	3	2	2+	Life
Reasons for leaving**	No relief, non clinical paperwork	Couldn't maintain 2nd practice	Sold out, practice grew too big	Achieved all possible given bureaucratic constraints	Professional isolation, no relief, children educ.	Better offer from nearby practice	Divorced, moved to be near children	Long hours, no relief, enhance family life
Total years in rural practice	6	1	20	10	12	6	10	11
Practice type	MS	MO	Private GP	MS	MSRPP	MSRPP	MSRPP	Private GP
Current location	Small rural	Large rural	Rural other	Small rural	Large rural	Rural other	Large rural	Large rural

GP, General practitioner; MO, medical officer; MS, medical superintendent (full time); MSRPP, medical superintendent (part time) with right of private practice; NA, not applicable; NZ, New Zealand; RFDS, Royal Flying Doctor Service.

Some dimensions are not easy to fulfill (or identify) in the Queensland setting, because the state public health system is a major provider of health services in rural and remote areas. For example, practitioners employed by the state (MS and MSRPP) are quite limited in what they can achieve in terms of institutional development (dimension 7), or developing health care resources (dimension 15). That said, several interviewees noted that their local area health managers were quite pragmatic about the allocation and use of resources.

Because many Queensland rural and remote towns are relatively small (generally 1000-3000 people), the health infrastructure and associated medical communities are small - typically a small hospital of not more than 30-40 beds and one or two practitioners. The larger communities (5000-10 000) have commensurately larger facilities and medical communities (perhaps 4-6 practitioners). It is therefore difficult to assess 'comfort' with medical community and institutions (dimensions 4, 9, 12, 13, 23), for example, except for the larger communities

Table 2: Evidence of experiential place integrated dimensions

Interviewee																	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**%**
Intended time in location																	
Life	*	2	>1	2	10	10	2	Long	5	2	*	*	3	2	>2	life	
Actual time in location																	
8	4	2	10	2.5	3	5	3.5	13	5	1	1	4.5	1.5	4	2	9	
Dimensions of security Confidence in medical abilities																	
P	P	P	P	P	P	P	P	P	P	A	P	P	P	P	P	P	94
Commitment to aspirations and goals																	
A	A	P	A	A	A	A	A	P	A	A	A	P	A	P	A	A	24
Ability to meet family needs (spouse happiness, education)																	
NA	A	P	A	A	A	A	P	A	NA	A	P	P	A	A	A	A	27
Comport with medical community and institutions																	
A	A	P	A	P	A	A	A	A	A	P	A	A	A	P	P	A	29
Degree of on-call coverage																	
A	P	A	A	P	A	A	A	A	A	A	P	A	A	A	A	A	18
Practice group environment and anchor person																	
A	A	P	A	NA	NA	NA	A	A	A	P	P	A	A	NA	NA	A	25
Community and medical institution development																	
A	A	P	P	A	A	A	A	A	A	A	P	A	A	P	P	P	35
Social cultural networks available																	
A	A	P	P	A	P	A	P	P	A	P	P	P	A	P	P	A	59
Respect of medical and at-large community																	
A	A	P	P	P	P	A	P	P	P	P	P	P	P	P	P	A	76
Dimensions of Freedom Challenge and diversity in medical work																	
P	P	P	P	P	P	A	P	P	P	P	A	P	P	P	P	P	88
Ability to consult more with patients																	
A	P	A	A	P	A	A	P	A	P	P	A	P	P	P	P	A	53
Co-operation within medical and at-large community																	
A	P	P	P	A	A	A	A	P	P	P	P	P	A	P	P	P	65
Respect of the medical and at-large community																	
A	A	P	P	P	P	A	A	P	P	P	A	P	P	P	P	A	65
Power in medical relations																	
A	A	P	P	P	P	A	A	A	P	P	A	A	P	P	P	A	53

Table 2: continued

Ability to develop health care resources																	
A	A	P	P	A	A	A	A	A	A	A	A	A	A	P	P	A	24
Diversity in social interactions																	
A	A	A	P	A	P	P	P	P	A	A	P	P	A	P	P	A	53
Involvement in community affairs																	
A	A	A	P	P	P	A	P	A	A	NA	P	A	A	A	P	A	38
Personal and family activities																	
NA	A	A	A	A	A	P	P	A	A	P	P	P	A	A	P	A	38
Developed perspective of self and place																	
A	A	P	P	A	A	P	A	P	A	A	P	A	A	P	P	A	41
Dimensions of identity Loss of anonymity																	
P	P	P	P	P	A	A	A	A	A	A	A	A	P	P	P	P	53
'Like-minded' practice group																	
A	A	P	A	NA	NA	NA	A	A	A	P	A	A	A	NA	NA	P	25
Roles played and responsibilities taken																	
A	A	P	P	P	P	A	P	P	A	P	P	P	A	P	P	A	65
Respect of medical and at-large community																	
A	A	P	P	P	A	A	-	P	P	P	A	A	P	P	P	A	59
Fulfilling aspirations in place																	
A	A	P	A	P	A	A	A	P	A	A	P	P	A	A	P	A	35
Seeing self as belonging to the community																	
P	P	A	P	A	P	A	P	A	A	A	P	P	A	P	P	A	53
Awareness of self in time and place																	
P	P	P	P	P	A	P	P	P	A	A	P	P	P	P	P	A	76
Creation of future goals in place																	
A	A	A	A	A	A	A	A	P	A	A	A	A	A	A	P	A	12
Dimensions present (%)																	
20	30	74	63	56	40	20	48	52	31	50	59	56	33	76	88	22	

A, Dimension absent; NA, not applicable, P, dimension present.
*No fixed time frame.

Conversely, the majority of interviews contained evidence that small communities and practitioner networks positively influenced 'respect' (9, 13, 23) and 'loss of anonymity'[20]. 'Respect' was high because of the close relationships that local practitioners developed with their communities and each other. The anonymity that was a feature of urban life evaporated for most rural practitioners.

The most sobering pattern in this analysis is the generally low presence of Security dimensions (1-9), particularly those related to professional issues. It is perhaps not surprising that

many of these dimensions are absent in interviews of practitioners who have left rural practice. However, of greater import is the fact that practitioners commonly made negative comments with regard to the Security dimensions.

> *For example: The health authority's orientation to priorities, to me, seemed rather strange. When you tried to get something up and running, there would be 45 committees to look at it. They're 250 km away and can't remember your name, yet they think they can make a better decision than we could, there on the ground. ... They were more worried about what the politicians wanted than they were about service delivery.* (Dimensions 4, 7, 9)

> *There was a lot of problems with health delivery in the district. ... But every time you brought up a problem, it was largely ignored. ... Basically, I couldn't see where anything was going to change.* (Dimensions 2, 4, 7, 9)

> *Paperwork requirements continually increased, without explanation or obvious reason. Requests for additional information would come through on the fax, often with a requirement for immediate response. Then there was accreditation!* (Dimensions 4, 9)

> *You are on call for the hospital for the whole time ... It takes its toll ... you don't get the chance to unwind and relax ... To some degree burn-out was a factor.* (Dimension 5)

> *I think the pressure really began when we started boarding our children. ... that became a huge strain on the family, that was the beginning of the end there.* (Dimensions 3, 8)

Compared with the rates for dimensions in the Freedom and Identity principles, loss of security (at least in terms of the listed dimensions) might well be the major reason for practitioners moving on. Perhaps, a loss of security is the final straw that causes practitioners to leave. A noteworthy feature in this respect was the quite low numbers of dimensions present in the interviews with five of the six practitioners (1, 6, 7, 14, 17) who did not see out their planned time.

By contrast, those practitioners with the highest numbers of dimensions present often left because of some external 'pulling' factor rather than some factor related to the location. For example, Interviewee 16 moved to be closer to his children, Interviewee 15 received a better offer from his previous principal (but only moved to the next community), Interviewee 3 held to his original plan, achieved much, enjoyed his time, but sensibly refused to burn-out in place. At the other end of the scale, interviewees demonstrating low numbers of dimensions often cited internal 'pushing factors'. For example, Interviewees 1 and 10 grew tired of the bureaucratic demands and lack of relief, Interviewee 2 left because of conflict with a colleague. That said, some better established practitioners (eg 8 and 9) were also subject to 'pushing factors', perhaps as the last straw in an already deteriorating situation.

Conclusion

The results suggest that a dedicated prospective study focusing on the three principles and their associated dimensions is warranted. In view of the high costs associated with a dedicated prospective study that would involve interviews before, during and after leaving rural practice, there is a need to establish a database over time in order to monitor all dimensions. If loss of security could be demonstrated to be a feature amongst those who leave rural practice, there would be a case for targeting policy or support initiatives at maintaining security for rural practitioners. Although considerable efforts are being made to provide practitioners with more relief for annual and sick leave and continuing medical education, on-call coverage remains a widespread problem. Perhaps it is time to take a radical approach to on-call coverage, rather than tinkering around the margins.

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