EXPERIENCES INFLUENCING PHYSICIAN RURAL PRACTICE AND RETENTION: A PHENOMENOLOGICAL STUDY

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by

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A PHENOMENOLOGICAL STUDY

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DEDICATIONS

- The MU-AHEC, MAHEC, and Rural Health Programs staff listened to me, supported me, and covered for me countless times when I was less able to do my job well. I am so lucky.
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ABSTRACT

A physician maldistribution exists when comparing rural with urban areas. It is necessary to ensure rural citizens have available, accessible, and acceptable quality medical care to remedy health disparities resulting from the lack of physicians. Using theories of symbolic interactionism and experiential place integration as the lenses for analysis, I sought to study the phenomenon of becoming a rural physician and the experiences that influenced physicians to choose rural practice. This was a qualitative study using a transcendental phenomenological approach. Fifteen individual interviews were conducted. For the participants in this study, rural upbringing, family values, early experiences regarding medicine, and identity in place were experiences prior to medical school that influenced the desire to practice and live in a rural area. Rural clinical medical school and residency experiences, the culture of the medical school, and preceptor relationships were experiences during medical school that influenced physicians' choices. Family, partners, and loan forgiveness were experiences that influenced practice type and location. Professional support and integration into the community were experiences

influencing retention. This information is valuable to medical educators, administrators, and community leaders interested in addressing the maldistribution of physicians and ultimately health disparities affecting rural citizens.

Chapter 1

OVERVIEW

Introduction

Physician shortages in rural areas nationwide lead to disadvantage and disparity when looking at factors such as health status, health infrastructure, and economic vitality. Nationally a physician shortage does not yet exist; however, a maldistribution of physicians does. While 20% of the population of the United States resides in rural areas, less than 9% of physicians practice in rural communities (Gazewood, Rollins, & Galaska, 2006). The rural population is one of the largest physician underserved populations in the U. S. (Rabinowitz, Diamond, Markham, & Rabinowitz, 2005). The number of U.S. physicians entering primary care specialties has decreased with only 3% of medical school graduates planning to practice in rural areas and small towns (Rabinowitz, Diamond, Markham, & Wortman, 2008). Physicians in rural areas are likely to be dispersed over much greater areas than physicians in metro areas making access more difficult.

The evolution of rural communities over the past half century has influenced physician maldistribution. Regarding health status, communities that have successfully adapted to changes in the local and global environment are more likely to have high employment, access to quality health care, and are less likely to suffer from poor health outcomes (Glasgow, Johnson, & Morton, 2004). Rural communities that have not been able to sustain their economy tend to face poor health outcomes due to lack of health care access. These depressed communities tend to be small, poor, and more isolated than those

communities that have found ways to thrive and adapt in today's changing environment (Zimmerman, McAdams, & Halpert, 2004).

A poor economic base further complicates the issues because it is more difficult to support a health care services infrastructure, a fact that then negatively influences the economic vitality of a community (Glasgow et al., 2004). Low population density also affects a community's ability to attract quality health care providers (Zimmerman et al., 2004). Quality health care attracts people, business, and industry into rural communities. If quality health care is unavailable, businesses hesitate to locate in these communities, thus making a strong economic base unlikely. Quality rural health care therefore affects the economic development and prosperity of rural communities, while the lack of services threatens the viability (Glasgow et al., 2004).

Research, both quantitative and qualitative, reports factors that influence physicians to practice in rural areas (e.g., Brooks, Walsh, Mardon, Lewis, & Clawson, 2002; Geyman, Hart, Norris, Coombs, & Lishner, 2000; Rabinowitz et al., 2005). Studies have also provided information as to why physicians, either urban or rural born, decide to practice and stay in rural areas (e.g., Cutchin, 2007a; Pathman, 1996; Rabinowitz & Paynter, 2000; Tolhurst, Adams, & Stewart, 2006). This study contributes to the literature by providing deeper knowledge about not only why physicians choose to practice in rural areas, but what it is about the rural practice and community that retains them in spite of the challenges rural areas face. This knowledge informs medical educators, policy makers, professional societies, and community stakeholders nationally in an effort to address the recruitment and retention of rural physicians. Health care delivery and rural economic vitality are hampered in many rural areas because of the lack or maldistribution

of physicians; addressing this is critical. Therefore, it was important to research the experiences that influence physicians to choose to live and stay in rural communities to practice as a first step to better inform policy makers about the lives of rural physicians.

Conceptual Framework

The framework of symbolic interactionism guides my research and informs my study. "Symbolic interactionism is the study of human social and symbolic interaction" (Charon, 2007, p. 144). Symbolic interactionism is a perspective that falls under the umbrella of social science. This perspective sees humans as active in their environment, making decisions about what they do, think, and become. People's points of view are made up of their perspectives which, in turn, define their reality. Reality is social and therefore, how individuals define reality is based on personal interaction with others (Charon, 2007). Perspectives are developed that then help us make sense out of our reality. A perspective is a bias as it contains assumptions, judgments, and ideas that influence how we act or react to our reality. Our perspectives can change as we move through our social worlds; they can help us understand our world or at times, keep us from adequately understanding our world. As we interact, our perspectives can be transformed. "Meanings are assigned and modified through an interpretive process that is ever changing, subject to redefinition, relocation, and realignments" (Benzies & Allen, 2000, p. 544). Behavior therefore, is unpredictable. We may think we know the perspectives one brings into a situation, but we cannot predict how the situation will change perspectives. We must recognize that people can put aside perspectives in favor of new perspectives that are presented and interpreted in any given situation. Ultimately humans are complex and dynamic. Symbolic interactionism is one way of helping to

understand how humans define, act toward, and use their environment. Its focus is on human beings and helps us to interpret human behavior according to ongoing definitions that arise from dynamic perspectives.

Symbolic interactionism attempts to answer questions regarding the essence of human beings such as: What are we? Why do we do what we do? How do humans live together in a society? Symbolic interactionists view humans as social beings whose interaction leads them to act in certain ways. "People, individually and collectively, act on the basis of the meanings that things have for them" (Benzies & Allen, 2000, p. 544). Society and individuals are shaped through interaction. Interaction, both in the past and present, is central to decisions we make in life. Human interaction with self and with others helps us understand and think through decisions. We are socialized through interaction, past and present, and use what we have learned to think about and define our present situations. Humans determine their own action. "To understand human action, we must focus on social interaction, human thinking, definition of situation, the present, and the active nature of the human being" (Charon, 2007, p. 30).

Research shows that the geographical background of a physician is a predictor of practice location (e.g., Brooks et al., 2002; Rabinowitz, 1986; 1988). These studies indicate that if medical schools recruit students from rural backgrounds and train them in areas similar to where they grew up, they are more likely to return to rural areas to practice medicine. Symbolic interactionism was useful in this study because, as the literature suggests, students return to practice in areas in which they have constructed meaning and are comfortable socially and culturally (Brooks et al., 2002; Rabinowitz, 1986). Those who grew up in rural areas have constructed their self-concepts, values, and

social structures that make life meaningful through interaction with others and they often wish to return to the familiar culture of rural areas to make a contribution (Brooks et al., 2002; Rabinowitz, 1986). These constructs are necessary for long term retention, since being integrated into a small town influences one to remain in a small town. Locations must match future physicians' interests and needs; students must "have some sense of personal fit" (Tolhurst et al., 2006, n.p.) to believe they cannot only practice comfortably, but live comfortably as well. Additionally, experiences beyond rural background that influence rural practice decisions were informed by the symbolic interactionism perspective.

Cutchin's (1997b) perspective of experiential place integration was also used to guide my research and inform my study. Experiential place integration helped me to explore physician retention by examining the connection and interaction between physicians, people, and the communities in which they work. Place integration is defined as the activity of becoming a part of place. Cutchin theorized that the process of integration is a continuous one. Cutchin posited that the connection between recruitment and retention is integration (1997b). Physician integration into the medical community and community-at-large is a process that builds bonds with place that encourages physicians to stay because they find meaning in both their personal and professional lives. That is, "the actual process that generates the continuing basis for making the decision to stay or to leave a rural practice setting is based in the quality of human experience in place" (Cutchin, 1997b, p. 28). For physicians, integration is "based on the enhancement of security, freedom, and identity in place" including the medical

community and the community-at-large (Cutchin, 1997b, p. 25). Significant meanings in place are derived from integration and facilitate retention.

Overview of the Literature

Medical schools across the country have made attempts to address the need of physician shortages in rural areas by encouraging more physicians to practice in rural communities. Many approaches have been utilized and studied to determine best practices. Research suggests rural background and upbringing, community service, stated intent, admissions policies, longitudinal rural clinical experiences, personal and professional factors, rural acculturation, rural residency training, and being prepared for rural practice are several strategies, determinants, or experiences that influence practice location and retention (e.g., Curran & Rourke, 2004; Laven & Wilkinson, 2003; Pathman, 1996; Rabinowitz, 1986; Rabinowitz, 1988; Tavernier, Connor, Gates, & Wan, 2003; Woloschuk & Tarrant, 2002).

The two major strategies utilized by medical schools to influence and prepare physicians for rural practice are: (a) increasing the number of students admitted to medical school who are from rural areas and communicate the desire to return to a rural area to practice, and (b) offering clinical rotations in rural areas during medical school (e.g., Curran & Rourke, 2004; Laven & Wilkinson, 2003; Rabinowitz, 1988; Rabinowitz, Diamond, Markham, & Paynter, 2001; Rourke, 2008; Tavernier et al., 2003; Woloschuk & Tarrant, 2002). The desire to practice in rural areas may be further influenced by offering clinical residency rotations in rural areas (DHSS, 2005; Rabinowitz, 1988). Thus, the medical school admissions process and curriculum can have a significant influence on specialty and practice location decisions.

Medical school programs do not exclusively use admission policies and clinical experiences to influence specialty choice and practice location. Recognizing the importance of offering opportunities throughout the physician training pipeline, the programs are comprehensive and multifaceted, spanning from pre-professional programs through medical school and beyond (e.g., Ackermann & Comeau, 1996; Lang, Ferguson, Bennard, Zahorik, & Sliger, 2005; Rabinowitz & Paynter, 2000; Stearns, Stearns, Glasser, & Londo, 2000). Programs include health career exposure experiences for elementary and high school students, mentoring or shadowing programs with rural physicians for undergraduate students, hands on clinical experiences or lectures as first and second year medical students, and rural community-based experiences during the latter years of medical school and residency. Studies suggest that intensive, longitudinal programs result in higher numbers of graduates entering rural practice (Brooks et al., 2002; Jones, Oster, Pederson, Davis & Blumenthal, 2000). Rural training and exposure is most influential when students consider their experience to be quality, they have the opportunity for hands-on training, they enjoy the relationships with their preceptors, their preceptor possesses good interpersonal and teaching skills, and they find meaning in the experience (e.g., Brooks et al., 2002; Jones et al., 2000; Rabinowitz, 1986).

Other determinants that influence specialty and practice choice include gender (i.e., more males than females practice in rural America), spouse or significant other's preference of practice location, size of practice community in comparison to size of hometown, referrals from faculty, practice partners, hospital services offered, proximity of residency training sites to practice location, and service orientation of students (Geyman et al., 2000). Rewarding professional growth opportunities, continuing medical

education offerings, and having contact with other physicians, both rural and urban, are also variables that influence place of practice (Jones et al., 2000). In addition, an institution's commitment to rural health and rural medicine programs and policies is associated with an increase in rural physician output (Wheat, Higginbotham, Yu, & Leeper, 2005). Finally, having faculty who support rural programming, staff placed in rural areas in support of students and their training, and a bridge program between pipeline components helping students transition are also associated with eventual practice choice (Wheat et al., 2005).

Quality rural experiences and learning opportunities are not enough to influence students' career decisions. Students must also have time and opportunity to acculturate into the rural lifestyle to be influenced to practice in a rural area. Students must not only understand the medical community, but develop an emotional attachment to rural living through connections with local people and community. Rural experiences help students determine whether or not practicing in a similar area will make them professionally and personally happy (Denz-Penhey, Shannon, Murdoch, & Newbury, 2005).

The impact of rural programming is dependent on physician retention in rural practice. Two residency factors correlating with retention are participation in rural rotations and an emphasis on underserved areas of health care. The most influential factor for retention is feeling prepared for rural careers (Pathman, Steiner, Jones, & Konrad, 1999). "Physicians' sense of preparedness for small-town living predicted their retention duration" (p. 810). Brooks et al. (2002) also suggested "the presence and duration of rural rotations appear to be the best predictors of retention in rural areas, a finding that is likely due to students being better prepared for what awaits them in rural practice" (p. 797).

Local features of a rural community such as the professional environment, lifestyle choices, and the community's economic viability influence retention once a physician settles in a rural area, especially if the physician has a family. Isolation, long work hours, lack of support from specialists, lack of opportunity for continuing medical education, and lower reimbursement rates all negatively impact the longevity of physicians in rural practices (Brooks et al., 2002).

To date, physician placement research findings have been mixed and an understanding of why physicians stay in rural areas is not well developed because the importance of community-physician interactions is often not included in rural curriculum program design. However, a qualitative study by Cutchin (1997a) indicated physician retention is the result of the integration process into a community. As physicians enter social networks, mutually beneficial relationships evolve and are built around trust, obligation, and expectations. Integration and retention become more important to the physician, the community, and its members. Communities that welcome and accept the physician into the local community increase the physician's social interaction and leads to social capital and the likelihood of retention. Interactive social capital mutually benefits both the physician and the citizens of the community (Flora, Flora, & Fey, 2004). Physician participation develops moral commitment to the community and identifies the physician as engaged in the community. Examples include being a school board member or a volunteer representative of a non-profit organization. This participation facilitates integration and retention.

In sum, the evolution of communities over the past 50 years based on their social, economic, and political issues has left some rural areas facing health disparities and a

lack of physicians to meet the health care needs. To address this, medical schools have been charged with influencing students to practice in rural areas. Research has shown some successes in preparing physicians for rural medicine. But, the retention of physicians is also vital to meet long term needs. Scholars have begun to determine which efforts in the recruitment and retention of rural physicians are most successful, but questions remain.

Purpose of Study

The purpose of this transcendental phenomenological study is to describe the meaning or essence of becoming rural physicians and to determine why they choose to stay in a rural area to practice medicine. I utilized transcendental phenomenological methods to learn about rural physicians' experiences that influenced their decision-making processes to choose a rural practice location. In addition, I explored the process of rural retention among these physicians who have practiced in rural areas for at least two years by looking at how they described the connection and interaction between their communities and themselves.

Research Questions

The research questions have both social meaning and personal significance as is necessary for a phenomenological study (Moustakas, 1994). I constructed the questions using Moustakas's (1994) recommended structure so the intent and purpose of the study were evident. The questions were informed by the conceptual frameworks of symbolic interactionism and experiential place integration in an effort to understand and explore the meaning of the lived experiences that influence physicians to choose to live and practice in rural areas.

1) How do rural physicians describe experiences that led them to rural practice?
2) How do rural physicians describe experiences that led them to stay in rural areas to practice?

Research Design

A transcendental phenomenological approach was utilized to ascertain common or shared experiences among participants to derive a deep understanding of the phenomenon (Moustakas, 1994). Transcendental phenomenology is best suited for this study because it focuses heavily on the participants' description of the experiences. I studied the phenomenon of becoming a rural physician and the experiences over time that influenced physicians to choose rural practice. Because I am not a rural physician, I relied on the description of physicians' experiences to create an accurate central meaning or essence of the phenomenon (Creswell, 2007). My study is grounded in the philosophical tenets or assumptions of phenomenology including epoche, the intentionality of consciousness, intuition, and intersubjectivity, which are the basis of this method (Moustakas, 1994).

Participants

Fifteen rural physicians participated in my study. I used criterion sampling (Creswell, 2007) to choose my participants because those interviewed were physicians practicing in Missouri rural areas of 18,000 people or less. All participants were University of Missouri (MU) School of Medicine alumni and alumnae from the graduating classes of 1997-2004. Some of the participants were purposely sampled from non-rural backgrounds to gain additional perspective on experiences influencing rural practice beyond rural background. Four participants were known to me through my

position of program director with the University of Missouri School of Medicine Rural Track Pipeline Program. This program is a longitudinal curricular and training program offered to pre-medical and medical students that exposes them to rural experiences. The intent of the program is to influence practice location in rural communities. Participants' names not known to me were obtained from the University of Missouri School of Medicine Alumni Department.

Data Collection

Single, in-depth, face-to-face interviews were conducted in a quiet location chosen by each physician. Interviews were recorded and transcribed.

Data Analysis

I utilized Moustakas's (1994) modification of methods of analysis. The appropriate order of analysis was utilized following protocol with one exception. Because I am not a practicing rural physician, I did not contribute a full description of the phenomenon. I did however, describe my relationship to the MU Rural Track Clerkship Program and discussed existing relationships that I have with some of the participants.

Definitions

Academic Health Center – Consists of 3 related enterprises:
(a) A medical school that trains physicians; (b) Research activities involving laboratory science, clinical investigation, or both; and (c) a system for delivering health care services that may include one or more hospitals, satellite clinics, and a physician office practice (www.Theinformaticiancom)

Call – Duty hours beyond the normal work day when physicians are required to be immediately available (http://www.acgme.org/acWebsite/about/ab_ACGMEglossary.pdf)

Clinical Clerkships – Clinical training and experience blocks third-year medical students must complete in teaching hospitals or affiliated training centers. The clerkships include Pediatrics, Obstetrics/Gynecology, Family Medicine, Internal Medicine, Psychiatry/Neurology, and Surgery (http://cancerweb.ncl.ac.uk/cgi-bin/omd?query=clinical+clerkship)

Community Based Physicians – Physicians with clinical faculty appointments who are granted appointments because they are board certified, willing to teach, and who have a rich, diverse practice, meaning their practice offers students the experiences necessary to learn the objectives of the clerkship (http://som.missouri.edu/curriculum.shtml)

Health – A state of complete physical, mental, and social well-being, not simply the absence of disease (http://www.who.int/about/definition/en/print.html)

Health Professional Shortage Area (HPSA) – An area with a ratio of less than one primary care physician per 3,500 population (Missouri Department of Health and Senior Services [DHHS], 2007)

Hospitalist – A physician whose practice is caring for patients in the hospital. A primary care physician turns their patients over to a hosptialist, who becomes the physician of record and provides and directs the care of the patient while the patient is hospitalized and returns the patient to the primary care physician at the time of hospital discharge (www.hayajneh.org)

Preceptorship – An educational program designed to give the professionally trained student experience outside the academic environment working in the specialty area of his or her choice with a physician (http://cancerweb.ncl.ac.uk/cgi-bin/omd?query=preceptorship)

Primary Care – The medical home for a patient, ideally providing continuity and integration of health care; provides a patient with a broad spectrum of care; both preventative and curative, over a period of time and to coordinate all of the care the patient receives. Specialties include Family Medicine, Pediatrics, and Internal Medicine (http://cancerweb.ncl.ac.uk/cgi-bin/omd?primary+care)

Residency Program Director – The one physician designated with authority and accountability for the operation of the residency program (http://www.acgme.org/acWebsite/about/ab_ACGMEglossary.pdf)

Resident – A physician who has completed medical school and is in the process of receiving specialized training (http://cancerweb.ncl.ac.uk/cgi-bin/omd?query=resident)

Rural – Communities of 18,000 people or less

Social Capital – The web of cooperative relationships between citizens that facilitate resolution of collective action problems (Brehm & Rahn, 1997)

University of Missouri School of Medicine Rural Track Clerkship Program – Program offering third-year medical students the opportunity to complete two or three of their required six core clinical clerkship rotations in a rural community (www.muahec.com)

Limitations

This study has several limitations. First, utilizing graduates as participants from only one medical school is a limitation as findings can only be suggestive to other medical schools. Second, the participants were limited to University of Missouri School of Medicine graduating classes of 1997-2004 who are currently practicing in Missouri communities of 18,000 people or less. The limited time period makes it difficult to

assume longitudinal outcomes as the longest any physician has been in practice is 8 years. However, the study likely has transferability to the experiences of rural physicians in other states and from other medical school programs. Third, the physicians in this study were in their thirties providing only young physicians' perspectives regarding integration. Integration may be limited due to physicians starting practices and having small children. Looking longitudinally at community integration and retention is necessary once practices are full and children are older and in school. Finally, I direct the rural clinical training programs at the University of Missouri School of Medicine and, because of my relationship to some of the physicians, there is researcher bias which is discussed in the dependability and trustworthiness section; however, my experience also provides access to the physicians and knowledge of the professional jargon, which may have enhanced participant comfortability.

Significance of Study

Physician workforce analysts do not always agree about whether or not there are too many or too few physicians, but they do concur that there is a physician maldistribution when comparing rural with urban areas (Whitcomb, 2005). It is necessary, from a social justice standpoint, to ensure that rural citizens have available, accessible, and acceptable quality medical care. In addition, existing health disparities resulting from the lack of physicians must be remedied. Using admissions policies and clinical training programs to influence students to practice in rural areas, policy makers and medical schools have been working toward this goal for several decades (e.g., Brooks et al., 2002; Geyman et al., 2000; Jones et al., 2000; Rabinowitz, 1986; Rabinowitz, 1988; Rabinowitz et al., 2005; Verby, Newell, Andresen, & Swentko, 1991). Yet, there

was much more to learn about physician choice in practice and physician-community interaction to enhance integration and retention in rural communities.

The knowledge resulting from this study provides a framework that can be used to better understand which students accepted into medical school are more likely to choose rural areas to practice and what experiences influenced them to choose rural practice and to stay. With this information, schools can better select students who are more likely to return to rural areas. In addition, schools and communities can provide, change, or enhance curricular and practical experiences that foster students' social constructions to influence them to make informed decisions to practice and live in professionally and personally satisfying rural areas. This information is valuable to medical educators, administrators, and community leaders interested in addressing the maldistribution of physicians.

Summary

Chapter 1 describes rural physician shortages as a long term issue that leads to disadvantage and disparity when looking at health status, health infrastructure, and economic vitality of rural communities. The chapter provides a rationale for research regarding the experiences that influenced physicians to choose to live and stay in rural communities to practice as a first step to address rural health disparities. Research suggests rural background and upbringing, community service, stated intent, admissions policies, longitudinal rural clinical experiences, personal and professional factors, rural acculturation, rural residency training, and being prepared for rural practice are several strategies, determinants, or experiences that influence practice location and retention. Additional knowledge was necessary to better understand the meaning or essence of

becoming rural physicians and to determine why they chose to stay in a rural area to practice medicine. Utilizing symbolic interactionism and experiential place integration as conceptual frameworks, I conducted a transcendental phenomenological study to explore the phenomenon. Significance of this research includes providing information to enhance admissions policies and curriculum and training opportunities to influence more physicians to practice long term in rural areas in order to address the current health disparities.

Chapter 2 begins with an historical overview of medical education and the physician migration out of rural areas that has contributed to today's physician maldistribution and related health access issues. This is followed by an explanation of the rural context of health care access issues looking at how rural communities have adapted to change in the local and global environments and how these adaptations have positively or negatively affected economic development and local sustainable health care delivery systems. Next, the national rural physician shortage is described along with resulting disparity issues. Reasons why there is a decline in the number of medical students choosing primary care practices in rural areas is discussed. Finally, relevant literature looking at factors and experiences that influence physicians' career choice, practice location, and length of stay before, during, and following medical school are reviewed at length.

Chapter 2

OVERVIEW OF THE LITERATURE

Introduction

The United States is experiencing a physician shortage in rural areas. Health disparities and the critical need to graduate physicians to address the underserved population in rural communities has been the charge of medical schools for several decades. Research indicates the rural focused education and training programs offered by medical schools have increased the numbers of physicians practicing in rural areas. It is not always clear however, if nature or nurture is the reason physicians settle and practice in rural communities. Research to date indicates personal background and characteristics, admissions policies, education and training, the medical community, and the community-at-large are some of the factors that influence physicians' practice choices. Factors or experiences that influence physician retention may be among these, but the research is less clear. Therefore, the maldistribution of physicians and related issues of health disparity will not be addressed long term until communities retain physicians over their career lifespan. Further study was necessary to determine what factors or experiences, or combination thereof, occurring before, during, or after medical school were most meaningful in physicians' decision making processes regarding practice location and length of stay.

Focus of the Review

Factors or experiences that influence physicians' place of practice and length of stay occur throughout the lifespan. Sources addressing factors and experiences before, during, and after medical school were necessary to capture the many aspects that affect

one's medical career decisions. The key words I used to find applicable sources included community, self, career choice, integration, physician retention, social capital, rural practice, workforce, qualitative analysis, rural medical education, practice location, urban, rural health care, and community sustainability to mention a few. Predominantly, my searches resulted in national and international refereed journal articles. Additionally, policy papers and issue briefs were found that described the necessity to address the maldistribution and related disparity issues through the implementation and funding of rural medical education programs. These sources helped explain the background of the issue and necessity of further study. Using symbolic interactionism to inform my review of the literature, I chose both quantitative and qualitative articles that adequately outlined the parameters of the topic. The qualitative articles were extremely useful in helping me to go deeper than numbers and into the mind action that symbolic interactionism requires to understand physicians' values, ideas, decisions, goals, identities, and motivations as they relate to experiences and their meaning. Thinking, deliberating, and reflecting, or mind action, allows humans to control their own action and take active roles in their environment. Mind action allows humans to problem solve, understand, interpret, and define others in a situation. Finally, mind action allows humans to plan for the future, remember the past, or create and perceive something new. This study provides a broad view of both quantitative and qualitative studies addressing factors and experiences that influence physicians' practice location and length of stay. Finally, the study incorporates scholarship from rural sociology to look at the importance of community-physician interaction in both the recruitment and retention process of attracting and keeping physicians in areas of need.

This chapter begins with an historical overview of medical education and the physician migration out of rural areas that has contributed to today's physician maldistribution and related health access issues. This is followed by the rural context of health care access issues looking at how rural communities have adapted to change in the local and global environments and how these adaptations have positively or negatively affected economic development and local sustainable health care delivery systems. Next, the national rural physician shortage is described along with resulting disparity issues. Reasons why there is a decline in the number of medical students choosing primary care practices in rural areas are discussed. Finally, relevant literature looking at factors and experiences that influence physicians' career choice, practice location, and length of stay before, during, and following medical school is reviewed at length.

History of the Issue

Standardization of Medical School Curriculum

Prior to the standardization of the national system of higher education in the United States, admission requirements, length of study, prerequisite training, and graduation requirements were defined by individual institutions. At times, these determinations were made simply to increase enrollments as opposed to prioritizing student quality (Leslie, 1997). In some cases, profits were a priority over providing adequate training to prepare students for their chosen discipline. Professional training was no exception. Medical training in particular was guilty of accepting unfit students and providing substandard training which, at times, led to deficient health care (Beck, 2004).

In the 19th century, medical education was gained through a hands-on apprenticeship with a local practitioner, at a proprietary school where groups of students

learned through lectures delivered by the physician owners, or through didactics and clinical training in a university affiliated with a hospital (Beck, 2004). There were no standards or licensing requirements defined to verify medical knowledge, aptitudes, or philosophies. Standardization efforts sought by the American Medical Association (AMA) were fought because of the lack of agreement on which philosophy of medicine (osteopathic, allopathic, eclectic, homeopathic, etc.) was superior. The turn of the century brought with it scientific breakthroughs that defined the superiority of evidence based medicine, which could only be mastered through active learning in a laboratory or at the bedside (Beck, 2004).

The AMA defined two reform initiatives for medical education. The first defined standard education requirements for entry into medical school while the second outlined standard medical education curriculum to include both laboratory experience and clinical training. In 1908, the Carnegie Foundation responded to a request made by the AMA to survey medical education in the United States to determine which schools met the two reform initiatives. A report was to be published in hopes that schools of medicine would meet standards or be eliminated as a result of being identified as a substandard institution (Lagemann, 1997). Therefore, Abraham Flexner was hired by the Carnegie Foundation to determine where discrepancies existed between the defined ideal standards and the self-imposed standards in each institution and report his findings (Lagemann, 1997).

In 1910, the Carnegie Foundation published Flexner's report entitled *Medical Education in the United States and Canada.* The report described the historical and present medical education situation as a case for reform. The report went on to describe the ideal standards of what medical education should address to ensure the ability to

provide quality health care to include education admissions standards, curriculum to include advanced clinical training, the necessary physician to patient ratio in society, and the needed affiliation of schools of medicine with university hospitals. Flexner's report reconstructed the national system of medical education. Subsequently, 79 of the 155 medical schools found to be substandard closed over the period of 1910-1930 (Lagemann, 1997).

Initial Primary Care and Rural Physician Shortages

Fewer medical schools meant the education of fewer physicians. Standardized training became less accessible to rural students as schools were located in larger, urbanized areas. At the same time, per physician visits nearly doubled during the time period of 1932-1945, while the physician-to-population ratio remained constant. Even though 80% of all physicians nationwide were family doctors, which made up the majority of rural practitioners at that time, physicians increasingly were setting up practice in urban areas, which initiated the scarcity of rural physicians.

Communities were expected to be self-sufficient by supporting health care through locally raised funds. This was not feasible in many rural areas in the 1930s. As a result, many rural communities did not have hospitals. Lack of funding and hospital support also influenced the scarcity of rural physicians. Rising health care costs and supply and demand inequities further complicated a problematic situation during the depression (Zimmerman et al., 2004). Between 1946 and 1974, the Hill-Burton Act provided federal grants predominantly to communities of fewer than 10,000 people to construct local hospitals. Two-thirds of the funding however had to be raised by the community. The result was that the grants disproportionately went to middle-income

areas. During the 30 year time period, the Act provided $6.1 billion in grants and loans increasing the ratio of hospital beds from 3.0 to 4.5 beds per 100,000 population. The hospitals were required to provide a level of charity care. In the South however, many Hill-Burton hospitals refused to treat African-American patients (Zimmerman et al., 2004).

The nation's supply of physicians steadily increased after World War II with the establishment of 40 new medical schools. Unfortunately, small rural communities did not benefit from the growth when compared to large, metropolitan communities (Geyman, Hart, Norris, Coombs, & Lishner, 2000). Despite the need for physicians in rural areas, the numbers choosing to practice in them actually declined between 1975 and 1995. The number of family practice graduates choosing to practice in areas of less than 2,500 people dropped 60.5% to only 3.8% while those choosing suburbs of large metropolitan areas increased by 23.5% to 11.2% (Geyman et al., 2000). The late 1980s brought economic restructuring in rural areas with a shift from goods producing jobs with benefits and living wages to service positions with low wages and no benefits, making rural areas economically less desirable for physicians to live or practice (Duncan, 1999). To further complicate issues, "during the 1980s, over 600 rural hospitals ceased operations as a result of closure, acquisitions, or mergers" (Zimmerman et al., 2004, p. 221).

Decline in Primary Care

By the 1990s, only 30% of U.S. physicians were practicing primary care. Causes for the decline in the interest for practicing primary care included income discrepancies between primary care physicians and specialists, and the perception that being a specialist allowed greater flexibility when balancing family with career (Ackermann & Comeau,

1996). In February 1990, a meeting of nine American medical societies concluded medical education again needed reform. A shift from hospital-oriented training to a community-based emphasis was necessary to influence and prepare primary care physicians to practice in smaller communities, thus responding to the public need of accessible health care (Verby et al., 1991). Many different medical school curricula have been implemented and their success will be discussed in the Factors or Experiences Influencing Rural Practice Choice section. With the current national priority to expand medical class size, there may be an opportunity to increase numbers of rural physicians; however, "expansion without consideration of physician distribution will likely perpetuate the concentration of physicians in urban areas" (Arvantes, 2008, p. 3).

The Rural Context of Health Care Access Issues

Historically, family farms were the dominant economic force in rural communities. During the past 50 years however, industrial agricultural production has become the norm with mechanization of food production replacing farm labor (Hodne, 2004). The loss of the family farm led to the migration of many people to urban areas to find employment. Rural communities today however, remain a strong component of our society. In fact, according to the Institute of Medicine's (IOM) 2004 Report, *Quality through Collaboration*, 20% of America's population (55.4 million) resides in rural communities. Some may perceive rural America as isolated or declining despite the critical mass residing there. To the contrary, many rural areas are thriving as manufacturing replaces farming as a major source of employment. Rural communities are also more connected to urban America because of advances in technology and transportation (Geyman et al., 2000).

The histories of individual communities have influenced their evolution including economic growth or decline and the availability of social, political, and community resources (Flora et al, 2004). "The nation's rural environment is diverse across its economic, social, environmental, demographic, and epidemiological dimensions" (Hart, Salsberg, Phillips, & Lishner, 2002, pp. 211-212). Rural communities that have not been able to sustain their economy tend to face poor health outcomes, food insecurities, poor diet and nutrition, and persistent poverty due to lack of health care access and jobs offering health insurance. Particularly vulnerable populations include immigrants, teenagers, the elderly, and those suffering from mental illness (Glasgow et al., 2004; Institute of Medicine, 2004). These depressed communities tend to be small, poor, and more isolated than those communities that have found ways to thrive and adapt in today's changing environment (Zimmerman et al., 2004). In some rural communities, out-migration by young people has led to an aging rural population and a decline in local amenities. People must travel greater distances to access products and services to include health care. A poor economic base further complicates the issues because it is more difficult to support a health care services infrastructure, a fact that then negatively influences the economic vitality of a community (Glasgow et al., 2004). Once communities are negatively affected by the economy, it is extremely difficult to find the resources to support a physician, especially a new graduate who may have upwards of $120,000 in medical school debt (NRHA, 2006). Low population density also affects a community's ability to attract health care providers. Fewer patients and the possibility of uncompensated care are financial disadvantages for health care providers who may be considering rural areas for practice (Zimmerman et al., 2004). In many rural

communities, there is a tenuous balance between meeting residents' health care needs and providing adequate income and quality of life to local physicians (Hart et al., 2002). If quality health care is unavailable, businesses hesitate to locate in these communities, thus making a strong economic base unlikely. In many cases, a weak economic base translates to a lack of basic core services such as primary care, emergency medical services, hospital care, long-term care, mental health and substance abuse services, oral health care, and public health services (IOM, 2004). In addition, many state and federal policy decisions profoundly affect the viability of rural health care delivery systems and consequently the local economic development (Hart et al, 2002) that can lead to the deterioration of community cohesion and identity (Farmer, Lauder, Richards, & Sharkey, 2003).

Communities that have successfully adapted to changes in the local and global environment are more likely to have high employment, access to quality health care, and are less likely to suffer from poor health outcomes (Glasgow et al., 2004). Quality health care attracts people, business, and industry into rural communities. In fact, health care services can be important to the livelihood and infrastructure of rural communities, as 15-20% of local employment can be attributed to health care positions (Farmer et al., 2003). For each physician there is a one million dollar per year economic impact on a rural community, which then translates into jobs and the preservation of rural health facilities (NRHA, 2006). Therefore, a physician in a rural community contributes to its local capital and affects the economic development and prosperity of rural communities, while the lack of services threatens community viability (Glasgow et al., 2004). Ultimately, "assurance of economically sustainable health care delivery systems that

provide high quality, accessible, primary medical, dental, and mental health services are essential to the survival of rural communities" (Missouri Department of Health and Senior Services [DHSS], 2005, p. 16).

The National Rural Physician Shortage Today

Physician shortages in rural areas nationwide lead to disadvantage and disparity when looking at factors such as health status, health infrastructure, and economic vitality. Nationally a physician shortage does not yet exist; however, a maldistribution of physicians does. Long-standing shortages of health professionals in rural areas are common. While 20% of the population of the United States resides in rural areas, less than 9% of physicians practice in rural communities (Gazewood et al., 2006). The rural population is one of the largest physician underserved populations in the United States, as 40% of rural residents (22 million) reside in federally designated primary care Health Professional Shortage Areas (HPSA) (Rabinowitz et al., 2005). "Nearly four times as many patient care physicians per 100,000 people practice in large metropolitan areas as practice in small rural areas" (Smucny, Beatty, Grant, Dennison, & Wolff, 2005, p. 733). As previously discussed, the issue is further complicated by greater morbidity, mortality, lack of adequate health insurance, and poverty of rural residents as compared to metro residents (Rabinowitz et al., 2005). The number of U.S. physicians entering primary care specialties has decreased with only 3% of medical school graduates planning to practice in rural areas and small towns. Factors associated with the decline of rural physicians include an increase in the number of female physicians (e.g., more males than females practice in rural America), the changing lifestyle preferences of young physicians, and the increased amount of medical school debt (Rabinowitz et al., 2008). Rural

communities with less than 10,000 people that are not adjacent to a metropolitan area represent the major problem of geographic maldistribution of physicians with only 92 physicians per 100,000 people as compared with 305 physicians per 100,000 people for large metropolitan areas. For rural areas with less than 2,500 people, the ratio drops to 55 physicians per 100,000 (Geyman et al., 2000). Physicians in rural areas are likely to be dispersed over much greater areas than physicians in metro areas making access more difficult.

It is important to understand more about why fewer physicians are practicing in rural areas. Is recruitment or retention of physicians the primary problem relating to rural physician shortages? Is it that communities cannot attract physicians or is it that they cannot personally and professionally satisfy them enough to stay? In 2004, Pathman, Konrad, Dann, and Koch determined rural shortages have more to do with too few physicians being recruited to rural communities as opposed to too few physicians being retained. This study assessed turnover in rural HPSAs with rural non-HPSAs and found retention duration to be similar. They concluded retention issues do not generally make physician shortages worse in rural areas. Rather, the study indicated local shortages develop when too few physicians are recruited, which happens "when local amenities, economies, and practice situations are unattractive" (Pathman et al., 2004, p. 1728). The authors support findings that conclude retention is unrelated to the amenities communities offer, but is related to work and family satisfaction in addition to their level of integration and attachment in the community.

Factors or Experiences Influencing Rural Practice Choice

Literature suggests several factors or experiences that influence eventual rural practice and retention. Factors and experiences can occur before, during, and/or after medical school. Factors and experiences that occur before medical school include: rural background and upbringing, participation in service activities, admissions policies, and stated desire at time of admission to practice in a rural area. Factors and experiences that occur during medical school include: medical school curriculum, rural clinical training, the combination of rural admissions with rural training, personal factors, medical school culture, rural acculturation, rural residency training with an emphasis on underserved areas, and rural career and small town living preparation. Factors or experiences occurring after medical school include: lifestyle preferences, personal and professional financial security, professional support received, and level of integration into the community.

Experiences Prior to Medical School

Studies show students with a rural background have a more favorable attitude toward rural medicine and are more likely to return to work in rural areas (Rabinowitz, 1986; 1988). A sense of rural background develops at the clear point of around 5 years of rural upbringing. Students with a sense of rural background are likely to develop intent to practice in a rural area several years before students unfamiliar with rural areas (Somers, Strasser, & Jolly, 2007). Rural background, to include service experiences in underserved rural areas prior to medical training, further influences future practice site choice (Tavernier et al., 2003). Even with this knowledge, it is not easy to recruit rural students into medical school, as many barriers to medical school exist for rural students including

"lower educational and socioeconomic statuses, fewer role models, less encouragement to pursue higher education, fewer academic activities, less technology, and the need to travel to obtain a degree" (Hyer et al., 2007, p. 1). The trend to higher required grade point averages, admission test scores, and rising tuition costs are additional barriers for rural background students (Hyer et al., 2007). Admissions policies at national and international medical schools rely on rural students to help meet their mission to increase the number of physicians practicing in rural areas and therefore consider students who possess rural backgrounds and a history of service for inclusion into medical school (e.g., Curran & Rourke, 2004; Laven & Wilkinson, 2003; Pathman, 1996; Rabinowitz, 1988; Tavernier, et al., 2003; Woloschuk & Tarrant, 2002). Medical schools with a rural mission that do not have admissions policies that look toward accepting additional rural students must consider implementing policies that reflect the health care needs of their state.

The medical school admissions process can have a significant influence on specialty and practice location decisions. Rabinowitz et al. (2005) have shown admitting students from rural communities increases the likelihood they will return to rural areas to practice. In fact, "rural doctors are two to four times more likely than urban doctors to have a rural background" (Tolhurst et al., 2006, n.p.). These special rural student admission tracks help increase the number of rural students attending medical school. However, the issues are further complicated as rural born medical student applications have seen a 47% decrease during the past 25 years in addition to a decline from 27% to 11% in rural student medical school admissions (NRHA, 2006).

Growing up in a rural area in addition to communicating a desire to return to a rural area at the time of admission increases the likelihood a student will choose a primary care specialty and eventual rural practice (Chan et al., 2005; Rabinowitz et al., 2001). In fact, Rabinowitz et al. (2001) found students who did not participate in rural clinical rotations at Jefferson Medical College, but who possessed these two admissions characteristics were 75% as likely to enter rural primary care practices when compared to participants who did complete rural rotations. Rural trained participants however, were more likely to be retained in rural practice. Rabinowitz (1986) found a 5.5-fold increase in the number of rural physician graduates when admissions policies gave preference to students with a rural background and the desire to return compared with admissions policies without these preferences. The combination of admissions policies that admit rural students who also have an interest in primary care with the offerings of rural clinical training further increases likelihood of students choosing rural practice.

It is unclear whether those already planning to enter rural practice choose to participate in rural clinical rotations or whether the rotations increase the likelihood of rural practice. Studies have indicated that rural practice is influenced by rural background and preexisting rural interests (nature), while other studies indicated the extent educational and training experiences have on choice (nurture; Brooks et al., 2002; Dunbabin & Levitt, 2003). It is argued that students with rural backgrounds may choose rural practice without the rural clinical experiences provided in medical school and residency, while others contend integrating students into communities through the education and training opportunities encourage preexisting choices and help students to be better prepared for living and working in rural communities (Lynch et al., 2001).

Experiences Primarily During Medical School

Medical schools across the country have made attempts to address the need of physician shortages in rural areas by encouraging more physicians to practice in rural communities. The two major strategies utilized by medical schools to influence and prepare physicians for rural practice are: a) increasing the number of admitted students who are from rural areas and communicate the desire to return to a rural area to practice, and b) offering clinical rotations in rural areas (e.g., Curran & Rourke, 2004; Laven & Wilkinson, 2003; Rabinowitz, 1988; Rabinowitz et al., 2001; Rourke, 2008; Tavernier et al., 2003; Woloschuk & Tarrant, 2002).

In addition to selecting students who are more likely to return to rural areas for practice, it is also necessary to provide rural clinical experiences that provide students with the opportunity to live and work in these communities. A pipeline approach that exposes students to rural practice is most often utilized. The programs medical schools offer vary with experiences ranging from a short term family medicine experience to programs that offer much more comprehensive experiences over a period of years. For example, some schools offer a 4 week rural family medicine experience during the third year of medical school, while other schools collaborate with high schools preparing youth for medical school and practice through longitudinal experiences during high school, college, and medical school then continue to work with physicians through placement in rural practice and beyond (e.g., Ackermann & Comeau, 1996; Lang et al., 2005; Rabinowitz & Paynter, 2000; Ramsey, Coombs, Hunt, Marshall, & Wenrich, 2001). Rural training experience generates or increases interest in rural practice among some rural and urban background medical students and can positively influence the decision to

practice in a rural community (Colwill, 2007; Jones et al., 2000; Rabinowitz, 2008; Rourke, 2008). Students who participate in rural programming are better prepared to work in interdisciplinary environments and are more likely to become involved in community-based programs and activities once in practice (Florence, Goodrow, Wachs, Grover, & Olive, 2007).

The pipeline programs primarily concentrate on medical school clinical training to influence specialty choice and eventually practice location. More family physicians graduate from schools that require family medicine clerkships (Pathman, 1996). Also, most physicians practicing in rural areas completed community-based clinical rotations (Colwill, 2007; Jones et al., 2000; Rabinowitz, 2008; Rourke, 2008). Experiencing rural medicine through rural training exposes students to the challenge of rural medicine and the enjoyment of a rural lifestyle, which are two important factors when considering rural practice (Chan et al., 2005). Studies suggest the intensity of the pipeline programs and the effects of longitudinal programs result in higher numbers of graduates entering rural practice. (Brooks et al., 2002; Tavernier et al., 2003). Programs that include advanced procedural skills training and a commitment to provide accessible continuing medical education via distance education once in practice also help physicians to be prepared and meet their professional development needs once selecting rural practice (Curran & Rourke, 2004).

Colwill (2007) indicated the 9 month experience offered through the Rural Physician Associate Program (RPAP) in Minnesota promotes student involvement in community-based efforts to deliver health education and to improve health. The RPAP "experience gives each student a strong foundation in clinical and communication skills,

a confident professional approach, and an understanding of the impact of health care services on a community's health" (Colwill, 2007, n. p.). According to students, the 9 month period allows them to establish relationships with their physician teachers, get a good feel for the realities of rural practice, and experience continuity of care with their patients. For example, students have the opportunity to follow a woman through part of a pregnancy and delivery and later care for the baby during a check up visit. This length of experience would also lend itself to include the four dimensions of community skills and knowledge outlined by Pathman, Steiner, Williams, and Riggins (1998). The community dimensions include: identifying and intervening in a community's health problems, responding to particular health issues of local cultural groups, coordinating local community health resources, and integrating into the community and its organizations. Experiencing these dimensions lends itself to students having an in depth understanding of rural practice and community perspective. These significant experiences are designed to occur during a formative time period in their academic careers and are important in fostering students' interest in rural care (Pathman et al., 1998). This is the case for RPAP students, as Colwill (2007) reported 40% of RPAP graduates overall are practicing in rural communities and, as reported by Rabinowitz (2005), 68% of the Physician Shortage Area Program (PSAP) graduates (1978-1986) who originally entered rural practice were still practicing in the same rural area. The Rabinowitz study did not address why graduates remained in rural areas; however, it showed that the PSAP program in particular influences retention. "The study is the first to show increased long-term retention of rural primary care physicians from a program designed to increase the rural physician supply" (Rabinowitz, 2005, p. 731).

In 2008, Rabinowitz et al. conducted a systematic review of six comprehensive medical school programs designed to increase the rural physician supply. They found that these programs have been highly successful, with an average of 53% to 64% of graduates practicing in rural communities. These outcomes are substantial in comparison to 3% of recent graduates nationwide who plan to practice in rural areas and 9% currently practicing there. This study indicated widespread replication of medical school programs aimed to increase the numbers of rural physicians could lead to a substantial increase in the output of rural physicians. Even small outcomes can lead to large impacts on small towns. For example, a program at Jefferson Medical College in Pennsylvania averaged only 14 students per year but contributed to 12% of rural family physicians in the state (Rabinowitz et al., 2001).

Medical schools in Canada are utilizing distributive learning models where off site instruction has an emphasis on local needs. Students complete their entire medical training, both basic and clinical, off site. Courses are delivered in interactive classrooms online being taught by faculty at the main campus. To date, students enjoy the use of technology in learning and believe they will be better equipped to use electronic forms of medicine in their future rural practices. The program in Canada has not been in existence long enough to show whether or not students actually choose to practice in rural Canada due to the instructional design (Kondro, 2006).

A unique study completed at the Medical University of South Carolina found that rural experiences can positively influence both urban and rural background students' preferences for rural practice. The study examined changes in students' perceptions toward rural primary care following a required rural clerkship during the third year of

medical school. Students held more positive perceptions after the clerkship about rural physicians' medical expertise, and they rated a rural physician's expertise higher than that of an urban physician. The students' perceptions of the primary care services provided by the rural physician also improved. While prior to the clerkship, students perceived that rural physicians provided a broader range of primary care services than did their urban counterparts, students' views were even more positive afterwards. Another positive effect was that students' perceptions of rural physicians' work demands decreased after the clerkship, meaning they perceived work demands were not as great as they originally thought. However, students continued to perceive these work demands as greater than those of an urban physician. The only perception of rural physicians that did not change was that rural physicians had a lower income potential in comparison to their urban/suburban counterparts (Blue et al., 2004).

Studies about urban students. As stated, students from rural areas are more likely to return to rural areas to practice. However, because fewer students from rural backgrounds are accepted into medical school, it is important to train and influence urban students to practice in rural areas. Interest in rural practice gradually increases as training and exposure to rural communities increase especially for urban students. In fact, "rural education during medical training has a significantly stronger influence on physicians raised in urban areas than on physicians raised in rural areas" (Chan et al., 2005, p. 1251). Therefore, two-thirds of new rural physicians are from urban backgrounds which positively influence rural physician numbers. Studies to include urban students who decide to practice in rural areas are important, as most rural physicians actually come

from cities and were greatly influenced by their rural clinical experiences (Chan et al., 2005).

Tolhurst et al. (2006) looked at experiences influencing exclusively urban background medical students' interest in rural practice. This study found that rural experiences, which include quality role model preceptors, influenced them to consider rural practice. Urban students were exposed to a variety of rural communities in relation to size and remoteness in an effort to help students find towns that matched their values and interests. Levels of altruism, interest in generalist work, and interest in certain leisure activities also influenced urban students to consider rural locations for practice. Existing relationships with significant others were an enabling or limiting factor in the students' ability to follow through with their rural interests as is the case with rural students. Colwill (2007) reports that of the 423 RPAP metropolitan background graduates, 163 (38%) are currently rural physicians. These outcomes are only slightly less than the 40% of RPAP rural background students practicing in rural communities (Colwill, 2007).

Overall, rural training and exposure for all students is most influential when students consider their experience to be high quality, they have the opportunity for hands-on training, they enjoy the relationships with their preceptors, their preceptor possesses good interpersonal and teaching skills, and they find meaning in the experience (Kerr, Neary, & Hartwick, 2006; Pathman, 1996).

> Scientific studies available to health educators and policymakers show that there are predictable factors that influence recruitment and retention in rural areas. Policies for staffing rural areas with primary care physicians should be aimed at both selecting the right students, and giving them, during their formal training, the

curriculum and the experiences that are needed to succeed in primary care in rural settings (DHSS, 2005, p. 17).

Personal and Professional Factors

Several factors beyond rural clinical rotations have been found to influence specialty choice and practice location. According to several studies (Geyman et al., 2000; Laven & Wilkinson, 2003), other predictive factors include gender (e.g., more males than females practice in rural America), spouse or significant other preference of practice location, size of practice community in comparison to size of hometown, referrals from faculty, practice partners, hospital services offered, proximity of residency training sites to practice location, and service orientation of students (e.g., volunteer activities, Peace Corps service, social need content). Students committed to community service and social justice issues matriculate with these interests and aspirations, which can then be fostered by faculty role models in practice. Rewarding professional growth opportunities, opportunities for continuing medical education, and contact with other physicians are variables that also influence place of practice (Jones et al., 2000; Rourke, 2008). Tolhurst et al. (2006) report specifically that urban students who were open to living in environments different from where they grew up, who reported high levels of altruism, had interest in primary care, and enjoyed outdoor leisure activities considered rural locations for practice.

A physician survey was conducted recently in an attempt to better understand perceptions of practicing in a rural area versus practicing in areas with a population of 50,000 or more (Cole, 2008). Rural physicians indicated they believed they had access to the same equipment and technology as their urban counterparts. They also believed their

profitability was the same or better in addition to having closer relationships to their patients as their practices were less volume-based. Lifestyle preferences were also important in choosing practice location such as little traffic and pollution, familiarity with the community, and having solitude and space. When physicians who had never practiced in rural areas were asked why, only 4% said they did not want to. Twenty-six percent said they had never found the right rural opportunity, while 23% indicated they had never been offered a rural position and 19% had simply never considered rural practice. This indicates physicians from backgrounds other than rural are open to rural medical practices, but may need to be approached before they will consider it. The survey indicated the community as a whole needs to take part in drawing potential physicians. Community development and good schools, in addition to recreational and cultural activities, all help to make rural areas more attractive (Cole, 2008).

Institutional Factors

An institution's commitment to rural health, in addition to rural medicine, programs, and policies, is associated with an increase in rural physician output (Wheat et al., 2005). Geyman et al. (2000) found four medical school factors strongly associated with students selecting rural practice sites: the medical school is located in a rural state, the medical school is publicly owned, has a focus on family practice, and receives lesser amounts of research funding from the National Institutes of Health. However, according to another study, these medical school factors did not influence retention in rural areas (Pathman et al., 1999). Finally, having faculty who support rural programming, staff who are placed in rural areas in support of students and their rotations, and a bridging program

between pipeline components to aid students with transitions are also associated with eventual practice choice (Wheat et al., 2005).

Rural Acculturation

Good rural clinical experiences and learning opportunities are not enough to influence students' career decisions. Students should also have time and opportunity to acculturate into the rural lifestyle to be influenced to practice in a rural area (Denz-Penhey et al., 2005). Students must not only understand the medical community, but develop an emotional attachment to rural living through connections with local people and community. Students must be exposed to the differing cultures within a community and the values, expectations, and mores each culture possesses as necessary to provide quality, holistic care. The experience must help students determine whether or not practicing in a rural area will make them professionally and personally happy. Experiences allow students to socially construct their ideas about being a rural physician. Locations must match their interests and needs; students must "have some sense of personal fit" (Tolhurst et al., 2006, n.p.) to believe they can not only practice comfortably, but live comfortably as well.

Experiences During Residency

Many family residency programs work to influence graduates to choose a rural practice. The success of and interest in rural clinical training residency programs is dependent upon the success of prior pipeline programs during medical school (Rabinowitz & Paynter, 2000). The medical school programs provide the students for rural residency programs. Family residency programs must design their programs with an understanding of students' previous experiences. Family residency programs most likely

to graduate rural physicians follow the lead of medical schools and offer more required rural rotations, have a rural mission, are located in a rural state, have a medical director with rural experience, and have fewer minority and women residents as these populations are less likely to practice primary care in a rural area (Bowman & Penrod, 1998).

With increasing specialization in medicine and the economic advantages of specialty medicine, it is important for residencies to remain diligent in their efforts to encourage primary care, especially in rural areas, to further continued success. One strategy to accomplish this is to locate residencies in rural areas to promote rural practice and retention. Elements of successful programs can serve as a model for other residency programs to increase the number of students entering rural primary care practice. Best practices include hands-on rural training rotations previously discussed; clinical topics pertinent to rural areas such as emergency care, mental health, and geriatrics; practice management to include such topics as time management, curriculum that emphasizes issues specific to rural areas; government funding; and Community-Oriented Primary Care (COPC), which provides experiences that foster local leadership roles in public health, community development, and political action (Stearns & Stearns, 2000).

Family physicians report they were inadequately prepared to conduct community assessments regarding health and resources (Stearns & Stearns, 2000). Residency programs would therefore benefit from curriculum improvements that address topic areas including rural health policy, rural hospital issues, adaptation techniques for integrating into rural life, outlining best practices regarding preparation for community roles and working in interdisciplinary teams (Stearns & Stearns, 2000). Engaging and mobilizing community stakeholders in health improvement and collaboration in health intervention

efforts are also necessary components to prepare physicians for developing their own COPC skills.

Community-Oriented Primary Care offers physicians with the framework necessary to help them integrate through interaction with their community. Integration is the key to retention and the sense of security, freedom, and identity necessary for physicians to become socially responsive and effective as health care providers (Cutchin, 1997b; Stearns & Stearns, 2000). "Physicians who know how to collaborate with community members on health improvement projects have skills that can also facilitate integration and, hence, retention" (Stearns & Stearns, 2000, p. 273).

The outcomes of several programs have been highly successful in placing primary care physicians in rural shortage areas. It is not known if actual numbers of rural physicians have increased because retirement and retention rates effect supply and these attrition rates are unknown (Rabinowitz, Diamond, Markham, & Hazelwood, 1999). It is also unknown if the programs will continue to be successful with the ever-changing health care system.

Summary of Experiences Primarily During Medical School and Residency

The overall impact of pipeline programs, factors, or experiences is not realized if physicians are not retained in the rural areas. In fact, for rural primary care physicians, 7 years is the median duration of time they practice in the same area (Rabinowitz et al., 2005; Rabinowitz et al., 2008). It is necessary to extend the rural retention of physicians to both increase the rural physician workforce and improve health outcomes for residents in these areas. Having one rural physician practicing for 35 years in one community is equivalent to having 5 rural physicians each for seven years (AAFP, 2002). Rural

communities can influence retention and health outcomes using strategies to enhance community structure, social relationships, and individual behavior by promoting pluralism and collective efficacy (Glasgow et al., 2004). Educators, policymakers, and rural communities have and continue to face the challenge of determining the most effective and efficient ways to increase the numbers of physicians practicing and remaining in rural areas (Rabinowitz et al., 2001). Medical schools continue to strive to apply Flexner's "uniformly arduous and expensive" brand of medical education and "attempt to balance academic ideals with economic and social responsibilities" (Beck, 2004, p. 2140).

Factors Influencing Retention

Medical School and Residency Factors

As mentioned, how long physicians remain in rural practice is related to the impact of medical school and residency programs, factors, or experiences. Two residency factors correlating with retention are participation in rural rotations and an emphasis on underserved areas of health care. The most influential factor for retention is feeling prepared for rural careers (Pathman et al., 1999). "Physicians' sense of preparedness for small-town living predicted their retention duration" (p. 810). Brooks et al. (2002) also suggested "the presence and duration of rural rotations appear to be the best predictors of retention in rural areas, a finding that is likely due to student's being better prepared for what awaits them in rural practice" (p. 797). Being prepared for the workload, on-call hours, and possible burn out keep physicians from thoughts of leaving rural areas as these factors are associated with rural practice (Eley et al., 2007). Feeling prepared for living in a small town is actually more important to retention than feeling prepared for practicing

rural medicine (Pathman et al., 1999). Rotations of three months or longer during medical school contributed to practice preparedness, but not to retention or being prepared for small-town living (Pathman et al., 1999). This suggests residents are more receptive to the overall experience and lessons learned during rural rotations as compared with medical students. These lessons include understanding rural communities, rural patients, and the joys and challenges of rural practice. Being prepared also includes having the social skills necessary to succeed in a rural area (Summerlin, Landis, & Olson, 1993). For example, rural physicians are often expected to take community leadership roles and to represent the community in public forums while also encountering patients in social settings. Long-term rural physicians must possess this set of social skills to be truly prepared and comfortable. Finally, learning rural-specific topics to include obstetrics and gynecology, trauma and emergency care, critical care, community-oriented care, and other skills provided by specialists in urban areas help rural physicians to be prepared. The more well-rounded education can promote a level of comfort necessary for the challenges physicians face in rural medicine (NRHA, 2006).

Personal and Professional Factors Related to Leaving or Staying

Many studies have been helpful in determining factors that influence a physician's desire to practice in a rural area and reasons that make it difficult to stay. Local factors such as professional support, a lifestyle that balances work and family, and competitive salary influence retention once a physician settles in a rural area, especially if the physician has a family. Social support, involvement in the community, community appeal, loan forgiveness, quality education for children, and employment opportunities for the physician and spouse are all factors that impact physician location and retention

(e.g., Backer, McIlvain, Paulman, & Ramaekers, 2006; Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007; Hart et al., 2002; Hays, Wynd, Veitch, & Crossland, 2003; Mayo & Matthews, n.d.). One study indicated that several physicians had considered leaving their rural practice because of long work hours and having to send their children away to school because of the lack of quality education offered locally (Hays et al., 2003). Other reasons for physician dissatisfaction in rural areas include lower incomes, underinsured patients, and distance from a referral center (Cutchin, 1997b). Some physicians find it difficult to maintain privacy and integrate into the community as an ordinary citizen (Farmer et al., 2003). "Isolated populations can tend to engender feelings that the doctor is 'owned' by the community" (Farmer et al., 2003, p. 678). Because of the lack of professional support in some rural areas, rural physicians believe they must be self-directed and seek out extra training and skills as necessary to work independently (Backer et al., 2006; Hays et al., 2003). In addition, lack of opportunity for continuing medical education and lower reimbursement rates also impact the longevity of physicians in rural practices. Support for retaining physicians should include policies that increase reimbursements and professional education opportunities and decrease workloads. The satisfaction of a physician's family is also ultimately very influential in the decision to locate, stay, or leave a rural community (Backer et al., 2006; Hays et al., 2003).

Reasons stated for staying include having a strong attachment, commitment, and loyalty to the community and patients, practice arrangements that allow for time off or a good professional support system, satisfaction gained from professional challenges while being able to be self-reliant and confident to meet the challenges, holistic care, availability of continuing medical education, access to quality education for families, and

knowing that providing health care services is essential and appreciated by the community (e.g., Backer et al., 2006; Cutchin, 1997b; Farmer et al., 2003; NRHA, 2006). Rural physicians report a desire to stay away from medical/community politics, business management, and external interference with their ability and desire to work autonomously. In fact, physicians who own their practice remain longer in rural areas (Pathman et al., 2004). It is theorized that buying a practice is a greater commitment to the community and, therefore, influences the physician to stay. A broad scope of practice, a wide variety of procedures, and clinical independence were all important parts of rural practices. Rural living was believed to be safer and offered more outdoor activities which the physicians enjoyed. Clean air and beautiful scenery were also reasons to stay (Farmer et al., 2003). Research concluded retention strategies should focus strongly on integrating physicians into the community, as satisfaction with the current setting, both professional and personal, is a deciding factor of whether to leave or to stay (Cutchin, 1997b; Hays et al., 2003) and recommended students and residents who consider rural practice to use these findings regarding personal and professional traits to examine their rural compatibility (Backer et al., 2006).

Integration and Retention

A study completed by Cutchin (1997b) indicated physician retention is the result of the integration process into a community. Cutchin posits a theoretical perspective that defines retention as "the ongoing manifestation of an underlying process of place integration" or the "activity of becoming a part of place" (p. 25). In this study, integration involved three domains: physician self, the medical community, and the community-at-large. Retention results when these three domains foster physician integration through the

development and enhancement of security, freedom, and identity in place. Cutchin calls this perspective of retention *experiential place integration,* which "creates focus on the connection and interaction between physicians and their local settings" (p. 27). Through on-going interaction with place and their status and role in the rural community (Farmer et al., 2003), "physicians become woven into the fabric of place" (Cutchin, 1997b, p. 28). The quality of the interaction and experience in place influences a physician to stay or to leave. Integration is also affected by the culture of the community, its history, economy, and demographics.

Physician self. As mentioned, integration involves the three domains of the physician self, the medical community, and the community-at-large. Cutchin (1997a) defines self as creative and independent, continuously being shaped by values, social groups, community, and rules. Physician self is characterized by historic, social, and emergent dimensions. The historic self consists of a physician's background, previous rural experience, mentors, education, and cultural matrix or beliefs, attitudes, language "and other symbolic significances ingrained over time" (Cutchin, 1997a, p. 1665). The social self consists of group affiliations, roles, family, institutional membership, and present cultural matrix of the physician as this matrix changes with time and socialization. The emergent self consists of values, aspirations, strength of identity, and creativity. The dimensions that define physicians ultimately influence their retention in rural practice. For example, if a physician grew up in poverty in a rural area, a draw to serve in a similar area may be present or if a physician had a role model or a mentor, the relationship may have influenced the physician as a child to do well in school which ultimately led to a medical degree.

Medical community. The medical community includes institutions and physicians. The institution dimension is defined by whether or not a community has a hospital, local practice structures, the size and power of institutions, the role of other extra-local institutions or institutions that have affiliations or are controlled from outside of the community, and the historical development of the medical community. The physician dimension is defined by demographics; medical ideologies; levels of cooperation, communication, and interaction; number of physicians; and types of innovations. The medical community's role and relationship with the physician and community-at-large plays an important role in a physician's retention. For example, retention will be compromised if a medical community is fractured by differing physician demographics, which result in opposing ideologies and competition as opposed to a collaborative culture.

Community-at-large. Community provides a framework of shared interests and commitments accomplished through social interaction. The community-at-large is defined by its social, economic, and political capital in addition to its historical development and geographic coherence. The social capital may include extra-local ties in addition to the sociocultural milieu (community activities, religious support), social networks, and class divisions. Better health translates to higher levels of social capital (Flora et al., 2004). Farmer et al. (2003) proposes that the social capital, as influenced by physicians, may contribute to benefits to the community beyond health outcomes. Physicians have the potential for high levels of interaction within and outside the local community that contribute to building social capital. Social capital can strongly contribute to community viability and the strong social infrastructure which leads to

community wellbeing. The existence of dense social networks is also said to build social capital, a concept currently popular among policymakers and social scientists in helping to explain communities' ability to adapt to change. Shared knowledge, history, and vision for the future enhance social relationships. Physicians "working and residing locally, make a valuable contribution to the social structure of remote communities, in addition to health care, social care, and economic contributions" (Farmer et al., 2003, p. 683).

The economics of a community-at-large are determined by development of available resources. Rural communities and their viability are affected by the economic development in the area (Glasgow et al., 2004). Communities must promote economic development by attracting quality jobs which will in turn attract quality health care.

The political institutions, leadership, level of citizen involvement, and vision define political capital. Decision makers set the agenda for and distribution of resources in the community. Knowledgeable, motivated leadership in local communities have influence in retaining physicians and their families based on the decisions they make (NRHA, 2006). These decisions directly affect the quality of life for citizens and influence the financial stability of the community (Flora et al., 2004; Duncan, 1999). For example, larger health care facilities locating in areas adjacent to rural communities may cause financial hardships for smaller rural hospitals or clinics. In health care, it is important to allocate resources to equipment and technology not only to stay competitive and profitable regarding procedures but to address issues of isolation for physicians (Flora et al., 2004). For example, if communities address professional isolation issues by purchasing telemedicine equipment, local physicians can consult with specialists while keeping health care revenue local. Rural communities need to build a population health

focus regarding the health care sector when making decisions (IOM, 2004). The historical situation, how the community framework developed, and the geographic coherence of a community are factors necessary to consider when changes in structure occur.

Experiential place integration. The place integration process described above is characterized by three primary integrative principles: security, freedom, and identity and their 27 component dimensions (Table 1) (Cutchin, 1997b) that form the basis of physician retention. These principles look at problems that may influence physicians to leave rural areas, but also at solutions physicians realize through action and integration into a community. The principles describe what physicians face, but physician experiences vary based on the place-physician context. Ensuring that a physician has satisfaction in these three principal areas will increase a physician's integration in their rural community and ultimately influence retention.

Cutchin (1997b) defines security as "the level of safety, stability, and confidence achievable in a situation" (p. 34). Freedom is defined as "the degree to which we can act upon desire, deliberation, and choice to refine and expand present activity toward an end-in-view" (Cutchin, 1997b, p. 35). Identity is defined as "the coherence of a self in its relation to another person, social group, community or environment. Strength of identity requires a certain level of security and freedom in place" (Cutchin, 1997b, p. 37). These three principles and the configuration of dimensions are individual for each physician. The meaning of experience and action in place that influence retention are dependent on a physician's satisfaction as it relates to each dimension. Therefore, each physician's integration path differs.

Table 1

Dimensions of Security, Freedom, and Identity

Dimensions of security

- Confidence in medical abilities
- Commitment to aspirations and goals
- Ability to meet family needs (spouse's happiness, education)
- Comfort with medical community and institutions
- Degree of on-call coverage
- Practice group environment and the anchorperson
- Community and medical institution development
- Social and cultural networks available
- Respect of medical community and community at-large

Dimensions of freedom

- Challenge and diversity in medical work
- Ability to consult more with patients
- Cooperation within the medical community and community-at-large
- Respect of the medical community and community-at-large
- Power in medical relations
- Ability to develop health care resources
- Diversity in social interaction possibilities
- Involvement in community affairs
- Personal and family activities
- Developed perspective on self and place

Dimensions of identity

- Loss of anonymity
- The "like-minded" practice group
- Roles played and responsibilities taken
- Respect of medical community and community-at-large
- Fulfilling aspirations in place
- Seeing the self as belonging to the community
- Awareness of self in time and place
- Creation of future goals in place

N.B., From "Physician retention in rural communities: The perspective of experiential place integration" by M. P. Cutchin, 1997, *Health & Place 3*(1), p. 32. Copyright 1997 by Elsevier Limited. Reprinted with permission.

Social capital, core participation, and community reconstruction. Cutchin's study (1997a) went one step further to describe social capital, core participation, and community reconstruction as three concepts that further explain the connections between self and community and ultimately integration into a community practice. On one hand, physicians can add to and utilize social capital. As physicians enter social networks, mutually beneficial relationships evolve involving trust, obligation, and expectations. The amount of social capital that develops depends on the quality and quantity of interactions (Farmer et al., 2003). Integration and retention become more embedded both in the physician and in the community as social capital strengthens. Physicians can then use their knowledge of the community and patients to proactively maintain and protect the health of its citizens. The physician is able to gain insight into problems that may evolve within the community (Farmer et al., 2003). Rural doctors, who make the commitment to become integrated and embedded into the community, find that it is more difficult to leave (Cutchin, 1997b).

Communities, on the other hand, can accept the physician into the local culture and community also increasing social capital and the possibility of retention. Interactive social capital mutually benefits both the physician and the citizens of the community (Flora et al., 2004). Core participation into the community, for example, being a member of the school board or a non-profit organization, develops moral commitment to the community for the physician and identifies the physician as an entity within the community. This participation facilitates integration. As changes in political, social, or economic capital occur, causing problems for physicians or their practice, retention can be maintained through community responsibility, cooperation, an effective community

power structure, and collective action. When communities are in need of reconstruction, decisions will be made that benefit the physician, the medical community, and the community-at-large. Pluralism, collective efficacy, and positive community structures, in addition to innovative health care, can lead to physician retention and inevitably positive health outcomes (Cutchin, 1997a; Glasgow et al., 2004).

Cutchin's study (1997b) found that the longer a physician is in practice in place, the more integration dimensions the physician experiences. He indicated some of the dimensions become less important as time passes and physicians settle into a community. The primary outcome of the study indicated retention must be studied as a social process that leads to place integration. Transactions, interactions, and self-actions need to be addressed when looking at issues of retention which historically has not been done. Implications for future research must also address other place components such as cultural, political, economic, ethnic, class, and gender. Cutchin concluded integration is the connection between recruitment and retention and that integration necessitates adjustment and change as problems arise in the transactions of place (1997b). The decision to stay in a rural community involves "a dynamic equilibrium of positive and negative factors, and issues such as overwork and poor adaptation to role changes easily upset this equilibrium" (Veitch & Crossland., 2002, p. 2). Veitch and Crossland interviewed 17 physicians who left rural practice. Their study showed that the low presence of security issues or the loss of security issues was a strong influence on physicians to leave. By contrast, physicians who reported the highest number of dimensions (Table 1) left due to *pulling factors* (advantages of urban medicine) rather than factors related to place.

> Community coalitions representing all aspects of the community are the focal point for assessment, planning, and resource allocation. The ability of a community to understand and effectively communicate the economic, social, and health benefits of an effective and efficient health care delivery system is essential to a system of care capable of recruiting and retaining physicians (DHSS, 2005, p. 19).

The more medical schools, medical communities, and communities-at-large can integrate students, residents, and physicians into the rural area the better they will understand rural health needs, the culture of the community, its resources, and beliefs. The more effective acculturation and integration are the better prepared the physician will be for practice and for becoming an integral part of the community. Ultimately, their job satisfaction and retention will be improved while the community enjoys quality health care.

Rationale of Focus and Questions

There are little consistent data regarding which programs, factors, or experiences are most responsible for success regarding physicians' specialty choice or place of practice (Rabinowitz et al., 2001). Research points to several programs, factors, and experiences, but the decision is complex. The most consistent findings are that a rural background and stated career plans to practice rural primary care at the time of medical schools admission are most predictive. Rural rotations, both during medical school and more so during residency, also influence location and retention decisions. It is unknown whether those already planning to enter rural practice choose to participate in rural clinical rotations or whether the rotations increase the likelihood of rural practice (Brooks et al., 2002; Dunbabin & Levitt, 2003).

My qualitative study looked at rural physicians, both from urban and rural backgrounds, who have and have not participated in rural rotations, to describe the

experiences that influenced them to choose and remain in rural practice. This allowed me to look more closely at the nature-versus-nurture question (Pathman, 1996) to help educators better understand physicians' choices. In addition, most medical program studies to date focus exclusively on family physicians entering rural practice as most in the rural workforce are family physicians. My study looked at physicians beyond family medicine in an effort to determine factors or experiences that influenced their choices. This knowledge increased the literature base in areas outside of family medicine.

Finally, there was much to learn about physician-community interaction to enhance integration and retention. "Additional research is necessary looking into the domains and social relations that shape the integration experience for physicians and suggest interventions that will make a difference to the physician self and rural community" (Cutchin, 1997a, p. 1672). My study contributes to this body of scholarship.

Summary

Twenty-two million people live in underserved rural communities. Significant progress has been made addressing the physician shortages existing in rural areas. Successful solutions to shortage issues must be addressed through multifaceted approaches (Hart et al., 2002). Medical schools and policy makers have worked hard to find effective strategies to admit, train, and place physicians in rural areas of need. Throughout the long educational pipeline, many students take advantage of the clinical training, instruction, and experiences provided to help them become familiar with and prepared for rural realities relating to both their personal and professional lives. Ultimately, the students who become and continue as rural physicians understand the

needs of rural communities while communities that are successful retaining these physicians understand the physicians' needs as well.

In Chapter 3, a definition of phenomenology and a brief explanation of its assumptions including epoche, intentionality, intuition, and intersubjectivity is provided. A definition for transcendental phenomenology is given along with reasons this method is best suited for this study. I describe the methods of preparation along with data collection. Moustakas's method of analysis is explained including horizonalization, transcendental phenomenological reduction, imaginative variation, and the synthesis of meanings and essences. I include the methods and procedures I followed to ensure dependability and trustworthiness. Finally, the chapter concludes with the description of ethical principles followed throughout the planning and implementation of the study.

Chapter 3

RESEARCH METHODS

Introduction

Nationally a physician shortage does not yet exist; however, a maldistribution of physicians does. Long-standing shortages of health professionals in rural areas are common. While 20% of the population of the United States resides in rural areas, less than 9% of physicians practice in rural communities (Gazewood et al., 2006). Regarding health care, the rural population is one of the largest physician underserved populations in the U. S. To alleviate inadequate access to quality health care, it is necessary to inform policy makers, medical schools, and communities about experiences that influence physician choice to live and practice in rural areas.

I used the framework of symbolic interactionism to study what experiences, and in what situations and contexts the experiences took place, that influenced physicians to make career decisions to practice and stay in rural locations. Experiences and interactions prior to, during, and after medical school were all important as individuals continuously create meaning through interaction with others (Bogdan & Biklen, 2007; Charon, 2007). The framework of experiential place integration was also used to explore retention through the connection and interaction between physicians and their communities (Cutchin, 1997b). Thus, the purpose of this transcendental phenomenological study was to describe the composite meaning or essence of experiences that lead physicians to live and work in rural areas.

Chapter 3 begins with a definition of phenomenology and a discussion regarding its philosophical tenets or presuppositions. This study was grounded more specifically in

transcendental phenomenology, which is also defined below. The methodology involves core processes in the derivation of knowledge. These processes are explained as they relate to the design and implementation of this study. I then describe the processes I used to choose a topic, select participants, develop questions, and collect and analyze data. Next, I illustrate the steps taken to ensure the trustworthiness of the methods, analysis, and outcomes. Finally, I reveal the ethical principles followed throughout the planning and implementation of the study.

Research Design

Phenomenology

The method of phenomenology involves interaction with participants as necessary to find the meaning of a phenomenon (Mohamed-Patel, 2002). Phenomenology is the study of human experience which helps describe the way things present to us in and through experiences (Sokolowski, 2000). "Phenomenon means to bring to light, to place in brightness, to show itself…" (Moustakas, 1994, p. 26). The intent of phenomenology "…is to reduce individual experiences with a phenomenon to a description of the universal essence" (Creswell, 2007, p. 58). The universal, or composite description, consists of textural and structural experiences. Textural experiences describe what the participants experienced, while structural experiences describe how the participants experienced the phenomenon. The outcome of a phenomenological study is to better understand what it is like to experience the phenomenon being studied. In other words, "…meaning is created, and knowledge is extended" through the description of shared or common experiences (Moustakas, 1994, p. 27) A phenomenology gathers rich

description from several individuals who have experienced a phenomenon as necessary to gain deep understanding of the phenomenon (Creswell, 2007).

Phenomenological Presuppositions

Phenomenology emphasizes four presuppositions or philosophical perspectives including epoche, intentionality, intuition, and intersubjectivity. These presuppositions lay the framework for phenomenology: the study of lived, conscious experiences through which the essence of a phenomenon can be described as opposed to analyzed or explained (Creswell, 2007; Moustakas, 1994; Sokolowski, 2000). Ultimately, phenomenology is grounded in the assumption that "…reality is subjective and multiple, as seen by participants in the study" (Creswell, 2007, p. 17). I briefly describe each of the presuppositions and their processes as necessary to illustrate the guiding framework of obtaining and analyzing data.

Epoche. Epoche means "…to refrain from judgment" (Moustakas, 1994, p. 33). Epoche is the disciplined and systematic process of suspending all judgments regarding the phenomenon being studied in an effort to cultivate curiosity. The hope is to conduct the study free of preconceptions, beliefs, or knowledge of the phenomenon due to similar experience or previous studies. The epoche process leaves the researcher open and receptive to the experiences the participants share so the phenomenon is viewed in a pure sense. (Creswell, 2007; Moustakas, 1994; Sokolowski, 2000). Epoche "…inspires one to examine biases and enhances one's openness even if a perfect or pure state is not achieved" (Moustakas, 1994, p. 61). The epoche process is the first step in the derivation of new knowledge.

Intentionality. Intention signifies consciousness of experience (Moustakas, 1994). Intentionality is the process of back and forth reflection on experiences as necessary to make meaning. This process helps us arrive at self-evident essences of meaning (Moustakas, 1994). Through the direct and deliberate examination of one's conscious experiences, meaning and understanding occur. Ultimately, one arrives at a comprehensive understanding that leads to conscious decisions, ideas, and judgments. Intentionality, or the freedom to choose, illustrates the decision to direct one's life (Mohamed-Patel, 2002). In this study, participants utilized intentionality as a longitudinal process to reach decisions about aspects of their career of choice while the primary researcher used intentionality as a way to increase trustworthiness in data collection and analysis.

Intuition. Intuition is the process in which "all things become clear and evident through an intuitive-reflective process, through a transformation of what is seen; first intuitively in the common appearance…then in the fullness and clarity of an intuitive-reflective process" (Moustakas, 1994, p. 32). Intuition brings something to presence (Sokolowski, 2000). It is cumulative and additive until fulfillment is reached. This process, like intentionality, was utilized by the participants in determining conscious direction and by the researcher in adding credibility to analysis.

Intersubjectivity. Intersubjectivity is the process of understanding others' experiences through one's own experiences. The process involves a community of persons experiencing and knowing each other through empathy and copresence (Moustakas, 1994). "There is an interchange of perceptions, feelings, ideas, and judgments regarding the nature of reality" (p. 57). Through social conversation and

dialogue, reciprocal correcting (ensuring understanding through verbal exchange) occurs in an effort to better understand each other culminating in truth regarding the phenomena of interpersonal knowledge and experience (Moustakas, 1994).

Presuppositions and conceptual framework. Intentionality, intuition, and intersubjectivity are all processes in which one makes meaning from interactive experiences with others and reflection upon those experiences. These processes work into the framework of symbolic interactionism, which suggests that people construct their social worlds actively and creatively through interaction with others (Charon, 2007; LaRossa & Reitzes, 1993). Self-concepts and social structures are built upon through interactions that ultimately influence choices that make life meaningful (Bogdan & Biklen, 2007). Experiential place integration also relates to the presuppositions in that interaction with place provides meaning and connection that influence the conscious decision making process (Cutchin, 1997b).

Transcendental Phenomenology and Rationale for Use

"Transcendental phenomenology emphasizes subjectivity and discovery of the essences of experience and provides a systematic and disciplined methodology for derivation of knowledge" (Moustakas, 1994, p. 45). The method utilizes data only available to consciousness (phenomenology) and "…adheres to what can be discovered through reflection on subjective acts (transcendental)" (Moustakas, 1994, p. 45). Transcendental phenomenology seeks to discover meanings "…through a state of pure subjectivity, while retaining the values of thinking and reflecting" (Moustakas, 1994, p. 49).

A detailed protocol of methods and procedures is followed in transcendental phenomenological studies. This protocol assists in establishing an organized, disciplined study that results in creating new knowledge (Moustakas, 1994). I used a transcendental phenomenological approach to gather participants' common or shared experiences in order to derive a deep understanding of the phenomenon (Moustakas, 1994). Specifically the phenomena I studied were the experiences of becoming a rural physician and those that influenced physicians to choose rural practice. Transcendental phenomenology was best suited for this study because the intent was to understand the common or shared experiences of participants that influenced them to live, work, and continue to work in a rural community. This type of phenomenology focuses heavily on the participants' description of their experiences. Sometimes it also includes the experiences of the researcher to further describe experiences. However, because I am not a rural physician, I relied on the description of physicians' experiences to create an accurate central meaning or essence of the phenomenon (Creswell, 2007).

Methods of Preparation

Formulating the Question and Topic

In a phenomenological study, the research and topic questions must have both a personal significance for the researcher and social meaning (Moustakas, 1994). Much of my career has focused on health disparities of at-risk or disadvantaged people. Because of my work experiences, I have knowledge of the prevalence of health disparities and how they negatively influence the social, political, and economic capital of the area. I also have knowledge of how a physician practicing in a rural community can positively influence both the economy and health of a rural community. The programs I currently

direct work toward the goal of placing physicians in rural areas that experience access issues to quality health care. I am passionate about disclosing more fully the essences and meaning of experiences leading physicians to live and work in rural areas. I felt challenged and obligated to address this societal and relevant need. My questions were designed in an effort to generate dialogue about the phenomenon. I sought comprehensive experiences from participants through dialogue regarding what and how the experiences the participants described influenced their life and career choices. The questions were developed in an effort to understand the shared lived experiences of individuals, to explore what those experiences mean for rural physicians, and how they influenced life and career choices.

Participant Selection

Each participant in phenomenological research is recognized as "…a truthful seeker of knowledge and understanding with regard to the phenomenon" (Moustakas, 1994, p. 108). I used criterion sampling (Creswell, 2007) to choose my participants. This sampling technique worked well, as those being studied all experienced the same phenomenon. Therefore, those interviewed were physicians practicing in rural Missouri areas of 18,000 people or less. All participants were University of Missouri (MU) School of Medicine alumni and alumnae from the graduating classes of 1997-2004. This timeframe was selected because it coincided with the years of the Rural Track Pipeline Program. This program is a longitudinal curricular and training program offered to pre-medical and medical students to expose them to rural experiences. The intent of the program is to influence practice location in rural communities.

The total number of potential participants was 31. I initially sent 25 interview requests based on physician proximity to maximize time and resource allocation. After receiving 10 responses, I was purposive in following up with potential participants, in order to invite participants whose backgrounds allowed me to have the richest sample possible. Fifteen physicians ultimately participated in my study. I included males and females, physicians who had and had not participated in rural programming, urban and rural background physicians, and specialists and primary care physicians. Four participants were known to me through my position as program director with the University of Missouri School of Medicine Rural Track Pipeline Program. Four other physicians, with whom I was not acquainted, for a total of eight, had participated in the rural programming, while seven participants had not. Three of the participants were from non-rural backgrounds (communities of more than 73,000 people) in hopes of gaining additional perspectives on experiences influencing rural practice beyond rural background. The remaining 12 participants were from communities of 18,000 people or less. Potential participants whose names were not known to me were obtained from the University of Missouri School of Medicine Alumni Department. Two physicians were specialists, one obstetrician and one dermatologist. The 13 remaining physicians were primary care doctors. Five participants were male while 10 were female. See Table 2 for demographic detail.

Table 2

Physician Participant Demographics

PRACTICE LOCATION	PRACTICE LOCATIONS ARE COMMUNITIES OF <18,000 PEOPLE														
GENDER (M/F)	M	M	F	M	F	F	F	F	F	F	M	M	F	F	F
PRACTICE TYPE	FP	FP	FP	FP	FP	FP	FP	FP/OB	FP/OB	FP/OB	IM	IM	PEDS	OB	DERM
YRS AT CURRENT LOCTION	2.0	2.5	<1	2.5	8.5	4.5	7.0	2.0	2.0	7.0	7.5	2.0	4.0	5.0	2.5
AGE	34	40	32	34	37	35	38	31	30	38	36	30	34	35	33
MARRIED/ SINGLE	M	M	M	M	M	M	M	S	M	M	M	S	M	M	M
SPOUSE EMPLOYED	Y/ PT	N	N	Y	Y	N	Y	N/A	Y	N	N	N/A	N	Y	Y
# CHILDREN	2	7	3	2	1	1	2	0	1	2	3	N/A	2	0	1
HOMETOWN POPULATION	2,866,517	N/A	958	13,699	73,912	1,985,429	8,752	1,283	1,992	3,729	10,978	16,651	10,892	17,043	997
UNDERGRAD UNIVERSITY (STATE)	MO	UK	MO	MO	MO	MO	MO	MO	MO	MO	MO	MO	MO	MO	MO
UNDERGRAD UNIVERSITY POPULATION (CITY)	16,988	108,863	84,531	49,100	84,531	16,367	84,531	17,139	150,928	10,892	84,531	37,156	84,531	150,298	84,531
RESIDENCY (STATE)	FL	MO	MO	IL	MO	MO	MO	MO	MO	MO	IA	MO	TX	AR	GA/ OH
RESIDENCY POPULATION (CITY)	54,055	84,531	150,298	22,162	82,820	1,985,429	84,531	150,298	150,928	150,928	546,599	84,531	1,598,161	184,422	429,500
PREVIOUS PRACTICE POPULATION (CITY)	1,100	N/A	8,318	376,427	N/A	1,985,429	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
YRS IN PREVIOUS PRACTICE	3.5	N/A	3.5	3.0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

It was necessary that the participants were interested in contributing to the nature and understanding of what it means to be a rural physician. These physicians were able to articulate the lived experiences that led them to rural practice. In addition, these physicians were willing to be interviewed at length and granted me the right to include their experiences in this study and any possible future publications based on this research (Moustakas, 1994).

Potential participants were contacted by phone, email, and/or in writing regarding the nature and purpose of the study. Once participants were identified, I explained the time commitment necessary to participate and how confidentiality would be maintained. I explained their right to withdraw from the study at any time. Follow up letters and written consent forms (Moustakas, 1994) were obtained prior to the interviews being conducted (See Appendix A and B).

Interview Questions

In a phenomenological study, participants are asked general questions as necessary to gather data that lead to textural and structural descriptions of the experiences and ultimately to an understanding of common experiences as they relate to the phenomenon. The broad, general interview questions guiding this study were:

1) How do rural physicians describe experiences that led them to rural practice?
2) How do rural physicians describe experiences that led them to stay in rural areas to practice?

If participants did not disclose or express sufficient meaning or depth of experiences as necessary to provide thick description, follow up probes or topical questions were asked to facilitate more in-depth disclosure of their experiences (See Appendix C). Those

questions were informed by existing research and by the symbolic interationism framework.

Data Collection

Data were collected in two ways: a survey to ascertain demographic data, and individual interviews. Demographic data were collected, prior to the interview, for each physician to include: gender, practice type, years at current location, age, marital status, employment status of spouse, number of children, hometown population, undergraduate university state and university town population, residency location state and residency city population, previous practice location population, and years in previous practice. In-depth, face-to-face interviews were conducted at a quiet location of the physicians' choice. The epoche process, or reflexivity, was followed as necessary for me set aside any preconceived thoughts so I could be open to the experiences of the participants.

An opening statement was read prior to beginning the interview as a standard way to start each interview in an attempt to help participants relax and begin to recall the phenomenon of experiences and meanings they wished to share. I tried to create an atmosphere that was comfortable for the participants so questions could be answered openly, honestly, and comprehensively (Moustakas, 1994). The hope was to establish "…interaction that inspires comprehensive disclosure of experience" (Moustakas, 1994, p. 123). Open-ended questions were asked along with topical-guided questions in the event that participants did not provide sufficient meaning and depth of the experience. The questions were written broadly to facilitate full, rich descriptions of the phenomenon (Moustakas, 1994). Interviews were audio taped using a digital recorder and transcribed verbatim. Follow up interviews were not necessary.

Data Analysis

I utilized Moustakas's (1994) modification of methods of analysis suggested by Stevick, Colaizzi, and Keen. This approach to analysis is highly structured and organized in an effort to develop a common understanding of a phenomenon. Below, the steps of analysis as suggested by this method are described. I followed this protocol with one exception as noted (Creswell, 2007; Moustakas, 1994). In conjunction with the initial epoche process, the first step in the analysis process is to describe my personal experiences with the phenomenon of study. Because I am not a practicing rural physician, I did not contribute a full description of the phenomenon. I did however, describe my relationship to the MU SOM Rural Track Clerkship Program and discussed existing relationships I have with some of the participants. This process helped me set aside my related experiences so I could better focus on the participants' descriptions. I also tried to limit bias and prejudice.

The next steps of analysis were completed for each individual, participant transcript:

1. *Horizonalization* is the process of reviewing each statement in a transcript as it relates to the individual's experience. Horizonalization gives each statement equal value in an attempt to clarify the described experiences thereby increasing the understanding of the nature and meaning of the phenomenon (Moustakas, 1994).
2. *Transcendental phenomenological reduction* is the process of writing a description of the meaning participants have experienced. The following steps are taken to derive a textural description:

a. List all nonrepetitive, nonoverlapping statements. These statements represent the invariant horizons or units of meaning for each participant.
b. Cluster units of meaning into themes.
c. Write a textural description, or what the participant experienced, using verbatim examples from the transcript. Textural descriptions include "…thoughts, feelings, examples, ideas, and situations that portray what comprises an experience" (Moustakas, 1994, p. 47). The intention of transcendental phenomenological reduction is to reach a sense of fulfillment in regards to the description of the meaning individuals' experience.
d. Develop a composite or universal textural description, or the integration of all participants' textural descriptions (Moustakas, 1994).

3. Through the process of ***imaginative variation***, "…a structural description of the essences of the experience is derived, presenting a picture of the conditions that precipitate an experience and connect with it" (Moustakas, 1994, p. 35). The following steps are taken to derive a structural description:
    a. Construct a list of structural qualities of each experience. A structural description of how the experiences occurred is written, for example, where the experiences took place and in what context such as in their hometown or in a physician's clinic.
    b. Cluster structural qualities into a list of themes.
    c. Integrate structural themes into an individual structural description.

d. Craft a composite structural description, or the integration of all participants structural descriptions, as a universal structural description. "The composite structural description is a way of understanding *how* the participants as a group experience *what* they experience" (Moustakas, 1994, p. 142).

4. Finally, synthesize the textural-structural descriptions from all of the participants' experiences and write a composite or universal description of the meanings and essences as analyzed using a symbolic interactionism lens. The essential essence of the experience illustrates an overall reality of the phenomenon (Moustakas, 1994).

Ultimately, the goal of these methods is to provide a rich description of the phenomenon of experiences that led physicians to live and practice in rural communities.

Dependability and Trustworthiness

The methods and procedures utilized during this study were organized, disciplined, and systematic as necessary to ensure the dependability and trustworthiness of the derived knowledge. Measures were taken to obtain accurate, detailed meanings of the phenomenon. I briefly describe the trustworthiness strategies I used to ensure an understanding of this phenomenon. The strategies I chose to ensure quality and understanding included: reflexivity, epoche, researcher triangulation or consensual validation, external audit, and thick description.

I direct the rural clinical training programs and because of my relationship to some of the physicians, I used reflexivity as a tool to think about how my values and experiences influenced the research process. Reflexivity helped me bring awareness to

how my experiences, knowledge, and values relate to the study. This process helped me illustrate how my biography played an active role in initiating and implementing the study. I understand that I am not free of social and cultural influences and that I interpret things from a particular set of perspectives. What I bring to a study also influences what I can see and how I see it (Charmaz, 2006). This reflection and awareness helped me define my biases.

My position gave me access to some of the physicians and knowledge of program and academic jargon; however, this positionality also created biases related to this study. I utilized the epoche process to bracket or set aside my personal assumptions in an effort to reduce the influence of my interpretation of the described experiences. Epoche allowed me to see and hear others' points of view from their words. I was better prepared to use the physicians' descriptions to have an increased understanding of the physicians' experiences, thoughts, and aspirations. These efforts enhanced the credibility strategies of this study.

My relationship with some of the participants has given me the opportunity of prolonged engagement. The comfort level of some of the participants with me was high and, as I knew them fairly well, I was confident of their dedication and interest in the study. My relationship with these physicians and their dedication to rural practice and rural health is reflected in the trustworthiness of this study.

A research team of two people was formed to review the analysis of the data. The research team consisted of me and a fellow qualitative researcher. The research team members have qualitative research experience and were familiar with and have practiced the epoche process. They also have experience analyzing qualitative data. Each research

member followed the data analysis protocol described above. The team met initially to compare, review, and reach consensus regarding invariant statements and then met periodically to review textural themes, structural themes, and finally, the essence of the phenomenon. More comprehensive, accurate views were derived from this team of researchers. Researcher triangulation assures the results of the research are not the interpretation or description of one person (Creswell, 2007; Pan, 2008). Additionally, I utilized an auditor whose expertise is in medical education to peer review the study and provide feedback regarding data collection, findings, and conclusions (Lincoln & Guba, 1985).

Finally, the findings of my study are rich with thick description and quotations from the participants. I describe in detail the universal essence of the phenomenon from the composite textural and structural descriptions of the participants' experiences. The intent is for the reader to be able to determine if the findings can be transferred to other settings including medical schools and residency programs.

Ethical Principles

Ethical principles as outlined for human science research were a guide for this study (Creswell, 2007; Moustakas, 1994). Institutional Review Board approval was obtained through the University of Missouri prior to initiating data collection. Correspondence with participants fully disclosed the nature, purpose, and requirements of the study. Clear agreements that outlined the demographic information I collected, in addition to the disclosure of experiences leading them to a rural medical practice, were completed with the participants. I asked for permission to record the interviews and to use personal information in presenting findings from my study. Strict measures were

taken to protect the confidentiality of each participant by assigning aliases to each of them. Participants were able to withdraw from the study at any time, as consent was negotiable. Participants were given the opportunity to provide input on the process of the interview to ensure their comfort and full disclosure. It was important that each participant understood the value of his or her contribution as it related to the derivation of new knowledge. Finally, the data from the interviews were stored in encrypted files on both a laptop and jump drive. The interviews were immediately erased from the digital recorder. Utilizing these ethical principles throughout the study helped to ensure open and honest self-reports while protecting the confidentiality of the participants.

Summary

This chapter began with a definition of phenomenology and a brief explanation of its assumptions including epoche, intentionality, intuition, and intersubjectivity. I provided a definition for transcendental phenomenology in addition to the reasons this method is best suited for this study. I then described methods of preparation along with data collection. Moustakas's (1994) method of analysis was explained to include horizonalization, transcendental phenomenological reduction, imaginative variation, and the synthesis of meanings and essences. I illustrated methods and procedures followed to ensure dependability and trustworthiness. Finally, I concluded the chapter with the description of ethical principles followed throughout the planning and implementation of the study.

Chapter 4

FINDINGS

Introduction

Physician shortages in rural areas nationwide lead to disadvantage and disparity when looking at factors such as health status, health infrastructure, and economic vitality. Nationally a physician shortage does not yet exist; however, a maldistribution of physicians does. While 20% of the population of the United States resides in rural areas, less than 9% of physicians practice in rural communities (Gazewood, Rollins, & Galaska, 2006). The rural population is one of the largest physician underserved populations in the U. S. (Rabinowitz, Diamond, Markham, & Rabinowitz, 2005). The number of U.S. physicians entering primary care specialties has decreased with only 3% of medical school graduates planning to practice in rural areas and small towns (Rabinowitz, Diamond, Markham, & Wortman, 2008). Using the lenses of symbolic interactionism and experiential place integration to inform my analysis, I sought to learn the experiences of physicians occurring before, during, and after medical school that influenced them to practice and stay in rural areas. More specifically, I wanted to understand the phenomenon of becoming and staying a rural physician. This knowledge could then be used by communities, policy makers, and medical schools to increase the numbers of physicians choosing rural practice, ultimately addressing rural health disparities.

This study reveals the meaning or essence of becoming a rural physician through the description of experiences that influence doctors to practice and live in smaller communities. This qualitative study contributes new knowledge into the depth of experiences that influence physicians' career choices. This chapter begins with a

summary of the themes and subthemes that emerged from the interviews. Findings within each theme are described and presented.

Themes and Subthemes

Using transcendental phenomenological methods, 15 interviews were conducted, transcribed, and analyzed using Moustaka's (1994) modification of methods of analysis suggested by Stevick, Colaizzi, and Keen. The following themes and subthemes emerged through the structured and organized steps of analysis (Table 3).

Table 3

Themes and Subthemes

Theme 1: Background and Personal Characteristics of Rural Physicians
• Rural background, family values and influences, and extracurricular experiences
• Identity as it relates to place
• Rural influences for urban physicians
• Career decisions/path/early experiences regarding medicine
• Spouse background and family gender roles
Theme 2: Clinical Experiences that Influence Specialty Choice and Decision to Practice Rural Medicine
• Rural medical school experiences
• Role models and preceptors
• Academic health center medical school experiences and culture of medical school
• Residency experiences
Theme 3: Experiences Influencing Practice Location
• Family location
• Desire to return to hometown
• Desire to meet a community need
• Practice type and clinical opportunities
• Scholarships or loan forgiveness
• Personal/Professional conflicts
Theme 4: Experiences Influencing Retention

- Community integration – professional, personal/family
- Professional support
- Personal and professional influences to stay
- Personal and professional influences to leave
- Personal and professional challenges in a rural area

Theme 1: Background and Personal Characteristics of Rural Physicians

The background, upbringing, family values, and personal characteristics of the physicians played a vital role in the decision making process to become rural physicians. Personal background and past social interaction helped these physicians not only define themselves, but their values, ideals, and goals. These experiences over time influenced the physicians to practice and live in rural areas.

Rural background, family values and influences, and extracurricular experiences. To gain a better understanding of background and personal characteristics on choice to practice in a rural community, physicians from rural and urban backgrounds were included in the study. Twelve of the physicians were from rural communities while three were from urban areas of over 73,000 people. None of the physicians had a parent who was a physician. In fact, only one physician had a parent in the medical field. Some of the other physicians' parents worked in rural school systems, on a family farm, or in blue collar jobs. Several physicians were first generation college students. The physicians were encouraged growing up to be involved in extracurricular and service activities and they talked favorably about their involvement in these activities. For example, one physician said, "I was one of those do-ers and I was in sports. I was in everything, every activity, so I think family medicine kind of suits that personality a lot." Regarding experiential and family influences to enter medicine one physician said,

> I had never spent any time in a hospital; I had no family influences, medically speaking. My parents were both teachers and the first ones in their family to be college educated. So, it wasn't like I had any of those kinds of influences to even think about medicine.

In this study, even though many physicians were first or second generation college students, most were highly encouraged to attend college. In fact, many stated that attending college was the expectation. Most did not have conscious intentions of going into medicine, but were encouraged by their parents once they had stated an interest. "In college, I thought about becoming a teacher instead of doing medicine, but my mother told me I had to finish medical school, so she really pushed me." The physicians in this study talked specifically about extra curricular school activities and community service. Their involvement in the community was meaningful and had some influence in their later decisions.

> My parents wanted me to be involved. They always wanted me to get out and meet kids from other schools and go places and then if I still decided to come back to a rural community then that would be fine. I was really thankful for all the opportunities I had growing up in a rural community.

Interaction with self and others leads us to make decisions and defines our path through our "stream of action" (Charon, 2007, p. 118). A stream of action is our reality of action. It is continuous and ends only upon death. Along the stream of action interacting with self and others, we evaluate what we do, we change our minds, establish new goals, make revisions, and new decisions. These decisions are constantly influenced by our interactions with self and others. These physicians experienced streams of actions and interactions growing up that helped them create and understand their goals and identities as necessary to assist them in creating their reality through planning, reflection, problem solving, and determined action.

Identity as it relates to place. Identity as it relates to place emerged as a vital experience as it relates to becoming a rural physician. The physicians identified with rural – the community, the practices, the culture, and the people. Their self-concepts had developed in these environments and helped them to establish their identities. Ultimately in all cases, the physicians fulfilled their aspirations in a place similar to or where they had developed a sense of belonging to the community whether through their upbringing or through other rural experiences. Some initially had no intentions of returning to a small community or their home town, but along their paths their future practice was created according to their reality of place. All of the physicians did not end up in their home town, but the majority had streams of action in close proximity to their eventual place of practice whether through their upbringing, college, or training experiences. Stated best,

> The farm provided me a lot of peace no matter where I was. [Being away] it never felt like home, like being on the land where my family works. My husband talks about how he, his parents moved around a lot and mostly to small towns, but he never had that sense of place. But this is my sense of, this is where I belong and I have always known that.

The identity in place was not so clear for another, "I did not have intentions of going back home so, I don't know, really, why that happened." Identity in place even goes so far that one physician could not conceptualize one day practicing in a rival town near her home town. "There's no way…there's no way a girl from Fairfax is going to go out and live in Middleton, that's ridiculous, just asinine!" One urban physician stated, "I grew up in Kansas City, always kind of thought I was going to stay. I tend to be more of a city girl, I always kind of thought I was going to stay in a city when I was working later." On attending college in a small town, she added,

> I definitely liked the feel of a smaller campus. This feeling translated over to smaller towns [for practice] too. Around here everybody knows everybody's everything and it's kind of a nice feeling. You feel like you're a little more protected, other people are watching out for you.

Another urban physician put it this way, "I'd rather be a big fish in a little pond than just another big fish in a big pond." After attending college in a small town he added, "I wanted [to practice] in a small town…something more like Ridgeton had been." Earlier integration into rural communities and interactions while in a rural place led these physicians to eventually define themselves both personally and professionally as rural doctors.

Rural influences for urban physicians. Urban background physicians are influenced by rural educational experiences in their decisions to practice rural (Chan et al., 2005; Tolhurst et al., 2006). In my study, the urban students were exposed to rural communities earlier through their undergraduate education differing from participants in other studies. One physician described her experience.

> When I first came here (rural town for undergraduate school), I had a huge culture shock. It was like, where's the theater, where's the mall? But, after a bit of time you realize, yeah, there's a movie theater, there's only one, but there is a movie theater and there's places to shop, there's not two million of them, but there's places to shop. When you're in a city, you tend to have the local places that you go and you go to them all of the time. You go to four or five restaurants because they are close to your house. Here, we don't have the options that we did in the city, but there you still only went to one movie theater and a few restaurants.

Another physician said, "While I was in Cayville (undergraduate school community), I decided that was going to be near the cap of the biggest place I was going to eventually settle, around 17,000." These experiences may have helped develop these physicians' sense of rural background earlier, and influenced them to later take advantage of rural training opportunities that further solidified their preference for rural practice.

Ultimately, the personal and professional rural interactions experienced by these physicians helped them determine that small towns would meet their needs.

Career decisions/path/early experiences regarding medicine. Some of the physicians had early thoughts or experiences regarding the profession of medicine that eventually influenced their career choice. Some students experienced pivotal or crucial moments when they realized a career in medicine was the right fit for them, while others, based on a desire to attend medical school, were pre-admitted to medical school and experienced a more focused path. Finally, some physicians knew they were destined to be physicians for as long as they remembered. These paths were influenced by interactions with family, mentors, role models, or school personnel.

Early thoughts or experiences regarding medicine influenced some to become doctors. One physician's own medical experience had an early influence on her.

> I was born with a cleft lip and palate, so I was in the hospital a lot when I was little. I think that influenced me to become a physician because I was in the hospital and saw a lot of physicians and just was interested in medicine. A lot of people say their family doctor was the person [who had an influence] and mine just gave me the creeps. I can't really say that he influenced me much.

Another stated,

> For me, growing up a doctor was, first of all, a family friend. We always knew who they were. It was a close relationship with somebody who pretty much did everything. My vision of a doctor was not a specialist. My idea of a doctor was somebody who dealt with…dealt with everything that came in. No white coats, they are people who work in the community with other people.

For another, "My pediatrician would literally swing by our house on the way home because he didn't want us exposed to other things." Some physicians knew they wanted to be physicians because of early interactions with others. One physician said,

> I had never been around a doctor and had never been sick. I was in vet med when an advisor asked me if I had ever thought about medicine because there was a huge demand for doctors willing to practice in rural communities. I changed my major to biochemistry.

In another case, during middle school, one physician had interviewed a young doctor just out of residency. "I interviewed her and it was like from then on I guess I wanted to be a doctor. Mom says I can't be a science teacher [like her] so I guess I'm going to be a doctor." One physician, while in high school, was listening to a physician known to her at a school assembly and stated,

> I was sitting out there in the audience and felt connected because I knew him and thought he was wonderful and I thought, well, I'm good at math and I'm good at science. I like Dr. M., I'll be a doctor. And so, sure enough, I just stuck with it.

Other physicians were preadmitted into the school of medicine. This position helped keep students on the path toward a career in medicine especially for those who may have been considering alternate careers. For example, one physician stated, "I got asked if I would fill out an application for the preadmissions…I'm not sure if I would have stuck to it as much. I might have found something else that would have had fewer requirements…like physician's assistant."

For some, being a physician had always been their goal. While growing up, one physician saw the need for rural physicians in her home town and said, "I didn't have like a specific doctor that I had in the family. I mainly just saw that we didn't [have doctors who stayed]. I had the ability to go to college, and I had the ability to go to medical school, so I did." One physician said,

> Frankly, my decision to be a doctor at the time was based on salary. At the top of the list for professions in America, it said neurosurgeons so I said, ok, that sounds like a good idea. While I was in high school, I had the pleasure of meeting a physician who was probably my biggest influence

> for going into primary care. He practiced internal medicine as a primary care physician and taught me a lot.

Finally, one physician without sharing any other reason than simply knowing stated, "I never really considered, honestly, I never remember wanting to do anything else. I never remember wanting to do anything other than being a doctor…never. It just didn't seem like an option to do anything else."

Only a few physicians in this study planned very early on to attend medical school. Physicians in this study had reference groups who influenced them to go to college, but not necessarily into a medical career. Most knew as undergraduates that they wanted to go on to medical school; however, several physicians in this study did not decide to do so until after college. Their thought and decision making processes add to the literature about how some young people determine their path into medicine.

Once the decision was made to become a physician, many of the interviewees went further by stating at the time of admissions they knew they were destined to practice primary care in a rural area. These decisions were further solidified through clinical experiences. All chose to follow their career goals stated upon matriculation into medical school when they finished residency. One physician stated,

> I had seen *Doc Hollywood*, which is really the only seminal moment that I've come up with for why I decided to be a small town doctor other than the fact that I knew once I'd been in Smithville that I wasn't going back to St. Louis. I really, I never liked living in a big city….I have a horrible sense of direction and get lost.

He went on to say, "I was pretty sure I wasn't going to want to do any of the specialties. So, and Mizzou is obviously well known for its primary care and rural medicine as well. So, I walked in the door to medical school with that as a plan." Another physician put it this way,

> I always wanted to go back to Fairfax and practice and have a rural practice and I think the…and the further I got along the more I realized that I couldn't be a pediatrician, that I wanted to take care of everything…I couldn't just be a pediatrician there.

Put most succinctly,

> I knew I wanted to do rural primary care. I knew that I couldn't practice specialty medicine and live in a small town. And, I love primary care, preventative care, and taking care of whole generations. There wasn't ever another option for me.

From my study, the need to give back, the need to help those most in need, and the desire to be near family were all vital in early decision making. These experiences will be discussed later in the chapter.

For preadmitted students in this study, the medical school admissions process did have an influence, not necessarily on specialty choice or practice location, but on attending medical school at the University of Missouri. These programs do not require students to take the Medical College Admissions Test and therefore, keep students in Missouri for medical school, but not necessarily residency. Where students train influences practice location and the majority of physicians in this study who had been preadmitted also took advantage of rural clinical training.

The findings of this study do not pinpoint specific experiences, but rather indicate that self is a dynamic process and that action is caused by a set of decisions made along a stream of action taking into consideration the definition of the situation, goals, plans, possible consequences, and knowledge from past and present experiences. In the cases of physicians who knew upon matriculation into medical school their desire to practice primary care in a rural area, their goals were imagined and determined early based on early interactions in their communities.

Spouse background and family gender roles. More males than females practice in rural areas (Geyman et al., 2000). In addition, a spouse or significant other's preference of practice location and employment opportunities influence practice location and retention (Jones et al., 2000; Rourke, 2008). The reviewed literature does not indicate reasons why more males than females practice in rural areas, but it may be because single physicians, predominantly female, are concerned about finding a spouse once settled in a small rural community. Three of the physicians in this study, two female and one male, shared personal stories about being unmarried in a small town. "I don't know it's never bothered me [not being married]. Getting married and having kids was never this huge priority for me. It's so nice to be so flexible and to be able to just go home and not have any obligations." The unmarried female physician returned home thinking,

> At first being single worried me more than anything because in my mind I already knew everybody at home and knew I didn't want to marry them. Later, I determined, God had put me there, I made that decision and I would meet somebody or not meet somebody, it's just as hard to meet somebody in a city as a small town…if anything it's actually harder, in my opinion, in a small town everything is very close knit, I have tons more friends. I didn't meet [my husband] until I moved home. The last thing he ever thought when moving home was that he would immediately meet somebody and end up wanting to get married….he had moved home for the same reasons that I moved home…he never got to see his family.

Quantitatively speaking, the one unmarried male in the study said,

> So, socially finding a mate in this area didn't really come up in my mind. I do kind of believe things will be what they are because even though the town is 12,000, there are at least three small towns within 10 miles that are 3-6,000, so in a county that has 30,000 people in it, and probably at least half of them are women and probably, um, 20% of them are in my age range…the odds that I wouldn't be able to even find somebody if I were truly looking never, never really would have bothered me.

In my study, four of the physicians, all female, have urban background spouses. One of the spouses drives into a metro area each day for work while the other three

husbands stay at home with children. This is a gender role reversal and may have special implications given that small towns are more prone to traditional gender roles. One doctor stated, "We decided when he came down here that he was going to stay home with our son." Another family's decision was due to difficulty with day care. "We couldn't find day care that we really felt confident with, even me knowing so many people here. So, he has stayed home."

In many cases, both the physician and the spouse were from rural areas, which worked out well for both practice location and retention. The urban spouses made compromises to be stay at home dads and give up their careers at least for the time being. Others also conceded to living in rural areas because of how important it was to their rural physician spouse.

> It kind of weirded him out that I was so sure I wanted to end up in rural Missouri. He came to the conclusion that he would like his kids to have that same sort of sense of place that I have. If he hadn't been interested in coming to a small town….how would that have affected things, I don't know because he knew that was part of me from the beginning.

This study makes a new contribution by highlighting the compromises personally and professionally that spouses make in order to make rural practice a reality. In this study, most couples were from rural areas, and in some cases both from the same area which made situations much easier. However, for those who could not find jobs in their area due to industry or the economy, all couples managed to work it out so their needs were met while keeping the needs of children highest in their priorities.

Theme 2: Clinical Experiences that Influence Specialty Choice and Decision to Practice Rural Medicine

Clinical experiences in rural areas and at the academic health center, during both medical school and residency, influenced the physicians' specialty choice and decision to

practice in a rural community. Learning experiences were most influential while the culture of the learning environment and role models or preceptors was also extremely important. Nine of the physicians in this study participated in rural clinical experiences while six did not. Two of the three urban physicians participated in rural clinical experiences while five of the rural-background physicians stayed at the academic health center for training due to marital status, family obligations, or perceptions of no need to experience rural medicine as they had lived in a rural area all of their lives.

Rural medical school experiences. During rural clinical experiences, students take a hands-on role under the supervision of a physician preceptor. The student works one-on-one with a physician preceptor, whereas in an academic learning environment, third year medical students have an observatory role because senior students, interns, and residents have priority. Some physicians in this study participated in a 6 or 8 week rural summer experience following their first year of medical school; a 6 month rural experience during their third year when they completed three 2 month clinical rotations that may include pediatrics, obstetrics/gynecology (OB/GYN), internal medicine, psychiatry/neurology, and family medicine; and/or 1 month electives during their fourth year.

One physician shared her plans related to rural practice: "I had never intended on doing rural medicine, never, not in college, not in medical school…never…no…no, I was not…100% no…I was not…" In this study, rural clinical experiences during medical school influenced specialty choice and ultimately practice location for most physicians. For the physician quoted above, and others who did not participate in rural rotations, the desire to be near family was ultimately a strong enough pull for them to rural or home

(i.e., rural) to practice. For those who took advantage of rural rotations during medical school, the descriptions are more about making a specialty choice than practice location; however, the experiences did stimulate thinking about what the specialty or actual primary care practice would be like in a rural area. In other words, these physicians were discovering what kind of medicine they wished to practice and what their lifestyle would be like as physicians after residency.

Some physicians communicated that they participated in rural medical school experiences for the one-on-one exposure. "I decided to do the rural track just because I wanted more experience," [in differing specialties in an effort to make informed decisions]. Some physicians were more future focused and participated as a way to learn more about rural practice. One physician shared, "I wanted to see what it would be like…being an OB/GYN in a university setting is a completely different lifestyle than being an OB/GYN in a rural care setting." These experiences not only helped them determine what they liked to do and where they liked to do it, but how the specialty fit with their personalities.

Through their learning environment and preceptor interactions, several physicians changed their minds about specialty during their training experiences.

> I thought after that summer I would do either pediatrics or family practice. I even took out scholarships for people who wanted to go into primary care. Then, during my fourth year when I did OB, I loved it. I mean sometimes you just find something that clicks with you. I'm a procedures person. I didn't know that at the time, going to school, but OB has a lot of a little bit of everything, you get to be in the hospital and do procedures, you get to do surgery, you get to do clinic. [And my preceptors], personality-wise I got along with them very well. So I think that, sometimes when you fit in, in a certain way that helps you make your decision.

Another physician describes her experience,

> I came down here [rural training site] because I thought I wanted to do OB/GYN. While on my family practice rotation, I thought I probably just liked it because we were doing deliveries. And then I went and did my OB rotation and I loved delivering, but I hate surgery…a lot. I just kept thinking, I really liked family practice, that was pretty cool and you could still deliver babies, but you don't have to do any surgery, and I like all the other stuff. I am always one that got really bored about three weeks into any rotation because I was tired of seeing the same thing over and over again. So, family practice is good because you don't see the same thing over and over. That is how I ended up in family practice.

At the end of third year, one physician had not yet decided on a specialty until she experienced a pivotal moment,

> I did my family medicine rotation last and it's just kind of like fate. I loved everything then thought how am I ever going to decide? Then I had family practice and you're like, oh, wait a minute we did…took off somebody's mole yesterday, delivered a baby today, saw a kid the next day and it just like of all came together. I was like, well, I really don't have to choose. I can have a little bit of everything doing family practice.

A physician who had been considering family practice said, "I realized I wanted to go into family medicine because that would be the most logical choice for going into a rural practice. I wanted to practice in a rural environment because cities scare me."

Finally, one physician who knew he wanted primary care prior to medical school learned this,

> The reason I chose internal medicine, specifically, is because I didn't do well with children…um, the whiny parents and the snotty nosed kid just wasn't my forte. And being 6'1" and heavy set, um, I was very intimidating to children, so, um, I knowing that I didn't want to do it, knowing that they probably wouldn't want me to do it, internal medicine seemed more of a likely option.

As demonstrated above, people are active in their environment, making decisions about what they do, think, and become. Individuals' viewpoints are made up of their perspectives, which, in turn, define their reality. Reality is social and, therefore, how individuals define reality is based on personal interactions with others (Charon, 2007).

Perspectives are developed that then help make sense out of reality. These physicians' perspectives regarding specialty choice changed as they moved through their training helping them to understand what their future reality would be like. As they interacted, their perspectives were transformed. They put aside current perspectives in favor of new perspectives that were presented and interpreted. Their definition of what they wanted to do changed based upon interactions with others. How perspectives develop and change as described by symbolic interactionists is closely aligned and consistent with perspective transformation. Perspective transformation is the foundation of Jack Mezirow's Transformative Learning Theory. This theory describes a learning process of "becoming critically aware of one's own tacit assumptions and expectations and those of others and assessing their relevance for making an interpretation" (Mezirow, 2000, p. 4). Like symbolic interactionism, transformative learning suggests individuals change their points of view through a reflection process regarding their beliefs and current perspectives. Through rational and analytical thought, realities can be redefined (Mezirow, 2000).

Role models and preceptors. Experiences and interactions with preceptors helped the physicians learn about what a rural lifestyle may be like for them as a physician in a small town, which again helped the physicians imagine their lives once in practice. "When I did my fourth year rotation, I learned from them what life would actually be like, call wise. Even though I take call a lot, I'm not necessarily working all the time." One physician shared this experience regarding what she learned about her preceptor's lifestyle,

> It was great to see how this physician got her groceries at 2:00 in the morning. She couldn't even get groceries without being stopped by tons of patients, so she did it in the middle of the night. I just didn't want that…so it was good, it let me make some decisions by seeing that.

One preceptor made conscious efforts to illustrate to his medial student what it means to become a doctor in a small town,

> I stayed at Dr. O's house. I got to know him…he took me out in the community and said, "practice in a small town, this is what it is." I decided I liked that, seeing people over a long time and getting to know them. I think some of it is the smallness, knowing who all the other doctors are and knowing what to tell patients to expect when they go see this surgeon versus that surgeon.

Preceptors' interactions with the physicians in this study influenced specialty choice and illustrated practice techniques in a rural area. Some physicians were deterred from a specialty based on interaction with their preceptor. "He kind of taught me that I didn't want to be an OB/GYN. He was very unhappy with his job and it kind of taught me a little bit about what rural OB could do to you…um, he was on 24/7. It teaches you that you need other people." Some female physicians had to determine what it was like to be a female physician and mother and how to balance professional and personal roles. One physician was profoundly influenced away from being a hospitalist.

> There was a female physician who was leaving the group because it was too much…too much time away from kids. She couldn't juggle it so she went to private practice and she was so much happier. So, that was probably my defining moment that I thought…it can't just be all about me anymore…dang!

This physician, who never planned to practice rural medicine, had a pivotal encounter with a preceptor that ultimately landed her back in her home town. "He just sat me down and he said, 'I really think this [being a hospitalist] is probably what you were meant to do, but you really have to consider how this is going to affect your family." Interestingly, this advice came from a male mentor who had started his career in a less demanding, outpatient practice. He put his family first, and he only moved to a hospitalist position

when his children got older. Another physician said, "I was very involved in Family Medicine Group. I got to know Dr. S. really well through that; and I think that's what solidified going into family medicine because I was like, this is what I want to do."

Physicians at the academic health center also influenced specialty choice for some.

> The family medicine attendings at MU kind of let you inside a little bit and talked about their families and talked about their life and balance. Attendings that are well rounded, they had this, in their life everything's important, their family was important versus when I was in internal medicine they never talked about their family. I wanted to be like the family medicine guys. I like everything that they are doing. I couldn't decide between all the other specialties, so it all just came together.

Other preceptors taught the physicians in this study how to practice and treat patients. In addition, they learned the leadership role of a physician in a rural community.

> I remember being really impressed with the fact that before I went into every room [the preceptor] would give me the story about that patient and they always knew everything about them…their daughter is doing this right now and I delivered their kid and I remember just thinking like, wow, they really know their patients a lot.

Another physician said, "Dr. M. is an immensely respected member of the community down there. And, I mean, no matter how high the pedestal, the most important doctor at Mizzou still hasn't got what Dr. M. has down there and his fiefdom." Put best,

> I really liked what I saw and how he had this profound effect on all these families and this whole community. This is something [become a rural doctor] where I could live in a rural community, which is something I have always known, I always wanted to do, and it's a service thing to me. I just wanted to serve a rural community in some way and be able to interact with people…after seeing the rural physician and how much valuable communication was and how much I liked that…I was just so taken by how much these families loved him and respected him and how valuable he was to the community.

For urban-background physicians in this study, quality role models and rural experiences influenced them to consider rural practice. Physician's social interactions during rural rotations helped determine their streams of action as necessary to process, problem solve, and clarify goals. One stated,

> It was a neat rotation. I liked it and getting to come back again [for third year clerkships after having done rotations after her first year] and build on it and actually know more stuff and occasionally impress them with something I knew, so it was kind of fun. I liked being able to have that continuity in a small community.

Another put it this way,

> The rural track opportunity was nothing you could get anywhere else, just being thrown to the wolves like that, but it was, it was perfect for what I wanted, what I needed, just the agonizing over stupid decisions, ah, do I order another test? We just did one yesterday, stuff now I wouldn't even think about, but making the decisions at the time and finally standing by and being able to defend myself for why I did this or why I recommended that…came back to Mizzou and was like, this stinks!

Symbolic interactionists believe reality is created through social interaction. People influence one another through communication and taking on the role of the other. Through physician/student experiences described in this study, the students' perspectives of rural practice continued to expand as they worked and learned. They were influenced by their preceptors. The physician preceptors seemed to also take on the role of the student as they taught the students at their level, but also exposed them to their reality as rural physicians. Student physicians also worked to keep physicians on their toes as their knowledge was up to date through recent learning and their access to technology. These experiences, especially because they were considered quality, caring ones, helped the students make more informed decisions about where they wanted to practice. As their stream of action occurred in rural sites, the students' reality became more lucid as they

prepared for their future. The students built on these experiences as they continued to make decisions regarding their career. Taking on the role of the other is aligned with a practice-oriented co-learner model as described by Paulo Freire (1989). Freire disagreed with the traditional student-teacher dichotomy. He believed reciprocity was key in the student/teacher relationship and, for effective learning to occur, the teacher must learn and the learner must teach. The preceptor/physician student relationships in this study are a good example of Freire's (1989) democratic educational method in action.

Academic health center medical school experiences and culture of medical school. Academic health center medical school experiences also influenced students' specialty choice. "I felt my [lower] class rank limited my options [to enter a specialty] and a high pressure specialty did not appeal to me. Family medicine was less pressure, family friendly, and my image of a doctor, my style." Many physicians in my study enjoyed their family medicine rotation. Put best,

> Family medicine at Mizzou? I loved it! I absolutely loved it. They seemed so much happier than anybody else…and it, they liked their job and I've always been of the belief that if you can't live on $100,000 a year, you're probably spending too much money, so I mean, I know that with the same med school degree I could get paid a lot more, you know, but they seemed happy and I would rather be happy.

An institution's commitment to rural health, in addition to rural medicine, programs, and policies, is associated with an increase in rural physician output (Wheat et al., 2005). Some of the medical school factors that are strongly associated with students selecting rural practice are: the medical school is located in a rural state, is publicly owned, has a focus on family practice, and has faculty who support rural programming (Geyman et al., 2000). The physicians in my study support the idea that the school's rural culture positively influenced them toward primary care and rural practice. "MU really

pushed us to be primary care physicians…most of my class went into primary care."

Several physicians mentioned the problem based learning curriculum the school utilizes and how it influenced their thinking and ultimately their professional choices.

> From the MU school side versus the clinical side, yes, there is a big push toward family practice, very much so and I think the problem based medicine approach definitely pushes people in that mind set, that it's always taken from the stand point of the generalist office, because otherwise it would give the case away.

Since MU is a research institution, there is some influence to go into clinical research, but it is balanced with primary care.

> The departments didn't deter primary care but their ranking nationally is based on what kind of research is being done. So there is a lot of pressure put on residents to do clinical research. But, when you worked with someone in the clinic [you learned] your name might not be on a plaque for solving some huge disease, but you are a success story to the objective of our program in getting primary care in areas of need to reduce health disparities.

Despite a supportive culture and rural mission at the institution, attendings and classmates may not have individually been supportive of primary care or rural practice. One rural background physician put it best,

> I had lots of deterrents along the way. I remember when I was in medical school, toward the end; well I was doing really well. I remember physicians and like attending physicians and classmates asking me, why would you want to do rural primary care when you could make more and do less and…I mean I was like third in my class so I could have done any sort of sub specialty and I just…didn't want to do that. It was kind of frustrating to me because they would say…wow, why would you want to practice in a po-dunk town where everybody's backward. But, it's never been that way…I wasn't raised around backward people…I wasn't.

The physicians in this study were influenced by the culture of the institution to enter primary care and were not deterred by the few individuals working or attending there that attempted to discourage primary care choices.

Residency experiences. More than half of the physicians in this study chose residencies in urban cities. The four physicians who had not decided earlier that they would return to rural Missouri to practice all went to urban residencies out of state. Six others attended Missouri urban residencies that emphasized primary care and preparation for rural practices because they were aware of rural challenges such as the lack of specialty referrals. Two physicians with strong desires to return to rural Missouri attended military residencies and three attended the University of Missouri School of Medicine.

The four physicians who attended urban, out-of-state residencies enjoyed them and described experiences that prepared them for their specialty rather than for a rural practice. For example one said, "They had a strong gynological oncology service that did lots of surgeries, so that's essentially why I liked it." These physicians eventually chose rural practice to be near family. The two military physicians also enjoyed their residencies, but primarily took them for the purpose of loan repayment. They met their military obligations and later joined practices in rural Missouri. The three physicians who attended MU did so for convenience reasons; one had a family, one lived in a rural town within driving distance, and one did so because he was accepted as an integrated resident (i.e., during his fourth year of medical school he did not have to compete for a residency spot). These physicians all planned to practice primary care without OB, so less specialized preparation was needed.

The urban, primary care, family medicine residencies did not offer rural rotations, but did offer environments that simulated rural hospitals that also served the underserved. These residencies were diligent in their efforts to encourage primary care, especially in

rural areas that promote rural practice and retention. They offered hands-on training and clinical experience pertinent to rural areas, such as emergency care and obstetrics.

The six physicians who attended urban residencies with specialty training for rural practice described many experiences that prepared them and built their confidence to practice rural medicine. “The thing about my residency, which was not at a major university hospital, was we were the only residency program at the hospital. The health care was completely run [provided], almost completely by the residency.” Another physician from the same residency explains, “We were doing aortic balloon pumps in the ER and managing those and seeing traumas…seeing people that had subarachnoid hemorrhages, and not blinking an eye.” These experiences prepared these physicians to have broad expertise which would benefit them in rural areas that did not have access to specialists such as emergency room doctors or obstetricians.

The family medicine residencies concentrated on training the physicians to do OB deliveries because many rural areas are not able to attract OB physicians.

> What it has [the residency] is a much more powerful OB training, um, compared to other family practice nationwide. I would say it’s gotta be in the top 1% as far as the quality and amount that you get and the fact that we have an OB/GYN as a faculty member, so you actually learn to do C-sections and most places you can’t, especially like at MU where the OB/GYN residents are learning all of that, there’s nothing, the family practice residents are getting the leftovers and there’s not enough.

Residency program directors’ expectations are high in order to prepare physicians to practice in rural areas. “You are held to the standards of an OB/GYN. The expectation for every single resident, their first and their second year, is to be managing OB like any other OB resident.” Training is individualized to meet the needs of the residents as they plan for what kind of procedures they intend to offer.

> Because family practice, we tend to go to more rural areas and so they kind of plan that you're going to be out by yourself in a rural area and so they give you a lot of ER and OB experience, they do a lot of procedures and give you a lot of flexibility in deciding what you want to do when you go out. It was kind of neat because their clinics give you a lot of continuity patients and so you kind of get the feel for what it is going to be like.

Again, preparation and confidence building were key,

> There wasn't an attending right there, which is great experience. It makes you learn and think and…great experience for going out to a rural area because you don't have anybody else to depend on, you're it. We loved that…when it was done, hey, I did that all by myself, I didn't have to grab somebody else to come and put that chest tube in, it wasn't an option, you had to get it in, you did it. And afterward you're like, wow, I did it. So, good experience, um, and a good group of people to work with, that made the biggest difference.

Finally, residency experiences, through learning, training, and interactions helped physicians become sure of, and confident in, their decisions regarding specialty choice and their near future in a rural practice. "I was surrounded by a bunch of smart people who are doing, all together, doing a wonderful…who also wanted to do rural medicine and that was really fun and encouraging." Another physician put it this way, "When you are going to work and you enjoy everybody you're working with and you're building confidence, then I love it and I said, oh, I'm definitely doing OB when I'd done. I kind of felt like, ah, this is what I am meant to do."

Residencies that promote rural primary care have fewer women residents because they are less likely to practice primary care in a rural area (Bowman & Penrod, 1998). This finding could have changed, as this literature is 10 years old; however, no more recent studies have been found. The ten females in my study did not mention a disparity between males and females in their residency class.

The most influential factor for retention is feeling prepared for rural careers (Pathman et al., 1999). However, feeling prepared for living in a small town is actually more important to retention than feeling prepared for practicing rural medicine (Pathman et al., 1999). Being prepared also includes having the social skills necessary to succeed in a rural area (Summerlin et al., 1993). The physicians in my study were well-prepared for rural practice as demonstrated above. They believe their training adequately prepared them to take care of myriad patient situations, including emergencies and obstetrics, because they were trained in these areas. They were also prepared for small town living because they came from rural backgrounds or had spent time in rural communities sometime earlier in their life. The additional time spent in rural areas while in medical school exemplifies the importance of clinical rotations as these experiences too prepare physicians for living in a small town. As these physicians have been in practice only up to 9 years, true outcomes regarding how their preparation will influence long term retention is yet to be determined however; 7 years is the median duration of time rural primary care physicians practice in the same area (Rabinowitz et al., 2005; Rabinowitz et al., 2008). Additional experiences that influence retention are discussed later in this chapter. Overall, medical school and residency experiences, to include the culture of the institutions and role models or preceptors, allowed the physicians in my study to socially construct their ideas about being a rural physician and they all entered rural practice because they believed they could not only practice comfortably, but live comfortably, in a small community.

Theme 3: Experiences Influencing Practice Location

According to the symbolic interactionism perspective, humans are dynamic; they think through situations and rationally solve problems. Humans overtly and covertly act in the present while using what has been experienced in the past and keeping in mind plans for the future. The perspective focuses on society as a process of humans cooperating, communicating, taking the role of the other, and working together in action. Interaction among and between individuals and society influences decisions and direction for both (Benzies & Allen, 2001; Charon, 2007). Thinking, deliberating, and reflecting, or mind action, allows humans to control their own action and take active roles in their environment. Mind action allows humans to problem solve, understand, interpret, and define others in a situation. Finally, mind action allows humans to plan for the future, remember the past, or create and perceive something new (Charon, 2007).

The physicians in my study have described their personal and continuous processes of interactions and resulting perspectives that have helped them work through mind action and determine their next steps in life. Their stream of action, or current realities, led these physicians to their defining decisions regarding specialty choice and commitment to rural practice. Now, a specific practice community and practice type must be chosen. Family, professional partners, employment by a health system or independent employment, work in a federally supported health clinic or hospital supported one, community type, patient mix, and availability of specialists for referrals are all things to be considered. The literature outlines some of these factors, (e.g., Backer, McIlvain, Paulman, & Ramaekers, 2006; Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007; Hart et al., 2002; Hays, Wynd, Veitch, & Crossland, 2003; Mayo & Matthews, n.d.) but lacks

description regarding the interactions and decision making processes that physicians experience to determine why they choose a certain practice type and community in which to work and live. My study provides thick description of the reasons physicians were drawn to and chose to practice in specific rural communities. Family, altruism, financial assistance, and practice opportunities are the major themes that emerged in my study. The physicians experienced dichotomies within these themes, which led to personal and professional conflicts. These conflicts are described and discussed.

Family location. The physicians in my study overwhelming stated that the strongest influences on their choice of practice location were where their family of origin and/or spouses' family lived. In some cases, family proximity extended to community members as well. "I think the older I got, the more I realized that I wanted to be around my family when I had a family myself. I wanted to take care of my mom and dad when they got older. And, I wanted to take care of people I knew." Another physician said, "We had a son. I definitely needed help with the two of us (she and her husband) having pretty demanding jobs so, we came home. Coming back home was because there is so much family here." Sometimes, physicians with spouses made compromises locating somewhere in between locations to be near both families. "This is kind of the perfect location for us because we're right between Kansas City and St. Louis. It's a little bit farther for my family to come down, but we're not so far away that we can't see them." Another physician brought out a map to help him and his wife decide on a location. "I drew a circle around the two [hometowns] and we wanted to be in that oval, in a town of less than 20,000 people. Those were my criteria and I was going to live there the rest of my life." These descriptions support the literature that physicians' families and spouse

preference are considerations when determining practice location; however, hearing about their interactions with families and their spouses helps us understand how these physicians determine their own actions. Human interaction with self and with others helped them think through their situations so the best decision was made for all.

Desire to return to hometown. Many physicians wanted to return to their hometown or a very similar environment and were fortunate enough to have that opportunity. One physician simply stated, "I'm just going to go home where I know people and my family will be closer to me. I mean, I had a good life there." Others knew that a city was not for them.

> I really prefer small town living, even though I've not lived in a city, like I really don't know this, but I'm pretty sure. I wanted to go back to where I was used to living, and my husband is a small town person. I also wanted to raise my children in a small town setting.

> My intent all along was never to practice in a big city. There are just too many people, too small of an area, I mean, you really, you can't stretch out, and you just can't do much without somebody always being right there. So we came [back to hometown] in 2006 because of closeness of relatives. The plan was to raise them (children) in an environment, low crime, community oriented with the added benefit of a more global experience through travel.

Studies show people with a rural background have a more favorable attitude toward rural medicine and are more likely to return to work in rural areas (Rabinowitz, 1986; 1988). This attitude, in addition to family preferences influence practice location. My study digs deeper to describe the importance of raising children and providing them experiences in a rural community similar to what they enjoyed and remember as children.

The small, hometown hospital and intimate community environment provide some physicians a sense of familiarity and closeness.

> I know the names of almost everybody that works in this hospital and I visit with them going down the hall. I am extremely high maintenance in the cafeteria and needy and they do anything you ask. It's a fun, pleasant place. If you're a people person you can really thrive in a place like this and I didn't feel like I could thrive in a big hospital and that was the same for MU (University of Missouri). If I'd stayed there for my whole life, I wouldn't feel like it was a homey place. The town is the same way. You get to know your same checker at the grocery store and the person that runs the register at the gas station.

Being in their hometown was not always as expected and, in fact, caused anxiety for some physicians.

> I think you're kind of held to a higher standard when you come where everyone knows who you are. If you mess up, they all remember it, or if you lose your temper, everybody remembers that. I also think professionalism isn't as high in the hospital in the bigger communities because they can get by with stuff and nobody's going to know when they go home.

Another physician was surprised by the reception he received from community members once at home in practice.

> It was interesting when we came back. Everybody was reluctant to see a new doctor. I had a few friends that were coming in but I was surprised that most of the people that came in were new patients I didn't know. I kind of thought I would know most of them. Talking to them out socially I heard, "I remember you as a kid, it's hard for me to come to you as a doctor." I was a little bit kind of shocked by that reception to some extent, but then after a few years, people say, "well I think he is going to stay and we've heard good things," so then my practice started to escalate out of control to where we couldn't keep up.

Another physician experienced her reception in a slightly different way.

> There is always an upper echelon of folks that thinks their local physicians and hospital is not good enough for them. I grew up with a lot of these people. It's been my biggest struggle convincing them that it's ok to have their baby here instead of St. Louis. I did exactly the same residency and sat for the same boards. It's been the hardest stereotype to get over.

Some felt it was too close to home to practice in their hometown and, instead, made the decision to practice in a nearby town. “I couldn’t go back to my hometown. There are a lot of medical politics in every town and it’s a lot easier to come into a situation where I don’t know where the lines are drawn. I didn’t want to deal with those politics starting off my professional life.” Finally, a physician who was excited about practicing in his wife’s hometown where his father-in-law also practices was disappointed when what he was promised in a practice did not materialize. He wanted an outpatient-only clinic with physician partners. However, he ended up being placed in a solo practice. Because he did not have in-patient responsibilities, the local medical community did not recognize him as a member of the medical faculty. The lack of support from colleagues was difficult; however, the community and patients welcomed this physician and have encouraged him to stay. This encouragement and the fact that he is near family has helped this physician alter his perspectives and stay for now.

> So, we moved here and I thought I was going to be a member of a primary care group, as in, people working together. It turned out that the doctors are in separate offices and we are basically set to compete against each other. I had no idea that’s how it would be. I was also told since I had a large family I could have an outpatient only practice. This was true, but I was not accepted by other physicians as a fully contributing member of the hospital.

For these physicians, their socialization through hometown interactions in their past did not accurately meet their expectations of their present situations. They were required to learn new expectations of themselves in their physician role, as set by the community, then reevaluate their behavior based on the generalized other (i.e., laws, tradition, customs). As physicians interacted in their present community, they learned how best to respond in their new role.

Desire to meet a community need. The physicians sought out small towns where they had an opportunity to meet a public need. They wanted to provide for a population in need of their care. In addition to family and wanting to be in their hometowns or a similar town, altruism, and an obligation to serve, influenced practice location. "I don't make as much money as I probably could in other places. I see a lot of Medicaid and I do a lot of things essentially pro bono, but at the end of the day it's worth it." Another physician said,

> I feel obligated to see Medicaid patients. And maybe it's different because I am not a specialist in that manner (providing primary care). I do pre-natal care and it's very important in my opinion. So whether or not you have Medicaid or insurance or what you have, you need pre-natal care. You can't live in a demographic and expect to not see that demographic.

Finally, one physician simply stated, "I wanted a practice where I was going to still be fairly close to my parents, but I also wanted to treat patients that need me the most." The obligation not only meant caring for those most in need, but also those known to them in the community. "I mean it's really been heartwarming to me because I'm getting to do some really good things for people who helped me get where I am." One physician believed that finding physicians with the mission to serve was becoming more difficult.

> A lot of primary care physicians are doing just clinics, no hospital, no OB. This means a nice schedule, no call, no weekends, no middle of the nights and, I can't understand why people would choose that. I would hate to give up a lot of what this means to me and the things that I love about my job, but it is hard to get people to see that this has a lot of merit and is what is needed. Coming out of medical school, they aren't really thinking in terms of mission. They're thinking in terms of, "I want my life that I haven't had because I've put everything on hold (being in medical school). It just not acceptable to have that busy of a work life. I have already given up so much."

The literature reports altruism as a characteristic rural physicians possess (Tolhurst, 2006). My study explains the multiple dimensions of what this means. The desire to give back and make a contribution to people in a community demonstrates that altruism may be a larger influence than the current literature suggests.

Practice type and clinical opportunities. The physicians in my study went into depth describing the importance of clinical opportunities as they related to practice type and professional challenge. It was very important to the physicians to have the opportunity to use the skills they had learned. "I'd still like to be able to do everything that I did in residency so I don't lose that knowledge. I didn't want to leave residency and narrow that much and lose all that knowledge I had worked on." Put another way,

> I decided to go to [town] because it's one of few places where you can do full scope family medicine and I knew that if I didn't do that then, then those skills would be gone. So, I had to do it then and if I decided to change, I could. I loved the group and the partners and it was an hour away from home. I didn't want to come to [hometown] right out of residency. I just felt like I wanted to be really experienced by the time I came back to my hometown and I think the first years of practice, I mean those are like your exponential learning curve and I felt like Dr. Quinn Medicine Woman who does everything.

In many urban areas, family medicine doctors are not offered privileges to do obstetrics because there are specialists in that area. So, the family medicine physicians in my study who wanted to do OB looked for practices that offered and supported these opportunities. "I really liked doing OB and in the city there are not a lot of places that a family practitioner can practice OB." Another stated, "It's a very primary care oriented community. [The hospital] has everything I need. It's got an excellent OB department, inpatient service with an Intensive Care Unit, all the specialists I want, and lots of back up." Therefore, this family practitioner who did OB felt comfortable doing so in the cases

where something may not go as planned. Most simply stated by a family practitioner, "I wanted a practice where I could do OB. I mean, that was a given."

Scholarships and loan forgiveness. As stated, being near family, practice community, and practice type were all extremely influential factors for the physicians in my study when deciding on a practice location. Loan repayment was also a factor that influenced practice location; however, it was secondary to having personal and family needs met and entering a professionally challenging practice. With the large amount of debt that physicians incur, loan repayment is an understandable consideration when choosing a practice. Many physicians had signed contracts to practice in their hometowns with the agreement that the hospital would pay off their debt. Others considered loan payoffs when selecting a job, but only after their personal and professional needs were considered. Still others took out loans during medical school that the state pays off if the physician practices in a rural or underserved area in need of physicians. One physician's situation illustrates the benefit of loan repayment, "I had $150,000 of school loans just from medical school. I am only 5 years out, have met my contract obligations, and I'm debt free." Another physician who knew early on she would return to an area of need said, "I decided to take the state loan. I knew this is where I wanted to end up so I might as well have them help pay for medical school. I mean I wanted to do rural family medicine, and that's what I always wanted to do." Both of these physicians are practicing in their hometowns. Other physicians in my study who had their loans repaid do not practice in their hometowns, and none of the physicians mentioned leaving their practice locations once their obligation was met. This suggests that while loan repayment was important, the rural location still had salience.

Personal/Professional conflicts. The strong desire to serve those in need and the opportunity to have full scope practices were extremely influential when determining practice location and type for the physicians in my study. As mentioned, family considerations, including spousal preferences, were of utmost importance. For both male and female physicians in my study, the professional need to serve and the desire to spend time with family often conflicted, leading to personal and professional imbalance. One physician bluntly stated, "If you have a [family] practice packed full of OB [patients], you just can't do it and still have a family." When weighing the pros and cons of two practices and communities, the predicted conflict between family and career was a struggle for one physician. This decision making process was not unlike others in my study when one location offered the career challenge while another offered what was wanted in a community. Regarding the first location,

> We were going to start a family now that residency's over and so I was horribly torn because on paper that [the practice] looked like the place we needed to go, that I needed to go for my career, but it was further from my family and I questioned whether I could maintain it [the challenges of a family medicine practice with OB]. It would be great for a couple of years, but I didn't know if I could do it long term. They had everything that excited me and challenged me professionally. The people, although they were great, they had this incredible mission statement, they had it all together, it was just neat. But, they were exhausted, they were tired, their families were suffering, they felt torn, you know.

Regarding the second location,

> It's [the community] closer to home and had everything we thought we wanted, but it didn't have the career part, the challenge part [family practice with OB and inpatient privileges]. We ended up going with [this location] mostly because of location. It was just closer to our families. Then she [daughter] was born and that's when the tides kind of shifted for us. We were getting embedded in this community and now I don't see us leaving. But, for a long time, I asked myself about coming here –

> was that the right decision? Now, I am embedded in their [patients] lives, so it would be hard to leave my patients at this point.

Many physicians have day-to-day struggles balancing work and family. One physician had to sacrifice delivering her patients' babies when she was not on call (something she wanted to do) when one of three partners left the practice because the demand on her time was too great. As a result, it was necessary for the participant in my study to give up this service to have private time at home with her own babies.

> We've [she and her partner] had a hard time. We have pet patients we really want to be with when they are in labor. When there were three of us, it'd be like, I'm not on call this weekend, but I'll come in and deliver that baby. Now, we've just had to say no, we're not going to do that and they'll have to understand.

Another physician stated,

> It's hard. Having a family was a huge priority for me. My whole life all I thought about was that I'm going to be a mom and I'm going to have kids. Having a family is hard with the job right now and that's the biggest thing. We (she and her husband) don't feel like we have been home enough with our daughter to add another child.

Yet another physician decided against being a hospitalist. For her, being a hospitalist would have been a more rewarding career, but she decided against it for her family and entered a clinic-based practice.

> I am rewarded with hospitalist work. I get rewards here everyday (in a clinic practice), but it is a different type of work. If I were to take a hospitalist job, which would mean 12 hour shifts where I would be away from my family even if they were sick. I wanted to be a hospitalist. I think you make a choice for your life and then you decide what is best for your children. I wanted to be a mommy who can come home.

One physician reluctantly gave up a professionally satisfying initial practice because of her growing family. She felt guilty leaving her partners with too many patients to treat, but felt she had not spent enough time with her first son and was now expecting twins.

She decided to live with the professional guilt rather than the personal guilt. She said, "My [first] job was brutal, but good in that you're doing so much and you're seeing so many patients and you're doing everything. When you go through that, then it just makes you appreciate the time you have with your family so much." This physician returned to her hometown to a smaller practice. She now has more time with her family and hopes to retain diversity and challenge in her practice.

The face of medicine has changed dramatically with many more females in the profession. More male physicians also place a premium on time with family. Today, physicians are not single males, or males who work 24/7 with wives who stay home to take care of the family. Conflict occurs between work and lifestyle not only for female physicians, but for their male counterparts as well. One male physician stated,

> The idea of a medical doctor has gone away from being a male, but the idea is still that it is someone who can work and be on call. I can't be doing a job that's 24 hours a day. I want a job that is flexible. I don't want to be unable to go away for the weekend because there are just too many other people on my team [in his family] whose schedules can't jive with mine.

Finally, a physician talks about how hospitalists have become employed so other physicians can maintain a balance between work and family. Hospitalists take care of patients in the hospital that other physicians have admitted but regularly care for in their clinic practices. She enjoys the time this allows with her family, but less control over her patients' care causes her professional discomfort and conflicts with what it means to be a rural doctor.

> I don't like [using hospitalists]. It's good in certain ways; it definitely controls your lifestyle a lot more because there is less call. You're not at the hospital all weekend every sixth weekend. But, I really liked doing inpatient and you lose a certain amount of control over what happens to your patients when they go into the hospital because they are being

> cared for by hospitalists. I had a really hard time with it. And some patients really hate it. They want me to come in and visit when they're in the hospital. Some people got mad that I didn't come see them. It caused nothing but problems. It was better for my family, but hard for my patients.

Family, community, practice type, loan repayment, meeting health care needs, professional opportunities, and maintaining a balance professionally and personally are all considered when the physicians in this study decided on their practice locations. My study makes a contribution regarding practice type and describes the importance of professional opportunities and challenge in a practice. The physicians want to be independent, have a wide scope of practice, provide needed services, and use the skills they learned in residency. Enjoying these challenges and opportunities often caused conflict when their professional responsibilities took them away from their personal ones.

Theme 4: Experiences Influencing Retention

Physician retention is the result of the integration process into a community (Cutchin, 1997b). Cutchin posits a theoretical perspective that defines retention as "the ongoing manifestation of an underlying process of place integration" or the "activity of becoming a part of place" (p. 25). In his study, integration involved three domains: physician self, the medical community, and the community-at-large. Retention results when these three domains foster physician integration through the development and enhancement of security, freedom, and identity in place. Cutchin calls this perspective of retention *experiential place integration,* which "creates focus on the connection and interaction between physicians and their local settings" (p. 27). Through on-going interaction with place and their status and role in the rural community (Farmer et al., 2003), "physicians become woven into the fabric of place" (Cutchin, 1997b, p. 28). The

quality of the interaction and experience in place influences a physician to stay or to leave. Integration is also affected by the culture of the community, its history, economy, and demographics.

In my study, the themes that emerged describing experiences that influenced retention include community integration, both professional and personal, and professional support. The physicians described many experiences that influenced them to stay and also those that could influence them to leave. Finally, the physicians described challenges their rural communities' face that may influence their futures in a given community.

Professional/Community integration. Most physicians in my study devote some of their time professionally integrating into the community. Some do so through community education.

> I have spoken to the Kiwanis and the Rotary and the Lady Voters of American. I speak to lots of groups about health issues. With my background in education, I do a lot of talking and a lot of what people need is just having things explained to them and figuring out where they stand with their medications.

Another physician was more specific about the variety of education she provides in her community.

> I try to do a lot of community outreach. There's a program coming up where I'll be speaking about cervical cancer and puberty and all sorts of things to mothers and daughters and informing them about new STDs and protection. I try to talk once in a while to a mother-toddler's group about potty training and feeding. I also meet with the school about nutrition and diet in school lunches.

Professional contributions are sometimes efforts continued from residency. For example, "We do free skin cancer screenings every May. That's just something I carried over from residency." Several physicians professionally integrate when they can, but prioritize time with their families. "I pay my dues to the West Central Medical Society, but I don't go to

meetings because they are on school nights and I want to get my kids to bed. The old men doctors just simply don't get that." One physician is doing his best to contribute and integrate into his community, but his efforts are threatened by cooperation from the community: "I am the medical director for the free clinic. We're having trouble garnering volunteers and if that doesn't settle down soon, it will be closing because I won't continue to fight for something that the community isn't willing to support."

The physicians in my study are doing their best to integrate through professional contributions, but due to building practices, family, and community issues, it is not the most pressing priority for them. Their level of involvement may be contributing to the social capital of the community, but I believe it will be several years before the physicians have the time to fully integrate in this way. For now, they are establishing relationships with their patients. Further, these relationships will bode them well when they have more time to integrate as leaders within their communities.

Personal community integration. Adjusting to life as a physician in a small community presents unique challenges and rewards whether it is a new community or one's hometown. One urban physician described her adjustment when trying to personally integrate with her patients outside of the office.

> We felt like big city folk in a small town, but then it just kind of grows on you. In the beginning, I would walk to work because I wasn't as busy. I was walking down the sidewalk and this guy drove up that I'd just seen the day before and say, "Hey, doc! What was my lab?" He had on sunglasses and I had no idea who he was. I can't remember who I saw because everybody is brand new, let alone his lab results! Now, I would holler back, "They look good!" Now, I totally recognize them when I see them coming.

Some physicians had an easier time integrating personally because they returned to their hometown or somewhere they had lived or were familiar with previously.

> I had an easy time acclimating to this community because I had kept active with my sorority. I'd never been far enough away that I couldn't come back for meetings. We came down here already knowing quite a few people and kind of had that social network to build on.

Another physician said,

> I have a close group of friends and we do things as families. Friday night to us is cooking a big bowl of chili and sitting around with children. We also do outdoorsy things. We like to hunt and fish and we have a lake house to go to if I have a weekend off.

One physician described how she and her family met people.

> We joined the Elks! So, we had a lot more friends, but we have family here too. I met people in my office; one of my best friends is my real estate agent that sold us our house. I don't think it was too hard meeting people. We have a lot in common with these people.

Another physician spoke of the welcome she received in her neighborhood. "The first week we were here, all of our neighbors came over and brought us cookies and cakes and introduced themselves. It doesn't take long to get into groups especially with kids." Finally, one physician believed he and his family might have difficulty integrating due to their political beliefs. "It's rural medicine so it's still a Republican stronghold. There is a pocket of liberalism here due to the artists so, it seems more tolerant. This was important to us given our personal philosophy and our politics."

Several physicians mentioned that their spouse's integration played a large role in their adjustment to the community and their reasons to stay.

> My husband is really outgoing and plays golf. This place has an 18 hole, really nice golf course, which in a small town is unheard of so, he is happy. He is on the board for the golf course. He is also on the school board. He started three years ago and our daughter will be going to school soon. He has a good grasp of what the school is like and we feel comfortable that she'll get what she needs with our help and encouragement.

Another physician's spouse was able to successfully adjust because of his connection with the outdoors. "My husband and my whole family hunt. I mean that's a culture in its own way. So, we fit well. It's not been hard for us to find friends in the area." Male spouses who stayed at home with the children had a more difficult time adjusting to the community. One female physician talked about her husband's efforts to integrate into her hometown.

> It's been very hard for him. It's helped to have family here, but obviously he doesn't know the amount of people I know here and the people he does know are through me. He's been out of the job market for 4 years now. He's trying to find what he wants to do with his life right now. Most of the other stay-at-home parents are women. He went to a library thing with the kids and he really didn't like that. He didn't feel comfortable, really. He's found more friends with hobbies and church.

Another female physician relates a similar description about her stay-at-home husband.

> He's discovered very quickly that he doesn't fit in with the stay-at-home moms. He's social but perfectly fine to stay at home during the day hanging out with our son. They go to swim lessons, he takes him to preschool, and they work on trucks, and play in the garage. That sort of guy stuff.

Female spouses of physicians in my study adjusted and integrated well due to experience with transitions, being in more traditional gender roles, being employed, or because they were social.

> My wife works part time and the kids keep her running pretty hard. She was with me when I was in the military. She has a well established protocol for how to set up new relationships when we arrive. My wife is good at making friends. She quickly found a playgroup and a mother's group. She goes to the library to read with the kids and has a couple of good friends she made in town fairly quickly.

Rural acculturation and integration experiences are important and necessary for physicians to develop emotional and professional attachments to rural living. Integration into the community was important to the physicians in my study, not only for themselves,

but for their families. Through previous interactions and rural experiences, the physicians had socially constructed their ideas about being rural physicians and had established a professional fit. For some, the family integration issues were still being addressed especially the stay-at-home dads who had given up careers to care for children. Most families had made adjustments to balance work and family and were living comfortably with their current situations. Future research looking at these physicians over time will determine if these families continue to collaborate over time as their children grow and the physicians have more time to integrate professionally. Further study about the male spouses' experiences reentering the work world, if they so choose, will be telling as spousal employment is a factor influencing physician retention.

Professional support. The physicians in my study believe that they were well prepared for the challenges of a rural medical practice. This is not to say that the professional support they received or were denied upon arrival has not influenced their professional experiences there. A good professional support system is not only important when recruiting physicians, but also in efforts to retain them (Backer et al., 2006; Hays et al., 2003). My participants experienced varying levels of professional support. For those who had less support, several have found ways to improve their situations through relationship building and confidence. Others are still struggling. It remains to be seen how the lack of support will affect retention.

Several physicians initially experienced less support due to political or competitive issues within the medical community. Even in areas where many physicians were available to provide guidance, physicians did not always get the help they expected. One physician described his introduction to the medical community. Interestingly, this

physician, who moved to his wife's hometown where her father is a physician, received little professional support from colleagues.

> Initially, I felt the professional support was poor, very, very poor considering there are 30 doctors on staff. I was put here in this building rather than across the street where there were three doctors. I had envisioned being in a group practice initially coming straight out of residency. It's not the case that I can't get on the phone and call somebody, people are generally pleasant but, in general, I've found the reception I've received to be not welcoming. The medical community was a big surprise to me. There needs to be a close connection between rural docs. Unfortunately, it's been a very, very tough two years. I had no idea that it would be so competitive. There are plenty of sick people to go around!

The medical politics in another physician's community caused some overarching professional support issues.

> There's a lot of bad politics between [health systems] and that's difficult. In a small town it gets more difficult because everybody knows everything about everything so the politics get amplified. It's hopefully something that will get worked out over time, but it's definitely an issue. In terms of people being individually supportive, yeah.

Some male physicians had issues with young, female physicians joining their practice group. Males with these power or gender issues were a reality the female physicians had to work through on the job. The descriptions here are from physicians who chose their practice locations to be near family. The first moved back to her hometown joining a practice with two male physicians.

> Dr. Myers is very fatherly, protective, because he's known me my whole life. I think Dr. Johnson is a little bit intimidated by the fact that I am a female and I'm from [hometown]. So, sometimes he can be kind of condescending. 'I'm older and know more than you.' I'm not a believer in that. I think there are a lot of people that come out of residency and are better at that moment than they may be ever again.

Another physician knew during the interview the lack of professional support and gender issues would be a reality; she was confident she could handle the situation. Despite these issues, she chose the practice because it was that important for her to be near family.

> In the interview, there's one older doctor who I am going to take his spot. And there's one younger doctor who was very gruff and kind of just rude during the interview. He asked me, 'When are you going to have a baby?' I just rolled with the punches. He said, 'What if somebody comes in with a ruptured aneurism? What are you going to do out here?' He's just pimping me during the interview and, that's fine. I was used to surgeons pimping (in residency) and I could handle it. But, do I really want to work with this guy? He was a total jerk.

Looking back over the 8 years she has been in practice with this man, she reflects,

> We just figured out how to work together. And, it took awhile. At the end of the first year I would have left because he was just still a jerk but, now I totally respect him. I don't know what it is, if he changed, or if I figured out how to deal with him. I think part of it was having to prove myself and just figuring out that relationship. There are some things that I go to him and want his judgment and he kind of does the same thing on issues. So, now it's this give and take and it's all worked out great.

Gender issues may become more prevalent as the number of female physicians grows. The descriptions in my study illustrate that the issues are real and varied.

Overall, the majority of physicians have strong professional support. One physician said, "They're very helpful not just with my patients, but I guess just on the ins and outs of practice, how to get into a groove here, what the flow is, how to get things done, ordering tests, and potential pitfalls with insurance companies and things like that. I try to oblige them by doing everything they ask of me." Another physician speaks highly of her mentor.

> I didn't want to start a practice on my own. I hope Dr. Garner never leaves. I'm learning a lot from him and I joined a very established practice. He, by the way, was raised here as well and his whole family is here. It's a good thing we have communication. It's nice to have him in the office because if I have a question, we use each other's eyes. I'm learning more and more and he's slowly wanting to cut out.

Finally, one very small town physician stays in touch with and gets support from friends she had in residency who now practice in nearby towns. "They are still my

buddies and that's important. We're meeting tomorrow night you know, just to talk and vent."

Professional and personal influences to stay. The physicians in my study described experiences, both professional and personal, that are influencing them to stay in rural communities to practice. Professional experiences relate to what physicians had hoped for when deciding upon a practice location, including being connected to their community, providing needed care, and having the opportunity to work in a challenging, yet cooperative practice. Several physicians feel a connection to their community and enjoy making a difference.

> I'm getting to do some really good things for people who helped me get where I am, people who I've known my whole life. I'm getting to help them and that's really more meaningful to me, but it also hits a little bit harder. I thought at first it would be a little bit too close for comfort, but I like it now.

Another physician is available whenever he is needed.

> The patients are fantastic. The patients are wonderful. I always take their phone calls, including weekends. People know they can call me. I meet people over here. Yeah, on Saturday a grandma, looking after a baby when both parents have gone away for the weekend calls and says, "Oh, I'm sure he's (i.e., the baby) ok, but what do I do?" I say, bring him to my office and we'll take care of it.

One physician practicing in her home town says, "It's a lot easier to have a quick and easy rapport with patients you already know. Getting that doctor/patient rapport and trust takes time and I already have that base." Several other physicians really enjoy the long term relationships they have with their patients. One says,

> I kind of have fun doing it (knowing all of her patients so well) and a lot of the students I teach have said that they like it. Before I let them go in with a patient I'll say, ok, well this is kind of the story of what's going on with them and here's their back history. It's kind of neat to sit down and tell students about it and realize that I know all this stuff about them

> because I've been seeing them for 5 years. I know all these people and I know what's going on. It's definitely fun to realize how much you know about people and how connected you get.

Put another way,

> There's a fair amount of stuff that you can skip when you walk in and you lay eyes on a patient. It's just pulling up the information in your head. You know them by their first name. You know the ones you have to coddle and the ones you don't. It's just a nice feeling to have a connection with them.

Another physician describes her feelings toward even the most difficult patients.

> I love taking care of the entire family and knowing the dynamics. Some patients are tough and I growl a little bit inside and say, "I don't have time for this today," but now I pick up their chart and see their name and I wonder how this is doing. I really genuinely look forward to walking through the door and seeing them even if they're grouchy or difficult to deal with at times. They have become endearing to me. I am embedded in their lives.

The need to serve and provide necessary care was a large professional influence to practice and stay in their communities.

> I've always had a heart for serving the underserved, the needy, and poor people because I grew up around these people. My best friends growing up were poor. They ran the tire shop or they worked as waitresses. That's where I'm from. I mean I'll bend over backwards to do what I can to help them. I'll fill out 10 pages of paperwork to get their medicine. I really have a heart for the working poor. In fact, we're boosting up the Medicaid so whoever needs to be seen, I'll see, especially kids.

Another physician described the fear people in her community felt about the possibility of losing her as their doctor.

> I know this community has lost a lot of doctors, some to retirement, and some to moving away. There's not enough, and people are so tired of changing doctors and I've had patients beg me, please don't move. And there's this fear, quite frankly… I'm very good friends with most of the OB nurses and I would feel really bad if I was the reason they didn't have their job anymore. I worry about people not having a doctor, people who…we have women who have so few resources, they leave a phone number but the phone is out of minutes and so we can't reach them. So, what's going to happen to all these people that are basically existing on

> the edge if we're not here, and I don't think they're going to get care. Our big issue is if we (she and her partner) give up OB, which we don't want to do, our community will suffer.

Finally, one physician described the balance he had in his life and how work and his personal life merged.

> It's kind of funny to think that originally my main motivation for being a physician was monetary and now it's the least thing that actually keeps me here. My life is very comfortable. I like my schedule. The people that I work with are absolutely wonderful. They're very open, caring, giving, and very funny. We share a lot of very common interests. I have several friends in the staff here. We go and watch sports together. I've got a good life here. I guess if you're happy you're less likely to try to find happiness. Besides, I never really believed the grass is greener on the other side.

The primary reason physicians in my study stated for staying in their community was their connection to family and extended family. The physicians believe they are establishing roots or becoming more deeply rooted depending on if they live in a new community or their hometown. "We really like it here a lot. It's a great place to raise kids. The schools are great, there are a lot of activities and you just have an easier way of keeping your eye on your kids. We can definitely see ourselves staying here." These sentiments were echoed by another physician. "The grandparents really enjoy having us so close. Really, all of my family is here. It makes getting together easy. I'm not planning on moving. I can raise my kids here in a low crime, community oriented environment." Another physician said, "We always knew we wanted to raise our kids in a small town. I think it's because we had such great experiences and didn't ever feel like we got shafted." Still another said this about being happy where she and her family were, "I think we'll just stay put. I don't think we'll ever be happy in a bigger city. I think because of the way we were raised." Finally, two physicians stated this about their personal reason to stay, "We are pretty anchored here. My husband just built my dream home from head to toe. I

love this house and would not move from it. You couldn't drag me away. It would be very hard for us to go somewhere else," and "We built our dream house. That's where I want to die. I built it handicapped accessible so I could die there!"

Professional and personal influences to leave. The physicians in my study described experiences, both professional and personal, that may influence them to leave their rural practice. Not having enough professional support, getting offers elsewhere with more challenging opportunities, and not having enough specialty business were professional considerations for leaving. "Being the only family practitioner who does OB makes life a little difficult. It would be better if I had a mix of other family docs that did OB because I can't share call with the OB docs because I don't do C-sections. There's no way for me to reciprocate." Another stated her dilemma with not enough specialists to help with OB. "Retention-wise, our biggest challenge is that we are not able to find a new OB doc. We (she and her family practice partner) can't do OB without a specialist available. I love my job. I'm passionate about it; I'm good at it, and to just throw it away…." Another physician would consider leaving one day for more challenge. "I really like hospitalist work. I think that once my children get in school and kind of settled, it will be harder to keep me here." Finally, a physician said, "I can't imagine, but if something happens with dermatology and the demand goes down, we will leave."

Personal reasons described for leaving a rural community include the lack of a quality school system, lack of diversity in the community, and unhappy spouses. One physician said this about the school system in his town. "Our town failed to pass a bond and now pays [teachers] less than any other surrounding school district. The school district is struggling to keep good teachers." The school system is also important to this

physician. “The only thing that would make us move is if I felt like [our daughter] wasn’t getting a good education.”

Several physicians noted their trepidation about remaining in a small town because of the lack of diversity and exposure to various cultures and points of view. “I worry a little bit about my children not being exposed to culture. There’s no racial diversity around here. And except for my family, all Republicans. This is not necessarily related to how big the town is, I know backward people who grew up in St. Louis!”

A spouse being unhappy is also a reason many physicians leave small communities. This physician talked about his medical community having a mission to set students up with locals while they are training in his town so they marry and stay. He says, “One of the barriers we find is the spousal commitment to a small place. I know a number of docs who have left in the past 10 years because their wives were unhappy. We tell students that our mission is to find someone for them to marry here so they come back.”

Personal and professional challenges in rural areas. Other reasons for physician dissatisfaction in rural areas include lower incomes, distance from a referral center, and uninsured patients (Cutchin, 1997b). Some physicians also find it difficult to maintain privacy and find they cannot integrate into the community as an ordinary citizen (Farmer et al., 2003). The physicians in my study did not describe dissatisfaction with their income, with the exception of one comment regarding recruitment of physicians to rural areas. “It’s not all about the money, but I really do think if you’re going to get people to rural family care, you have to pay them appropriately.” One physician believes he actually received a higher income in comparison to his colleagues by going to a rural

area. “The offers for me were higher than the standard salary for internal medicine coming out of residency in the Midwest.” The physicians described situations where they are in need of local specialists and also mentioned difficulties patients had getting to specialists who are located in larger areas. One physician voiced her concerns.

> How are they going to go out of town to see another doctor? There are women in other towns who don’t get care from an OB. We have that problem, too. When the gas prices were so expensive, it was a big issue. We set times for patients to see specialists for co-management of high risk OB and they’ll simply say, “I don’t have gas money, I can’t go.” If we’re not here, I don’t think they’re going to get care.

Several physicians described their experience with Medicaid reimbursement. For those clinics designated by the federal government as rural health clinics, reimbursement for Medicaid patients is paid as billed for services. However, for physicians who work in non-rural health clinics, a loss is taken for services provided to Medicaid patients. In both cases, the paperwork requirements to provide care and receive reimbursement are complicated and time consuming. Without adequate incentives and reimbursement, it is financially difficult for some physicians to see Medicaid patients. Many of these patients go without care.

> It’s frustrating when you have somebody that you need something for and you can’t get it. You have to do paperwork and you have to argue. There are constant obstacles in your way and it makes you kind of cynical fighting through the system. With private insurance there are definite hoops, but they’re hoops and not concrete barriers.

Another physician describes her experience with Medicaid not allowing some tests. “Getting some tests is a problem. There’s a test where within 2 or 3 hours you can know whether something is herpes simplex or not and, it’s just not available. Without it, you do a lot more, you treat it, you send it off and it might be back in a week. You have to sit and wait.” Illustrating how patients would not be served in many communities

without rural health clinics, one physician said, “We have people who drive quite a ways. The other primary care physicians in town don’t take Medicaid. So, we are it for them.” In some rural areas, there are too few private insurance patients to support private practice. “We had two doctors that opened a private practice that sold out to the hospital after one year. They couldn’t make ends meet. They could not get a patient population here that had enough private insurance to sustain their practice.” Finally, one physician suggested providing Medicaid incentives for providing quality care and improving the reimbursement payment structure.

Maintaining personal privacy was mentioned by many physicians in my study. For some, seeing a patient in public was an issue while for others, it was an accepted or welcomed aspect of being a physician in a small town.

> That’s one drawback of a small town. If I say I am going to run to the store and grab some milk, it should take 5 or 10 minutes. It’s gonna take 30 or 40 minutes because there is no way I can get in and out without somebody seeing me and stopping to talk. You go to soccer practice and there are 30 people…It’s gotten better over time. I try to discourage, but you can’t be rude. It’s like when I see our plumber; it’s hard not to talk about plumbing issues.

Another person described her experience in her hometown.

> It’s amazing how people ask you questions even in the McDonald’s drive through! I have to have a sense of humor to put up with it because it can be unreal. The other thing is people calling me about their kids who aren’t my patients. A lot of times I redirect them to call their doctor or call my office for an appointment. Pushing that gets rid of the chronic offenders.

Even without contact with patients, physicians must consider the perceptions of people in their towns. “Your life is under scrutiny. People always assume you are working, so I don’t drink in public.” Finally, two physicians were more tolerant and welcomed people approaching them in public.

> It doesn't bother me because the large majority of the people are very respectful. It takes me a lot longer to get out of the store, but it doesn't bother me. I like talking to people and a lot of times people just want to get to know you outside of the office because you are their doctor. People think doctors are interesting. And a lot of people just come up and chat and ask, "How are you? Oh! Is this your son?"

"I love seeing people in the store! I love it! My husband says we can't walk through the store…everybody's got something to tell me and it's wonderful!"

The physicians in my study described challenging issues regarding rural practice. None of these issues were described as ones that would influence the physicians to leave a rural area, but they are issues that physicians deal with daily in their professional and personal roles. This information adds reality and depth by giving a sense of priority regarding which issues are most challenging. The descriptions provide input into the specificity of the issues which may lead to more detailed and effective solutions.

Experiential place integration. Integration involves the three domains of the physician self, the medical community, and the community-at-large (Cutchin, 1997a). The physician self is defined as creative and independent, continuously being shaped by values, social groups, and community. Physicians' background, previous experiences, mentors, attitudes, language, beliefs, family, aspirations, identity, "and other symbolic significances ingrained over time" (Cutchin, 1997a, p. 1665) characterize and define them and ultimately influences retention. The medical community and its make-up also influence retention. Professional support, the size and power of institutions, physician cooperation, and types of innovation all must be considered during a physician's career and influence whether or not one stays or moves. Retention is also affected by how a physician integrates into and is supported by the community-at-large. This relationship

has the potential of making important contributions to a community's economic viability and health status.

The three domains of the physician self, the medical community and the community-at-large are characterized by three primary integrative principles: security, freedom, and identity and their 27 component dimensions that form the basis of physician retention ([See Chapter 2, Table 1]; Cutchin, 1997b). These principles look at problems that may influence physicians to leave rural areas, but also at solutions physicians realize through action and integration into a community. The principles describe what physicians face, but physician experiences vary based on the place-physician context. Ensuring that physicians have satisfaction in these three principle areas increases physicians' integration into their rural community and ultimately influences retention.

When listening to the physicians in my study describe the experiences that led them to practice and stay in rural communities, it was apparent that the journey to their present reality included the domains of self, medical community, and community-at-large. The physicians had processed interactions and communicated with themselves to establish their identity as a rural physician in their specific community. These processes were not without conflict as some medical communities were unwilling to adjust their present culture to improve cooperation with the physicians. In all cases however, the physicians integrated professionally and personally and only one was considering relocation.

The three principles of security, freedom, and identity, and the configuration of dimensions, were individual for each physician regarding the meaning of experience and the action in place that influenced retention in place. Therefore, each physician's

integration path differed as his or her stream of action differed however, all of the physicians very specifically described many of the dimensions of experiential place integration. The dimensions of security, including having confidence in their medical abilities and having the respect of the medical community and community-at-large, were described as important. Their interactions and experiences during residency had prepared them to be confident in their skills, which also helped them gain respect from medical partners and patients. The physicians compromised professional aspirations and goals in order to meet their families' needs. Professional and personal happiness were important influences of retention. Finally, the physicians had worked to fit into and contribute to their practice group, the medical institution, and community with or without initial ease. Making professional and personal contributions is important to the physicians and increased the security they felt in their communities.

The physicians' descriptions in my study support the dimensions of freedom as a principle of experiential place integration. The physicians had worked hard to find practices that provided them with challenge, depth, and diversity. They were anxious to maintain the level of expertise they had earned while in residency and knew with some practices, this level of knowledge and skill would not be possible. As with security, the freedom dimension includes cooperation within and respect from the medical community. Most physicians were fortunate to enter practices that included these dimensions while others had difficulties being treated as an outsider or addressing gender issues present in their communities. Overall, physicians made attempts to avoid the political and power issues in the medical community. Instead they were interested in establishing their practices, making a contribution, and meeting their patients' needs one-

on-one. Being involved with their families and in community affairs was extremely important regarding integration and retention. In fact, family was the most influential experience that led the physicians to practice and stay in a rural area. They felt at peace in their home and in their work and definitely described their identity in place.

Finally, the dimension of identity was described by the physicians in my study. For the most part, the physicians had joined practices in which they were valued and felt comfortable taking and giving advice and providing consults. They were fulfilling their aspirations in place and were aware of the contributions they were making professionally and personally to their patients and to those in their communities. They saw themselves as belonging to the community and being an integral part of it. They were aware of the experiences that had brought them to their current reality and had made personal, familial, and professional adjustments in order to balance their lives. Further, they were creating their future goals in place. Most did not intend to ever move again. They looked to the future as a place their family and practices would grow. Most had young families and were currently integrating into the community more through their children's activities than professional opportunities; however public education and other medical integrative programs had occurred. The physicians in my study, very much supported Cutchin's (1997b) study by describing experiences supporting experiential place integration and its principles of security, identity, and freedom.

The male physicians in my study were somewhat typical of the males in the literature in that their wives took responsibility for the majority of care for their children so they could work longer hours and be more involved in their professional communities. They did, however, mention the importance of spending more time with their children by

being able to go to sporting events and on weekend trips. In particular, the female physicians made an attempt to do it all even if they had a husband that stayed at home. Their roles as mothers were very traditional and they wanted to be the parent who put the children to bed and woke them in the morning. Work and home responsibilities led to little sleep and exhaustion, but also to joy being with their kids and satisfaction with the quality of patient care they provided.

Some female physicians face sexist attitudes. Male colleagues treated them as if they could not fully contribute to medicine and their practice due to family obligations. Some male physicians gave the impression that they knew more and were better care givers than the females. However, one male physician who tried to design an outpatient practice so he, too, could spend time with his family was ostracized and told he was not a "real" doctor. As more time goes on and even more females enter the world of medicine and more men shed the expectation of working 24/7, fewer prejudices should be evident. In addition, hospitals and clinics have already begun to design practice opportunities that allow physicians to reach a personal and professional balance. As communities-at-large and medical communities adjust and adapt to the changing needs of both male and female physicians and their families, job satisfaction and retention should improve while communities enjoy quality health care and economic viability.

Summary

This chapter presents the description of experiences that influence doctors to practice and live in rural communities. Descriptions of experiences occurring before, during, and after medical school fell into themes and subthemes that emerged from 15 interviews. Background and personal characteristics including rural upbringing, family

values and relationships, early experiences regarding medicine, spouse background, and identity in place were experiences occurring primarily prior to medical school that influenced the desire to practice and live in a rural area. Rural clinical medical school and residency experiences, the culture of the medical school, and role models and preceptor relationships were experiences during medical school that influenced physicians' choices. Family, partners, and scholarships and loan forgiveness were among the experiences that influenced practice type and location. Balancing personal and professional roles were also extremely important determinations for physicians when choosing a practice and location. Finally, the professional support received, and professional and personal integration into the community were experiences influencing physician retention in their community of choice. Many personal and professional experiences were described that influenced decisions to stay and some influencing consideration to leave. Finally, personal and professional challenges of living and working in a rural area were described. Chapter 5 will present a universal description, or essence, of the phenomenon of becoming a rural physician and staying in a rural area to practice. This essence is the synthesis of the experiences. Findings are also discussed as they relate to the literature. Finally, Chapter 5 presents implications for research, policy, and practice.

Chapter 5

DISCUSSION OF FINDINGS

Introduction

Physician workforce analysts concur there is a physician maldistribution when comparing rural with urban areas (Whitcomb, 2005). It is necessary, from a social justice standpoint, to ensure rural citizens have available, accessible, and acceptable quality medical care to remedy health disparities resulting from the lack of physicians in certain geographical areas. Using admissions policies and clinical training programs to influence students to practice in rural areas, policy makers and medical schools have been working toward this goal for several decades (e.g., Brooks et al., 2002; Geyman et al., 2000; Jones et al., 2000; Rabinowitz, 1986; 1988; Rabinowitz et al., 2005; Verby, Newell, Andresen, & Swentko, 1991).

Additional effort is necessary to increase the numbers of physicians choosing to live and work in areas of need. This study contributes descriptive experiences occurring before, during, and after medical school that influence a physician's choice to practice in a rural area. Further, physician-community interactions that enhance the integration and retention of the participants in rural communities are discussed. The knowledge resulting from my study provides a framework that can be used to better understand which students accepted into medical school may be more likely to choose rural areas to practice and what experiences may influence them to choose rural practice and to stay.

The findings from this study can help shape and develop additional strategies to be implemented to potentially increase the number of rural physicians. For example, medical schools can better select students who are more likely to return to or choose rural

areas; and schools and communities can provide, change, or enhance curricular and practical experiences that foster students' social constructions and promote the positive aspects of rural practice and lifestyle to influence them to make informed decisions to practice and live in professionally and personally satisfying rural areas. The real world rural and clinical experiences are compelling and may help overcome ignorance or perceptions about rural life especially for urban students. This information is valuable to medical educators, administrators, and community leaders interested in addressing the maldistribution of physicians and ultimately health disparities affecting rural citizens.

This chapter presents a composite description or essence of the phenomenon of becoming and remaining a rural physician. The essence of the experience illustrates an overall reality of the phenomenon. Next, the findings are discussed as they relate to the literature with the unique contributions being highlighted. This chapter also provides research, policy, and practice implications for consideration.

The Essence of the Phenomenon

Definition

"The final step in the phenomenological research process is the intuitive integration of the fundamental textural and structural descriptions into a unified statement of the essence of the experience of the phenomenon as a whole." (Moustakas, 1994, p. 100). Essence means that which is common or universal (Moustakas, 1994). The essence is a short, descriptive passage. "The reader should come away from the phenomenology with the feeling, 'I understand better what it is like for someone to experience that'" (Creswell, 2007, p. 62). In my study, the synthesis of the experiences represents the essence of the phenomenon from my point of view with the input of my research team at

this particular time. The essence presented is the "establishment of knowledge" (Moustakas, 1994, p. 100) resulting from an exhaustive and reflective study of the phenomenon of becoming and remaining a rural physician.

The Essence of Becoming and Remaining a Rural Physician

Identity as it relates to place is the foundation for a person's choice to become a physician who practices and stays in a rural community. Identity in place describes their connection to and reality in their environment. Many experiences contribute to identity as it relates to place. Through these experiences and related interactions, identity in place is the key connector between self and the decision to become a rural physician and making the commitment to stay in a small community to practice.

In my study, the background, upbringing, family values, and personal characteristics of rural physicians play a vital role in the decision making process to become rural physicians. Personal background and past social interactions help physicians not only define themselves, but their values, ideals, and goals. Rural physicians identify with rural communities, their culture, and the people. Their self-concepts and identities have developed in these environments. Along their paths, future practices are created according to their reality of place. Rural physicians define themselves both professionally and personally as rural doctors.

The strongest attraction for physicians to rural communities is the desire to live and work near family. Rural background or exposure to rural locations was also a very powerful influence. The small, intimate community environment gives rural physicians a sense of familiarity and closeness; thus there is great importance placed on raising children and providing them experiences in a rural setting similar to what they enjoyed

and remember as children. Physicians and their spouses compromise both professionally and personally to make rural practice and living a reality. In addition, rural physicians want to give back to communities and help those most in need. Rural physicians possess altruistic characteristics and feel an obligation to serve. They seek out small towns with public needs to be met and provide the necessary care.

Rural learning experiences and interactions influence physicians to practice in rural areas. The culture of the learning environment and quality interactions with role models or preceptors are extremely important. Through training and experiences, rural physicians discover or confirm what medical specialty they wish to practice. In addition, interactions with preceptors help physicians experience what a rural lifestyle may be like for them, which helps them imagine their future lives. In other words, rural training helps eventual rural physicians to be sure of, and confident in, their decisions regarding specialty choice and rural practice. Rural physicians enter rural practice because they desire and believe they can not only practice comfortably, but live comfortably, in a small community.

Rural physicians love the challenge and diversity of rural practice as it provides breadth, stimulation, and fulfillment. The desire to have full scope practices and the desire to spend time with family often conflict leading to personal and professional imbalance. At times, rural physicians must compromise professional goals or aspirations in order to meet family needs. Professional and personal happiness are both important as they relate to retention.

Rural acculturation and integration experiences are important and necessary for physicians to develop emotional and professional attachments to rural living. Rural

physicians enjoy professionally integrating into the community but, due to building practices and family, integration may not be the most pressing priority for them especially for newer physicians. Priority is given to establishing relationships with and giving time to patients. The successful integration of physicians' families is also an important factor regarding physicians' desire to stay.

Rural physicians appreciate professional support from their peers and make efforts to establish professionally beneficial relationships. They work to fit into and contribute to their practice group, medical institution (e.g., hospital, clinic), and community. Rural physicians are worried about the need for more local specialists in addition to the on-going need for general practitioners and believe some patients go without care due to access and reimbursement issues.

Rural physicians feel at peace in their home and their work and are able to describe their identity in place with ease. They fulfill their aspirations in place and are aware of the contributions they make professionally and personally to their patients and to others in the community. Rural physicians see themselves as belonging to the community and being an integral part of it. They are aware of the experiences that brought them to their current reality and make personal, familial, and professional adjustments to balance their lives. They are establishing roots and most will never move again. They look to their future in a rural community as a place where their families and practices will grow. In essence, they are creating their future life's goals in place.

Discussion of Findings

This study reveals the meaning or essence of becoming a rural physician through the description of experiences that influence doctors to practice and live in smaller

communities. The literature suggests several factors or experiences that influence eventual rural practice and retention. These can occur before, during, and after medical school. Themes and subthemes that emerged in my study mirrored the literature in that the experiences described occurred over the physicians' life spans. Contributions to and differences from the literature also emerged. Additionally, the majority of previous literature reports quantitative outcomes, whereas this qualitative study contributes new knowledge into the depth of experiences that influence physicians' career choices. Finally, my study looked at physicians beyond family medicine in an effort to determine factors or experiences that influenced their choices. This knowledge increased the literature base in areas outside of family medicine.

The findings in my study support the findings in previous studies that physicians who were from rural areas had very favorable attitudes toward rural medicine (Rabinowitz, 1986; 1988); however, a few physicians in my study did not originally plan to return to a rural area to practice but ended up in one primarily because of family. In all cases, the physicians' sense of rural background, a need to serve, and/or family ties eventually influenced their intent to practice in a rural area. Similarities with extant findings also occurred in that the physicians' service experiences prior to medical training influenced future practice site choices (Tavernier et al., 2003). Unlike in previous studies, physicians in this study were very much encouraged to pursue higher education, were involved in many academic activities, and did not have to travel too far to obtain a degree. The physicians stated that attending college was an expectation for them and never an option. And, in Missouri, there are plenty of regional universities making attendance near home feasible.

Descriptions in my study, from both urban and rural background physicians, support the literature that finds rural training increases or solidifies interest in rural practice and positively influences the decision to practice in a rural community (Colwill, 2007; Jones et al., 2000; Rabinowitz, 2008; Rourke, 2008). Experiencing rural medicine through rural training exposes students to the challenge of rural medicine and the enjoyment of a rural lifestyle, which are two important factors when considering rural practice (Chan et al., 2005). The results of my study also support the literature that reports the intensity of the pipeline programs and the effects of these longitudinal programs upon the number of graduates entering rural practice (Brooks et al., 2002; Tavernier et al., 2003). The exposure throughout the pipeline fostered interest and, more importantly, prepared physicians for rural practice and rural living.

The results from my study support both nature and nurture as influential in choosing a rural practice location (Brooks et al., 2002; Dunbabin & Levitt, 2003). All participating physicians, regardless of background or participation in rural rotations, ended up in rural areas. The physicians indicated family and/or rural background or exposure to rural locations (for urban-background physicians) was the strongest pull to rural. The physicians who did rural rotations while in medical school did so more often to gain hands-on experience as a way to determine specialty choice rather than experiencing rural practice. Supporting the literature, some who were determined to practice in a rural community chose not to participate in rural training, as they felt they knew enough about rural medicine or because they had other priorities such as family (Lynch et al., 2001). For the urban-background students, going to undergraduate school in more rural areas, in addition to rural clinical experiences, helped them solidify their choice to practice in a

rural area. Unfortunately, this study cannot solve the nature vs. nurture debate, but maybe it is both and not either/or. For physicians from urban-backgrounds, this study supports the literature stating quality role models and rural experiences influence them to consider rural practice (Jones et al., 2000; Rourke, 2008).

The physicians in my study went into depth describing the importance of clinical opportunities as they related to practice type and professional challenge. Cutchin (1997b) found that the love of challenges and inherent diversity of patients and diagnosis in a rural primary care practice were commonalities among the physician participants in his study. "The excitement and challenge of rural practice provides breadth, stimulation, and fulfillment for physicians in rural places" (Cutchin, 1997b, p. 36). The physicians' descriptions and desire for challenging, full scope practices in my study supports Cutchin's findings.

The literature states the importance of professional support as a factor that influences retention. Professional support, from colleagues and specialists, provides guidance, opportunity to balance work and family, and comfort knowing that physicians can call on one another to provide quality health care through coverage and making referrals (e.g.,. Backer et al., 2006; Daniels et al., 2007; Hart et al., 2002). My study contributes specific descriptions regarding positive and negative professional support issues physicians face in rural areas. These descriptions are important to process and understand for recruitment and retention of physicians, especially female physicians, as the women are necessary to meet the health care needs of rural citizens. Hospital systems, medical communities, and communities-at-large need to be aware of the potential poor treatment female physicians may receive from physicians or community members who

are not prepared for the changing face of medicine. This awareness including actions to alleviate gender issues, are important in the recruitment and retention of female physicians.

My findings mirror the literature albeit giving greater detail through description of their personal experiences as to why they may one day leave (e.g., Backer, McIlvain, Paulman, & Ramaekers, 2006; Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007; Hart et al., 2002; Hays, Wynd, Veitch, & Crossland, 2003; Mayo & Matthews, n.d.). Fostering the experiences positively influencing retention should be of utmost importance to medical communities and communities-at-large. The study illustrates that the professional and personal reasons to stay far outweigh the professional and personal reasons that could influence the physicians to leave their community.

A lifestyle that balances work and family influences physician desire to practice and stay in a rural area, but fails to provide nuanced descriptions of the context of the balance or the conflicts (e.g., Backer, McIlvain, Paulman, & Ramaekers, 2006; Daniels, VanLeit, Skipper, Sanders, & Rhyne, 2007; Hart et al., 2002). My study offers specific descriptions regarding the personal and professional conflicts that occur when choosing a practice and the compromises or sacrifices physicians must make to balance their professional and personal lives. It also includes many female physicians' perspectives that the literature does not address. The gender findings may, in fact, be the most telling contribution of my study. My findings inform the literature, especially through the voices of female physicians who are not well represented in the medical literature.

Implications for Research

This study points to five important questions for future research. First, how much do childhood experiences influence physician choice? For most physicians in my study, early influences from parents or teachers put thoughts of medicine in their minds. Further study regarding early influences toward medicine may help determine educational or other experiences that put young people on track toward a career in rural medicine. Interactions with significant others or reference groups who socialize youth into medical careers may be beneficial. At a community level, stakeholders should offer medically-related educational opportunities such as shadowing in order to "grow their own" physicians as many physicians returned to their hometowns. Stream of actions that help students create and understand their goals and identities to match their aspirations are necessary to assist young people in creating their reality through planning, reflection, problem solving, and determined action. It is necessary for students to plan, think, and use mind action (thinking, deliberating, reflecting) to set medical school goals earlier due to the growing competition for admissions to medical school.

Second, how many female physicians today are choosing to practice in rural areas and how many of them have spouses who stay at home with children? How have the partners adjusted to giving up careers? Are they able to reenter the workforce when children become school age? Is a partner's happiness more or less influential than the physician's happiness regarding retention? The majority of female physicians in my study had partners working in non-traditional roles such as being stay-at-home dads. The families had made adjustments and sacrifices personally and professionally to do what

was best for the children. Further research is necessary to determine how these families, particularly the male partners, have adjusted as their children grow and enter school.

Third, how prevalent is sexist behavior toward female physicians and how does it affect retention in rural or urban areas? A couple of female physicians in my study dealt with poor treatment from male physicians because they were female in a traditionally male occupation. It is unclear whether the problem is more universal or if these female physicians simply had the unfortunate exposure to and poor treatment from specific individuals. The female physicians in my study were able to successfully deal with their situations and did not indicate that retention would be affected. However, would this be the case for others who had similar experiences?

Fourth, are small town experiences additive or multiplicative with rural clinical experiences for urban students? Do early rural experiences influence urban students to take advantage of rural clinical experiences in medical school? In my study, the urban students had all had small town experiences prior to medical school through family or undergraduate school that they enjoyed and that piqued their interest in living in a small community. They indicated that these experiences influenced their desire to obtain further training in a rural area.

Fifth, how is place integration and retention affected as females and internationally trained physicians change the face of medicine and enter rural practice? The female physicians in my study mentioned negative interactions in their communities related to gender. It is probable that international medical graduates also experience negative interactions in rural communities related to race or ethnicity. Despite the need for physicians in rural areas, are community members willing to adjust and change in

order to welcome and integrate those different from them and different from their expectations of who physicians are into their communities? What are the best practices in communities that help to retain female and international medical graduates?

Implications for Policy

This study points to two questions for policy makers. First, what funding issues can be addressed as necessary to improve the recruitment and retention of rural physicians? Rural physicians provide 15-20% of care at no cost to the patient (Hart, 2000). Policies must be changed to insure the uninsured so rural physicians are reimbursed for provided care. Efficient funding for hospitals is also necessary to keep physicians in rural areas. Federal programs that promote practice ownership should also be implemented (Pathman et al., 2004). Many of the physicians in my study provided care at no cost because they knew care would not otherwise be received. Lack of payment, however, is a deterrent to rural practice. It was also mentioned that an insufficient number of insured or self-pay patients were living in some places making it impossible for physicians to be in private practice.

Second, how can policy makers help communities improve health outcomes? Communities must receive funding adequate to provide quality health services. Rural communities must then be efficient with these resources and have effective leadership to address fiscal and capital issues. Efficient use of social, political, and economic capital is necessary to improve the performance and quality of health care in small communities. Efforts to improve rural health must also "promote stable, rewarding, and fulfilling professional and personal lives for rural health care providers" (Hart et al., 2002, p. 211).

With adequate funding and its efficient use, the needs of the population and physicians will be met and health outcomes over time will inevitably improve.

Implications for Practice

This study points to four important questions for practitioners. First, what can medical schools do when admitting students to increase the number of enrollees who are likely to practice in rural areas? Growing up in a rural area in addition to communicating a desire to return to a rural area at the time of admission increase the likelihood a student will choose a primary care specialty and eventual rural practice (Chan et al., 2005; Rabinowitz et al., 2001). Simply by asking students during admissions interviews about their intentions for practice could increase the number of those admitted who end up in rural areas. This was true for a few of the physicians in my study.

Second, what can medical school practitioners do to increase interest in rural medicine? Curriculum changes can be made to help students obtain more exposure to rural medicine. This increased exposure will also improve preparedness for living and working in a rural area especially for urban background students. The physicians in my study were appreciative of the curriculum at MU, which promotes independent self-directed learning necessary to succeed and feel confident in a rural practice. Adding challenges to residency programs to include ER or OB patients also promotes confidence in rural practice. Medical schools should also work to increase the value in students' minds of primary care medicine. In my study, MU did a good job of this; however, some participants in my study reported individuals within the faculty attempted to guide them away from primary care and rural practice.

Third, what recruitment and retention efforts can medical communities make to increase the numbers of rural physicians? A self assessment of the hospital should be completed with regard to state-of-the-art equipment and ancillary services. Ensuring other physicians in the practice or the community are supportive and including them in the hiring process help to give them a sense of ownership in the decision making. Practice opportunities can be designed or modified in order to meet the personal and professional needs of incoming physicians. Physicians in my study wanted balance between home and work. For example, if family practitioners want to do OB, ensure that they are provided with this challenge without overwhelming them with too many patients so the opportunity does not negatively affect time with family. Hospitals can orient the physician to the practice, hospital, and the community. A clinician mentor can be assigned to the new physician to answer questions and foster a sense of belonging. Medical employers can then encourage physicians to integrate into their communities in an effort to grow their own next generation of local physicians. Physicians could be asked to spend time with youth educating them about medicine in efforts to influence them early toward a medical career. Transformative learning (Mezirow, 2000) may take place as young people change their frame of reference or assumptions regarding a career in medicine. Finally, medical communities can foresee the future and embrace change. When change is not looked at as opportunity, it is harder to get things done and to stay abreast of necessary changes to keep competitive. Young physicians are likely to make suggestions for changes in procedures or technology. If medical communities are not open to change, physicians may not be retained.

Fourth, what recruitment and retention efforts can rural communities-at-large make to increase the number of rural physicians? Communities can conduct a self-assessment with regard to its attraction to potential physician candidates. The assessment could include looking at the quality of public schools, the availability of private schools, selection and availability of quality housing, and cultural opportunities. Additionally, communities can facilitate opportunities to help physicians and their families develop social and professional networks to increase integration and retention.

Conclusion

Enacting policies and practices that successfully encourage and eventually place and retain physicians in rural areas are extremely important to citizens, and rural and medical communities. The positive economic impact to a community through the placement of one family physician is $1,048,595 (AAFP, 2009). Other health care providers are attracted to communities with practicing physicians. Health access, status, and outcomes ultimately improve as more medical professionals locate in small towns. Businesses are also attracted to communities providing quality health care because their employee base remains stable and healthier. It makes good economic sense for state and federal legislators to adequately fund efforts that recruit and retain physicians in areas of need.

My study shares the experiences of 15 rural physicians in Missouri. From them, we learned that family, professional opportunities and support, and the ability to balance work and personal lives are critical in recruiting and retaining rural physicians. Hopefully, their experiences can inform policies and practices in Missouri and in medical schools and practices outside of Missouri.

APPENDIX A: LETTER TO RESEARCH PARTICIPANT

Date_____

Dear_____,

Thank you for your interest in my dissertation research on the experience of becoming a rural physician. I value the unique contribution you can make to my study and am excited about your participation in it. The purpose of this letter is to reiterate some of the things we have already discussed and to secure your signature on the participant release form also included.

The research model I am using is a qualitative one through which I am seeking comprehensive descriptions of your experience. In this way, I hope to answer my questions:

1. How do rural physicians describe experiences that led them to rural practice?

2. How do rural physicians describe experiences that led them to stay in rural areas to practice?

Through your participation, I hope to understand the essence of becoming a rural physician as it reveals itself in your experience. You will be asked to recall specific episodes, situations, or events that you experienced prior to, during, and following medical school. I am seeking vivid, accurate, and comprehensive portrayals of what these experiences were like for you: your thoughts, feelings, and behaviors, as well as situations, events, places, and people connected with your experience.

I value your participation and thank you for the commitment of time, energy, and effort. If you have further questions before signing the consent form, I can be reached at 573-356-3560.

Sincerely,

Kathleen Quinn

APPENDIX B: CONSENT FORM

I agree to participate in research regarding the phenomenon of experiences that lead physicians to practice and stay in rural communities. I understand the purpose and nature of this research and I am participating voluntarily. I grant permission for the data to be used in the process of completing a Ph.D. degree, including a dissertation and other future publications. I understand that a brief synopsis of each participant will be used and will include the following information: population of practice location, age, gender, marital status, spouse employment, children, population of hometown, undergraduate university, residency state, population of any previous practice locations, years in current location, and specialty. I grant permission for the above non-identifying personal information to be used. I agree to meet at _____(place) on _____(date) for an interview of 1 to 2 hours. If necessary, I will be available at a mutually agreed upon time and place for an additional 1 hour interview. I also grant permission to tape recording the interview (s).

_____ _____

Research Participant/Date Researcher/Date

APPENDIX C: TOPICAL RESEARCH QUESTIONS

If participants did disclose or express sufficient meaning or depth of experiences as necessary to provide thick description, topical questions were asked to facilitate more in-depth disclosure of their experiences. Based upon Moustakas's (1994) suggestions, while using the literature and a symbolic interactionism lens, the following topical questions were used to probe deeper into the participants' experiences:

1. What dimensions, incidents, and people intimately connected with the experience stand out for you (parents, significant others, children, professional partners, community members, faculty, preceptors)?
2. What factors or experiences occurring prior to medical school influenced your decisions (background and upbringing; participation in service activities; admissions policies; stated desire at time of admission to practice in a rural area)?
3. What factors or experiences occurring during medical school influenced your decisions (medical school curriculum; rural clinical training; the combination of rural admissions with rural training; personal factors; medical school culture; rural acculturation; rural residency training with an emphasis on underserved areas; feeling prepared for a rural career and small town living)?
4. What factors or experiences occurring after medical school influenced your decisions (lifestyle preferences, personal and professional financial security; professional support received; and how integrated one becomes into the community)?
5. What changes associate with decisions you made based upon your experiences?
6. How were significant others affected by your experiences?

7. How were your experiences affected by significant others?
8. What feelings do you associate with the experiences?
9. What thoughts, feelings, or emotions stand out for you?
10. Is there anything else you would like to share that is significant to your experience?

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VITA

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Ms. Quinn began her career at the Human Development Corporation and later at the Private Industry Council where she helped low-income women obtain education and employment through the Job Training Partnership Act. In the mid-nineties, Ms. Quinn worked educating at-risk women about the importance of early detection through the Breast and Cervical Cancer Control Project. For the past ten years, she has worked for the University of Missouri School of Medicine with the Rural Track Pipeline Programs. These programs work toward increasing the numbers of rural physicians to address health disparities that exist in rural communities.

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