WORKFORCE Valuing place in doctors' decisions to work in remote and rural locations

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ABSTRACT

Recruitment and retention of medical practitioners is a challenging contemporary issue for rural and remote areas. In this paper, we explore the importance of what it is that doctors value in rural and remote places from their own personal, organisational, social and spatial lives. We do this by drawing on original research from Scotland that explored doctors' decisions on choosing, or not, to work in remote and rural locations. Three themes are explored: moving and staying, using place to think holistically about places beyond the language of work that recruitment and retention implies; how doctors' professional values and their capacity to enact those values change with time; and how policy landscapes interact and shape rural and remote locations as valued places for doctors to live and work. We end the paper by reiterating the World Health Organization findings that a whole-of-society approach is required to support rural and remote communities to flourish, thus, encouraging doctors and their families to value such places and, ultimately, *move and stay*.

KEYWORDS: rural, migration, retention, doctors, recruitment

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The place of remote and rural medicine

The recruitment and retention landscape of medical professions in rural and remote areas has been an expanding research area over the last 20 years.[1–3] The key challenges of recruiting and retaining rural medical staff have been repeatedly documented.[4–8] This research has been complemented by the wider social science's (particularly the geographical sciences) interest in health and place.[9–13] Note also the global work around geographies of healthcare work itself.[14–16] For research on recruitment and retention, place means understanding what makes specific spaces meaningful to people. Herein, we respond to this special issue's focus on value by extending that to consider what makes people value specific places. We reflect on the importance of a relational and holistic approach to recruitment and retention in rural areas as they are experienced and 'informed by a myriad of highly interactive dimensions within personal, organisational, social and spatial domains.'[17] Further research has also been published on retention of physicians in rural areas.[4,18–21]

In this article, we consider what it is that doctors value in a place from their own personal, organisational, social and spatial lives. We do this by drawing on a research project from Scotland. For more information on the project 'Enhancing recruitment and retention of rural doctors in Scotland: a mixed-methods study', see the project website (www.abdn.ac.uk/hsru/what-we-do/research/projects/enhancing-recruitment-and-retention-of-rural-doctors-in-scotland-a-mixedmethods-study-227) as well as the related ongoing National Institute for Health and Care Research-funded work exploring the role of local community-led initiatives to improve recruitment and retention of healthcare staff in remote and rural areas (https://fundingawards.nihr.ac.uk/award/NIHR133888).[4] This project involved 56 interviews with doctors working across Scotland. Ten initial interviews were focused on service provision but also included aspects of their own biography, and 46 further interviews explored doctors' decisions on choosing, or not, to work in remote and rural locations. The research focused on doctors in primary and secondary care, and the sample included doctors in the final years of specialist training, secondary care doctors and general practitioners (GPs; both salaried, and single handed or partners). All doctors were either full time, part time or locum, as well as some doctors who had very recently retired. Doctors were recruited from across Scotland, including those who currently worked in rural places and others who had worked or trained in rural or remote settings and had since moved elsewhere, as well as those who had never worked in such settings. This recruitment was done through multiple channels, including email lists of societies (eg Scottish Rural Medicine Collaborative), GP clusters and snowball sampling from initial service provision interviews. The interviews were transcribed verbatim and analysed thematically and iteratively as the research was undertaken; all names are pseudonyms.

We explore three interrelated themes building on this issue's focus on value. First, we explore *moving* and *staying*, using place to think beyond the narrower focus on jobs and work that language such as recruitment and retention implies. Second, we consider value across the life course, and how doctors' professional values and their capacity to enact those values change with time. Third, we take a broader look at how policy landscapes can interact and shape rural and remote locations as valued places for doctors to live and work.

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Moving and staying or recruitment and retention: place versus job

The language that surrounds recruitment and retention puts primary focus on the job itself. It is that aspect that professional organisations, whether an NHS board/trust, hospital or GP practice, have most control over. However, studies exploring the recruitment and retention landscape of doctors highlight the multiple influences on someone's decision to take a job and to stay in it, including family social life.[22] This language of recruitment and retention, we argue, emphasises the job rather than why a person ultimately chooses to move in relation to recruitment, and stay in relation to retention. A doctor's individual values, or indeed any person's values, are not solely professional but also personal, familial, social and spatial. Gillian (GP partner) gives an example when asked about a job that a colleague was advertising:

> *[My colleague asked] 'Would you apply for it?' Not asking me because he knew, obviously, I had the partnership. And I said, 'Well, no, I wouldn't because my husband wouldn't be able to work on [the island] so it's a non-starter.' And that's a huge issue because, you know, I think some people still work on the thought that a rural doctor in Scotland used to be a man and the wife didn't work because the doctor's job gave the family enough. So, the woman didn't work and brought up the kids, might have been a secretary or an accountant within the practice. It just doesn't exist anymore! … My income could more than cover both mine and my husband's income, but my husband wouldn't be happy not working and following his passion, you know? That wouldn't align with his values. So, where we work … was ultimately dictated by his job and it just so happens, you know, we feel very fortunate that we both found jobs in the area within the same time and it's worked out to a certain extent, but that's not the case for a lot of people.*

NHS organisations often by default focus first on the job; for example, the hours, the pay, the size and organisation of the practice, and the out-of-hours expectations. Even when we frame the conversation around what doctors value, we find that much professional literature assumes that the values that matter most to doctors are professional values around patient care and the ability to practise medicine effectively and to a high standard. But neither is the whole story. We argue that decisions to move or stay result ultimately from multiple reasons and values, reflective of wider research into human migration.[23,24] The job and professional values are, of course, important but so are many other valued aspects of life, and it might not be the job itself that turns out to be the deal breaker in someone's decision to take up or not take up a post, or to leave a post.

We present the account of one doctor who describes the complex juggling of different values and preferences within the family that have led to his choice of post; Fraser, GP partner:

> *I compromise, from a family life, so my wife, you know, in terms of rurality, and living in more sparse areas, I think it's a good balance for her, so she probably wouldn't like to be as rural as me. If it was up to me, I'd be on one of the islands, I think, you know, I certainly would have seriously considered it, but it's a good balance to be close to family, in terms of my wife's family here from [another location], although it's still quite a long way away. And I'm good mates with friends and family who live in town, in more rural areas, so it's a compromise, but I would certainly think about more rural, for me. But I think what I do in my job and where I live, it's got everything that I could ask for, in terms of rural and the challenges with that, in professional work.*

The issue of money regularly appears in the literature, though there is limited evidence to support proposed solutions to recruitment issues, such as golden hellos and salary increases.[25–28] Resentment at recent changes to pensions and feeling undervalued as a result is certainly a recurring theme in our discussions with doctors, which is affecting retention for doctors close to retirement. However, salary itself was rarely mentioned as a driver or a disincentive to moving to a rural post by participants in our sample. Within the context of recruitment, money does not replace a vibrant, welcoming community, access to services or scenic landscapes; Adriana, salaried GP:

> *The work side of things felt fairly safe in a way, like I knew what to expect from the work scenario, but it wasn't really work that kept us here, work was the one we were trying to fix, so that we could stay. It wasn't work opportunities that kept us here, we had started to build a bit more of a community of friends, and people here, what else? Honestly, I think the scenery has a lot to do for it … They think of us as being deprived of things, but actually I think of the urban folk as being deprived of things, because they might think that we're deprived of, I don't know, public transport or cinemas or restaurants or whatever, … but I see the city folk as being deprived of nature and beauty, and lovely walks, and pure fresh air, and sea lochs that you can go swimming in, and actually that to me is more valuable, and that's why I'm here, I suppose.*

As Gillian and Fraser hinted at earlier, values, although held over time, might be enacted differently over someone's lifetime due to personal or place-based reasons.[23,24] One thing that the 'Rediscover the Joy of Holistic General Practice' project has done is to tap into people at the end of their careers who want a new challenge, in this case providing short-term GP cover across different areas of Scotland.[29] Key to this project's success has been the appreciation of values held by the doctors themselves for delivering patient care but as part of a flexible, supportive environment. Indeed, many of these doctors might have otherwise left the profession.[29] In our research, one participant described how they felt a rural post offered a chance to get back to 'what I'd been missing' in terms of job content and style of practice; Freddie, secondary care consultant:

> *No, it really was, you know, was it an impulse decision? It wasn't an impulse decision, it was accumulation that then led to an impulse. I think when I saw the advert, I realised that actually that ticked a lot of my boxes, I thought the [rural general hospital] environment would be nicer to work in. I thought the nature of the work I would be doing would be more what I'd been missing, I think. So, I hadn't been looking for a rural job at all.*

Experienced doctors in the latter stages of their career may both feel more confident about practising in remote locations, perhaps with fewer colleagues, and can also be less constrained by family circumstances. By contrast doctors who are at the point in their life of raising a family may often be in the position of having to trade off professionally held values against family values. The decision

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on what job to take may be prioritised by how it aligns with their family values rather than the preferred type of medicine that they would like to practise (for example, taking up an opportunity providing holistic generalist care in a remote location against choosing a semi-rural location with better local services, as in the case of Fraser earlier). Another doctor explains why staying in a remote location was driven largely by family values and their child's schooling, even though they were unhappy with aspects of their job; Sophie, salaried GP:

> *If it had just been us, we would have left, as much as I love everybody, and I love my house, and love my everything here, we would have had to, because it just like, yeah, you just, you can't do it … I think like 5 or 6 years is probably as much as you can do kind of being, well probably much less than that to be honest, but yeah, [the out-of-hours commitments] was just destroying us to be perfectly honest, … so I think we would, we definitely would have left, and we probably should have left, to be honest, but the problem was, was that we sort of limped through it, and then [our child] started school, and then we were just like, we just can't, like, we can't take her out of this amazing little school, it's like all these amazing pals that she's had for like her whole life, and so we've just got to find some way of making it work, which was why we opted out [of the out-of-hours commitment], because we were like, we want to stay, like we just need this to be, and I think it's good for the community as well, if we stay, you know, because like, you know, to have, I think they probably would recruit again, but I don't think people would stay.*

Doctors who are very happy in a remote or rural job may give it up because of competing family values. This seemed particularly common around the transition of their children from primary to secondary school, a time that close access to their school may be valued more highly than job content and even other valued aspects of life (such as living in a beautiful, friendly and safe community that Adriana spoke of previously).

One additional contemporary factor is the COVID-19 pandemic and whether the experience of practising within a city during that time has shifted some doctors' focus towards rural medicine and the opportunity to work somewhere with fewer people and more space, and one that was an emerging discourse in our own research. Whether this is a systemic change or a short-term impact is yet to be determined and something that future research should consider.

Valuing rural and remote communities

Our concluding discussion around value in relation to remote and rural medical practice, be it in general practice or secondary care, is that rural places can be somewhat undervalued in medicine and in policy (both health policy and more broadly). Current research and articulated experiences held by those who we have interviewed as part of our project is that smaller places, smaller teams and the hands-on experience that rural placements often provide are enjoyed and valued by the doctors who undertake them.[30,31] In Australia, such placements have been heavily invested in by the Australian government alongside recruiting students from rural backgrounds to medical schools and this is one of the few interventions supported by evidence as going some way to tackling the issue of rural recruitment and retention.[32,33] Such placements demonstrate to rural communities that they are valued and allow doctors to value such experiences and gain a real-life perspective on what rural practice would be like.

In the Scottish context, proposals for a rurally based new medical school would complement existing strategies (such as rural placements by some medical schools or the rural focus of the Scotland's graduate entry, undergraduate medical programme (SCOTGEM) at St Andrew's University), and could help encourage more students from remote and rural backgrounds to apply for medical school. Alongside rural placements, being born or brought up in a rural area is one of the strongest predictors of willingness to practise rurally. However, one participant reported conversations with a senior staff member in medical education who dismissed the idea of trying to enrol more of such students as 'the tail wagging the dog … for a small number of people' (Hamish, secondary care consultant). In the UK, doctors take at least 10 years at undergraduate and postgraduate level to train, so policies need to have cross party agreement at government level for the long-term interest of rural places, and beyond, to have staff available to fill the roles.

Beyond medical education and the health service, the challenge is, of course, to focus on broader policies that address the whole of society in remote and rural areas.[3] This means that policies attempt to counter negative aspects relating to housing; digital and physical connectivity and infrastructure; education; and employment to make rural places vibrant and sustainable.

> *Policies pertaining to the development, attraction, recruitment and retention of health workers in rural and remote areas are also tightly linked to global progress on sustainable development and universal health coverage. To achieve gains, a whole-of-government and whole-of-society approach, involving different sectors and stakeholders along with community engagement, will be necessary. Embedding rural health policies in national health plans can increase accountability and enable monitoring, leading to more strategic, evidence-informed health workforce planning.*[3]

These policies will not necessarily come from the Department of Health or those involved solely in health governance, but require a relational appreciation of how policies across governance can have positive outcomes beyond their sole remit or area. For us, this 'whole-of-society' and 'whole-of-government' approach will be integral to addressing doctors choosing to move and stay in rural and remote areas. Unless rural and remote communities are supported to flourish, encouraging doctors and their families to *move* or *stay* will remain more a matter of personal serendipity than systematic action. ■

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