PHYSICIAN LIFE AND PRACTICE IN UNDERSERVED COMMUNITIES: GUIDANCE FOR STATE OFFICES OF RURAL HEALTH

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The North Carolina Foundation for Alternative Health Programs[1]

Abstract: The North Carolina Office of Rural Health conducted a two-year study of rural physicians to obtain a qualitative view of the factors that attract physicians to rural practice and those that lead to their departures. In-depth interviews were carried out with physicians who had recently left rural practice and with those who had recently arrived to rural communities, who were interviewed upon and one year after arrival. Spouses of the physicians also were interviewed. Findings showed that emotional issues—such as conflicts with practice partners, autonomy, community relationships, and family time—often outweighed issues of earnings, hospital facilities and spousal employment. The study results provide important insights into the dynamics of physician location decisions and can provide State Offices of Rural Health with valuable guidance in the design of programs and technical assistance.

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I. Overview and Purpose of Project

Despite publicized projections of a physician oversupply by the year 1990 and decades of government policies and programs to influence the distribution of providers, rural America is struggling to attract qualified physicians and nonphysician primary health care providers to its communities. Nearly 30 percent of the nation's rural population lives in a county with a shortage of primary care physicians. In 1988, there were 62.8 primary care physicians for every 100,000 rural (nonmetropolitan) residents, compared to 108.8 primary care physicians for every 100,000 urban (metropolitan) residents.[2] As of 1992, the percentage of primary care physicians in the U.S. was 40.2 (or 253,493); only 13.3% of these physicians were in nonmetropolitan counties.[3]

Since 1975, the North Carolina Office of Rural Health and Resource Development, a state government agency in the N.C. Department of Human Resources, has been charged with recruiting medical providers to underserved areas of the state. Demand for their staff's services has increased over the years. In 1993, the Office is recruiting providers for more than 320 openings in 180 rural and urban communities that are medically underserved. The Medical Placement Services staff of the Office of Rural Health has had relatively impressive success recruiting primary care providers. Between 1981 and 1992, 696 physicians and 29 nonphysician providers were recruited through the Office, including almost 400 through the National Health Service Corps. As of October 1992, 47 percent of all those providers remained in the same community to which they were recruited.[4] About 65 percent of those providers were still practicing in North Carolina in 1993.

Historically, rural parts of the state have experienced significant problems retaining providers in their community. Yet while an impressive body of literature exists concerning physician recruitment issues, little is known about retaining physicians and other providers in underserved communities.[5] In order to improve their efforts

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2 American Medical Association. Physician Characteristics and Distribution in the U.S., 1989 edition. Chicago, IL: American Medical Association, 1989.

3 American Medical Association. Physician Data by County–1993. Chicago, IL: American Medical Association, 1993.

4 Unpublished data, N.C. Office of Rural Health and Resource Development, March 1993.

5 Pathman and Konrad have written a series of revealing articles concerning the retention of National Health Service Corps and non-Corps physicians in rural communities. These include "The

to retain primary care providers in N.C. communities, the SORH sought to develop a study to learn the views of rural practice physicians in the current environment and to determine what a state office of rural health could do to influence physician location decisions. Staff developed an extensive survey form of questions, which was used during in-depth interviews conducted with rural (nonmetropolitan) primary care physicians in 1992 and 1993. The specialist conducting the interviews worked closely with field staff of the Office of Rural Health, whose responsibilities include providing technical assistance and provider recruitment services to 55 community-based health centers in the state.

The study used open-ended personal interviews, conducted by a health care systems specialist, to ascertain a deeper understanding of rural practice and physician satisfactions and dissatisfactions. Physicians, along with their spouses, in two different stages of their careers were interviewed: those who were beginning to practice in rural communities and those who had decided to leave rural practices. The survey revealed several critical aspects concerning the recruitment and retention of rural health providers. Issues examined included:

(1) The realities of medical practice in a rural community
(2) Aspects of the rural medical community
(3) Lifestyle and community issues
(4) Physician characteristics and preferences

In conducting the survey, the SORH sought to broaden its knowledge of the needs and expectations of physicians. The findings will be integrated into a fairly sophisticated system of providing technical assistance and recruitment services to rural and underserved communities in the state.

II. History of Recruitment and Retention Efforts at the N.C. Office of Rural Health

The North Carolina Office of Rural Health has developed a fairly sophisticated system of recruiting physicians and other health providers to medically underserved rural and urban communities. Its staff's approach to recruitment is not only to serve as a broker between towns needing doctors and physicians seeking

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Comparative Retention of National Health Service Corps and Other Rural Physicians: Results of a 9-Year Follow-Up Study," *JAMA*, September 23/30, 1992, Vol. 268, No. 12, pp. 1552-1558.

rural practice. The staff uses community development skills to help both communities and physicians and seeks to integrate the interests of both parties so that lasting relationships are formed.

In 1976, the Office signed an agreement, the first of its kind, with the U.S. Department of Health, Education and Welfare (now the Department of Health and Human Services) to serve as North Carolina's coordinating agency for the NHSC. Using interview techniques to discover physician preferences combined with computer data bases of community profiles, the recruitment staff places an average of 50 to 60 physicians each year, both from the private sector and the NHSC. The Office's recruitment effort consists of comprehensive and personalized services for both the community and the health care provider. Its recruitment efforts involve not only a four-member recruitment team but also the state's extensive system of nine Area Health Education Centers (AHECs) and the members of the Office field staff, who work with communities on a daily basis. This holistic effort provides a means of examining the dynamics of the placement process from a multitude of views.

In order to secure health care services for rural communities from the shrinking pool of available primary care physicians, the Office of Rural Health instituted in the 1970s a program to recruit physician assistants, family nurse practitioners and certified nurse-midwives. North Carolina pioneered the use of mid-level practitioners in the early 1970s, when mid-levels were the primary caregivers in the state's first Rural Health Centers. North Carolina's Medicaid program reimbursed for mid-level services before the federal government instituted such payments.

The Office of Rural Health also serves as an informed voice supporting rural physicians and providers in the health policy debate in North Carolina, and its philosophy includes a belief that enhancing physician payments and physician participation in Medicaid is an effective way to improve retention rates among rural physicians. The Office also offers reimbursement analysis and other technical assistance in finance to community-based health centers and private rural practices. Other services offered by the Office on an on-going basis are:

1. design services from two in-house architects;
2. assistance in implementing proper business practices;

3. service as a liaison between the community and physicians in areas such as salary, facilities and other aspects of medical practice;
4. linkages with residency programs in North Carolina's four medical schools and AHEC to enhance recruitment of residents;
5. when appropriate, incentive packages to physicians, such as loan repayment programs and participation in the state's Rural Obstetrical Care Incentive program (which helps offset malpractice insurance costs for obstetricians and family physicians who delivery babies in rural, medically underserved areas).

The Office has an impressive history yet finds itself facing new challenges in recruiting and retaining primary care providers in underserved communities. Its leadership decided to undertake an extensive survey of physicians in order to refine its efforts and have greater precision in its placement services.

III. Process of Survey

The North Carolina Office of Rural Health conducted a two-year study of rural physicians to obtain a qualitative view of what factors attract physicians to rural practice and what factors lead to their departures. In the spring and summer of 1992, interviews were conducted with physicians and spouses who had decided to leave rural practices and those who were beginning to practice in rural areas or small towns. Of the twenty-one "leavers," nine had already departed and were established in new positions. Approximately one year after the initial interviews, follow-up sessions were conducted with 11 of the 12 "newcomers" who were still in practice (three of the 15 newcomers had left their practices by the time of the follow-up interviews) and two of the "leavers" who had relocated to neighboring areas.

The interviews were open-ended, relatively unstructured and lasted between 45 minutes and three hours. The questions on the interview guides (included in Appendices A, B, and C) were used to "jump-start" or keep the conversations on track. The detailed questions were not always asked. The guides for the initial interviews were developed with input from health services researchers, physicians and staff from the SORH. The follow-up interview guide was based largely on earlier findings.

Most interviews (approximately 80 percent) were conducted in person (the remaining 20 percent were conducted by telephone), in physicians' homes and offices. Spouses were interviewed approximately 70 percent of the time, with the physician or separately. Key points were extracted directly from the tape-recorded interviews or from interview transcripts. Themes and particular insights from the initial interviews were distilled in background papers and presented at a staff retreat of the SORH in March 1993 and at a workshop with program participants of The Robert Wood Johnson Foundation initiative *Practice Sights* in June 1993.

Summaries of the background papers and key findings from the follow-up interviews are presented in the following report. Minor details have been altered slightly in the interests of confidentiality. Quotes are not exact but capture the essence of a particular physician's or spouse's response, or summarize comments of several interviewees.

Participants. The participants in the study were selected from physicians identified by health systems specialists from the SORH to include doctors from different specialties, geographical areas and with different demographic characteristics. Physicians in private practice and community-based practices were selected. (Community-based practices are defined as health centers with community, consumer boards. Most practices receive federal or state funding.) Physicians from both in- and out-of-state were purposely included in the sample of newcomers. No foreign medical graduates were interviewed.

Sixty-one percent of physicians were family practitioners; the remainder were internists, pediatricians and obstetrician-gynecologists. The 39 percent that were in private practices were almost equally divided among solo practitioners, physicians practicing with a partner and those in groups (three or more physicians). The other physicians were working in community-based practices. Forty-two percent of the physicians were female, one-quarter were African-American, and just over three-quarters were married. Physicians were relatively young when they began in their practices. Over half were 30 years old or younger; nearly 80 percent were 35 or younger. Sixty-one percent of the doctors were NHSC (National Health Service Corps) physicians or were participating in other programs with service obligations, e.g., state-sponsored loan repayment programs. (A more detailed breakdown of

"leavers" and "newcomers" across demographic and practice characteristics is included in Exhibit 1.)

IV. Findings

"LEAVERS"

All was not bleak for physicians and spouses in rural North Carolina. Many enjoyed the friendliness, convenience, and intimacy of their communities, the availability of outdoor recreational activities, and they discovered they had needlessly worried about such matters as making new friends, finding a good baby sitter, or securing a well-paying, satisfying job for their spouse. Physicians often said they were gratified by helping patients who would not otherwise receive medical care, by treating medical problems that urban practitioners routinely refer to specialists, and by making an impact on the larger delivery system. Some spoke highly of hospital facilities and services, about opportunities for continuing medical education, and the financial and technical assistance provided by the SORH.

Problems, frustrations, and unmet needs raised by physicians and spouses varied from community to community and from physician to physician. Doctors and spouses frequently explained that they were gradually worn down by a variety of factors, that their needs changed as they entered different life stages, and that over time they realized that they would have to make a change to achieve a desired goal or objective.

EXHIBIT 1
Physician and Practice Characteristics

	Leavers	Newcomers	Total	(%)
# Physicians	21*	15	36	(100%)**
Specialty				
Family Practice	13	9	22	(61%)
Internal Medicine	5	3	8	(22%)
Peds	1	0	1	(3%)
Med-Peds	0	2	2	(6%)
OB/Gyn	2	1	3	(8%)
Setting				
Community-Based Practice	13	9	22	(61%)
Private-Solo	2	3	5	(14%)
Private-Partner	3	2	5	(14%)
Private-Group	3	1	4	(11%)
Demographic Characteristics				
Male	13	8	21	(58%)
Female	8	7	15	(42%)
White	17	10	27	(75%)
African-American	4	5	9	(25%)
Married	18	10	28	(78%)
Single	3	5	8	(22%)
Ages - When Began				
≤ 30	12	7	19	(53%)
31-35	6	3	9	(25%)
36-40	2	3	5	(14%)
41-50	1	1	2	(6%)
>50	0	1	1	(3%)
Ages - When Left				
31-35	14		14	(67%)
36-40	3		3	(14%)
41-50	4		4	(19%)
Service Obligation				
NHSC	8	2	10	(28%)
Other	6	6***	12	(33%)
None	7	7	14	(39%)
Intentions When Came				
To Stay	9	7	16	(44%)
Open to Staying	7	6	13	(36%)
Planned to Leave	5	2	7	(19%)

* Nine had already departed
** Due to rounding, sections may not total 100%
*** Six were initially involved in loan repayment or similar programs. Others "signed on" by the follow-up interview.

Of the 21 physicians interviewed, nine remained in the area (the same or a neighboring county) and four went elsewhere in the state. Approximately half of the doctors who said they were planning to stay or were open to staying when they first arrived remained nearby. Two who initially thought they would have liked to remain in their communities never really tried. One explained that he saw few opportunities other than starting a solo practice or working in the emergency room, neither of which he wanted to do. All those who planned to leave at the outset left not only their practices but the larger area as well.

Not all were dissatisfied or left to get away from unhappy situations. Some went to fulfill other aspirations—they were "moving towards something" rather than away. Physicians often spoke of their plans to support rural doctors and underserved areas in ways that were more indirect, but nevertheless significant. For many, the decision to leave was not quick or easy. Physicians often left reluctantly, feeling that no one ever "really tried to get them to stay" by finding out their true reasons for leaving, by aggressively trying to improve the situation or by recruiting them to a practice elsewhere in the state.

Not all who had already departed said that "all was well" in their new surroundings. Physicians and spouses missed things they had left. One doctor explained how he now had less influence over hospital matters, greater restrictions on clinical freedom, saw fewer challenging and needy patients, and lived in a community where people did not know each other. Another, who seemed fairly satisfied with his large group practice, was doing less obstetrics and less hospital work, which he missed. Many families spoke of their desire to return to a rural town at some point. "In the back of my mind is the idea that we will eventually move back somewhere nearby," said one spouse. One physician said he planned to return to rural medicine when he was ready to give up hospital work, obstetrics and a higher income. Some maintained contact through friends in the area or by subscribing to the local newspaper. (Refer to Exhibit 2 for the length of time physicians spent in their practices and their destinations.)

The following sections highlight problems discussed by different physicians and their families as outlined in Exhibit 3. (See Appendices D and E for more complete lists of problems, frustrations and reasons for leaving, and notes on circumstances under which physicians said they would have stayed.)

EXHIBIT 2
Tenure and Destination

# Physicians	21

How Long Did They Stay?	
<3 years	6
3-5 years	9
6-10 years	5
>10 years	1

Where Did They Go?	
Location	
Stayed in the Area*	9
Elsewhere in the State	4
Out of State	8
Setting	
Community-Based Practice	2
Emergency Room	3
Private Practice	
Solo	2
Group	6
University (faculty member or fellow)	6
Other	2

* Moved to a practice in the same or a neighboring county.

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EXHIBIT 3
Problem Areas*

Practice; Medical Community

- Excessive and Unending Demands; Insufficient Time Off
- Money
- The Business of Medicine
- Partners
- Scope of Clinical Practice
- The Medical Community (the "medical establishment," competition, instability of physicians and the hospital)
- Respect
- Community-Based Practice (operations, the board, lack of autonomy and control, administrators, government regulations, compensation system)

Lifestyle; Community

- Integrating into the Community
- Schools
- Isolation
- Women Physicians (desire for part-time work)
- Career Opportunities for Spouses
- Disillusionment (lack of support for school bond issues)
- Racial Discrimination

* Please refer to the Appendix for a more complete list of problems, frustrations and reasons given for leaving.

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REALITIES OF PRACTICE

Excessive and Unending Demands; Insufficient Time Off. While physicians in community-based practices often reported manageable workloads—seeing fewer than 20 patients per day, taking call one night a week and every fourth weekend, working every other Saturday morning and having a half day off per week—the

demands on others were excessive and largely responsible for the physician's decision to leave. Physicians told stories of:

- working 80, 90 and 100 hours a week
- taking call every night or every other night
- covering two offices
- traveling back and forth to a hospital 20-25 minutes away
- being approached by patients in parking lots
- having patients stop at their homes after hours
- working with medical examiners and rescue squads who expected them to always be available
- developing new hospital and community services, and
- assuming other responsibilities in addition to caring for their own patients, such as supervising staff in a nearby nursing home.

Some doctors felt that they should be able to do it all—hospital medicine (including intensive care), obstetrics and ambulatory care. Some also felt that they should be able to balance work with the demands of a family with young children (six physicians became parents for the first time while in practice). Physicians' high expectations for themselves and difficulties with "saying no" and "setting limits" contributed to their "burning out."

Doctors wanted time for backpacking, hiking, kayaking and fishing—the recreational activities that initially drew many to the rural setting. They wanted "time off" to really be off, not time to do hospital rounds and catch up on paperwork. And they needed vacations they did not take because *locum tenens* services were expensive or because some doctors felt guilty leaving their patients. Many physicians went into practice expecting to bring in other doctors as the workload warranted but discovered they could not afford to pay a competitive wage or find someone willing to come when the workload increased. After his two-year-old son asked him where he lived (convinced that he lived at the office), one doctor made the decision to leave his rural community, knowing that if he stayed his child would grow up and he would not be part of his life. He had been working 95 hours a week, was never home before dark, and was always exhausted.

Money. While money was not a major problem for all, it was for some physicians.[6] Physicians discussed the pressures of trying to make ends meet when reimbursement was inadequate to cover overhead; of not being able to afford to accept Medicaid patients; and of "hurting their practices" by continuing to see a high percentage of Medicare patients rather than younger, healthier patients with private insurance coverage. Medicare compensated rural physicians less than their counterparts in nearby cities, physicians explained, despite the high costs of "shipping in" supplies and maintaining sufficient staff to operate labs and x-ray machines, which some considered to be needed for high quality care.

"We didn't have extravagant needs and only became concerned about money when we wanted to make a down payment on a house," explained one spouse. Others were concerned about affording college tuition for their children. Even those doctors who did not identify money as a major issue felt strongly that rural doctors should be compensated according to their training and skills, consistent with those in the larger region. It was distressing for physicians to think about the earnings of those who entered practice in the city straight out of residency. They earned significant salaries from the start, physicians said, and their earnings quickly doubled.

"The problem is the amount of money you make for the time you work," said one doctor who spoke for many. "What frequently happens," explained another, is that a 'high-minded' doctor comes, works hard and does not charge much. He makes $25,000. When later he wants to buy a house and have a family, he leaves. Wouldn't it be far better to get this physician on solid ground so that five years later he's happy with what he is making and will stay for the long run?" he asked.

Physicians, particularly those doing obstetrics, said recent state efforts provided some financial relief—improved reimbursement for obstetrics from Medicaid, subsidies for malpractice insurance premiums, and cost-based reimbursement for practices with mid-level providers. While many had hoped that the Resource-Based

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[6] Physicians typically earned between $55,000 and $70,000 the year before they left (range based on those who left 1990 - 1992). Earning significantly more were those in obstetrics/gynecology and a family physician in private practice who treated a fairly homogeneous population (few Medicaid patients) and reported a collection rate of 95%. The average salary for physicians who worked in a community-based practice (family practice, internal medicine and pediatrics) was slightly higher ($66,000) than the average of those in private practice (low 60s, excluding the high-earning outlier).

Relative Value Scale (Medicare's new reimbursement scale for physicians) would improve things further, others remain doubtful.

The financial performance of their practices could be improved, said some, if they increased their charges (many reluctant to do so), improved on coding, were more aggressive about billing and collecting and streamlined their operations. The high-earning family physician provided evidence that a favorable financial picture was possible, at least in some places and under some circumstances (e.g., limiting Medicaid). "A doctor can make $80,000 to $100,000 in a small efficient group practice if he worked extremely hard," said one physician. But the alternatives became too attractive to this doctor, and some others. It was clearly easier to make $100,000 a year working in the emergency room for fewer than 40 hours a week with no call.

The Business of Medicine. Many physicians who were eager to begin private practice were beaten down by the demands of practice in the 80s and 90s. They complained about Medicare "tightening the screws"; the threat of fines for incorrectly coding diagnoses and treatments; regulations that constantly changed; the burden of CLIA (the federal Clinical Laboratory Improvement Amendments); inadequate reimbursement; and insulting, upsetting letters from the PRO (Professional Review Organization) that frequently incorrectly questioned the appropriateness of their care.

Some doctors felt uncomfortable mixing money and medicine. Said one doctor, "I never felt good about charging, about not charging, about collecting, or not collecting." After struggling with money in a small private practice, he concluded that physicians should not be entrepreneurs with the same considerations as those in other small business. This doctor went to work in a setting where he felt he would be somewhat insulated from such matters.

Physicians felt insufficiently trained to deal with the business aspects of the practice, including many of those who had taken courses in practice management during their training. Some could not find or afford office staff who were capable of managing the practice. And competent staff were critical to efficient management of a practice, many discovered.

Partners. Many physicians had difficulties with their partners. Conflicts were about whether to expand or contain the practice (more time for family); how to allocate revenues (pensions, staff salaries, physicians' incomes); whether physicians were carrying their fair share; practice styles; and whether medical students should rotate through the practice (reduced patient volume and revenue). Physicians spoke about personality conflicts and joining the practices of weary physicians who relied too heavily on newcomers because they badly needed relief.

Often communications were poor, there was little effort to work out differences and bad situations grew worse until they reached "the point of no return." While some physicians did stay in the general area where they had practiced, this was not an easy option for others. Some feared going out on their own without the support they felt they needed. Non-compete clauses in employment contracts also served as obstacles to remaining nearby.

Physicians emphasized that a doctor often spends more time with a partner than with a spouse and it is difficult to evaluate a prospective partner unless one has had a chance to work closely together. Conflicts are less problematic in a group practice where other physicians can serve as buffers and defuse tense situations, doctors said.

Scope of Clinical Practice. Physicians came to rural North Carolina expecting to practice "the kind of medicine" they were trained to practice. For many family physicians that meant doing obstetrics, treating sick hospital patients, and seeing a wide range of clinical problems in children, middle-aged adults and the aged. Because of other physicians in the community, patient expectations, logistics and financial realities, the practices for family physicians and other primary care doctors were often more limited.

Reluctantly, many family physicians gave up doing obstetrics. It was difficult to leave a waiting room full of patients to deliver a baby, to trek back and forth to the hospital that in some cases was 20 or 30 minutes away, and to find others to share call. Arranging obstetrical backup for high-risk deliveries and Cesarean sections was a major stumbling block for many. Family physicians told stories about obstetricians who did not think family practitioners should be doing obstetrics, obstetricians who viewed them as competitors, and obstetricians who were already overworked,

fearful of malpractice suits and not eager to be referred only difficult cases, particularly in the eleventh hour and for little reimbursement.

Because patients' families in his community wanted their loved ones to be referred to the "experts" and family physicians referred patients they could not treat to city specialists rather than local internists, an internist said he functioned almost exclusively as a primary care provider and rarely as a consultant to other doctors. A pediatrician explained that "I didn't see newborns because patients delivered in a nearby town where a favorite obstetrician practiced." An obstetrician-gynecologist said he did not do some procedures he was trained to perform because the hospital was not properly equipped and nurses were not adequately trained. Like many other physicians, he was concerned about losing clinical skills. But there were those who were able to practice the kind of medicine they wanted and would have been unable to do so in urban areas where more is referred and falls under the auspices of specialists.

The Medical Community. Those who had problems with other physicians, the hospital or the medical establishment spoke about the stress of working around inadequate surgeons, obstetricians and specialists who, sometimes, were the only "game in town." Physicians were frustrated by the "good old boys," the "old guard," and "old-timey" physicians who were obstacles to changes that would improve the quality of hospital care or who were concerned about protecting their own turf. Three physicians shared the following about their experiences:

- "It took me years before doctors in a nearby community agreed to share call with me. I got the 'cold shoulder' when I came."
- "When I decided to hospitalize patients at another facility, the hospital established an outpatient center near my office."
- "Doctors opposed bringing in midwives because of the negative economic impact it would have on their own practices."

In looking back, one physician admitted that he had been arrogant when he first arrived and learned that a doctor must "earn" respect. Another, who faced opposition from physicians on the medical staff in his efforts to update the care in the hospital, observed a more successful colleague who was "extremely patient and

persistent," was more permanent and had a longer-term stake in the medical community than the temporary NHSC physician interviewed.

The instability of physicians and hospitals in some communities took a tremendous toll on doctors. "As physicians moved in and out of the area, our workload fluctuated; call increased and decreased; and our incomes rose and fell," explained one doctor. As they saw hospitals close and services deteriorating or eliminated as revenues dwindled, doctors feared that they would not have what they needed for patient care. Poor hospital employee morale, staffs who feared cutbacks and a hospital's poor reputation wore physicians down. Some felt deeply about the hospital's plight and were painfully aware of the effect they personally had on the hospital's bottom line. Physicians spoke of the feeling they had when a hospital suffered a loss because they treated a patient whose "DRG" (or Diagnostic-Related Group, a method of Medicare reimbursement) did not cover the costs. Some were highly critical of the hospital governance and administrators who were "asleep at the wheel" or who did not see the need for change. One physician summarized her feelings about practicing in a rural community: "I always felt insecure and like I was standing on thin ice."

Respect. While many said they felt highly regarded by patients and community leaders alike, others did not. "Many people assume that rural physicians are inferior ... When someone comes without any pay-back obligation everyone wonders what they are running from," said physicians. A doctor who left for a more prestigious setting spoke about the irony of treating patients who would have bypassed him in rural practice. But some physicians understood why patients went elsewhere for care. "After seeing a train of physicians come and go, it is no wonder," one said.

The low regard for rural doctors, physicians explained, often extended beyond the community to larger medical centers where they were often derogatorily referred to as "LMDs" or local medical doctors who "miss diagnoses" or "screw-up treatments." One physician felt snubbed by doctors at a medical center meeting who he felt assumed he was incompetent.

It is interesting to note that incoming physicians reported relatively few negative "LMD" experiences during their follow-up interviews. For the most part they felt that medical centers and specialists in practice needed and valued the referrals. And

they seemed to have few qualms about going to another consulting physician or center if they were not being treated appropriately. One incoming physician was truly ashamed at how he had regarded rural physicians when he was a resident surrounded by state-of-the-art equipment and other doctors for easy consultation.

COMMUNITY-BASED PRACTICE

Seven of the 13 doctors in community-based practices came to fulfill NHSC obligations. Many were angry or extremely disappointed when they arrived, having preferred the "private practice option" to a community health center, or an urban setting or another state. In spite of their initial unhappiness, some were eager to work hard and "make a difference." Others felt that they were "putting their lives on hold" or "marking their time."

Many community-based practice physicians spoke highly of their centers, citing staff who were stable, exceedingly competent and anxious to incorporate new ideas; competent management; and important support received from the board. Others were very critical of different aspects of the center's operations. Among their comments were:

- The community-based practice was run at the staff's convenience rather than the convenience of patients or physicians.
- The community-based practice had too cavalier an attitude toward finances. It took too long for the practice to learn to code correctly, to bill and collect aggressively and to run like a business instead of a charity.
- The board was politically appointed, did not understand medical care and micro-managed the practice instead of setting policy and providing community input.
- Board members were "unthinking and prejudiced."

Some who tried to change the image of the center from a free, walk-in clinic to a medical office where patients were expected to make and keep appointments were frustrated. One physician explained that he was constantly fighting the common belief that a doctor who works in a community-based practice could not get a good job elsewhere. The stigma associated with a center in some places seemed to automatically transfer to its physicians. A community-based practice was legitimized as a high quality center when board members, community leaders and their families came for medical care. The "indigent clinic" image was reinforced when they sought care elsewhere.

Those who wanted more autonomy and control over the scheduling of patients, staff and policies and did not have it were frustrated as well. Doctors explained how they often felt powerless to readily respond to problems such as improper billing when they were identified by patients. Some complained about being controlled by unqualified administrators. It was clear to one physician that community-based practices would be in better shape if they were under the management of doctors, rather than non-clinicians. "Doctors know what is best for their patients," said one doctor who never felt like the practice was his own. Others wanted no role in management but wanted the practice to "run efficiently" so they could be "free to treat patients."

Physicians also complained about government regulations that reportedly prevented one doctor from cutting back to part-time, and burdensome paperwork that often had "little to do with the quality of patient care." It was a strain to work with other doctors who did not share a similar style of practice, said doctors.

Salaries should be tied to productivity so that those who work harder and take on more responsibility will be more fairly compensated, thought some. Under such an arrangement, one physician was convinced, the volume of patients seen at the center would increase substantially.

LIFESTYLE AND COMMUNITY ISSUES

There were pluses and minuses to living in a place where everyone knows everyone else. On one hand, physicians said, people were extremely considerate and helpful. The bank would call before bouncing your check, and the garage would deliver your car to your office after being repaired. It was nice to be greeted on the street and run into people you knew. But it would have been nice to have some privacy, such as being able to visit a counselor without everyone recognizing your car in the driveway. "Seventy-five percent of the time, I was happy about [living in a community where everyone knows everyone else] and 25 percent of the time I was not," said one doctor. The "fishbowl" existence, thought one physician, is probably most difficult for single women and those who were not used to everyone knowing each others' business.

Integrating into a community where the social life often revolved around the church and extended families was a significant problem for some. "No one ever told us they were glad we were here ... People didn't even have us for dinner ... We never felt part of the community," said one physician who spoke for others. Some interviewees discussed the reasons physicians and their families had difficulty integrating into the community in these terms:

- Rural residents find it harder to accept outsiders than those in the city ... It takes them longer to warm up to outsiders ... And they expect longevity. When they fear they will lose someone, they are less likely to embrace them. It is not like the city where people are more accustomed to short-term, come-and-go relationships.

- People find it difficult to think of doctors and their spouses (better educated and often from a higher social class) as friends and not physicians. "Friends at work would have felt uncomfortable coming to my house," said one spouse. "After all, I was the doctor's wife."

- It was hard to let one's guard down and to find friends among people in the community. Everyone was a patient or former patient.

- People in the community were extremely provincial and intolerant. In our community, to be "different" and "wrong" were the same thing.

Some interviewees recognized that they were partially responsible for not developing closer ties with people. Physicians had little free time. Some who considered themselves as temporary did not want to invest the time and energy necessary to cultivate relationships. "People have told me that it generally takes between five and six years to feel part of a community. In my situation it would have taken ten," said one African-American physician.

Interviewees who reported little trouble integrating into the community were often from the area or a similar rural community or took the initiative to build relationships and become involved in community activities. Because of their involvement in the community, explained one physician, we stayed longer than expected and had a difficult time deciding to leave.

Some physicians and spouses were dissatisfied or frustrated with other aspects of rural life. Their problems included:

- **The Schools.** Elementary schools were often regarded as excellent while middle and high schools generally were not. What seemed to trouble interviewees most was the overall educational environment where residents had limited aspirations for their children. Interviewees wanted their children to be challenged, to have broader horizons and to be able to compete with those educated in other places.

- **Isolation.** "One can't really understand what it is like to be isolated until one lives it for a year or two—until one sees what it's like to drive several hours over and over again to buy something fairly commonplace like baby socks, ballet slippers, a wedding gift, or to take children to swimming meets."

  Her friends helped her survive "the intense practice" and "a lack of cultural things," said one single woman doctor who, like many others, felt friends were very important. Interviewees recalled the major loss they felt when one of their few close friends moved away. Because there was little free time and a small pool of "like-minded people," physicians' and spouses' personal friends were often professional friends or other transplanted professionals. The best solution at least one African-American physician seemed to find was to live in a larger community with more middle and upper-middle class African-Americans.

- **Women Physicians with Small Children.** Some woman physicians with small children found it difficult to work part-time. One was not given the option by the practice where she would have liked to remain. Despite her efforts to cut back, another doctor ended up working full-time but making half the money. Working mothers had little time to build relationships with others.

- **Career Opportunities for Spouses.** Jobs were not a problem for the wives of most physicians or the physician husbands of women doctors. Career was an issue for one wife and the one husband who was not in a medical or health-related field. (Eleven of the 18 spouses were in medical or health-related fields.)

- **Disillusionment; Lack of Support for School Bond Issues and Community Programs.** Physicians and spouses were often idealistic when they came but became disillusioned when the community defeated school bond issues or did not support youth-oriented programs. It became painfully clear (often after much work) that those in the community had different priorities and different values than they, and that things were not likely to change, or at least not in the near future.

- **Racial Discrimination.** Some African-American physicians spoke about racism and exclusive white private schools. Their children first heard the work "nigger" when they moved to the area, said one couple.

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Two strategies often advocated by those who struggle with the problems of access and physician "overload" in underserved communities are the expanded use of mid-level providers (physician assistants and advanced practice nurses) and alternative models of delivery. Departing physicians discussed these two issues in depth.

Mid-level Providers. Attitudes toward mid-level providers were discussed with incoming physicians during initial and follow-up interviews as well as with those who departed their practices. Physicians had a greater appreciation of nurse practitioners and physician assistants after having been in practice. Those who had been somewhat skeptical initially and worked with mid-level providers felt comfortable with their ability to handle and refer patients. In many instances physicians said they had incorporated, or were considering incorporating, physician assistants and nurse practitioners into their practices. Mid-levels were often contemplated only when doctors were unable to recruit physicians who could take call and more fully share the workload.

Physician assistants and advanced practice nurses will not relieve physicians of some of the most critical problems they face in practice, some doctors said. "They can't take full call, admit patients to the hospital and they generate additional work." Repeatedly doctors said, "What the physician needs is a night off. If a doctor has to backup a nurse practitioner, he is not really off. He can't, for example, go to the city for dinner. A nurse calling from the ICU or a doctor calling form the ER doesn't want to speak with a nurse practitioner, but to a doctor." Physicians were not always comfortable being liable for the actions of mid-level providers. Competition and expense probably inhibited some physicians from incorporating mid-levels in their practices, interviewees thought.

Alternative Practice Models. Physicians were asked about adopting an alternative practice model where family physicians would provide outpatient services and refer

patients to pediatricians, obstetricians, internists and specialists for inpatient care. Under such an arrangement, it would seem, family physicians' workloads would be more manageable. "I don't want to give up delivering babies or hospital medicine," some said. Opposition to such arrangements arose from beliefs that it was important to maintain continuity between outpatient and inpatient care; that hospital medicine keeps them "current" and reduces professional isolation; and that they wanted to do what they were trained to do. One doctor explained:

> Family physicians are ingrained to believe that you are less of a doctor if you do not take care of your patients in the hospital ... When a doctor becomes known as a "cold doctor" who refers patients who are really sick and need to be hospitalized, the doctor loses his credibility and patients go to the physician who can take care of them ... A family physician who provides only ambulatory care is burning his bridges.

This physician was convinced that the reason he was able to obtain privileges at a major hospital after years in a rural area was because he had not restricted his practice. But not all physicians seemed as concerned about these matters. Some preferred and chose to provide only ambulatory care.

"NEWCOMERS"

Nine of the 15 incoming physicians interviewed were family practitioners, three were internists, two trained in both internal medicine and pediatrics, and one was an obstetrician-gynecologist. Nine physicians were working in community-based practices and six were in private practice. Three of the physicians in private practice were solo practitioners, one was starting a practice with a partner, and two joined already-established practices.

Prior to working in a rural, small town in North Carolina, ten doctors were in training and five had been in practice. Upon entering practice, two doctors said they planned to stay temporarily, seven hoped to remain permanently, and six were open to the possibility of staying indefinitely. Only two interviewees were NHSC doctors; six were involved in other programs with service obligations, e.g., state loan repayment programs. (Refer to Exhibit 1 on Page 8 for a more detailed breakdown of participants across practice and demographic characteristics.)

By design, the study of incoming physicians included 15 doctors who came from both in- and out-of-state (nine were not raised in North Carolina) and doctors who had attended in-state and out-of-state medical schools and residency programs (eight had attended out-of-state medical schools; six had trained in out-of-state residency programs). It is interesting to note that all six of the doctors who were not raised in North Carolina and who had not attended North Carolina medical schools or residency programs had prior connections to the state, such as relatives living in the state, attendance of in-state colleges, or past vacations in North Carolina. Nine of the 15 physicians interviewed were raised in rural areas or small towns.

During the interviews, physicians discussed their interest in primary care and rural medicine. Doctors and spouses described what they were looking for in a community and a practice, their recruitment experiences, and their reactions to different recruitment approaches. They shared their experiences and feelings as they were settling into the community.

Interest in Primary Care and Rural Medicine. Doctors pursued rural primary care despite the negative attitudes regarding primary care and rural physicians which many encountered during medical school.[7] Physicians wanted to develop ongoing relationships with patients and their families and to be "the primary detective on the front end," not the doctor who saw the patient after he was "sent down the pike." In family practice, doctors could do "a little bit of everything" and not be limited to treating one organ system or those in a certain age category," interviewees said.

It was not "rural medicine" *per se* that they were often seeking. Physicians sought places where they could help the underserved, live near the mountains, the beach, or escape from traffic, crime and impersonal cities. The desire to serve the needy was often linked to a physician's religious faith. Feeling that they could serve the

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[7] One physician recalled being told that "family medicine is a dying specialty." Another was advised to pursue a combination of internal medicine and pediatrics instead of family medicine. Students got double messages at her school, said one doctor. The dean told students that "primary care is where it's at" while the faculty on the wards put pressure on students to subspecialize. The messages seemed fairly clear: family physicians tried to do too much and were undertrained. Smart doctors specialize and do research. Interviewees said that doctors form negative impressions of rural physicians or "LMDs" (Local Medical Doctor, a term often used in a derogatory context) early in their training.

needy at home as well as abroad, some who were interested in working overseas elected to work in the states, closer to their families.

SELECTION

What They were Looking For in a Community. Some physicians and spouses who were weary from moving during their medical school and residency years spoke about "delayed gratification" and their desire to establish roots. They wanted to be "part of a community," to "belong somewhere" and to live "where people knew each other." They were after a "good quality of life," where their families could feel safe (leave their car doors unlocked), comfortable (attend a church where they would feel at home) and in easy reach of outdoor recreational activities. A "good location" was critical to many. For some that meant being close to a "significant other," grandparents or parents who were ill. For others that meant being near a city, salt-water fishing, or as noted earlier, the beach or the mountains.

When asked what they were looking for in a community, interviewees identified different features. They wanted communities where people knew each others' children; spouses could pursue their careers or other interests and find interesting people (people involved in crafts and the arts); housing was affordable; and people supported the school system. Some interviewees were after a more relaxed lifestyle than they had had previously.

What They were Looking for in a Practice and Medical Community. Physicians were looking for practices that matched their own philosophy toward patient care and where they would see the cases they wanted to treat. Newcomers wanted to steer clear of "turnstile operations where every patient was viewed as a buck." Some were intent on finding a practice whose main purpose was to serve the needy.

Physicians frequently said they wanted to work in a place where "everything wasn't referred" and where they could follow their own patients in intensive care. Those who preferred ambulatory care sought practices where they would be expected to do little hospital medicine. Many family physicians looked for communities and practices where they could do obstetrics.

Time and money were concerns. Doctors frequently emphasized that they wanted to go where they would have an "outside life," where call schedules were reasonable and where they would have the freedom to take vacations. One woman physician wanted a part-time position and two planned to take maternity leave soon after

arriving. Physicians sought secure salaries, income guarantees, and situations where they felt they could generate "a good living" before too long.

Practices with efficient systems and up-to-date equipment (transcription services, FAX machines) that would help physicians do their jobs effectively were high priorities for some. One physician, who did not want to be involved in the day-to-day management of the practice, was particularly interested in joining a practice with a good administrator. Physicians wanted to ensure that the hospital was secure and malpractice coverage was adequate. Many were after sites that would qualify for the NHSC or other loan repayment programs.

Why did interviewees select one site over others? Among the chief reasons cited:

- the physicians in the practice and the community
- visiting consultants were available to see patients
- the community was dynamic and growing
- economic incentives[8];
- an impressive, competent administrator
- the proximity to the referral center where the physician trained
- a high quality hospital that seemed secure and committed to maintaining quality, and
- a well-equipped and efficient office.

(Please refer to Exhibit 4 for features that influenced physicians to select and eliminate specific sites.)

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8 Repayment of medical school loans, below-market rents and guaranteed incomes were among the economic incentives physicians mentioned. Of the six physicians who entered private practice, four established new practices. All were guaranteed incomes from the hospital their first year in practice. The median income for the 12 full-time physicians for whom data were available (includes salaries for community-based practice doctors and private practitioner guarantees) was $76,000. The highest community-based practice salary of $90,000 was topped by only one private practitioner who was guaranteed $95,000 for her first year in practice. The lowest community-based practice salary was $66,000.

newcomer who was establishing a practice suggested that the SORH provide residents interested in rural practice with management skills and encouragement during their residencies and a practice's start-up.

Physicians suggested that the SORH more actively promote the loan repayment program to medical students. One doctor recommended that the Office support efforts to develop a statewide computer-assisted site selection program similar to the American Academy of Family Physicians' national program. Medical conventions provided "good" opportunities to learn about practice opportunities but often they were "overwhelming." In discussing the American Academy of Family Physicians' Computer-Assisted Site Selection (COMPASS) program, physicians noted that some appealing places were not included because of the cost of listing a practice or were eliminated because the criteria were quite narrow.

Rural practice seems to appeal to physicians with varying backgrounds, interests and needs. Among the categories of physicians that the SORH and others who seek rural physicians might target that emerged from the interviews were:

- **Retired military physicians.** Those who have supplemental incomes, do not want the responsibility of running a practice, are accustomed to what one physician termed "socialized medicine," and whose children are grown (schools not a concern) seem well-suited to community-based practices. One doctor explained how military physicians, like rural doctors, often work with limited resources in small hospitals far from tertiary centers. There may be opportunities to recruit military physicians given "the new world order," he thought.

- **Those interested in serving as medical missionaries or overseas** who might be drawn to rural areas where they can find similar rewards. (Medical missionaries often spend time in the United States between tours or before re-enlisting.)

- **Young families looking for a place to "put down roots."**

- **Pioneers and entrepreneurs** who, to different degrees, are interested in "striking out on their own."

- Families seeking **lifestyles that offer easy access to kayaking, hiking and other outdoor activities.**

EXHIBIT 4

	ATTRACTORS; REASONS SITES SELECTED	DETRACTORS; REASONS SITES ELIMINATED
Practice/Medical Community	• The "chemistry" with prospective partner • Really feeling wanted • Economic incentives, (repayment of medical school loans, income guarantees, overhead allowances) • Physicians: high quality, up-to-date, younger; in medicine for the "right" reasons, not there because "didn't fit in" elsewhere; visiting consultant available to see patients; the partner (precepted in the doctor's residency program) had an excellent reputation • The practice's particular emphasis (ambulatory care); the patient mix (children and adults) • Supportive of physician's particular interest (to work with HIV-positive and AIDS patients); willingness to meet physician's particular needs (would allow the doctor to live outside the county and reimburse him for renting a room to use when on call) • An opportunity to work part-time • Practice administrator (competent, anticipated questions and needs) • A well-equipped office and staff who were willing to add services and equipment requested by the incoming physician • Community-Based Practice: atmosphere (lovely surroundings, warm people, "private practice atmosphere"); practice strongly supported by the community; overseen by a community board rather than the hospital (different priorities) • Hospital: fairly secure (not at risk of closing); committed to upgrading, renovating or opening services; supportive emergency room staff • Accessible to the referral center where trained	• Lack of chemistry with other physicians • Didn't really feel needed; concerned would get bored (too many "worried well") • Site not eligible for loan repayment program • Lack of financial security • Excessive reliance on "revolving door doctors" (only there to fulfill service obligations); high turnover • Practice's philosophy/approach to medical care differed from the physician's (functioned like an urgent care center); patient population (practice didn't treat children) • Size (practice too large/less personal) • Poor management (scheduling and billing problems) • Physicians and the hospital were "at odds"
Lifestyle/ Community	• The community was growing, seemed dynamic; "things were happening" • The town was not too small; it had more than one grocery store, a nice library, "okay" shopping and access to a decent airport • The community was near where the physician was raised	• Town seemed to be "dying" • Proximity to extended family (too close or too far) • "Cars outnumbered trees" • Area too commercialized • Town seemed "snobbish"

Search Process. Residents usually began their job searches by the end of their second year or in August or September of their last year. Physicians followed diverse paths to select their practices. Some took the initiative by contacting hospitals, health departments and other agencies rather than responding to calls and ads by search firms. For the most part, interviewees were suspicious of "headhunters" and slick letters, ads and brochures. They preferred more personal, straightforward materials that emphasized the characteristics of the doctors in the practice and community, the friendliness of local residents, and opportunities for recreational and other activities, rather than "the size of the shopping mall and the large guaranteed income." Physicians and their families want to be able to envision how they might fit into a community, newcomers said. Physicians were on the look-out for information from proven and reliable sources.

Physicians disliked receiving prospecting telephone calls when they were seeing patients at the hospital and the office, and spouses preferred calls after childrens' bedtimes. One physician described feeling annoyed but flattered when a practice called him on Christmas morning. When a physician says he is interested, warned one doctor, a recruiter should not "drop the ball." Several key people in the community—other physicians, the hospital administrator and those with information requested by the doctor and spouse—should contact the candidates, making them feel wanted.

Initial recruitment visits were often very short—a half day to two days—and offered interviewees relatively little opportunity to get a good sense of what life would be like. "Unless you do a rotation in a practice, it is difficult to get a good feel for doctors you would be practicing with," interviewees contended. More than a third of the physicians were familiar with the practices or communities where they settled, i.e., they had lived or had done a rotation or elective in the community or in a nearby area.

Physicians and spouses were drawn to places where they met people who were confident, competent, genuinely interested in meeting the spouse's needs, and with whom they could identify; where they felt really wanted; and where people anticipated their needs (provided pleasant accommodations, free meals and transportation, baby sitting and a chance to explore the community independently). Also especially appreciated were opportunities to get to know prospective partners

over an informal, leisurely dinner at a doctor's home rather than in a restaurant and to meet with other physicians in the community.

Hospital administrators, doctors in the practice and community, clinic administrators, staff from the SORH, and members of a church were among the people identified as instrumental in attracting interviewees. "The administrator and I really saw eye-to-eye on a lot of matters," explained a physician who was impressed by the administrator's medical care philosophy and the hospital's interest in opening new services. Many interviewees emphasized the critical and positive role SORH recruiters and "field" staff (who help organize health centers) played during and following their recruitment. SORH staff were enthusiastic, easy to relate to, quick to respond to questions and concerns, and eased their way by persistently dealing with obstacles involving loan repayment and relations with hospitals, interviewees said.

The Decision. While physicians readily identified objective reasons why they chose one practice and community over other alternatives, they often described their decision in emotional rather than rational terms—things "clicked" for them. Physicians and spouses seemed willing to take risks with call, obstetrics backup and other matters if the "chemistry" was right. While some interviewees seriously considered their long-term needs when they decided on particular practices and communities, others did not seem to think far into the future—about job opportunities for spouses who might decide to return to work, their families' long-term financial needs, or schools for their children when they grew older. (More than half of the physicians had children three-years-old or younger, or planned to have children in the near future.) While many hoped to establish roots and remain in the community, they generally felt that if things did not work out they could move fairly easily. After all, "there were a lot of good opportunities out there."

Recruitment Approaches. Interviewees considered residency programs as good recruitment channels for state agencies and physicians and hospitals recruiting on their own. Recruiters are most effective when they became familiar with residents on an individual basis, are easy to contact, and do not bother those who are not interested, according to interviewees. Physicians suggested bringing in enthusiastic practitioners to speak and invite students and residents to visit their practices, and organizing get-togethers with potential candidates identified by recent graduates. A

- Physicians who are **interested in learning about the business of medicine** before venturing into private practice or assuming leadership roles in community-based practices.

SETTLING IN

"It's like the job came with a food supplement," said one physician when asked what people did that made her feel particularly welcome. Others commented on hospital receptions, letters of introduction from specialists, dinners at the homes of physicians in the community, meals with board members, invitations to join civic clubs and to speak with community groups, and flowers from the hospital. Those who received assistance in finding suitable housing were particularly appreciative.

Not all interviewees felt welcomed. Some physicians were disappointed that the hospital made no announcement of their arrival or did not arrange for an orientation or a welcoming dinner. Housing was a significant problem for many who explained that rentals were almost nonexistent.

As interviewees began to settle in, they became aware of inconveniences and problems they had not fully comprehended when they visited, such as the time it actually took to reach the hospital, the grocery store, and extended families. A lack of equipment, shortcomings of support staff and additional job responsibilities were also mentioned. Physicians were anxious about "loose ends" that remained: arrangements for sharing call, unsigned contracts and hospital privileges that were not yet granted.

Four of the six physicians who were beginning private practice were establishing new practices. With the exception of one physician who had been in practice for years prior to settling in North Carolina, doctors felt overwhelmed and would have liked more assistance with the "start-up," even those who had help from consultants and the hospital. But while they wanted assistance, they were intent on maintaining control; they did not want to be managed by others.[9]

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[9] Some physicians relied on financial projections from the hospital and the hospital's willingness to guarantee an income and provide an allowance for operating expenses in determining that the practice would be financially successful. Physicians who worked with consulting firms hired them to do a limited amount of work (computer hardware and software, marketing plans, procedure manuals) rather than to provide comprehensive services (set up systems, hire and oversee staff).

Physicians identified reasons which might lead them to leave. In addition to distances to extended family and inadequate housing were:

- problems with a call group
- the hospital and the organization overseeing the health center
- incompatibility with partners
- money (not enough soon enough)
- lack of free time
- inefficiencies in the practice
- lack of support for the physician to deliver the "kind of medicine" that s/he wished to provide
- dissatisfaction with the schools
- desire for their children to have a "more cosmopolitan view of the world"
- dissatisfaction of their spouse, and
- a decision to pursue additional training

Not surprisingly, the concerns and possible reasons for leaving were similar to those raised by the leavers in earlier interviews.

FOLLOW-UP WITH "NEWCOMERS"

Three of the 15 doctors originally interviewed had left their practices by the follow-up interviews. All had practiced previously, but outside of the state. Follow-up interviews were conducted with 11 of the 12 remaining physicians and seven of the eight spouses of married doctors.

As expected, many newcomers identified problems mirroring those experienced by leavers, including some they had not anticipated. The call schedules of several physicians were unexpectedly difficult. Instead of having call every third or fourth night, physicians found themselves taking call every night, every other night, or for a week at a time every other week. Arrangements for obstetrical coverage or backup did not materialize as planned. Some doctors were feeling the strain of excessive demands, too little time off, and paperwork. "I don't have a day off and it is starting to have its effects ... Little things that people do seem to bother me more than they would normally," said one practitioner who was hoping to be joined by a partner. "The thing that is most worrisome to me ... is what if we don't get more doctors,"

said another doctor who saw the workload of remaining physicians change as other doctors left the practice.[10]

Like the leavers, many doctors were struggling to balance work and young families. "We're both stretched pretty thin," said one physician-father with young children about himself and his wife. The eight physician-parents all had children younger than five years of age.

Physicians tried to address many of the problems they faced. Approximately half were recruiting other physicians to share the workload. One doctor who happened to attend a session on "stress and burnout" at a medical meeting was actively taking steps to alleviate pressures in his office. Another physician intentionally delayed taking on additional hospital duties until other doctors were recruited. He discussed the demands of rural practice and the need to set limits.

> I'm always finding myself saying, "how can I do everything they expect me to do" ... When you are a rural doc, people expect you to be there for everything. But, we [the physician and his partner] just had to set limits. And we've had to really stick by them. The few times I've given my phone number out, or agreed to go into the ER when I wasn't on call, I regretted it. We just said this is the way it is, and this is why ... We work very hard. We're doing what we can do. And for awhile that [setting limits] was really hard to do.

It was important for the practice to say, "you don't have to be every place, every time," explained one physician who attended many evening meetings and was concerned about neglecting her children. Like others, she had difficulty saying "no." She was always afraid she'd miss something critical if she skipped a meeting.

Only one of four private practitioners failed to earn his/her targeted income during the first year in practice. "Internal medicine is not as lucrative an adventure as one would hope for ... You have to really do volume to make much money," said one physician who attributed her problems to underestimating start-up costs,

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10 Most full-time physicians estimated working between 60 to 70 hours a week. This included "active call," i.e., time spent in the hospital or on the telephone while on call. Generally doctors saw 20-25 outpatients a day. One physician estimated averaging 16; others saw 25-30. What took extra time, physicians often explained, were the geriatric patients. In addition to their office and hospital practices, many physicians had assumed other responsibilities in the health department, the hospital, teaching programs and in the community. A part-time physician reported working significantly more than planned.

undercharging, overestimating revenues, poor collections, and assuming her practice would be similar to that of a family physician whose practice included children. In budgeting for the coming year, she projected earnings 25% below those assumed in the first year. She was considering obtaining additional training that would enable her to do upper endoscopies and other procedures to increase her revenues by treating patients she would otherwise refer. She had gone into practice with little management assistance.

The other three private practitioners (all family physicians) exceeded their more conservative income projections. One doctor, who was doing obstetrics and limiting the number of Medicare patients, surpassed her guarantee by $15,000. A physician in a community-based practice reported a salary increase of 35% for the coming year. (Note: As noted earlier, many physicians received money to repay their medical school loans. These moneys were in addition to the stated salaries and income guarantees.)

Relations with hospitals and community physicians were positive for some physicians but not for others. Most community-based practice physicians spoke of supportive boards of directors. Inefficiencies in clinic operations and the appeal of private practice (more control and autonomy) were noted by a few of the doctors. Not all interviewees were satisfied with their social lives or felt integrated into their communities. One woman doctor reported having few friends and being approached about medical problems at social functions. One single physician answered *"Nada,"* when asked about the social life in the community. This doctor was living in another community where many transplants lived and went out-of-town for entertainment. Other interviewees said they "blended right in," and things were "better than expected." "It really is a child town," said a spouse who explained that she had met a lot of professional women who were staying home with the children. She greatly valued her one-hour access to a larger city where she was considering joining a YMCA and the fact that she could buy airplane tickets and get away. Only one spouse seemed to be having difficulty working out a satisfactory work life. Schools and an "anti-education" feeling they had picked up were beginning to concern some newcomers. No physicians reported significant conflicts with practice partners.

Newcomers were concerned about losing patients to doctors in networks and health care reform. One doctor saw community residents seek care in a neighboring state where they worked and where physicians were approved by employers and insurers. Several were involved in newly-established networks or indicated that community physicians were investigating the feasibility of different arrangements. When speaking about rural physicians and health care reform, one doctor said:

> I think we're really at risk ... I think a lot of us are operating on much thinner margins to begin with, and we don't have a safety net to fall back on ... All the capitated systems are going to be a nightmare for anybody in rural health ... We're not big enough to really be able to do the actuarial work ... When I look at the patient population that I'm seeing, we're seeing people who are older as a general rule ... and patients who are less likely to take good care of themselves. They're more likely to not stop smoking and to not control their cholesterol ... I have a lot of fear that any sort of capitated system is not going to work to a rural health person's advantage.

The view of another:

> I can't understand how we're going to integrate into anything bigger because there's nothing bigger. I mean, there are only a few of us and the hospital. You know, it may be that we're going to have to all come together in some form of group in order to continue to get paid but I hope not ... It's nice to be independent.

But a single-payer system was somewhat appealing to at least one private practitioner who was dealing with different payers and reimbursement rates, was working without a computer or outside management assistance, and was routinely returning to his office at night to catch up on paperwork. This physician, who was wary of expensive, "long-winded" consults who want to "sell [their] time," was interested in having effective and affordable management training (for employees) and assistance that he could trust.

Like many leavers, newcomers were relatively inexperienced in rural practice when they came. Ten of the 11 follow-up interviews were with physicians who had just completed their training. Many physicians explained the difficulty they had in determining what they should handle locally and what they should refer elsewhere. "One of the biggest frustrations for me," said one doctor, "has been learning when to send people away from this hospital. Because I trained in a place where I didn't

have to send anybody anywhere ... it was all readily available ... and it's such a big deal to send somebody." Physicians frequently said that they were "too compulsive" and spent "eons of time" on things that they probably did not need to do. "Medical school teaches you to be thorough and comprehensive in leaving no stone unturned," commented one doctor.

One physician, who was accustomed to working with a "team" of residents, discovered that her practice functioned very differently than she had expected. This is "more fragmented ... more like a cluster of individual practices, under the same building, working for the same corporation and sharing call," she explained.

As they looked back at the year and discussed their training, physicians offered suggestions for medical educators. They said that rural primary care physicians needed to know about substance abuse, child abuse and common medical problems; how to triage, handle in-office emergencies and do office procedures; and how to manage a typical workload of 20 to 25 visits a day. One doctor said that he would have liked to have a better sense of what one should not do in the office but should send to the emergency room or refer to a surgeon. A full month rotation in a lab, more exposure to the "medical staff" (bylaws, policies and meetings), and more interaction with physician assistants were among the suggestions offered. "Down-to-earth" practice management was recommended by both private practitioners and physicians in community-based practices. Physicians emphasized the importance of geriatrics, cardiology, orthopedics, and preventive medicine. One internist suggested an optional fourth year of internal medicine residency training to learn to do upper endoscopies and other procedures she felt were suited to rural practice.

Doctors felt that students and residents needed to work in community-based hospitals where "you cannot order every test" and spend more time in rural areas. "I probably would been better off if I had trained in "less of a tertiary care setting," concluded one physician after her first year in practice. One doctor stressed the importance of learning how to have an "integrated lifestyle"—of balancing one's personal and professional lives. Many interviewees were interested in teaching. Some had medical students during the year and were hoping to bring in residents or were precepting at teaching centers.

competition from HMOs and others gearing up for health care reform, they need to accurately assess and respond to trends and changes that affect the physician supply.

- Maintain mechanisms for assessing and responding to trends and changes that affect the supply of primary care providers, including trends in medical school graduates (increases in the number of women and minority medical students) and changes in licensing of providers. SORHs should make use of survey results available from AHECs, residency programs and others regarding what physicians are looking for in a practice site.

- Seize opportunities to shape the physician supply of the future as medical schools and residency programs who are reexamining admissions policies and revamping curricula to focus on primary care and community-based training seek input and assistance from those in rural medicine.

Develop a Pool of Candidates for Rural Practice. Physicians can be targeted during various points in their career for recruitment efforts.

Medical Students

- Sponsor seminars and informal get-togethers where students (and residents) can meet with enthusiastic rural practitioners and positive role models. Arrange field trips to and electives in rural practices and community-based practices.

- Ensure that students are aware of the resources and assistance available to physicians who practice in rural areas from the SORH and other sources, e.g., loan repayment programs, assistance with start-up, ongoing technical assistance, mini-fellowships.

Residents

- Assign a SORH liaison to each in-state primary care residency program. Liaisons should identify and work with residents who are interested in rural health.

- Sponsor get-together with potential candidates identified by recent graduates and others.

- Provide/expand programs which support residents who are particularly interested in rural health. For example, develop a program that provides residents who agree to serve in underserved areas with a stipend to supplement their incomes during training.

Other Physicians

- Target recruitment efforts/promotional materials to physicians and spouses with particular backgrounds and interests, e.g., military doctors, retiring doctors, those who seek to work with the underserved.

- Maintain contact with physicians who have left and might be interested in returning.

- Try to place physicians who are disenchanted with their practices/communities elsewhere in the state.

- Ask physicians in training and in practice to identify candidates.

Preparing Practices, Communities and Other Local Physicians. Local leaders and residents could benefit from technical assistance to help them prepare for recruitment and retention of an additional provider.

- Help communities assess whether they can support a physician practice and are likely to attract and retain candidates. Develop a checklist communities can use for self-assessment.

- Assist practices in designing positions that can be adapted to physicians with different needs, e.g., those who are interested in part-time work or more flexible hours, those who also want to teach or prefer to do ambulatory care.

- Help communities organize for recruitment and retention efforts—to identify a committed core of people with defined responsibilities and develop a process. Meet with health center boards, community leaders and others to discuss physicians' and spouses' perspectives, recruitment strategies, what "makes a difference" in site selection and the interview process, and how the Office of Rural Health can help with recruitment. Provide community recruiters with background materials and tools to assist them. (Issues relating to retention should also be covered.)

- Help integrate osteopathic doctors and other alternative providers (such as advanced practice nurses and physician assistants) into practices and communities by educating and working with community physicians, health center boards, administrators and hospital and practice personnel prior to recruitment.

Matching providers and communities is often imprecisely done and requires exceptional sensitivity.

- Appropriately match physicians and families to practices and communities. Understand the kind of practice the physician prefers and the family's needs and interests.

- While a recruiter may feel that an African-American physician is well-suited to a community with a high percentage of African-Americans, this is not necessarily the case. African-American doctors and their spouses may not be happy in a community with few African-American professionals, where they are not welcome to live where they choose, or where the private schools will not accept their children.

- Families who are very concerned about the schools and have school-aged children are unlikely to be happy in communities with poor schools.

- "Recruit to retain." Resist the pressure to "fill a slot" when it is clearly a poor match.

Preparing for Arrival. The period between acceptance and arrival can be difficult for physicians and families. They need assistance from the Office and those in the community in pulling together loose ends and getting settled.

- Identify a community "buddy" to anticipate candidate's needs and to ensure the physician and his family are made to feel welcome. Assistance with temporary and permanent housing is critical.

When On-Site, shift the focus to retention.

- Ensure coordination between the community buddy who works with the family prior to and upon arrival and the person designated to routinely "check-in" and intervene when there are problems as suggested under the retention strategies.

- Maintain direct contact with the physician and spouse as they settle in and after they are in practice. The Office should build on relationships developed during recruitment and matching as it begins to support the physician and family when in practice.

Feedback. Obtain and respond to feedback from physicians/spouses as well as placement sites regarding recruitment efforts.

Strategies to Enhance Retention (In Addition to Recruitment Efforts)

Excessive Demands. Burnout prevention can be carried out on various fronts.

- **Educate community boards, administrators, patients and others who make demands and interact with physicians** about what they can reasonably expect from doctors (roles/responsibilities, workload, call) and physicians' needs (time off, freedom to get away for weekends, vacations and Continuing Medical Education).

- **Try to develop a critical mass of physicians.** Practices that determine physician staffing in conjunction with neighboring practices, health departments, hospitals and teaching programs may be able to develop a critical mass/group more quickly than if they planned to meet their needs totally independently. Practices might be able, for example, to bring in three physicians at the outset even if only two are projected to be "statistically needed."

- Facilitate **call-sharing and cross-coverage for vacations** by working with community physicians prior to recruitment. When arrangements break down, be prepared to bring in doctors from residency programs, university medical centers and temporary agencies to provide, as a minimum, weekend and vacation relief. Develop an affordable or non-profit *locum tenens* program (some residency programs have hired faculty to provide vacation relief to doctors in rural practices).

- **Orient incoming physicians** to rural practice and small-town life. Physicians and spouses often have little experience living and working in rural communities. They are unaware of resources available to them through the SORH and other entities in the state. The Office can assist physicians and their families by bringing in veteran physicians and others to share their experiences, offer advice and ensure that they know where they can seek help and assistance down the road.

- Assist interested physicians in developing **physician mentoring relationships.** Some incoming physicians feel they could benefit from closer relationships with veteran physicians and faculty in

residency training programs. The Office could assist doctors in linking up with compatible and supportive doctors.

- Incorporate **advanced practice nurses and physician assistants** into the practice. Mid-level providers can benefit physicians in some circumstances (high outpatient load). Those who advocate greater use of mid-level providers should recognize the limitations (can not fully share call) and the additional responsibilities and demands mid-level providers can place on supervising physicians (liability, time to review charts, increased inpatient load).

- Develop an **early warning system** to detect and address burnout and other problems and dissatisfactions before they grow. Among the possibilities that might be explored are: designating an appropriate person on the health center board or in the community to meet routinely with the physician and spouse to determine and help address potential problems and future needs; self-administered questionnaires which assess sources and levels of stress; stress management; a list of recommended counselors who are skilled at working with physicians and their families.

Integration into the Community. Community residents who wish to retain doctors and their families must incorporate them into their lives. Often, it seems, physicians and their spouses are "left alone" after they have "signed on" or treated as "the doctor" and the "doctor's wife" rather than "Mack" and "Susie."

Partners. This relationship is perhaps the most important community match to make.

- Use medical school and residency **electives and extended rotations** to get to know prospective partners.

- Consider **recruiting physicians in pairs**—those who wish to work, or trained together.

- Try to **prevent/resolve problems** between partners by outlining key issues for discussion and agreement, alternative approaches, and common points of conflict and helping them develop skills to address problems as they arise.

The Business of Medicine. Physicians felt ill-prepared for this side of medicine.

- Provide management assistance as practice plans are being developed, during "start-up" and after the practice is operational. Offer different options regarding the scope and nature of support. Some physicians/practices want comprehensive services; others wish to contract out for selected services only; and some want access to a trustworthy referral service that has screened and can recommend high quality/reliable vendors and suppliers.

- Provide management training for physicians and staff. On-site training and workshops which make use of teleconferencing facilities (allow interaction with instructors, require less travel time) should be considered along with subsidizing tuition for courses and seminars that are widely offered, circulating videotapes, annotated bibliographies and other printed materials on selected practice management topics. (Note: Physicians often assume administrative and management responsibilities without having had sufficient training or experience. They are not always aware of the skills that are required or of the resources that are available, and frequently they have little time to acquire them. Offices of Rural Health can help physician-managers develop the skills they need and support them in practice.)

- Provide quick access to "experts" who can advise doctors and managers on how to handle specific issues/problems as they emerge, e.g., steps that should be taken prior to firing an employee.

- Work with medical schools and residency training programs so curricula are "down-to-earth" and better prepare doctors for practice.

Problems Family Physicians have in Maintaining Obstetrical Services. SORH staff should help local providers develop satisfactory arrangements among family practitioners, obstetricians and midwives by addressing the concerns and conflicts on a community-by-community basis.

Physicians Who Prefer Part-Time or Less Traditional Jobs. These positions are primarily aimed at female physicians with small children and others who seek more flexible, less traditional hours.

- Design alternative positions: part-time positions; jobs which are four days a week and 10-12 hours a day; opportunities to do

ambulatory care only or to combine patient care with teaching and/or research; positions which may be fulfilling for temporary physicians who may wish to develop management skills which they can apply elsewhere (ideally in another center in the state). As noted above, jobs could be developed in collaboration with other practices, teaching programs, universities and the Office of Rural Health.

Community-Based Practices. Conflict with community boards and management were significant for some providers.

- Expand or refine the technical assistance SORHs provide to board members, administrators, and physicians. Help the parties clarify and agree on the center's mission; understand each others' roles, responsibilities, and needs; identify problems; and learn to resolve differences effectively.

- Design and implement alternative organizational structures that place physicians in key management positions, as directors and co-directors who jointly manage a center with an administrator. Ensure physicians are prepared to assume these roles and get the support they require; help administrators, boards and physicians learn to work as an effective team.

- Develop compensation systems where productivity is taken into account.

Money. Continue to offer loan repayment and other financial incentives, and to ensure that earnings are commensurate with other physicians in the region.

Hospitals. Continue to re-configure and upgrade hospital facilities and services. As evidenced by physicians' comments, much has already been accomplished to improve hospitals in North Carolina.

Continuing Medical Education. Continue to expand and refine opportunities in continuing medical education. AHEC programs are often the best resource. The N.C. AHEC Program offers extensive CME opportunities through its nine-site network throughout the state.

Health Care Reform. It became clear during follow-up interviews that physicians are increasingly concerned about health care reform and the impact it will have on rural physicians. Strategies for retention include educating, advising and, in some instances, directly assisting doctors who wish to form or join networks.

Other Strategies to Support Physicians and Their Families

- A user-friendly **resource guide** which tells physicians who to call for what, e.g., loan repayment, malpractice insurance subsidies if doing obstetrics, mini-fellowship opportunities, reimbursement problems, assistance in converting to cost-based reimbursement.

- An easy-to-read **newsletter** that highlights resources, meetings and issues relevant to practicing and living in rural communities. The newsletter could be aimed at spouses and office managers as well as physicians.

- **Mini-fellowships** that includes physician coverage for the practice. Physicians identified procedures and areas of medicine they would like to learn about if offered a mini-fellowship. Among those noted were flexible sigmoidoscopies, upper endoscopies, cardiac stress test training, counseling, neonatal life support, pediatric advanced life support, adult cardiac life support, and the business side of practice.

- **Meetings and informal get-togethers** for physicians **and their families**, locally, regionally and statewide. (Spousal involvement considered to be very important.)

Feedback. Conduct exit interviews with physicians who leave rural practice and their spouses.

VI. General Conclusions

Despite great progress in upgrading health care services and attracting physicians and other providers to rural communities, rural America faces a deepening shortage of health care professionals that will likely be left unanswered by health care reform. A new national or state-based manner of financing health care will do little in the short term to bolster the short supply of primary care physicians. Health reform will

likely place additional pressures on rural communities, whose systems depend on primary care providers.

Those who wish to meet the health professional needs of rural communities in the long term must pay greater attention to retention, particularly as competition for primary care providers intensifies. By failing to keep doctors who are currently in practice, communities are undermining their efforts to retain and recruit physicians in the future. High provider turnover bodes poorly for the futures of both rural communities and physicians. Physicians, it seems, are more likely to leave communities where they are not integrated and often will not locate in communities with a high turnover in providers. Likewise, communities are reticent to embrace and support incoming physicians and their families when they have seen a high turnover of doctors.

State Offices of Rural Health, even those with modest resources, can design many types of programs to assist local communities in their attempts to retain physicians. But first SORH staff must understand—and help those in rural communities to understand—the needs and expectations of physicians and families and the problems and frustrations they encounter once on site. Staff from SORHs should recognize the importance of continuing to respond to provider needs as they change. Those who wish to successfully recruit physicians and families must not only satisfactorily address major issues that concern physicians and families but also must sufficiently attend to the details that make an impression on candidates.

Physicians in rural areas are often unaware of resources and support available from various government and private agencies, institutions and organizations, including funds for repayment of medical school loans, opportunities for continuing medical education, medical malpractice premium subsidies for physicians providing obstetrical services, or technical assistance. State Offices of Rural Health can serve as a focal point for physician inquiries and as an agent that quickly accesses resources and intervenes on the behalf of physicians.

Finally, State Offices of Rural Health can learn a great deal and become more responsive if their staff members retain an interest and maintain contact with providers who practice in medically underserved areas, particularly those in more isolated rural communities. These providers' viewpoints and expectations—going

beyond raw data or numbers—can provide important insights and help to develop programs that are effective in recruitment and retention.

APPENDIX A

INTERVIEW GUIDE

DEPARTING PHYSICIANS AND SPOUSES

Interview Guide - Deptg./Deptd. Phys. Interview #
Date:

NOTE: COVER THE MAJOR CATEGORIES. USE OTHER QUESTIONS TO STIMULATE DISCUSSION AND KEEP CONVERSATION ON TRACK. WHAT IS COVERED WILL DEPEND LARGELY ON THE TIME THE PHYSICIAN HAS AVAILABLE

INTRODUCTION

I'm here to talk with you about rural practice:

(1) to gain a better understanding about what it is like to practice and live in a rural setting

- what is rewarding and satisfying
- discouraging and frustrating

and,

(2) to determine what might be done to make rural practice more attractive to physicians

- to identify activities/strategies that the Office of Rural Health and others could undertake to help retain physicians (or possibly extend their stays) in rural communities in North Carolina - in the short- and long-term.

I'd like for us to talk about issues which fall into 5 general areas. Your background and decision to go into rural medicine; medical practice in the community; life in the broader community; your decision to leave your job; and what can be done to attract and retain physicians in rural settings in the future.

The information I'm gathering will be used to help the Office of Rural Health and others concerned with rural practice. No individuals will be named in any reports that we prepare. So that I don't have to take copious notes, I'd like to tape our conversation. Is this okay with you?

It may help you to know a little bit about me before we begin. I've been doing health planning, administration and policy analysis for almost twenty years - in a variety of settings. My husband is a pediatrician. We have two daughters - ages 9 and 13.

I. DECISION TO COME, PERSONAL BACKGROUND

Tell me a little bit about yourself. If we could begin by talking about the past - your background, your decision to go into rural medicine and this practice/community, particularly.

When did you first become interested in rural practice?

What was appealing about it?

Did you grow up in a rural area? Where? Approx. population?

Is this the first rural practice you've been involved with?

Experience with/exposure to rural health prior to this?

Training (medical school, residency (place/specialty), subspecialty training, board eligible/certified).

Position(s) held prior to this (last 2 or 3):

How did you first hear of this practice opportunity? Were you recruited (by whom?), respond to an ad, other?

What other options (places, work) did you consider?

What was attractive about them?

What did you and your family hope to find in this smaller community that you did not think you would find in a larger one? What was attractive about this community (e.g., small town, climate, serving needy, lack of traffic/pollution)? *(Note reponse for follow-up question later)*

Did you have any concerns about the community - things you and your family thought you might not like? (Probe)

What about the practice/job? What did you hope you would find here that you might not find elsewhere? What was attractive about the practice and the job? *(Note reponse for follow-up question later)*

Did you have any concerns about the practice/job - things you thought you might not like? (Probe)

Why did you ultimately choose this community and practice (over others)?

When did you actually come to this community? To this practice (month/year)?

How old were you?

When you came here:

Were you fulfilling a service or loan repayment obligations with the NHSC or other program (e.g., N.C. Student Loan Program, state loan repayment)?

Did you have debts from med.school? About how much?

Debts from undergraduate school, or personal debts?

How long did you think you would stay? *(If didn't intend to stay, use version "2" on Part IV, Decision to Leave. If intended to stay, use version "1".)*

What were your long-term career plans (e.g., thought good chance would ultimately go on for subspecialty training)?

II. TOWN, MEDICAL COMMUNITY, YOUR PRACTICE, YOUR JOB

We just spoke of what you hoped to find when you came. Now if we could talk about what you actually found. As mentioned earlier, we'd like you to help us understand what it is like to live in this community and work in this practice. What is rewarding and satisfying. What has been disappointing, discouraging and frustrating.

TOWN

Can you tell me a little bit about the town - its size, about the population, its proximity to other larger towns and cities (SKIP IF LACKING TIME)

Town/size -

County/size -

Distance to larger towns (miles/time) -

Population composition (demographics - elderly, minorities, % poverty) -

MEDICAL COMMUNITY

Can you talk about the medical community. The kinds of physicians and practices in the area. Whether or not you have the specialty backup and support you need. How you were received when you came. How you are regarded by others now. About the hospital.

About how many primary care practices (internal medicine, family practice, pediatrics, Ob-gyn) are there in the area?

Where do you refer patients when they need to see specialists (surgery, mental health, cancer treatment)? Does this work well for your patients and you? Explore.

How would you characterize your relationship with other primary care and specialty physicians in the area, e.g., respectful, satisfactory. Any contact socially with other

physicians in the area?

Which hospital is closest to your practice?

Miles/time from practice)?

About how big is it (beds)?

Is this the hospital you use? If not, why not?

What services does it have (OB, intensive care)?

Are services missing that you feel are important?

How do you perceive the quality of the services provided by the hospital, in general?

(If this is not the hospital used)

Which hospital do you use?

Why have you selected this hospital?

What services does it have (OB, intensive care)?

Are services missing that you feel are important?

How do you perceive the quality of the services provided by the hospital, in general?

How are/were your opportunities for continuing education? Involvement with AHEC? Time off for continuing education?

Are/were the opportunities for continuing education sufficient?

If not, any suggestions about what might be done to improve opportunities for continuing education?

Are there aspects of the medical community or practice environment that exceeded or failed to meet your expectations?

Many physicians report about conflicts with those in the medical community - with

administrators, physicians and others - over privileges and how things should be done? Have you experienced any problems of this sort? (Elaborate)

Any other thoughts about the physicians, other providers or the hospital?

PRACTICE

Now if we could talk about your practice. About the patients, the staff and internal operations. About how decisions are made and your role in decision-making. About how the practice is it doing financially. About morale. About things that run smoothly, and things that don't. About what you like about the practice and what you don't like.

Volume

First, how busy is the practice?

Avg. patient visits per day -

Avg. patients per provider per day -

Patients

Can you describe the kind of patients the practice sees - age, income level, minorities, insurance coverage (M'care; M'caid; private, none)

Is this the patient population you expected to see?

Do you like working with this population and treating the kinds of clinical problems you do?

Were there patients you would have wanted to see, or services that you would have wanted to provide which you were not able to?

Were there services that you were required to provide that you would rather not have provided?

To what extent do patients use this practice rather than going out of the town for care? (In some places, we are told, patients go to their practice for routine problems and elsewhere for major ones.)

Health care providers talk about barriers to health care - things which stand in the way of patients getting the care they need. They talk about transportation problems, cultural beliefs, patients who distrust "outsiders," and lack of education. Have you found such barriers? Do you personally find dealing with these issues to be challenging/stimulating?

Frustrating/overwhelming?

Type, Ownership, Profit/Nonprofit

Can you tell me a little bit about the formal structure and ownership of the practice. Is it a nonprofit corporation? A private for-profit partnership? A federal- or state-supported community health center? Other?

Management

How is the practice organized - Board, Administrator, Medical Director? If an independent group practice, is it a partnership? Do you have any ownership interest or are you an employee?

How are decisions actually made, e.g., salary levels, hiring, purchasing equipment, collection/charity policies, other.

Do you have a role in making decisions and managing the practice? Explain. Areas of responsibility? Degree of authority/power (e.g., makes ultimate decision; gives input)? Examples. Is your role satisfactory to you?

Have there been conflicts about policies or other aspects of the practice? Examples. How have they been resolved? Have the decisions been satisfactory to you? Has the process for resolving conflicts been satisfactory to you?

Any other thoughts/feelings about how decisions are made and the practice is managed?

Financial Matters

What about the financial side of the practice?

Do you know who financed the practice initially - the start-up and early operations (loans, grants, other)?

How is it currently supported (pt. revenues exclusively)?

How has it done financially in last 3 years (cover expenses, profit/net income, current debt/outstanding loans)?

What is projected for the future?

Do you all provide a lot of care without charge/payment (e.g., 10% of patients don't pay or pay very token amount)?

Are there problems with collections/bad debts?

Any other thoughts/concerns about the financial performance and prospects for the future?

Operations

If you could talk briefly about internal operations. About how smoothly things run. Whether staff is sufficient and well-trained. Whether ancillary and support services are adequate and efficient. About morale. About what you think is good about the practice and not so good.

Staff

Physicians (#/specialties) -

N.P./P.A./Other Practitioners (#/types) -

Admin.,ancillary services, support (#/types) -

Sufficient #/ adequately trained/turnover of physicians, other staff/moral. (Did you replace someone?)

Ancillary Services, Administrative Systems and Equipment, e.g., lab, xray, pharmacy, medical records, billing/collections

What's good & what needs improvement? Explain.

JOB

Now if we could talk about your job or position. Your responsibilities. Your call schedule. Your compensation and benefits. What you like about your job, and what you don't like.

Responsibilities

Do you have administrative, teaching, or other responsibilities along with patient care? Explain.

(If teaching responsibilities)

Tell me a little bit more about your involvement in training? Medical students? Residents? Other personnel?

How do you feel about teaching (rewarding, frustrating)?

Do you feel that you were adequately prepared to teach?

Do you follow your own patients in the hospital? Does this work well? Any frustrations?

Do you do OB/deliver babies?

Did you want/not want to do OB?

About how many hours do you work in a typical week?

How often are you on call - evenings/weekends? What arrangements do you have for coverage?

What about vacations?

When was the last time you took vacation?

How did you spend it?

Do you get a set amount of vacation a year? Do you take the full amount?

If you had an extra day a week (8 instead of 7), how would you use the extra day?

Do you feel you have enough personal time off (evenings, weekends, vacations)?

Does your family?

(If not) What do you think would be a reasonable amount of time off?

Are there arrangement that could be made so that this could be possible? If so, why haven't they been made?

Do you feel you work too hard?

Would you mind discussing your income with me?

On what basis are you paid (salary, net income from practice, bonus, other)?

Some income ranges are listed on this sheet (hand out sheet). Can you circle the range that corresponds with your income from your job - say in 1991. Can you underline

the range that corresponds with your starting salary.

< $30,000	70,000 - 79,999	120,000 - 129,999
30,000 - 39,999	80,000 - 89,999	130,000 - 139,999
40,000 - 49,999	90,000 - 99,999	≥140,000
50,000 - 59,999	100,000 - 109,999	
60,000 - 69,999	110,000 - 119,999	

Do you feel this is fair/sufficient? What do you think would be reasonable and acceptable?

What benefits do you/family receive (if employed) /take (if self-employed) - health insurance, malpractice insurance, disability insurance, pension, sick leave, vacation?

Are these satisfactory? If not, what do you think would be reasonable and acceptable?

Do you think that you were/are a good match with this practice/job?

How so?
How not? If not, what kind of person might fit better?

Do you think you were well-prepared to work in this practice and this job?

How not? What could have been done to better prepare you?

Did you have a practice management course? Useful? If not, why not?

We talked earlier about what you hoped to find when you came. What did you hope for that you did not find?

What about your job do you like/find the most rewarding and satisfying?

What about your job don't you like/do you find disappointing, dissatisfying, discouraging, frustrating, would you like to change?

III. LIFE FOR SELF AND FAMILY IN THE COMMUNITY

Now if we could switch gears somewhat and talk about life in the community - for you and your family.

Are you married? Do you have children (boys/girls, ages)?

How did your wife/husband & children feel about moving here?

How have you and your family been received/accepted by those in this community? Did you feel valued and appreciated? Do/did you and your family feel part of/integrated in the community?

How have you all liked living here (positives/negatives)? Any difficulties adjusting?

Spouse (work, ease of finding job, social life)

Kids (school, activities, friends)

Physician

We talked earlier about what things you hoped to find in the community when you came. What did you hope for that you did not find?

Are there things that are extremely important to you or others in your family which you have not found here (e.g., homogeneous people)?

In thinking about what life would be like for you and your family if you were to remain permanently, what concerns come to mind, e.g., raising your children here?

(If African American, a woman or of another minority)

Have you or others in your family encountered any difficulties (in the community, your practice, the medical community, the schools) because you are a woman/African American/other? Elaborate.

Do you feel you have been treated differently because you are a woman/African American/other? Examples from own experience.

(If not a minority but working with primarily with minorities, continue. Otherwise skip to section IV.)

Have you or others in your family encountered any difficulties (in the community, your practice, the medical community, the schools) because you are not African American/other? Elaborate.

Do you feel you have been treated differently because you are not African American/other? Examples from own experience.

IV. DECISION TO LEAVE *Use appropriate version depending on circumstances*

IV(A)(1) - Departing/Thought Might Stay
IV(A)(2) - Departing/Didn't Intend to Stay
IV(B)(1) - Departed Already/Thought Might Stay
IV(B)(2) - Departed Already/Didn't Intended to Stay

IV(A)(1) DECISION TO LEAVE - DEPARTING/ THOUGHT MIGHT STAY

Now if you could talk about your decision to leave and your plans for the future.

Earlier, you said that when you came you thought you might stay indefinitely. When did you first think about leaving?

Was it a combination of things that led you to this decision or one thing in particular - things relating to the community, your practice/job, people, the medical community, family needs? Or things you realized about yourself?

Were any factors more critical than others in your decision than others?

(Probe with following if necessary)

Earlier, you spoke about things that you and your family hoped to find and didn't. To what extent did "the lack" of these things influence your decision to leave?

(Refer back to points mentioned)

Are there things that you found which you hadn't anticipated that influenced your decision to leave?

Are there any circumstances under which you would have considered staying? Things that could have been done that would have made you want to stay?

Now, can you talk about your plans for the future?

What's next (community, setting, job)?

What are you looking forward to in your new situation? What is appealing?

Are there things about your new job that you are uncertain or apprehensive about?

(As appropriate) It sounds as though your career plans have changed somewhat. Why do you think they have changed?

Are there things you realized about primary care, rural practice or yourself that have steered you in a different direction?

Looking back, do you wish that you had done things differently (e.g., training, job)? Elaborate.

IV(A)(2) DECISION TO LEAVE - DEPARTING/ DIDN'T INTEND TO STAY

Now if you could talk about your thoughts about leaving and your plans for the future.

Earlier, you said that when you came you intended to stay for a limited time only. After you were here, did you ever consider staying?

What made you consider staying?

What made you decide not to stay?

Are there any circumstances under which you would have considered staying? Things that could have been done that would have made you want to stay?

Now, can you talk about your plans for the future?

What's next (community, setting, job)?

What are you looking forward to in your new situation?

Are there things about your new job that you are uncertain or apprehensive about?

(As appropriate) It sounds as though your career plans have changed somewhat.
Why do you think they have changed?

Are there things you realized about primary care, rural practice or yourself that have steered you in a different direction?

Looking back, do you wish that you had done things differently (e.g., other specialty)? Elaborate.

IV(B)(1) DECISION TO LEAVE - DEPARTED ALREADY/ THOUGHT MIGHT STAY

Now if you could talk about your decision to leave, your current situation and your plans for the future.

Earlier, you said that when you came you thought you might stay indefinitely.
When did you first think about leaving?

Was it a combination of things that led you to this decision or one thing in particular - relating to the community, your practice/job, people, the medical community, family needs? Or things you learned about yourself?

Were any factors more critical than others in your decision to leave?

(Probe with following if necessary)

Earlier, you spoke about things that you and your family hoped to find and didn't. To what extent did "the lack" of these things influence your decision to leave?

(Refer back to points mentioned)

Are there things that you found which you hadn't anticipated that influenced your decision to leave?

Are there any circumstances under which you would have considered staying? Things that could have been done that would have made you want to stay?

Can you tell me about your current situation? Talk about how it compares to your time in practice in _____. Describe what you like and don't like about it.

What about your long-term plans? Any long-term plans?

(As appropriate) It sounds as though your career plans have changed somewhat.
Why do you think they have changed?

Are there things you realized about primary care, rural practice or yourself that have steered you in a different direction?

Looking back, do you wish that you had done things differently (e.g., other specialty)? Elaborate.

IV(B)(2) DECISION TO LEAVE - DEPARTED ALREADY/ DIDN'T INTEND TO STAY

Now if you could talk about your thoughts about leaving, your current situation and your plans for the future.

Earlier, you said that when you came you intended to stay for a limited time only. After you were here, did you ever consider staying?

What made you consider doing so?

What made you decide not to stay?

Are there any circumstances under which you would have considered staying? Things that could have been done that would have made you want to stay?

Can you tell me about your current situation? Talk about how it compares to your time in practice in _____. Describe what you like and don't like about it.

What about your long-term plans? Any long-term plans?

(As appropriate) It sounds as though your career plans have changed somewhat. Why do you think they have changed?

Are there things you realized about primary care, rural practice or yourself that have steered you in a different direction?

Looking back, do you wish that you had done things differently (e.g., other specialty)? Elaborate.

V. PHYSICIANS AND RURAL PRACTICE: STRATEGIES FOR THE FUTURE

Now, I'd like for us to talk about strategies for attracting and retaining, or possibly extending the stays of physicians in rural practice in the future.

What thoughts/advice can you give to the Office of Rural Health and others who are concerned about attracting and retaining physicians in rural practices in North Carolina (and elsewhere).

Are there things that should be done in <u>recruiting physicians and matching</u> physicians to communities? (Good ways/places to <u>advertise</u>?)

Are there things that should be done to <u>better prepare</u> physicians for practices before they come - skills in management, developing a team, working with a board, clinically.....

Do <u>salaries, benefits, physician responsibilities/authority need to be altered</u>, e.g., cafeteria plan including reimbursement for college tuition?

Is additional <u>support needed</u> - on an ongoing or "as needed" basis?

<u>Clinical</u> support, e.g., better access to up-to-date medical literature, advice from experts)?

<u>Administrative support?</u> Management consultation (e.g., to develop new systems, to solve problems)?

Other?

Are additional opportunities for continuing education or to be involved in training of residents, medical students or others needed?

Should more support be provided for the physician and his family - day care, job search for spouse, opportunities to meet with other rural physicians and their families?

Many say that changes need to be made in medical education and residency training if we are to attract and retain more physicians in rural practices?

Thoughts?

Many feel that physicians who have certain characteristics/backgrounds are more likely to be satisfied in rural practices and rural communities, and that medical schools and primary care residency programs should be accepting more people with these characteristics/backgrounds.

Any thoughts on what these characteristics/backgrounds might be?

(May skip - may have been adequately covered)

Do you have any other thoughts on what changes need to be made or things that might be done to help attract, retain or extend the tenure of physicians in rural practice?

Changes in community health centers and other organizations and entities that provide care - management structure, operations of the practice, training of personnel, equipment, physical facility?

Factors in the medical community - referral patterns, the hospital?

Attitudes in the community - regard for the physician?

VI. CONCLUSION

Before we close, I'd like know:

What advice would you give to the next physician in this practice?

Any overall words of advice to physicians who are considering rural practice or to physicians who have made the decision and are about to begin?

Is there anything else you could share that might help us get a better understanding of rural practice and what might be done to improve physician retention or extend the tenure of physicians?

I'd also like to know how you felt about this interview and the process? Do you have any suggestions about what we might do to improve the interview or the process?

Again I want to assure you that your name will not be used in connection with any of these responses - unless you tell me otherwise. There are pieces of information and perspectives that different physicians would like me to pass along to someone at the Office of Rural Health. Is there anything you'd like me to pass along? May I use your name?

I want to thank you, sincerely, for your help and giving so generously of your time. I may need to clarify some of what we covered. Would it be all right if I called you to do so? Best place and time to reach you?

HANDOUT

Interview # _____

< $30,000	70,000 - 79,999	120,000 - 129,999
30,000 - 39,999	80,000 - 89,999	130,000 - 139,999
40,000 - 49,999	90,000 - 99,999	≥140,000
50,000 - 59,999	100,000 - 109,999	
60,000 - 69,999	110,000 - 119,999	

Circle range - last year's salary
Underline range - starting salary

APPENDIX B

INTERVIEW GUIDE

INCOMING PHYSICIANS AND SPOUSES

Interview Guide - Incoming Phys. **Interview #**
Date:

NOTE: COVER THE MAJOR CATEGORIES. USE OTHER QUESTIONS TO STIMULATE DISCUSSION AND KEEP CONVERSATION ON TRACK. WHAT IS COVERED WILL DEPEND LARGELY ON THE TIME THE PHYSICIAN HAS AVAILABLE

INTRODUCTION

I'd like to talk with you about a variety of things: your decision to practice in a rural/small town setting; the preparation you received during your training; how you went about selecting the practice you did; your thoughts on recruitment efforts; and your expectations.

(For those who have been there for a month or more)
I'd also like to talk to you about your current perspectives on the practice, your job and the community.

The information I'm gathering will be used to help the Office of Rural Health and others concerned with attracting and retaining doctors in rural/small town practices. The information that you will be sharing is confidential in that no individuals will be named in any reports we prepare. So that I don't have to take copious notes, I'd like to tape our conversation. Is this okay with you?

It may help you to know a little bit about me before we begin. I've been doing health planning, administration and policy analysis for almost twenty years - in a variety of settings. My husband is a pediatrician. We have two daughters - ages 9 and 13.

I. PERSONAL BACKGROUND, INTEREST IN PRIMARY CARE, RURAL HEALTH/SMALL TOWN PRACTICE

If we could begin by talking a little bit about your background and your decision to come to this practice/community.

Did you grow up in a rural area? A small town? Where? Approx. population? What about your parents, did they grow up in rural areas/small towns?

Where did you go to medical school? Do your residency? Specialty? Board certified? Other training, e.g., fellowship, other residencies?

When did you first become interested in primary care (family medicine, internal medicine, OB-gyn)? Ultimately decide to go into primary care?

What was appealing about it?

Were you particularly interested in going to a rural area/small town? Why? When did you first become interested in doing so?

Position(s) held prior to this (last 2 or 3):

Are you fulfilling a service or loan repayment obligations with the NHSC or other program (e.g., N.C. Student Loan Program, state loan repayment)? Explain.

Did you have debts from med school (types)? About how much? What about undergraduate debts or large personal debts/obligations, e.g., alimony/child support?

Are you married? Children (gender and ages of children)

II. PREPARATION FOR RURAL MEDICINE AND PRIVATE PRACTICE - MEDICAL SCHOOL AND RESIDENCY

Were you exposed to rural practice during your training (medical school, residency)? Describe experiences (extent & nature). To what extent did these experiences influence your decision to go into primary care/rural/small town practice? How so?

(If not exposed to rural/smaller town practice), what about exposure to a community or private office practice? Explain.

Do you feel you were well-prepared to practice here? In what ways do you think you could have been better prepared during medical school or your residency?

How comfortable are you with the business side of a medical practice? Where did you learn this, e.g., courses/exposure to practice management? Explain. Did you find these were valuable? How so? How not?

Some people report that faculty members encouraged students or residents to pursue (or not pursue) particular areas of medicine.....that faculty members were oriented towards or favored particular areas or kinds of practices. For example: primary care or specialty care; rural settings over urban settings; academic medicine over community practice; single-specialty group practices over solo practice or multi-specialty groups; HMOs over fee-for service medicine.

Did you experience anything like this during medical school (primary care versus specialty care)? What about during your residency training?

What kind of advice did you receive from faculty members about jobs? Things to look for? To avoid? Advice on salary levels? Other?

III. SEARCH/SELECTION OF PRACTICE

START LOOKING: When did you actually start looking for jobs?

(As appropriate), reasons you wanted to make a change?

Were you looking to make a permanent move? Explain.

IMPORTANT TO YOU: In considering communities and jobs, what was particularly important to you? Were there things you wanted to be sure to find - in the community, the hospital, the medical community, the practice? Were some more important than others, i.e., critical to your decision to come? Explain.

Were there things you wanted to guard against?

Any other special concerns on your part?

(As appropriate), any special concerns of your spouse, e.g., employment, cultural opportunities?

Special concerns regarding your children, e.g., childcare, schools, community attitudes regarding college for children), ensuring your children are prepared/competitive for college?

SEARCH PROCESS: How did you go about your search?

Process, e.g., systematic search over an extended period, traveled and interviewed extensively?

What places did you seriously consider? Did you visit? Why did you rule other places out?

Role of faculty members? Alumni? Spouse? Use of search firms? Did you respond to head hunters? Ads in journals? Specifics.

Tools used, e.g., checklists, weighting factors across different sites? Who provided you with these tools, e.g., residency program? Useful?

WHAT MADE YOU CONSIDER COMING TO N.C.?

(If from out of state), do you have any prior ties to North Carolina?

Any ties to this community?

Did you have a particular image of North Carolina? Where do you suppose this image came from?

Did you see ads for N.C. opportunities? Ads by the Office of Rural Health? Impressions of these.

HOW DID YOU FIRST HEAR OF THIS PARTICULAR PRACTICE OPPORTUNITY? *(IF RECRUITED),* BY WHOM? Other specifics.

During the search process, were you able to adequately find out about the things that were important to you/things you were concerned you?

How did you find out about these things here, e.g., interviews, visiting doctors in their offices, hospitals?

Were there things that were important/concerned about that you didn't get a handle on? Explain.

During your visit (s) here, what interaction did you have with doctors and others in the medical community? What were the attitudes of those you met? How did they feel about you coming here, e.g., strongly encouraged you to come and intent on helping you, pleasant but not particularly supportive, suspicious.

DECISION: When it came right down to it, what made you and your family decide on this practice/ community over the others you looked at, e.g., the medical community, financial arrangements (guarantees), the hospital, community support)?

(May have already been answered)

Some physicians that I interviewed told me that before they would commit to coming to the community or their practice, they wanted certain guarantees or had to be confident they would find certain things. In some cases, they said that if these things weren't part of the package or didn't exist, they would not have come, e.g., improvements in the hospital, certain salary levels, employment for a spouse. Were there such things in your case? Explain.

Where certain people particularly instrumental in getting you to come?

(As appropriate), was it you or your spouse that was most excited about coming to this particular practice/community?

How did your spouse feel about coming here? About leaving the community you left?

How good are the employment opportunities for her/him here?

What about your kids? How did they feel about coming here and about leaving the community you left?

How are the schools? What about (other) things you mentioned you were concerned about?

Did you or your spouse primarily make the decision to come?

When will you/did you actually come to this community? To this practice (month/year, at what age)?

INTENTIONS: How many years do you think you will stay in this position?

If it doesn't work out here, what do you think the major problem will be?

What do you think you will do if/when you leave?

IV. RECRUITMENT EFFORTS; SEARCH/INTERVIEW PROCESS

Now, if we could talk a little bit about recruitment efforts and the search/interview process.

As we know, hospitals, medical groups, other organizations and agencies are all actively involved in recruiting physicians. And they use a lot of different approaches - letters, phone calls, exhibits at conferences, ads, etc. I'm interested in hearing about the kinds of things you encountered, what you thought was appealing and effective, and what was not?

Did you receive letters/brochures/phone call from search firms and head hunters? Peruse/respond to ads? Visit exhibits at conferences? Read recruitment magazines? Other?

What approaches appealed to you and did you find effective? What was appealing/effective about them? What kinds of letters did you keep? Phone calls did you feel positive about?

What approaches turned you off/were not effective? What about them turned you off? What kinds of letters did you throw out?

What about the Search/Interview Process? Do you think it served you well? How so? Were there things that were frustrating about it? Are there things you would have done differently? Things that you think should be changed about the process?

If you were in charge of recruitment for the Office of Rural Health or for rural/small town practices, what kinds of things would you recommend doing? Staying away from? Ideas for

new approaches, e.g., videos introducing alternative sites/people?

NOTE: WITH PHYSICIANS WHO HAVE BEEN IN PRACTICE FOR SEVERAL MONTHS ESPECIALLY, EXPLORE HOW THINGS ARE PANNING OUT IN SECTIONS V - VIII.

V. COMMUNITY

Can you tell me a little bit about the town? About how big is the town? Demographics? Proximity to other larger towns and cities. How would you describe the community?

Earlier we talked a little bit about what was appealing about coming here and concerns that you had. How are things "panning out?" Is it too early to say?

How have you all liked living here so far? Any surprises? Any concerns at this point? Things that you miss a lot?

How have you and your family been received/accepted by those in this community so far?

Tell me about the things the community/people did that really made you feel accepted and welcome. Were there any things they did that made you feel unwelcome? Are there things that could have been done/could be done to make you feel welcome?

Do you feel you will be valued/appreciated?

Do you feel like it will be easy/difficult for you and your family feel part of the community/make friends?

Spouse - ease of finding job, social life?

Kids - school, activities, friends?

(If African American, a woman or of another minority)

Do you feel that you or others in your family will encounter any difficulties/be treated differently because you are a woman/African American/other? Elaborate.

(If not a minority but working in a community heavily minority)

Do you feel that you or others in your family will encounter any difficulties/be treated differently because you are not African American/other? Elaborate.

Are there ways you think that you could have been better prepared for life in a rural area/small town or in this community particularly? Things you wish you had known?

Are there things about the community that you wish were different?

VI. MEDICAL COMMUNITY

Now if we could talk about the medical community - primary care physicians, referrals to specialists .... the hospital? *(Before coming,)* did you/do you have certain expectations and concerns?

About how many primary care practices (internal medicine, family practice, pediatrics, Ob-gyn) are there in the area?

Where will you refer patients when they need to see specialists? Do you think this will work well for your patients and you?

How would you describe the medical community? Competitive, collegial, collaborative? Any thoughts on the quality of care?

Many physicians report about conflicts with those in the medical community - with administrators, physicians and others - over privileges and how things should be done? Have you experienced, or are aware of, any problems of this sort? Elaborate.

(If problems noted), are there things that could be done to assist you with these problems?

Hospital. Will you follow your own patients in the hospital?

(If so), do you expect to have a large hospital practice (avg. in hospital)?

(If family practice), will you do OB/deliver babies?

(If not), did you want/not want to do OB? Why don't you (e.g., malpractice premiums, difficult to leave outpatient practice)?

Which hospital will you use? Is this the one closest to your practice? If not, pursue. How far is it from your practice? Your house? Number of beds?

What services does it have (OB, intensive care)?

Are services missing that you feel are important?

How do you perceive the quality of the services provided by the hospital, in general?

How are the opportunities for continuing education? Time for continuing education? Local

conferences/AHEC? Other? Are these sufficient? If not, any suggestions about what might be done to improve opportunities for continuing education?

Are there aspects of the medical community or practice environment that you are concerned about? Things you'd like to see changed?

Are there things that you want to accomplish/see happen regarding health care and health care services in this community? Do you expect/wish to serve in different capacities in the health care community? For example, do you want to develop new services in the hospital, provide training for hospital nurses, establish or work with other programs in the community (hospice, health dept., EMS)?

Are there things you wish you had been told about the medical community that you were not?

Any other thoughts about the physicians, other providers or the hospital?

VII. PRACTICE/JOB. Now if we could talk about the practice and your job.

Do you have certain expectations about the kind of patients/clinical problems you'll be seeing? About how many hours you'll be working? Or about how the practice is managed and functions? Any particular concerns?

Are there specific things that you wanted to to see happen in the practice with regard to patients (e.g., different mix) or how the practice functions? Or things you are particularly looking forward to doing or accomplishing?

Workload: How busy is the practice? Avg. patient visits per day - by the practice/you expect to see?

About how many hours do you expect to be working a week? In the office? In the hospital? Other? Do you see this changing in the future?

How often will you be on call - evenings/weekends? What arrangements do you have for coverage? Reasonable/acceptable?

How much vacation will you get? Is it sufficient? If not, what would be sufficient/fair?

How much CME time will you get? Will you receive a certain amount of money for continuing medical education? How much? Is the CME time and money sufficient? If not, what would be sufficient/fair?

Any concerns now about the work schedule/amount of time off? If so, what do you think would be a reasonable schedule/amount of time off?

Other Responsibilities

Will you have administrative, teaching, research or other responsibilities along with patient care? Will you be involved in other activities with the health department, EMS, a nursing home, a hospice or other entities? Explain.

(If teaching responsibilities)

Tell me a little bit more about the involvement you will have in teaching (medical students, residents, others). How do you feel about teaching, e.g., rewarding, frustrating, stimulating, a drain on time and productivity? Do you feel that you are adequately prepared to teach?

What kind of assistance would help you handle your teaching and administrative roles better?

Patients: Can you describe the kind of patients the practice/you will see - age, income level, minorities, insurance coverage (M'care; M'caid; private, none)

Do you like working with this population and treating the kinds of clinical problems you expect to see/treat?

Are there patients you'd like to see, or services that you'd like to provide which you do not expect to? _

Are there services that you will be required to provide that you'd rather not provide?

In some places, physicians tell us, community residents go out of the area for care, i.e., they bypass their practices. I've been told of cases where patients call the physician for help in the middle of the night but obtain the remainder of their care from physicians in the city. And of cases where patients come to the physician for routine problems but go to the city for anything that is at all complex - even problems that the local physician is capable of handling.

To what extent do you think this will happen here? Any thoughts on how you will feel about this if it does happen?

Health care providers talk about barriers to health care - things which stand in the way of patients getting the care they need, e.g., transportation problems, cultural beliefs, patients who distrust "outsiders," and lack of education about health care? Do you expect to find such barriers? Do you think you will find dealing with these issues to be challenging/stimulating? Frustrating/overwhelming?

Salary, Benefits. Would you mind discussing your income with me?

On what basis will you be paid (salary, net income from the practice, bonus, other)?

How much will you be making inititally (after practice expenses, before taxes)? What do you expect you will be making in 5 yrs./eventually?

Or if seems sensitive: Some income ranges are listed on this sheet. Can you underline the range that will correspond (probably) with your income from your job in the first year - before taxes. Any idea what your potential earnings are likely to be - in 5 years? Can you circle the range that corresponds with your potential earnings -before taxes (after practice expenses).

< $30,000	70,000 - 79,999	120,000 - 129,999
30,000 - 39,999	80,000 - 89,999	130,000 - 139,999
40,000 - 49,999	90,000 - 99,999	≥140,000
50,000 - 59,999	100,000 - 109,999	
60,000 - 69,999	110,000 - 119,999	

Do you feel the salary/income is fair/sufficient? What do you think would be reasonable and acceptable?

What benefits will you/your family receive (if employed) /take (if self-employed) - health insurance, life insurance, malpractice insurance, disability insurance, pension, sick leave, vacation?

Are these satisfactory? If not, what do you think would be reasonable and acceptable?

(If spouse is working), how much will your spouse be making?

Do you think you be able to save enough money to send your kids to college? Or for you to retire?

Type, Ownership, Profit/Nonprofit, Management

Can you tell me a little bit about the formal structure and ownership of the practice? Is it a nonprofit corporation (board, administrator, medical director)? Is it subsidized by the state? The federal government? Is it a partnership? Will you have any ownership interest? Do you expect to in the future?

Who makes decisions about hiring, salaries, purchasing equipment and policies regarding appointments/walk-ins, charges, collections, charity care?

Will you have a role in making decisions and managing the practice? Explain. Examples. Would you like to have more authority, power, responsibility? About what matters?

Any other thoughts/feelings/concerns about how decisions are made and the practice is managed?

Financial Matters. Now if we could turn to financial matters.

Do you know who financed the practice initially - the start-up and early operations, e.g., loans, grants, community funds?

How is it currently supported,e.g., patient revenues, state subsidies?

Do you know how the practice has done financially in the last several years (cover expenses, profit/net income, current debt/outstanding loans)?

Do you know whether the practice provides much care without charge/payment (e.g., 10% of patients don't pay or pay a token amount)? Are you aware of any problems with collections/bad debts?

Any idea about the practice's financial prospects for the future? Any concerns about the financial side of the practice? Explain.

Operations. Any concerns about how the practice functions? About staff, ancillary and support services?

VIII. SATISFACTIONS & REWARDS; DISSATISFACTIONS, FRUSTRATIONS & CONCERNS

What about your job do you think you will like/find the most rewarding and satisfying?

What about your job are you less enthusiastic about/do you think you might find frustrating or difficult?

Do you feel that you were a good match for this practice/job? How so? How not?

(Skip if already adequately addressed)

Are there ways you could have been better prepared (clinically, in the management of the practice, to expect certain things)? Things you wished you had known?

Many feel that physicians with <u>certain characteristics/backgrounds</u> are more likely to be satisfied in rural practices and rural communities.

Any <u>thoughts</u> on what these characteristics/backgrounds might be?

Assistance

(As appropriate) Do you feel, looking ahead, that you or the practice might benefit from assistance from the Office of Rural Health or others? Kind of assistance? Elaborate. *(Be sure the physician understands that this is a study and the interviewer is not in a position to actually*

offer assistance.)

Any thoughts/advice for the Office of Rural Health and others who are concerned about recruiting and supporting physicians in rural practices in North Carolina and elsewhere?

IX. CURRENT OUTLOOK

Any overall words of advice to physicians who are considering rural/small town practice, or to physicians who have made the decision and are about to begin practicing?

X. FOLLOW-UP

The Office of Rural Health may expand this project to follow-up with physicians who have entered rural/small town practices. How would you feel about being contacted by the Office of Rural Health in the future? Any feelings about whether this should be done in person, by telephone, by mail? Or at what point (s), e.g., after 6 months, every year?

XI. CONCLUSION

I'd like to know how you felt about this interview? Do you have any suggestions about what we might do to improve the interview or the process?

Do you think it would have been better if we had interviewed you at a different time - after you'd been here for a longer time? Or arranged for a meeting with incoming doctors - together - prior to/soon after their arrival? Explore - purpose and benefits of interview and/or meeting.

Again I want to assure you that your name will not be used in any reports unless you tell me otherwise. *(If appropriate)* I think that staff in the Office might benefit by hearing what you have to say about the kind of support that might be helpful to you or your practice. How would you feel about me passing along your thoughts on this specifically?

Some physicians that I interviewed felt comfortable with me sharing this tape with others who could gain from hearing our discussion. In fact, some actually encouraged me to do so? How do you feel about this?

I want to thank you, sincerely, for your help and giving so generously of your time. I may need to clarify some of what we covered. Would it be all right if I called you to do so?

HANDOUT

Interview # _____

< $30,000	70,000 - 79,999	120,000 - 129,999
30,000 - 39,999	80,000 - 89,999	130,000 - 139,999
40,000 - 49,999	90,000 - 99,999	≥140,000
50,000 - 59,999	100,000 - 109,999	
60,000 - 69,999	110,000 - 119,999	

Underline range - beginning salary
Circle range - potential salary

APPENDIX C

INTERVIEW GUIDE

FOLLOW-UP WITH INCOMING PHYSICIANS AND SPOUSES

Interview Guide - F/U Incoming Phys. Interview #
Date:

NOTE: COVER THE MAJOR TOPICS. USE OTHER QUESTIONS TO STIMULATE DISCUSSION AND KEEP THE CONVERSATION ON TRACK. WHAT IS COVERED WILL DEPEND LARGELY ON THE TIME THE PHYSICIAN HAS AVAILABLE

INTRODUCTION

It's good to see you again. My main purpose today is to hear how things are going. I'd also like to get your thoughts on some specific issues and approaches which address some concerns raised by physicians and their spouses. In addition, I'd like to hear your thoughts on medical education and residency training.

As before, I'd like permission to tape our conversation and have it transcribed. At the conclusion of our discussion, I'll be asking you to consider letting me share our conversation with others who are concerned about recruitment and retention of physicians in rural areas.

Once again, I'd like to tell you a little bit about me. I'm doing this project for the N.C. Carolina Foundation on Alternative Health Programs which is closely affiliated with the Office of Rural Health. I've been working in health planning, administration and policy for about 20 years. I'm married to a physician and I have two daughters - 13 and 10 years old.

I. ISSUES, PROBLEMS, CONCERNS - PANNING OUT

Well, how are things going with the practice? Have things turned out pretty much as you expected? How so? How not? What's going well? Any particular problems and concerns? Needs that are not being met? Do you feel valued/appreciated? What about the hospital and relations with other doctors? Any thoughts/concerns about schools, social/recreational activities or other aspects of community life? Have you made friends? Do you feel that you are part of the community? Are you working *(to spouse)*?

Ask about:

- *Specific expectations, concerns and problems raised during initial interview*
- *Workload, earnings, hospital, etc. - Attachment A*
- *Problem areas identified by other physicians - Attachment B*

Probe into specific dissatisfactions/problems/concerns; what is being done to address the major problems particularly; role ORH could play.

II. KEY ISSUES

Get input on key issues as appropriate: With those interested in doing obstetrics, discuss OB coverage/backup, relationships among providers who do deliveries, any problems that exist and alternative models for delivering OB services in rural areas; with women physicians, discuss concerns and suggestions for attracting women into primary care and rural medicine; with African-American physicians, discuss racial difficulties they or their families have encountered.

III. OVERALL ASSESSMENT; THE FUTURE

Do you think you made a good decision by coming here? *Probe: Are you a good match for the practice and community? Would you say that you are happy/satisfied? Do you feel that there is anyone in particular who is looking out for your well-being? That anyone is trying to ensure that your needs are being met? Have certain people or "things" been particularly helpful to you/your family - in working in the practice or the hospital, in integrating into the community or supporting you in your new situation, e.g., family who live close by, good child care, mentor/sounding board?*

Last year we discussed your intentions regarding the future *(review)*. Have your feelings about the next few years and the long term changed? *If so,* how and why? If you decide to leave, what do you think the reasons will be? *Probe.*

If in private practice (solo or with a partner): After having worked in solo practice/with a partner for nearly a year, do you feel differently about things? Do you think you'd rather be working with a larger group? Or for a larger organization on a salary where administrative and support services are under the authority or management of someone else? Elaborate.

If in a community-based practice: After having worked in a community health center/rural health center/under a community board for nearly a year, do you feel differently about things? Do you think you'd rather be in private practice (solo/with a partner/in a group)? Elaborate.

In thinking about what the future might be like for you and your family if you were to remain here permanently, do any concerns come to mind that you haven't mentioned? Elaborate.

IV. APPROACHES, STRATEGIES AND MODELS

Suggestions which address some of the issues/concerns raised by physicians and spouses in the interviews we have been conducting are listed on these sheets *(distribute Attachment C)*. Any thoughts about any of these? Which are good ideas? Value/benefits? Advice or suggestions on how these might work? Any interest in becoming involved/participating in any of these approaches or programs?

Are there any other strategies which you think the Office or someone else should be actively pursuing to prevent problems/increase the level of satisfaction/help retain physicians and families in rural communities and small towns?

V. PREPARATION FOR PRIMARY CARE AND RURAL PRACTICE DURING MEDICAL SCHOOL AND RESIDENCY

Last year we spoke about medical education and residency and your preparation for primary care and rural practice. Any words of advice to educators from your current vantage point? Are there ways in which you could have been better prepared for practice and life in this community - during medical school, residency or by the Office or others before you came? Are there things you wished you had been taught, told, had realized or experienced?

How about any overall words of advice to physicians who are considering rural/ small town practice, or

Interview Guide - F/U Incoming Phys. Interview #
Date:

Attachment A

Supplement to Section I of the Interview Guide

1. Workload

   a. About how many hours do you work per week (on average including time on the telephone or at the hospital when on call))? _____ Is this satisfactory/too much/too little? _____ What do you think is reasonable? _____

   b. How often are you on call? _____ Arrangements for coverage? _____

   _____

   Is the call schedule satisfactory? _____ What do you think is reasonable? _____

   c. Do you serve in other roles or have other responsibilities along with providing clinical care in the practice, e.g., hospital practice, follow patients in intensive care, work in the health dept., nursing home, oversee PAs and NPs, perform administrative duties, conduct research, teach?

   _____

   d. Have you taken any vacations during the last year? _____ Are you planning any in the next 6 months (elaborate)? _____ What kind of vacation coverage do you have? _____

   Is the amount of vacation and the coverage satisfactory? ____ If not, what would be satisfactory? _____

   e. Have you taken any CME time? _____What did you do?_____ _____ Is the amount of time satisfactory? _____

2. Earnings

   a. Last year, how much did you earn (salary or income after expenses, before taxes)? _____Are you satisfied with this? _____

   b. What do you expect to make this coming year? _____Are you satisfied with this? _____

   c. What do you expect you'll be making in 5 years? _____Do you think you will be satisfied with this?

3. Hospital

   a. How far is the hospital from your home (miles and time)? _____ From your practice ? _____

   b. Are you satisfied with the hospital? _____ Any concerns with services, staff, quality of care, financial viability? _____

PROBLEM AREAS

MEDICAL PRACTICE

1. Excessive demands, multiple roles and responsibilities, difficulty recruiting other physicians to share workload

2. Call, time off, vacation coverage

3. Insufficient backup, particularly for OB

4. Lack of support from those in the community, e.g., go elsewhere for medical care

5. Feeling unappreciated

6. Income

7. Patients

8. "The system," where "proud patients do not obtain needed medical services because of finances and many Medicaid patients routinely seek care which they don't need."

9. Clinical practice, e.g., not being able to practice "the kind of medicine" they wanted/were trained to practice.

10. Clinical preparation

11. The "business side of medicine." Dealing with the demands of managing a practice; feeling ill-prepared.

12. Partners

13. Community-based practices (with community board),
e.g., degree of control over policies and operations, compensation, inability to work part-time, practice inefficiencies, regard patients have for physicians' time, center's image, staff, practice style of other physicians, administrators, the board or particular board members, paperwork.

14. Insufficient time/opportunities for teaching/research

THE MEDICAL COMMUNITY

15. The "medical establishment"

16. Other physicians in the community

17. The hospital(s)

18. CME (continuing medical education)

19. Referrals centers, physicians to whom refer, other professional supports

LIFESTYLE AND COMMUNITY

20. Recreational, cultural activities

21. Social life, friends, being part of the community

22. Racial discrimination

23. For spouses - employment, professional and personal contacts

24. For women physicians - ability to work part-time, other professional women to befriend, time to build relationships, finding companionship/partners

25. Schools

26. Values and priorities of people in the community, e.g., as demonstrated by failing to pass school bond issues.

Attachment C

SUGGESTIONS*

1. **Physician mentoring program**

   Could match incoming physicians with a veteran physician (local or in another community). The veteran physician might provide advice, emotional support, clinical feedback, assistance in becoming integrated into the community.

2. **Orientation for newly-placed providers**

   Agenda might include: exposure to the support/assistance/resources available through the Office of Rural Health, others in the state and nationally; information on clinical and practice management issues; discussions with veteran physicians about handling situations that might arise and are problematic.

3. **Affordable locum tenens program**

   Non-profit. Determine amount physicians are willing to pay for coverage.

4. **Mini-fellowship** (with free coverage)

5. **Flexible job positions**, e.g., job-sharing, part-time positions.

6. **Networking**

   Assist providers and spouses establish relationships by organizing meetings, through mailings and possibly a newsletter.

7. **Electronic mail/bulletin board** between physicians/health centers, the Office of Rural Health and medical centers.

8. **Management training**

   Suggestions include: subsidized tuition for courses/seminars, workshops at local meetings, on-site staff training, annotated bibliographies, a lending library, videotapes on selected practice management topics.

9. **Management assistance/support**

   Offer different levels of service, e.g., comprehensive management of a practice, services for which providers could selectively contract, short-term consultation.

10. **Alternative models to maintaining obstetrical services**

11. **Increase in the number of midlevel providers**, e.g., PAs, FNPs, nurse midwives.

12. **Facilitating the development of more organized delivery systems**, e.g., provider networks, group practices, PPOs, HMOs.

* These suggestions are aimed at problems other than call and reimbursement

13. **Rural fellowships**

    Fellows would have experiences and develop skills to help them succeed in rural medicine. A portion of their time might be spent providing coverage for vacationing practioners.

14. **Community-based teaching of medical students and/or residents**

15. **Technical assistance to Community-based Practices,** e.g., Community Health Centers and state-sponsored Rural Health Centers

    For example, assistance in streamlining operations and in defining/negotiating the roles and responsibilities of the board, administrators and physicians.

16. **An "early warning system"**

    To help detect physician dissatisfaction and allow for early intervention. Determine how this might work in practice.

Interview Data Sheet **Update from Initial Interview**
Interview # _____ **Date:** _____

1. Month and year began in practice: _____

2. Age when came: _____ Currently: _____

3. Specialty practicing: _____

4. Gender:

5. Race:

6. Where raised?
   Rural area/small town?

7. Marital Status:

8. Children (gender and ages) when began in practice: _____

   Currently: _____

9. Undergraduate school: _____

10. Medical school: _____

11. Residency: Place _____ Specialty _____
12. Board certified? _____ Board eligible? _____

13. Spouses background/occupation/interests:

14. NHSC? _____ Extent of obligation: _____
    Other loan repayment program/obligations? _____

    _____

15. Where prior to this practice, e.g., residency, military: _____

16. Previous ties/familiarity with N.C. prior to entering the practice (for those who were not raised, did not attend medical school and did not do a residency in North Carolina)?

17. Type of practice, e.g. private solo, CHC: _____
    Name of practice: _____

18. Community where practice located:

19. Community where physician resides:

20. Intentions when came:
    Intentions now:

21. Salary/net income - last year: _____
    Expected salary/income in 1993: _____
    Expected salary/income in 5 years: _____

22. Hours work per week:

23. Frequency of call:

24. Interview method, e.g., in person, by telephone:

    If in person, place of interview: _____

25. Interview time (approx.): _____

26. Date of initial interview:

27. Date of follow-up interview:

Departing Physicians

PROBLEMS, FRUSTRATIONS, REASONS FOR LEAVING

Medical Practice

1. **Excessive and Unending Demands and Needs; Multiple Roles and Responsibilities; Unrealistic Expectations.** Inability to recruit other physicians to share workload because of insufficient income (i.e., in private practice) and competition.

2. **Excessive Call; Too Little Time Off; Inadequate Vacation Coverage; "Time Off Isn't Really Time Off"**

3. **Insufficient Backup, particularly for OB**

4. **Lack of Support from those in the Community,** e.g. go elsewhere for medical care

5. **Feeling Unappreciated and Like No One is Looking out for "Me"**

6. **Lack of Respect.** Comparatively low earnings; low regard by local residents in some places (some simply seeking more stable medical care); attitude of academicians in some cases.

7. **Money.** Money became more important to doctors as their families and financial needs expanded (down payment on a house, college tuition.) Feel should be compensated as others with equal training and skills.

   Private practice: inadequate reimbursement from Medicaid and Medicare (new physicians were paid at lesser rates); difficulty making ends meet; inadequate income to compete/hire another physician; often reluctant to increase charges and collect; greater efficiencies might be realized in operations.

   Community-based Practices: some felt salary was unfair, e.g. not compensated for greater productivity.

8. **Patients.** Frustrating and disheartening to constantly deal with people who lead desperate lives and who do not take precautions.

9. **"The System"** where "proud patients do not obtain needed medical services because of finances and many Medicaid patients routinely seek care which they don't need."

10. **Clinical Practice.** Disappointment at not being able to practice "the kind of medicine" they wanted/were trained to practice because of other physicians in the community, patient expectations, logistics and financial realities. The desire but difficulty of trying to "do it all" as a rural family doctor especially in a solo private practice.

11. **Lack of Clinical Preparation.** An internist trained in a tertiary care center felt inadequately prepared; an OB-GYN hadn't really understood the limitations of practicing in a small hospital.

12. **The Business Side of Medicine.** Feeling ill-prepared; couldn't find or afford trained office staff; coping with "tightening screws" by Medicare and others; dealing with fines, constantly changing regulations, insulting letters questioning appropriateness of care; CLIA (Clinical Laboratory Improvement Amendments).

13. **Partners.** Different practice styles, priorities, needs and values; personality conflicts; disagreements over how things should be done; poor communications. Difficult to really "know what getting into" when join a practice.

14. **Disparity between Expectations/Promises and Reality,** e.g. call, clinical mix, backup.

15. **Community-based Practices** (specifically)

    a. Physician often didn't want to be there from the beginning (wanted urban setting, private practice option or private practice)

    b. Too little autonomy and control over schedule, patients, staff, policies, etc.

    c. Compensation doesn't reflect when physicians work harder than others, i.e., not always productivity-based

    d. Lack of flexibility (to work part-time)

    e. Desire to change image of the center and how patients regard center and physicians' time

    f. Staff - poor attitude or inadequately trained

    g. Different practice style than other physicians (didn't choose partners)

    h. Feeling that administrators and/or board "don't understand" or are not qualified

    i. Frustration with paperwork that "had little to do with quality"

    j. Feeling that center is inefficiently run

k. Stigma of being associated with a center

l. Frustration at "reinventing the wheel" and tracking down available resources

m. Physicians who were NHSC or came to fulfill other service obligations are often viewed/treated as temporary by those in the practice and others

The Medical Community

16. **Feeling Insecure and Like "Standing on Thin Ice."** As doctors come and go, the practice fluctuates so physicians are never sure about income or time. Always worried about the hospital closing and not being able to practice the "kind of medicine" they want.

17. **Poor Physician Relations.** Attitudes of other doctors (e.g. "family doctors shouldn't be doing OB"); difficulty getting established physician to share call ("cold shoulder") or to form a group; competition ("greedy").

18. Hospitals

    a. Poor reputation
    b. Financial vulnerability
    c. Inadequate facilities/inadequate staff
    d. Poor relations/competition between Community-based Practices/private practices and hospitals
    e. Inadequate hospital administration/ board

19. **The Medical Establishment.** The "good-old-boy network" and "old-timey" physicians. Incompetent physicians; difficulty introducing changes.

20. **CME (Continuing Medical Education).** Problem for some.

21. **Referrals Centers.** Negative attitudes toward LMDs (local medical doctors) often reported. Some physicians praised the consultative services offered to local doctors by such referral centers. Those who knew people at a referral center or practiced near a residency program were often at an advantage.

Lifestyle and Community

22. **Too Little Time to Enjoy Recreational Activities and Family**

23. **Racial Discrimination**

24. **Not Feeling Welcomed or Truly Integrated Into the Community**

25. **Inadequate Social Life** (single women particularly); **Finding "Like-Minded" People**

26. Feeling Too **Isolated Culturally**

27. **Lack of Privacy**

28. **Spousal Concerns** (in addition to many of those noted above)

    a. Employment. A problem for one male spouse and a female spouse. The other male spouses (all physicians) were practicing. At least one had "ups-and-downs" about practice.

    b. Professional isolation ("may need to make special efforts to go to meetings in the city").

29. **Unique Concerns and Issues of Female Physicians**

    a. Desire to work part-time to have more time with children. Community-based practices sometimes lacked the flexibility to allow part-time work. Because of the demands of private practice, one female doctor whose position was "part-time" ended up working full-time although her salary was part-time.

    b. Lack of (many) other professional women to befriend. Little time to build relationships, especially if have children. Difficult for African-American single women physicians who wish to find other middle and upper-middle class African-American single professionals.

30. **Disillusionment.** Idealistic, naive and then disappointed about making changes in the schools and the community.

31. **Poor Schools.** Often the alternatives unacceptable. Concerned about bringing up children in an environment where children are often raised with more limited aspirations.

Physicians' Characteristics

32. **Unrealistic expectations of self;** overcompulsiveness; guilt; concern about bringing in enough money; concern about image and how regarded; concern about always being available; reluctance to increase rates, charge and collect; reluctance to seek help; assumption that things will improve (eventually burn out and reach the "point of no return"); concern for and involvement with vulnerable hospital and employees.

33. **Lack of preparation and experience.** Inexperienced as managers and community leaders. Often without perspectives/mellowing gained from working "in the real world" over a number of years. Frequently naive about the politics of the medical community and community life.

34. **Coming with a "heavy-handed social agenda" or unrealistic expectations** about changing things in the community, e.g. disillusioned because of lack of support for changes in the schools.

35. **"Temporary mindset"** so don't get too involved in community activities.

Other

36. **Attractive Alternatives Plentiful; Prospects for the Long Term, if Stay, Not Very Appealing; Other Forces Pulling Physicians and Families Away**

37. **Obstacles To Staying in the Community When Become Disenchanted With the Practice,** e.g. non-compete clause in contract, fear of going out on own without support.