

PERSONAL VIEW

Community involvement in medical practitioner recruitment and retention: reflections on experience

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ABSTRACT

The provision of health services to rural and remote communities has been the source of much concern and debate in recent times. One aspect of this is the universal problem of insufficient medical practitioners in rural areas and the associated issues of recruitment and retention. Rural communities can play an important role in the recruitment and retention of health professionals, particularly in terms of aiding the integration of health professionals and their families into the community. Community 'involvement' is not community 'development' in the usual sense of that term. Community involvement is about engaging and facilitating active community participation and leadership in the process at hand. This article reflects on experience gained through working with rural and remote communities in Queensland, Australia, with the key purpose of facilitating active community involvement in the recruitment and retention of medical practitioners. This article raises and discusses a number of issues arising from these experiences, with particular focus on barriers and opportunities to community involvement, and working with other agencies. Communities and agencies that attempt to increase rural community involvement in health service planning, provision, recruitment and retention should consider the following. For communities: Involvement must be real – active participation; Expectations need to be achievable (short and long term); Outcomes should be sustainable; Resources and capacity should remain in the community. For agencies: Avoid creating unrealistic community expectations; Be aware of time and resource requirements and constraints; Be consistent, forthright and honest in all dealings with communities; Keep communities informed of pending policy changes; See the process through to whatever conclusion.

Key words: community involvement, rural health workforce.



Introduction

The provision of health services to rural and remote communities has been the source of much concern and debate, particularly during the decade from the mid-1990s. The debate has been set against increasing medical technology costs, fiscal restraint, increased community expectations of local services and declining rural population. One aspect of this is the universal problem of insufficient medical practitioners in rural areas, which has been the focus of various training and recruitment initiatives¹⁻⁵. The retention of rural practitioners was often seen as a simple extension of recruitment, but there has been increasing recognition in the literature that retention involves a different set of factors from recruitment⁶⁻⁹. This is because decisions to take up rural practice are made outside the contextual setting of rural practice, whereas decisions to remain occur within that setting and are based on experience there¹⁰⁻¹². The relationship between integration and rural physician retention has been demonstrated^{10,13,14}. Rural communities can play an important role in both the recruitment and retention of health professionals, particularly in terms of aiding the integration of health professionals and their families into the community¹³.

This article is a reflection on our experiences of working with rural and remote communities in Queensland, Australia, with the key purpose of facilitating active community involvement in the recruitment and retention of medical practitioners. The importance of active community involvement and support on rural practitioner retention and integration has been demonstrated^{10,13,15}. This article raises and discusses a number of issues arising from our experience, with particular focus on the barriers and opportunities to community involvement, and working with other agencies.

What is community involvement?

Community 'involvement' is not community 'development' in the usual sense of that term. Community involvement is

concerned with engaging and facilitating active community participation and leadership in the process at hand (in this instance, practitioner recruitment and retention).

Additionally, 'community' means more than local government representatives, special interest groups, or active individuals. These people are often important in transforming ideas into action, but the greater the 'grassroots' community support and/or knowledge, the greater the likelihood of achieving a successful, sustainable outcome. Community involvement requires the following:

- Community commitment and willingness to act
- Active participation of community members
- Knowledgeable/experienced local 'leader' or 'facilitator'
- Rigorous needs/capacity assessment or audit
- Building capacity according to needs
- Keeping the whole community informed

It is important that community members are committed to the purpose and process, and that they then take and play active roles in the development, roll-out and maintenance of initiatives. If community members are not committed to these, there is little likelihood that initiatives will be either enacted, or sustainable. Having said that, there is a clear need for a knowledgeable, respected community 'leader' to develop and maintain community involvement throughout the process. Often, however, an external 'facilitator' is beneficial in circumventing local 'politics' and keeping the process on track, as well as providing advice and information that may not be available within the community.

An important early step is an audit of community capacity – that is, what knowledge, skills, abilities and resources (appropriate to the task) already exist within the community? What others are required to ensure a successful outcome? How can these be imparted to the community so that they remain within the community (capacity building)? Allied to this process is the conduct of a rigorous, but not necessarily complicated or expensive, assessment of community needs



in terms of the broad purpose. Sometimes, recent needs assessments can provide much of the required information, necessitating little or no additional activity. At other times it will be necessary to collect more information^{13,15}. Information collected in a needs assessment should be used to guide the development and roll-out of the initiative for two reasons. First, this will ensure that the community's needs and priorities are addressed; and second, it will generate active community involvement (ownership), because the process is clearly addressing community issues, not those of the external facilitator or sponsoring agency¹⁶. Finally, it is imperative that the broad community is kept informed of progress, as well as of hurdles, and given the opportunity to contribute to the process.

Clearly, community involvement is a key element in the development of sustainable local health services, as demonstrated by the University of Washington Community Health Services Development Program¹⁶. However, the entire process is likely to be most successful and the outcomes sustainable, when the community itself has recognised the need and actively sought external assistance. Unfortunately, the need is often identified by an external agency that then attempts to engage the community in a process that may not reflect community beliefs or expectations. In these circumstances, there is the risk of little true community commitment to the process. Indeed, it can sometimes be counter-productive.

Case example: One town was identified by an agency as being under-resourced 'on paper'. A visit to the town was met with suspicion, and locals wondered if the agency was there to close the local hospital. Additionally, it stirred up acrimony between the town's doctors, and promoted a 'whispering campaign'. This was exacerbated because one of the project staff also had another role: that of providing family support to rural medical practitioners, including one of the local practitioners.

Barriers to success

Impediments to community involvement

The issues outlined below are those that we have commonly encountered. There are, doubtless, many others.

- Health system not geared for community involvement
- Community experiences and contributions not valued
- Communities find it difficult to respond rapidly
- Outside players' focus may not accord with community focus/needs
- Some players not prepared to participate
- Frequent changes to policy/interpretation is destabilizing, frustrating and demoralizing for all players
- Taking on neediest cases first may result in 'failure' and demoralization.

The broader health system, such as at state level, is not geared for community involvement. First, many elements of the now outdated paternalistic, medically-dominated ideology and practice continue within state-based systems. However, even at the local level, such attitudes continue. Changing such mind-sets is a generational process and cannot be necessarily enacted, even through legislation or dictate. Second, system-wide changes, even with good will, take considerable time to work through an entire system. Thus, sometimes certain elements of the system can be supportive of community involvement, while others are either unable or unwilling to assist. Finally, the broader system is often so large that it is not possible for communities (and sometimes personnel on the periphery of the system) to identify the most appropriate section or officer to contact.

Case example: One community participated with a number of government departments and agencies, over several years, to develop an innovative plan to improve service provision and medical practitioner



retention. A senior government department official was invited to and participated in planning teleconferences during this period and sometimes offered advice on how the community could overcome bureaucratic obstacles. At the time the community was ready to submit the initiative to the department for what the community expected to be approval, the government official visited the community and informed residents that the proposal had never been on the department's agenda and it would not be approved. The result was wide-spread community disillusionment and a sense of futility.

Community members are the repository of knowledge and experience regarding local service history and needs. Community participation is likely to be greatest when residents feel valued and that what they contribute is recognized as important. Good community leaders or external facilitators ensure that residents' views are sought, heard and acknowledged¹⁶. Equally, all sectors of the local community need to feel that they have been involved in the process^{15,16}. If people feel that their contributions have not been valued, they are less likely to participate actively. Finally, residents should be not only kept informed of progress, but encouraged, through public meetings or submissions, to contribute at each stage of the process^{15,16}. Unfortunately, too often community input is sought at the beginning and rarely thereafter.

Communities can find it difficult to respond rapidly to opportunities or change. This can be the result of insufficient knowledge or understanding of either the opportunity, or the application process. This is one area where many communities require considerable assistance/capacity building. Sometimes, a lack of resources, both human and financial, can impede rapid action (eg staff shortages; lack of a local proponent to 'sell' the importance of an opportunity). It is not uncommon to find that the local person most capable of progressing the opportunity is also one of the busiest and therefore unable to either take on the task, or make the deadline. For example: one community could not identify a single local person who had the skills, and even more

importantly who was available in the time-frame, to work in paid employment to progress the project. An external project officer proved very useful in progressing the project by doing the 'nuts and bolts' work required to get a proposal in and build support for it.

At other times, local structures prevent rapid response (eg timing of local government meetings; local communication channels). Division within the community can also impede rapid action; indeed severe division can prevent any progress whatsoever. Community 'inertia' is another impediment to progress.

Case example: After trying for years to get additional health services buildings, a community was next on the 'priority list' of a federal department. A support agency helped produce an application, but the town council could not agree on local input and the deadline was missed. As this was the last funding round of that program, the opportunity was lost forever.

Some communities have been unsuccessful, or have felt let down in the past and are, therefore, reluctant to try again, for fear of further disappointment. Others believe that some outside agency should be responsible (both for recognising the community's need and acting, eg 'the system should be doing that, not us'). Still others, particularly in relation to supporting health professionals, are not philosophically supportive of the concept (eg 'others come and settle here without community support, why can't they?'). Sometimes, it is difficult for communities to see that by actively participating in practitioner retention, they are making an 'investment' rather than an 'expenditure' and that the longer term 'benefit' will likely exceed the shorter term 'cost'. For example, some communities spend considerable amounts of money and time, at regular intervals, advertising for a medical practitioner, but cannot see the 'benefit' of investing that same amount in practitioner retention. Some communities simply have other priorities.



Case example: A small, remote town that was marginally viable for a private medical practice, was desperate for stability in the medical workforce. Yet the mayor was adamant that providing practice premises was the practitioner's or the health department's responsibility, even though the town had vacant premises that were suitable. A support agency was able to make a financial case with the local council that it might not cost them more. Nonetheless, the proposal was not accepted.

Linked to this, is that the focus/priority of an outside agency or individual may not match the community's priorities and needs. If the outside agency does not, or will not, adapt its focus/priority to match those of the community, the end result will likely be failure and community disillusionment.

Some stakeholders, both local and distant, are not prepared to participate, often for reasons such as those outlined above. This is of particular concern when an individual's personal stance/interpretation over-rides their professional responsibility. It is not uncommon, for example, for a local health professional to say, 'I know what my community needs' and therefore refuse to participate. In reality, the health professional 'knows' what services the community seeks from them, but is not truly aware of what those who seek services elsewhere want or need. Equally, officials within the health system who have a personal motivation (eg career advancement), or some inverted sense of power through obstruction are not being fair to the community or true to their job description.

Case example: A medical practitioner in a small community had been publicly supporting the community's bid for an additional practitioner, and had been pushing for an assessment of the economic viability of an additional practitioner. However, at a series of community meetings it became obvious that the community was taking the lead and community members openly disagreed with the resident practitioner on priorities, especially the demand for universal bulk-billing. The practitioner, who was bulk-billing for a substantial proportion of the

practice population already, was offended. Unbeknown to the community, the practitioner was planning to sell the practice and was concerned that the value of the practice would be undermined. This individual privately obstructed the economic viability study and progress on the project was stalled.

One impediment to continued community involvement is the tendency for government policy interpretation and implementation to change frequently and rapidly. Communities working on a particular 'opportunity' sometimes find that some change within the agency (eg personnel, focus, policy) results in either changed requirements (meaning considerable reworking), or even extinction of the initiative (equates to wasted effort and resources). Whatever the reason, the end result is community frustration and disillusionment. This means that it is even more difficult to convince a community to chase the next opportunity. Quite possibly, also, the time-lag between recognising the next opportunity and action will be greater which, in turn, increases the likelihood of the opportunity disappearing and therefore greater community disillusionment.

Case example: During a 4 year period in which a small remote town had been working with an agency to develop a proposal for additional services, both formal and informal federal, state and support agency policy changed on several occasions. The community, although clear on its priorities, was slow to mobilise and by the time the community was ready to act, the funding guidelines had again changed and the proposal was ineligible. A previous council had considered using a levy on local rates to help pay for an additional medical practitioner, but later councils opposed this. As this decision was the cornerstone of the community contribution required by the funding body, rejection of the community's demands was much easier for department officials to rationalise.

There is both a tendency and a sense of obligation amongst agencies attempting to improve rural health service provision



to take on the 'neediest' cases first. Yet these very cases pose the greatest threat to 'success', which can lead to disillusionment all round. In the first instance, the 'neediest' cases tend to have deep-rooted difficulties that take considerable time and funds to alleviate before the agency's priority can be truly addressed. Most government departments and other agencies work to annual budgets and policy timelines, so the time and funds taken to deal with 'non-core' difficulties (in a bureaucratic sense) will likely not reflect well on staff, nor future funding opportunities. Small but definitive successes in the early days of a new program will increase the likelihood of refunding and/or budgetary increases. For those attempting to facilitate community involvement this latter path can be uplifting and result in raised standing in the eyes of other organizations and communities.

Opportunities

The issues now outlined provide real opportunities for committed communities and organizations willing to contribute positively to the process.

Small planned, focused changes

Small changes or initiatives are easier and faster to plan and, therefore, are more likely to be able to take advantage of funds. They are also more likely to be both seen to be, and actually achievable. Small changes or initiatives are also more likely to be within local capacity – this is something that some funding agencies specifically require. Small changes/initiatives are more likely to fit funding guidelines and timeframes. As a result, they are capable of relatively rapid results and so build confidence, morale and enthusiasm within communities. It is not uncommon for small wins to lead to greater wins.

Active, willing, committed, adaptable, realistic communities will succeed

The communities most likely to succeed are those that are active, cohesive and committed. However, there is a need for

adaptability, partly to meet funding agencies' requirements and partly to reflect changing social expectations and conventions. Finally, communities need to have realistic goals and aspirations. In this respect, the external facilitator and local 'leaders' play an important role.

Successful communities can act as role models for others

Communities that are successful at achieving their goals can act as role models for other communities. Communities in the process of planning their initiatives might invite a 'leader' from a 'successful' community to participate in the planning process. In this way, one community's experiences can be used for the benefit of others.

More funds are becoming available

In recent years funds have become available specifically to enable communities to take more active roles in services planning. The various agencies involved in rural health workforce training, recruitment and support (ie Divisions of General Practice and Rural Medical Workforce Agencies) can assist communities to identify likely suitable sources. Equally, University Departments of Rural Health are well-placed to assist communities to develop and prepare their applications.

Conclusions

The following suggestions for communities and agencies are the result of our experience and observations, along with those of others attempting to increase rural community involvement in health service planning, provision, recruitment and retention. Despite that, too often the opposite can occur.

For communities

- Involvement must be real – active participation
- Expectations need to be achievable (short and long term)
- Outcomes should be sustainable



- Resources and capacity should remain in the community

Communities that increasingly take the lead in the process and come to use the external facilitators/agents as resources, rather than 'leaders', are exemplars of 'active participation'. Unfortunately, some communities lack either the 'leaders', or the will to take the lead and continue to rely on external agents to lead.

Achievable expectations reflect recognition of what is possible within a particular timeframe and resource base. Unfortunately, we have worked with some communities who have remained fixed on unachievable expectations (eg resident specialist services) despite the best efforts of agencies and health professionals to demonstrate why those expectations were unachievable.

Sustainability should be the core aim of the process. Communities that engage in the process do so because some aspect of their current health services is either missing or at risk. It is therefore imperative to develop a sustainable response to the issue. If the issue is, for example, high practitioner turnover, the process must first (honestly) identify the reasons for high turnover and then develop strategies or plans that truly will reduce turnover. We have found some communities that were not prepared to 'face the facts' regarding high turnover and therefore continued to make the same errors over and over. One solution to this dilemma might be the University of Washington's Community Health Services Development Program approach that requires communities to sign an agreement to enact whatever strategies or plans are developed by the process¹⁶.

Another aspect of sustainability is developing capacity within communities, so that communities themselves are better able to address future issues that arise with their health services. The most efficient way of developing capacity is to train local people in various aspects of the process. What is more, the more people trained, the greater the likelihood of sustainable community capacity.

For agencies

- Avoid creating unrealistic community expectations
- Be aware of time and resource requirements and constraints
- Be consistent, forthright and honest in all dealing with communities
- Keep communities informed of pending policy changes
- See the process through to whatever conclusion

Many of the health service issues in rural communities are the result of external agency policy or decisions. Often these are made without community consultation or explanation. However, when external agencies do try to engage communities, they may create unrealistic expectations. These often arise from a 'hard sell' of the benefits of a particular program or initiative, without sufficient information or support about what's required or involved and, importantly, the timeframe for action. The end result may then be that the community receives nothing from the initiative, except a sense of failure or having been let down.

Communities work at paces that reflect both their history and their capabilities. Many external agencies, driven by annual budgets and strategic plans, require rates of progress at variance from that of the communities that they profess to assist. Again, the University of Washington CHSD Program¹⁶ emphasizes the importance of working at the pace with which each community is comfortable – this is the reason why the CHSD program is scheduled for 3 years, although some communities progress much faster.

Sadly, we have seen examples where external agencies and/or their officers have not been forthright or honest with communities and have related one such instance above. In another instance, an agency representative encouraged a community to work towards a proposal for support but later withdrew all support when the community's rate of progress did not fit that representative's personal requirements. This left the community distressed and disillusioned.



Following on from the previous points, agencies often know in advance that policy changes are pending. Informing communities that a policy change may be pending, gives communities the opportunity to either increase their rate of progress, or to make a pragmatic decision to cease activity until the policy change is known. Then they can work within the new framework. It is not suggested that agencies or their representatives inform communities of likely new policies, simply that they inform communities that the life of a current policy is nearing the end.

We have seen several instances, some outlined in this article, where agencies and/or their representatives have not seen community-based activities through to their conclusion. This is particularly distressing for communities when the encouragement came from that particular agency/representative.

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References

1. DeFries GH, Ricketts TC. Primary health care in rural areas: an agenda for research. *Health Services Research* 1989; **23**: 931-974.
2. Kamien M, Buttfield I. Some solutions to the shortage of general practitioners in rural Australia: Part 1. *Medical Journal of Australia* 1990; **153**: 105-107.
3. Strasser R. How can we attract more doctors to the country? *Australian Journal of Rural Health* 1992; **1**: 39-44.
4. Craig ML, Jackel CA, Gerrits PB. Selection of medical students and the maldistribution of the medical workforce in Queensland, Australia. *Australian Journal of Rural Health* 1993; **2**: 17-21.
5. Kazanjian A, Pagliccia N. Key factors in physicians' choice of practice location: findings from a survey of practitioners and their spouses. *Health and Place* 1996; **2**: 27-34.
6. Pathman DE, Konrad T, Agnew C. Studying the retention of rural physicians. *Journal of Rural Health* 1994; **10**: 183-192.
7. Cutchin MP, Norton JC, Quan MM, Bolt D, Hughes S, Lindenman B. To stay or not to stay: issues in rural primary care physician retention in Eastern Kentucky. *Journal of Rural Health* 1994; **10**: 273-278.
8. Forti EM, Martin KE, Jones RL, Herman JM. Factors influencing retention of rural Pennsylvania family physicians. *Journal of the American Board of Family Practice* 1995; **8**: 469-474.
9. Hays RB, Veitch PC, Crossland LJ, Cheers B. Why doctors leave rural practice. *Australian Journal of Rural Health* 1997; **5**: 198-203.
10. Cutchin MP. Physician retention in rural communities: the perspective of experiential place integration. *Health and Place* 1997; **3**: 25-41.
11. Cutchin MP. Community and self: concepts for rural physician integration and retention. *Social Science and Medicine* 1997; **44**: 1661-1674.
12. Kamien M. Staying in or leaving rural practice: 1996 outcomes of rural doctors' 1986 intentions. *Medical Journal of Australia* 1998; **169**: 318-321.
13. Boucher M, Lynch M. *Easy Entry: Gracious Exit*. Newcastle, NSW: New South Wales Rural Doctors Network, 2003.
14. Veitch PC, Crossland LJ. Exploring indicators of experiential place integration in a sample of Queensland rural practitioners: a research note. *Rural and Remote Health* 1, 111. (Online) 2001. Available: <http://rrh.deakin.edu.au> Accessed 7 May 2004.



15. Veitch PC, Harte JL, Hays RB, Pashen D, Clark SL. Community participation in the recruitment and retention of rural doctors: methodological and logistical considerations. *Australian Journal of Rural Health* 1999; 7; 206-211.

16. House PJ, Hagopian A. *Community Health Services Development Program: History, experience and findings*. Seattle: University of Washington, 1994.
