PHYSICIAN-COMMUNITY INTEGRATION: A CASE STUDY OF PRACTITIONER EXPERIENCES AND RETENTION CHALLENGES ON BRITISH COLUMBIA’S HAIDA GWAI’I/QUEEN CHARLOTTE ISLANDS

by

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Abstract

Social life, and particularly health care delivery, in a small isolated community is more complex and nuanced than has been reflected in much of the literature on physician retention, which has never extended the notion of the “workload” past the physician’s formal role in the health care setting. Despite having been acknowledged by provincial and national government policies, few of what Anderson and Rosenberg (1990) describe as “unidimensional solutions” have resolved the “multidimensional issues” of physician retention in northern Canada. This thesis employs a qualitative framework to investigate the practice and lifestyle experiences of general practitioners on the Queen Charlotte Islands (Haida Gwaii) to provide a local analysis of physician retention problems experienced by isolated communities. By including both physicians and community members as key informants, the project attempts to determine whether a difference exists between physicians’ perceptions of place and their roles and the voiced expectations of the communities they serve. The research uses a combination of in-depth interviews and questionnaires with physicians (n=6) and community members (n=12) to determine the various roles played by a physician in a small community. It queries whether the community in question expects physician to take up roles outside of the medical space, whether physicians are influenced by these expectations and whether these may contribute to the cessation of practice in remote communities. This thesis examines not only health care-related factors involved in medical practice, but also the informal settings of the community at large, including the general interactions that are incorporated into a physician’s character in a close-knit and isolated place. The findings of the thesis demonstrate that there are significant gaps between what community members and physicians believe is reasonable behaviour and the reality of physicians’ experiences in their respective island communities. The lack of boundaries perceived by physicians in their communities often leads to social isolation, which has the opposite intended
effect of respite, instead leading to further disengagement from the local community, finally resulting in a decision to locate elsewhere.
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My research was made possible by the participation of local residents on Haida Gwaii and I am grateful for the wholehearted support I received from islanders during my research interview period in July and August 2008. I interviewed caring and motivated community members in Sandspit, Queen Charlotte, Masset and Port Clements. I extend thanks to the health care staff, physicians, community leaders and residents who welcomed me and my ideas.

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Chapter 1

Introduction

1.0 Rural and Remote Health Care Distribution: Physician Retention in Resource-Dependent Communities

This thesis explores well-documented shortages of frontline health care providers in rural and remote locations in Northern British Columbia. The primary goal of the thesis is to identify whether a relationship exists between the social dynamics of small, isolated communities and the pressures experienced by island physicians where long-term retention has historically been a challenge. In particular, the research focuses on the socially constructed experiences of physicians in communities where burnout and fatigue contribute to chronic physician shortages. The thesis is based on literature findings in the areas of health geography that discuss past approaches to social service provision using spatial and social analyses, particularly in rural and remote settings in North America and Australia. These studies identify a gap in the literature pertaining to the lived experiences of rural physicians in close-knit communities. To contribute to this literature, the research process involves a case study used to target and better understand the social interactions between physicians and communities where physicians also reside; a topical area suggested by past researchers as having minimal adequate coverage within the geography and community health literature.

Using qualitative interviews, the research findings explore the experiences of physicians and community members on British Columbia’s Queen Charlotte Islands, a group that interacts closely on a daily basis in both clinical and community settings. The discussion reviews these responses and articulates the emerging relationship between retention difficulties and the social characteristics of island communities. The thesis concludes with a discussion of the implications for understanding these data in a broad geographic context, a summary of the limitations of the
research project and a view to work that may further enhance geography’s understanding of practitioner-community relationships within Canada’s rapidly changing political and demographic environment.

1.1 Geographic Context of Northern British Columbia and Haida Gwaii (Queen Charlotte Islands)

Haida Gwaii, named by the British in the late 1700s as the Queen Charlotte Islands, are an archipelago of over 200 islands off the northwest coast of British Columbia (See Appendix 5 – Figures 1 and 2). The islands have been home to the Haida people, an indigenous group of separate clans (on the north and south islands) which employed a trade economy that brought them into contact with indigenous groups to the north, in what is now Alaska, and to the east, on BC’s northwest coast, where the Skeena River feeds into the Pacific Ocean. At the end of the 1800s, the United Church became a strong socio-cultural presence on the islands and began to implement various social service institutions, including schools scattered throughout the islands. In 1897, several Haida clans were forced to locate at the present site of Skidegate, and later on, Queen Charlotte City emerged as a social centre, from its early beginnings as a sawmill site (Henderson, 1985). According to church historian and island resident R.W. Henderson (1985), the first Queen Charlotte Islands General Hospital (QCIGH) was built in 1909. The island physician, Rev. Dr. J.C. Spencer, was both the general practitioner and minister of the Queen Charlotte Methodist Church, supported by a few short term physicians who “didn’t stay long”, until 1955, when the current QCIGH was constructed.

The islands’ temperate rainforest, dramatic landscapes and cultural history enabled the establishment of most of Moresby Island, the major southern portion of the archipelago, as a UNESCO World Heritage Site, attracting several thousand visitors each year from around the
world (Village of Queen Charlotte, 2009). Over the past century, strong resource-based industries have developed on the islands; historically mining, whaling, fishing and logging drew residents from the mainland, while more recently fishing, forestry, logging and a growing ecotourism sector support the slightly shrinking island-wide population. In general, northern British Columbia is characterized by its resource extraction industries and increasingly as a regional tourist destination with global appeal. Because of fluctuations in external demand for natural resources, local economies have experienced sporadic development (Hanlon and Halseth, 2005). As a result of this, northern communities, including those on Haida Gwaii, have difficulty maintaining stable populations and face significant challenges attracting the professionals needed to provide essential services to local residents who work in the resource sector. Approximately 5,000 people live on the islands, scattered between Sandspit, to the south, and Masset, at the northern edge of Graham Island (Table 1.1). The islands’ total population fluctuates seasonally and reflects the ability of the forest industry, primarily, to continue harvesting operations cost-effectively.

The archipelago is made up of two major islands; Graham and Moresby, around and between which are hundreds of smaller, mainly uninhabited, islands. Queen Charlotte, on the more populated Graham Island, is considered to be the “hub” of the four main communities. It contains many of the government offices that conduct and control resource extraction operations; the Ministry of Forests and Range, Department of Fisheries and Oceans and various public service agencies operate out of the community situated on the northern side of Bearskin Bay (Village of Queen Charlotte, 2009). Also on Graham Island is Skidegate Landing, the BC Ferries Terminal connecting services to the mainland and to Moresby Island, to the south, where Sandspit is located. Sandspit is a community of 400 people who work in the logging and tourism services industries, primarily, along with a core of individuals employed by the airport authority, Air
Canada, and a few smaller carriers providing services around the islands and to the mainland. Port Clements and Masset are located on Graham Island; the former is almost entirely dependent on forestry and logging. The former location of a Canadian Forces base, Masset carries a population of approximately 1000 people, is the northern gateway to Naikoon Provincial Park and is the oldest municipality on the islands (Village of Masset, 2009). The Haida Nation is located between two reserve villages where the Haida were forced to relocate at the end of the 1800s due to smallpox and the introduction of the reserve system. Old Masset is located outside of Masset at the mouth of Masset Inlet, and has a population of approximately 700; Skidegate, at the mouth of Skidegate Inlet (which feeds Bearskin Bay) contains approximately 1000 people and acts as a service centre for traffic between the south and north ends of the islands. Physician and hospital services for each Haida village are provided in the adjacent non-reserve community; Old Masset residents utilize services in Masset, Skidegate residents use the Queen Charlotte clinic and hospital. Both villages are served by on-reserve medical clinics providing basic preventive care services, prenatal clinics, and nurse clinics.

Table 1.1: Population Counts for Selected Communities on Haida Gwaii/Queen Charlotte Islands, 2006

<table>
<thead>
<tr>
<th>Villages/Reserve</th>
<th>Non-Aboriginal Population</th>
<th>Aboriginal Population</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Masset</td>
<td>620</td>
<td>320</td>
<td>940</td>
</tr>
<tr>
<td>Masset Reserve</td>
<td></td>
<td>694</td>
<td>694</td>
</tr>
<tr>
<td>Port Clements</td>
<td>425</td>
<td>10</td>
<td>435</td>
</tr>
<tr>
<td>Queen Charlotte</td>
<td>800</td>
<td>135</td>
<td>935</td>
</tr>
<tr>
<td>Sandspit</td>
<td>380</td>
<td>20</td>
<td>400</td>
</tr>
<tr>
<td>Skidegate Reserve</td>
<td></td>
<td>781</td>
<td>781</td>
</tr>
<tr>
<td>Tlell</td>
<td>585</td>
<td>20</td>
<td>605</td>
</tr>
<tr>
<td>Total</td>
<td>2810</td>
<td>1970</td>
<td>4780</td>
</tr>
</tbody>
</table>

Source: 2006 Census of Canada
1.2 Physician Retention in Underserviced Regions

This research study deals with not only the various factors involved with physician satisfaction and subsequent retention such as time available away from work, but the quality of the time spent away from work, the nature and quality of community interactions and the perceived exchanges between communities and physician-community members. Is a physician seen as a community member without the doctor “hat” on, when they are outside of the medical environment? This research incorporates the notion of “community commitment” suggested by Pope et al. (1996) as a key attribute for positive physician retention as well as Cutchin’s (1997) concept of “experiential place integration” as ways to determine the likelihood that a physician will make a long-term commitment to a rural or remote community.

While delivery of health care in areas remote from even regional urban centres has been a historic challenge, the problem of physician shortages in small, rural communities is now exacerbated by changes within national and provincial health care systems. Policy and administrative changes targeting health care delivery in rural and remote regions of North America, particularly the supply and retention of health care professionals, has become more prominent in the past decade and a half. These changes are necessitated by changes within local and global economies as well as the ubiquitous issue of population aging. They have also, fortunately, been better enabled by emerging technologies in health care communications and advancements in educational program structures in countries where attention is increasingly paid to the upcoming practitioner shortages and the unique needs of distantly located healthcare users. Medical school seats have increased only marginally though some success has been seen in the construction of medical programs in northern cities whose mandate is to serve the under-represented communities of northern Canada. This provides students from small rural
communities, often first-generation university attendees, an opportunity to consider medicine as an option and to pursue medical careers closer to home and valuable social support networks.

As shortages emerge in all areas of health care delivery, task forces have been commissioned to address the regional and federal shortfalls and to provide solutions for a new era of healthcare organization (Ministerial Advisory Council on Rural Health, 2002; Romanow, 2005). The findings of these investigations began to influence government strategies for service distribution to northern areas, where there exist populations employed and supported by local-regional resource industries. In many cases, including that of British Columbia, the changes involved the restructuring of provincial ministries to regionalized service bodies that could more closely monitor needs and tailor service delivery within the “healthcare services delivery area” (HSDA). With increasing regionalization of health care delivery areas, expertise and practitioner training opportunities are often concentrated at regional facilities where specialized services are available. Across Canada, family medicine is losing popularity as a specialty for new medical graduates (Society of Rural Physicians of Canada, 2005). In addition, incomes for highly specialized practitioners are often considerably higher than for general practice and located in larger urban centres with the desired access to amenities and highly concentrated professional networks. Finally, as senior physicians begin to retire, overall physician shortages and distribution challenges will be compounded and geographic retention issues will become more pronounced.

The interplay of these variables has significantly contributed to the now acute problem of physician supply in communities further away from urban and suburban areas. Attempts have been made to address the problem at several levels. At the national level, this has involved employing increasingly neo-liberal strategies such as privatization or withdrawal of what are deemed “non-essential services”; childcare, home support and family caregiver compensation. At
the provincial and local level, strategies to improve physician retention outcomes, particularly in rural or remote areas, have included financial incentive programs, medical student and residency training in rural and remote areas, and reorganization of work scheduling between physicians to allow for increased time off and lightened patient loads. These programs and incentives may be offered by the communities themselves or in combination with provincial funds and grants administered through regional health authorities.

1.3 Rural Health Care: Isolation, Restructuring and Staffing Challenges

Rural health care delivery is inextricably connected to and affected by distance factors, physical/landscape barriers, unique social geographies and administrative difficulties in terms of both supply and demand. The individuals who provide care are at the apex of these factors. The rural, remote, health care practitioner must reconcile the realities of distance and isolation with their practice and quality in the health care delivery setting. While the physicality of isolated and rural areas is important to understanding how to retain physicians, the socially-constructed nature of medical practice in a small, close-knit community is equally vital to examine during research and planning of physician services in the north. This is not a new issue in the broader health care access literature and has been identified by both academic researchers and professional health organizations (Kazanjian and Pagliccia, 1996; Lee et al., 2009; Society of Rural Physicians of Canada, 2009). In response, improvement of physician retention in rural BC has been approached through a series of initiatives that include locum tenens programs, improved telehealth communications systems and opportunities for teaching and education to further physicians’ professional development while they are employed in rural or remote communities.

Provincial restructuring in the mid to late 1990s led to the dissolution of local community health councils and the establishment of regional governance under the umbrella of the Northern
Health Authority, based in the mainland-interior city of Prince George (Hanlon and Halseth, 2005). The islands experience chronic shortages of health care professionals, including nurses, lab technicians, social workers, physiotherapists and family physicians. There are no specialist practitioners on island, which results in significant patient travel for medical treatment (to Vancouver or Prince George) and a broadened scope of practice for island physicians. In a rural community, physicians are more likely to manage complex patient care (and subsequently be required to have a larger set of skills than the average general practitioner) before referring patients to specialists located at more central tertiary care centres.

Throughout early studies of retention, the positive aspects of physicians’ roles include the variety of the work itself, relationships with patients and the communities where physicians live and work. On the other hand, the negative components of their experiences are excessive work demands and paperwork, “bureaucratic interference” with medical care, and a lack of professional development opportunities (Pathman et al., 1996). A number of scholars have suggested that research is required which addresses the specific rural or remote places where physician retention outcomes are poor in order to facilitate the recruitment of the kind of physician who will integrate into a rural community effectively (Rosenberg and Anderson, 1990; Cutchin, 1994; Pathman et al., 1996; Pope et al., 1998; Lee et al., 2009).

In some instances, physician shortages in “medically underserved areas” have been approached as an outcome of market failure; where despite strong demand and availability of certain amenities, physicians do not choose to locate and remain for long-term practice. The Royal College of Physicians and Surgeons, however, have argued that research needs to push beyond finding the factors that lead to attraction or recruitment of practitioners and focus on “retention and on understanding the factors that influence physicians to stay in their rural settings” (Pope et al., 1998). This thesis attempts to address this call for research and explore the
intersections between physicians’ practice and community membership which cumulate in a unique experience in rural and remote settings. The experiences of physicians on Haida Gwaii are directly related to the physical and social geographies of the region and indicate a need for further attention to the draws that these place-related factors can, and do, have on retention outcomes.

The remainder of the thesis is organized between a literature review (Chapter 2), methodology (Chapter 3), integrated discussion and results section (Chapter 4), and conclusion (Chapter 5). The next chapter reviews the historical and socio-cultural implications for health care distribution as well as the place-based and professional factors that affect physician practice in rural and remote communities similar to those on Haida Gwaii. Chapter 3 reviews the research methodology, the participant population and the data analysis process. Chapter 4 is separated into three sections. Overall, the chapter is concerned with both the analysis of the qualitative findings and the major ideas that emerged through the research process. Each of the first two sections (4.1.2 and 4.2.1) analyse a distinct participant group; physicians or community members. The final section of the chapter (4.3.1) summarizes the general findings and discusses the context-specific issues that were identified by both groups and which make up the main findings of the thesis. Finally, Chapter 5 addresses the research question and goals of the thesis, examining the limitations and implications of the project and establishing scope for future studies surrounding rural and remote healthcare providers.
Chapter 2
Literature Review

2.0 Rural Medical Practice and Physician Satisfaction

Recruitment of physicians to rural practice continues to be a major concern to most rural communities. This problem has been extensively studied, and evidence now exists that physician characteristics, training environments and a rural training curriculum are a few of the important factors related to attracting physicians to these practice locations. More recently, however, the concern has shifted and studies have begun to focus attention on retention and on understanding the factors that influence physicians to stay in their rural settings.

(Pope et al., 1998: p.209)

Keeping physicians in rural communities and long-term clinical practices has been a significant challenge in Canada, the United States and Australia. Studies carried out in the late 1970s and early 1980s examined the experiences of rural physicians and how they link to retention challenges and successes (Cordes, 1978; Parker and Sorensen, 1978; Hassinger, Gill, Hobbs, and Hageman, 1980). There is also a strong body of work on physician location choice in the Canadian context (Anderson and Rosenberg, 1990; Jennett and Hunter, 1988; Kazanjian and Pagliccia, 1996). Few studies have focused on the effects of the community-physician relationship, and the non-medical relationship of the physician-community member in a small town. These interactions are the focus of this study. Rosenthal et al. (2005: p.1932) argue that “while views on the adequacy of the national physician workforce vary widely…most seem to agree that physicians are maldistributed, with too few in rural areas” and is supported by physicians in British Columbia who argue that the place effects of rural practice have been inadequately addressed thus far as a unique factor, separate from “regular” stressors and occupational factors (Kazanjian and Pagliccia, 1996; Thommasen, 2001; Larsen Soles, 2008).
Rural medicine has historically been considered a first-point of care that can be managed at major urban centres following initial consultation and primary assessment. With increasing establishment of populations in northern and remote areas where resources and natural amenities are found, health care services have had to adjust to serve these groups in-place. In partnership with regional and national government, medical schools and communities have sought candidates with high integration potential; that is, who would stay long-term and settle in the local area. It is clear that the best retention rates have emerged with the new cohorts of students training in northern locations. By completion of their medical training, students at the Northern Ontario School of Medicine (NOSM) have spent over 40% of their clinical time in rural or remote communities and are thought to have a high likelihood of remaining in the north following residency training (Wilson et al., 2005; Northern Ontario School of Medicine, 2008).

Denz-Penhey and Murdoch (2007: p.1) use Australian historian Geoffrey Blainey’s term “tyranny of distance” to capture how a geographically heterogeneous and physically vast region can undermine the equitable distribution of healthcare. Their use of the term in the Australian context fits the current North American scenario as well. Social service distribution challenges, particularly related to health care, are well documented in medical and health geography research dating back to the 1970s (Smith, 1979; Joseph and Bantock, 1984). Urban and suburban primary health care services, though fraught with their own challenges of access and uniquely urban health issues, are at least proximal to the catchment population requiring care. Rural health care is inextricably connected to and affected by distance factors, physical/landscape barriers, unique social geographies, and administrative difficulties in terms of both supply and demand. The individuals who provide care are at the apex of these factors. The rural, remote, health care practitioner must reconcile the realities of distance and isolation with their practice and quality in the delivery setting (Rourke, 2005). While the physicality of isolated and rural areas is important
to understanding how to retain physicians, the socially constructed nature of medical practice in a small, close-knit community is equally vital to examine during research and planning. These factors are as important to address as different from an urban or suburban setting as are the more visible and immediately apparent physical features of northern or remote landscapes.

2.1 Past Approaches to Physician Retention Research

Throughout early studies of physician retention, the most positive aspects of physicians’ roles were the variety of the work itself, relationships with patients and the community where they lived and worked. Most often, the negative components of the experiences were excessive work demands and paperwork (Cordes, 1978), “bureaucratic interference” with medical care (Hassinger et al., 1980), and a lack of professional development opportunities. What is now required is research that specifically addresses rural and remote places where physician retention has proven difficult in the past. This will enable more directed and context-appropriate suggestions for the recruitment of physicians who integrate successfully, and for a substantial period of time, into the community in question (Pathman et al., 1996; Cutchin, 1997).

In some instances, physician shortages in “medically underserved areas” have been approached as an outcome of market failure; where despite strong demand and availability of certain amenities, physicians do not choose to locate and remain for long-term practice (Newhouse et al., 1982; Wise and Zook, 1983). These studies have used an economic lens to determine why physician supply and demand fluctuate between rural communities and suburban or urban regions. Primary care specialists are viewed as multi-product firms that compete with general practitioners, which obviously leads them to maximize those skills and locate in a large urban centre where they will be in demand (Newhouse et al., 1982). General practitioners must locate in areas where their generalist skills will be required and where a different threshold of
referral is utilized. In a rural community, physicians are more likely to manage complex patient care and issues of wider scope (and subsequently be required to have a larger set of skills than the average family or general practitioner) before referring patients to specialists in larger cities.

Anderson and Rosenberg (1990, p.35) have questioned the reliability of using the supply-demand model approach to address physician “maldistribution” in Ontario. In this context, administrative controls over choice of practice location and financial incentives are used to solve the highly complex reality of “disequilibria between the over-supply of physicians in some [rural and remote] areas and unmet demand in others”. Standard location theory, utility maximization, induced demand and inter-specialty location patterns have been used to understand the push-pull factors associated with relative choice and location decision “thresholds” (Newhouse et al., 1982, p.3-7).

Market-related failure (or supply/demand interactions) alone, however, does not account for the “tipping of scales” that takes place when all the “right” factors are in place (physician history, supportive medical community and income, etc.) (Pope et al., 1998). Deeper, place-based interactions are occurring when a rural community has chronic practitioner vulnerabilities and cannot retain individuals who will commit to practice in the rural setting, yet has provided the requisite financial incentives, basic amenities and continuing medical education (CME) opportunities. Hanlon and Halseth (2005, p.21) argue that blanket analyses of health care without regard to the unique settings and needs of rural locales are ineffective:

provincial governments increasingly impose standard benchmarking techniques with no regard to place-specific levels of need or the specific challenges of service delivery in smaller and more spatially remote populations.

The common belief, according to Pathman et al. (1996, p.367) is that “as long as physicians find rural practice less satisfying” it will be chronically difficult to attract and retain those individuals. As a result, the challenges of physician retention in these places has been approached through a
series of initiatives that include *locum tenens* programs, telehealth communications systems and opportunities for teaching to further professional development (Pathman et al. 1996).

2.2 Re-thinking Approaches to Successful Retention: Satisfaction, Investment and Integration

Pathman et al. (1996) identify three key areas that are associated with satisfaction of physicians practicing in rural areas: satisfaction with the community, professional goal attainment and earnings. However, they argue that in order to improve physician experiences in rural or remote health care delivery areas, rural communities and health administrators “should focus on those areas that predict longer retention and other important outcomes”. Kajanjian and Pagliccia (1996) found that spousal influence was one of the strongest influences on practice location. This is supported by an array of literature on retention, which emphasizes the importance of supporting physicians’ families as opposed to focusing solely on individual physician satisfaction (Conte et al., 1992; Pagliccia et al., 1995; Pathman et al., 1996; Lee et al., 2009).

In an American scenario, Movassaghi and Kindig (1989: p.130) determined that “higher income, fewer work hours, a greater number of insured patients, and closer proximity to a medical referral center predicted overall practice satisfaction for physicians in small rural counties nationwide. In another study, Lepnurm and Trowell (1989: p.14) found that satisfaction among Canadian rural physicians was associated with their perceived opportunities for social interaction, opportunities for "periodic rest," opportunities for spousal employment, and adequate compensation. Age is also considered a factor in long-term retention, as noted by Ramsbottom-Lucier et al. (1995) older rural physicians in Kentucky who had close interactions with a strongly connected group of colleagues and whose practices were strengthened by this external support network of professionals built up over time.
Cutchin (1997: p.27), on the other hand, identifies deeper alliances that impact decisions by physicians (and their spouses or families) to stay in a rural community; arguing that identity formation and experience is rooted in location and that “selves are place-based because interactions are centered in the communities of our locales”. The physician “self” is grounded in the community, which Cutchin (1994: p.227) argues is made up of a “diverse set of activities and interests” and which merely provides the “framework” for unity of various parties into “comprehensive interaction, commitment and responsibility” (Selznick, 1992). This responsibility and commitment is the cornerstone of long-term integration in a small community. Rural identity develops out of activities and responsibilities taken on by the rural physician, who becomes a community member, as opposed to just a service-providing professional in a particular place. Instead, Cutchin’s (1997) notion of a place-based self emerges out of choices and activities that are centred in the communities of the physician’s locale.

Decisions to integrate into areas beyond the medical community and job-related commitments are considered by Pope et al. (1998) to be the reason that the “scales” tip towards staying in-place. The authors suggest that retention research should focus on the aspects of medical practice that “tip the decision-making scales” that influence physicians’ decisions to stay or leave a small community. They delineate three major “influencing categories” for conceptual analysis of complex retention properties: “community commitment, medical confidence and compensation” (Pope et al., 1998). Each of the three circumstances impacts how physicians balance personal lifestyle with commitment to community, how confident they are in fulfilling that “responsibility” and the suitability of compensation received and the way that the scales tip, towards either staying in or leaving a place. This balance is constantly renegotiated as influencing factors change in the practice-location or as externalities shift such as regional and national governance. Furthermore, balance is found differently by each physician when “for every factor
judged positive by one physician there is another who sees the same situation in a different light”. For example, a physician may perceive a rural practice environment as “challenging or overwhelming” depending on their level of confidence and it is this “high level of personal challenge” that often leads to retention of physicians interested in, and suited to, practicing rural medicine (Pope et al., 1998).

According to Pope et al. (1998: p. 214) rural medical practice is a double edged sword; “it is more than a vocational commitment…the physician often develops a very close relationship with the community” which can be both “a positive and a negative experience….” Situations faced by rural physicians necessitate “quick decision-making” and creative use of often limited resources (including their own capabilities, staffing and diagnostic equipment) (Pope et al., 1998). To the physician, these situations are either challenging experiences full of potential for growth or overwhelming, “unwelcome” sources of stress and anxiety (Pope et al., 1998: p.214).

2.3 Stress Factors in the Rural Practice Environment

Using a qualitative framework, Lee et al. (2009) explore the sources of pressure experienced by rural physicians and the ways that this group has managed to mitigate factors that impede their personal and professional lives. Physician stress is approached by the authors in the context of solutions and management strategies employed by Canadian practitioners who are faced with daily stresses caused by personal, occupational and systemic factors (Lee et al., 2009). The authors found that physicians generally belonged to one of two groups: proactive planners or reactive responders. These groupings were interfaced with the response style for different stress factor areas; for example, a physician may deal with their “personal system” in a proactive manner, yet find later on that they are forced to deal with the occupational system as a “reactive responder” (Lee et al., 2009, p.289). This approach is useful within a discussion of the challenges
of rural medical practice. Lee et al.’s (2009, p.289) notion of strategizing within the three systems takes into account such “proactive planning” responses as counterbalancing time pressures and demanding patients with realistic scheduling, setting limits (in the clinic, although rural physicians may need to implement this action outside of the clinic as well) and counterbalancing complex and challenging medical problems with the active pursuit of continuing medical education opportunities.

Thommasen et al. (2001) discuss stress experienced by physicians in northern British Columbia in the context of mental health and intention to relocate due to place-based factors. The study examined communities where physicians had been forced to take part in job action for five months, due to “clinic work plus on-call requirements [that] had become so onerous they were becoming exhausted and facing burnout” (Thommasen et al., 2001: p.738). The authors point to the Canadian Medical Association’s (CMA) Code of Ethics, which states that physicians should strive to manage situations that might lead to “impairment” such as personal and professional stress; and to a CMA policy summary that states “maladaptation to stress…might lead to emotional withdrawal, social isolation, and denial of problems, conditions that can ultimately affect quality of care” (Thommasen et al, 2001: p.741). Rural physicians, however, face an onslaught of what Lee et al. (2009) might categorize as personal, occupational and systemic factors, (including social isolation, heavy on-call requirements and provincially-mandated bed closures) which lead to substantial stress and which Thommasen et al. (2001: p.741) argue “make it increasingly hard to provide optimal patient care”.

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2.4 Rural Place Integration and Retention

Thommasen et al. (2001: p.121) discuss physician retention in the context of local healthcare structure characteristics, emphasizing that long term retention is ultimately attributed to a combination of:

- personal demographics (e.g., rural background or not),
- family status (e.g., raising a family or unattached),
- medical school training (e.g., exposure to rural medicine during training or not),
- professional concerns (e.g., medical confidence),
- practice characteristics (e.g., solo v. group),
- satisfaction with compensation (e.g., financial, professional, personal) and lifestyle preferences.

Individual community characteristics, such as the size of the community, cultural opportunities available, percent of the population aged 0–5 years and over 65, and the presence or absence of a hospital, also affect physician location.

Cutchin (1997) acknowledges that two perspectives have dominated retention research: volume of physicians retained in a rural area and the factors that lead to retention of physicians in rural settings. The definition of retention is difficult to establish; a physician may be “retained” in a community for a decade and leave practice due to any number of factors, or for one single factor alone, such as spousal unemployment or dissatisfaction (Kazajian and Pagliccia, 1996). Retention is different from initial location, as Cutchin (1997) outlines, because the initial decision to locate takes place from outside that place, whereas the decision to remain in a location is influenced mainly by factors from “within” the place, as an insider. Cutchin (1997: p.1662) emphasizes the need for research that focuses on the context of community that influences the physicians’ “stream of experiences” in the setting as opposed to mere measures of physician satisfaction that provide a singular view of the physician-community relationship.

Cutchin (1997: p.1661) focuses on three “domains” of physician integration: the self, the medical community and the community at large which are put forward as “conceptual anchors” for future physician retention research. In addition, the author explores the notion of experiential place integration as a strategy to reduce physician scarcity in rural regions of the United States.
These are affected by the communities’ levels of social capital, core participation and community reconstruction. The community’s role in shaping the physician “self” leads to their subsequent level of integration and development into the environment and impacts their decisions to remain in an area for an extended period of time. Cutchin’s (1997: p.1671) notion of “domain cohesion” is vital to the establishment of the physician in a rural area as components of their “self” are actualized and grow in relationship with the place where they practice. Self, the “operative presence” is, according to Dewey (1989: p.202), “intimate and omnipresent” and is split into the historic, the social and the emergent. Components of place impacting the level of citizen involvement and subsequent integration include education and medical administration, as well as any social disruption that negatively impacts the aforementioned factors. Elements of shared trust, information and cultural norms, which are embodied by all community members and result in what Cutchin (1997: p.1671) describes as “the constellation and cohesion of domains in a place create the base of social capital to be used by local physicians and communities”. This contributes to a physician’s entrenched sense of self and can foster the core participation by physicians in small communities. Education is not merely that of the physician, such as CME or increasing social awareness of the place, but includes the relationship between the medical and civic communities. These may be formal associations between the health care community and the community at-large, which can lead to a beneficial democratization of local medical care and decision making. This may be hindered or enabled by a “rural oligarchy”, depending on the context and the involvement of community advocates.

While not every case of physician turnover is more rapid than in a larger health service delivery area (HSDA), because of the vulnerabilities of small rural populations, turnover is experienced in a more acute manner by the population that is left behind (Pathman et al., 1997). Thommasen et al. (2001) extend this notion of the subsequent harm to the community, inherent in
physician turnover, arguing that “poor community health is negatively affected by physicians who do not stay in a community long enough to establish good working relationships with their communities”. Pathman et al. (1996) found the best long-term retention outcomes appeared when physicians were either practicing in the area where they grew up or were trained, or when they themselves were raising a minor-age child. There was no notable correlation between the same level of retention and factors such as age, ethnicity, gender, town size, mean income, or physician density (Pathman et al. 1996). Because the study was carried out in the United States, physician practices were often privately owned and managed. Those who ran their own practice and were on-call less than 2 days a week were retained for a considerably longer period of time than the rest of their colleagues.

Pathman et al. (1996: p.1726) conclude that “poor retention is not the reason that some rural communities develop physician shortages” and state that the root of the “retention problem” actually lies in the success of recruiting physician in the right numbers and providing opportunities and incentives for those recruits to set up private practices that will foster a sense of personal integration and investment in the local community. They do not link later retention to community factors or physician characteristics but to the investment of a physician into their own practice and patient population. Unfortunately, this finding cannot be translated into the British Columbia model of physician employment, wherein physicians are privately contracted to the regional health authority and are not allowed the same option to invest personally in a practice and a community in a way that parallels the findings of Pathman et al. (1996). In a broader sense, this study, however, reveals the importance of the personal commitment of a physician to the local place and the influence of personal and material investments into the community where they work and reside.
It is these investments and relationships with the social and professional networks of a small community that are essential to examining retention on Haida Gwaii. The authors highlight that programmatic changes to how recruitment is carried out could improve retention because “retention is related to modifiable characteristics of work, whereas recruitment is related to the relatively immutable characteristics of physicians' backgrounds and professional and lifestyle preferences, as well as the socioeconomic features of communities” (Pathman et al. 1997, p.1727). Solutions are found in the physicians’ sense of “personal investment and control” that can be improved by providing them with “greater voice in clinic policies and work schedules”. In addition, on-call schedules can be better managed with the use of telephone emergency triage systems, full-time physician staffing in emergency rooms can be set up and cross-coverage arrangements encouraged and enabled by the local and regional health administration (Pathman et al., 1997).

While work-related factors such as relief coverage, compatibility with the medical community and specialist consultation are important, the socio-cultural situation, medical care context, regional economic stability and geographic situation are the most important themes to address when examining local physician retention improvement (Cutchin 1994). Cutchin (1994: p.1664) emphasizes that research does not sufficiently address why physicians leave underserved areas and “how they can be coaxed to stay”. The most common responses to the out-flow of practitioners is that local poverty, social and professional isolation, lack of amenities and hardships of rural medical practice (long hours, frequent “call” and low compensation) become too much of a burden.
2.5 Regionalization of the Health Care Structure and Physician-Community Response to Access Challenges

Rural physicians “must be able to articulate who we are in order to convince the bureaucrats to provide the resources, both human and material, to effectively perform our job” according to Dr. Trina Larsen Soles, president of the Society of Rural Physicians of Canada (SRPC) speaking at the 13th Annual Rural and Remote Medicine Conference in Quebec City in 2004 (Larsen Soles, 2004). This statement reflects the way that physicians and rural/remote health care advocates have had to self-advocate and position their roles and the unique characteristics of health care delivery to government bodies in order to improve discouraging retention and quality of care patterns in Canada’s northern communities (Larsen Soles, 2001).

Public engagement through health council formation, community representation on healthcare committees and local political action has filled a need for the advocacy of physicians’ situations to higher level decision makers in rural locations (Larsen Soles, 2001). Bruni et al. (2008) argues that public engagement in health care decision making is a powerful way to support front line healthcare workers and improve local efficacy of service alterations. Larsen Soles (2001: p.25) states that increased political action has taken place on a variety of levels by rural physicians themselves, while there has also been an “increased awareness of the issues among the rural population”; residents have partnered with physician groups, such as the SPRC, in response to the regionalization of health care services, which the provincial government in British Columbia intended to bring health care decisions into the hands of those affected”. This regionalization, argues Larsen Soles (2001: p.25) has also been associated with an “impending sense of crisis in many rural areas” and a heightened local responsibility towards the challenges facing the achievement of reasonable access to health care services.
Advocates for the improvement of medical services in northern and rural locations (often physicians themselves in response to immense stress) have had to position the care demands they work within as unique in order to attract government funding which would enable them to make changes to scheduling arrangements or begin training new doctors in rural locations. Sibbald (1998) argues that rural training has been shown significantly to improve the number of medical graduates who stay in northern communities and voluntarily commit to long-term practice “with their eyes open” (Sibbald, 1998). Medical association literature emphasizes the unique position of rural physicians and the roles they play in the clinical and social settings that set them apart from urban colleagues. Sibbald (1998: p.1506) makes the comparison between truck drivers and rural doctors to highlight the “dangerous double standard” that rural physicians are held to in their practices (and which Thommasen (2001) alludes to elsewhere as a potential practice impairment): "rural doctors are on call 24 hours and are then expected to work the next day, yet truck drivers are fined if they drive more than 12 hours”.

In light of this increasing pressure from regional and local populations to improve healthcare service access, considerable attention by government and policy-makers has been devoted to recruitment-centred financial and structural characteristics of physician contracts in British Columbia. Less attention, however, has been placed on the informal sphere of practice within a small community. These include the non-economic, non-structural aspects of retention in close knit communities which affect an individual’s attachment to the place either positively or negatively. Cutchin et al. (1994: p.277) emphasize that “the role of the local rural community may be more important in retention than in recruitment” and suggest that the socio-cultural aspects of practice and integration into rural communities must be examined in a context-specific manner (in-place) to “enhance the understanding of the rural retention process”. Despite the implementation of rural medical programs in Canada, it should not be assumed that improvement
of practitioner supply in rural communities will naturally follow. After examining the problem from a rural-American perspective, Cutchin et al. (1994: p.273) demonstrated that “even with an increasing pool of available physicians, diffusion of medical practitioners has not taken place”.

The place-based characteristics that impact physician experiences and levels of investment in communities must be investigated and articulated. This will improve understanding by various interest groups, academic and policy-related, of the complex dynamics that impact long-term location decisions on the part of medical practitioners in close knit, remote and rural areas. Hanlon and Halseth (2005: p.6) argue that “any shift in provincial social welfare policy will have very different implications for northern BC communities than they will for more populous and demographically stable communities in the south”. Amidst broad demographic changes taking place in Canada as the population ages, communities in the north experience a unique struggle to retain balanced populations where resource industries struggle and the tax base is depleted. The authors’ findings are supported by the findings of provincial and federal task forces; namely, the Ministerial Advisory Council on Rural Health (2002: p.2), which stated that “rural realities and rural health needs are different from those in urban areas” and that “service access by rural residents is a growing challenge”; and the Romanow Commission, which in 2002 found that major changes were needed in the education and distribution of health human resources sector workers to keep up with shifts in the broader economic and demographic landscape of Canada (Romanow, 2002).

Eley et al. (2009: p.48) argue that there has been too much focus on the recruitment of physicians who are of “rural origin” or have primarily “rural experience” and that this focus is a detriment to medical schools’ “ability to identify and nurture a future crop of rural doctors who have the prerequisite temperament and character traits” for long-term rural practice. The authors find that because “rural/remote medical practice involves a high degree of uncertainty,
independent decision making and adaptability” rural settings “require individuals who can tolerate uncertainty and enjoy a degree of excitement, whereas primary care specialties are more people oriented” (Eley et al., 2009: p.48). This may conflict with the assumption that a rural physician must be a people person; in fact, it suggests that a more important trait is the ability to manage complex medical situations independently while maintaining a pragmatism and setting boundaries between and within the medical and social environments in small and isolated communities.

Denz-Penhey and Murdoch, (2007: p.1), emphasize that rural physicians must have a socially oriented and patient centred focus, along with a deep knowledge of the “community expectations of social roles; and the personal cost of being a rural doctor”. Successful, long term rural practice involves a balance of clinical expertise that is likely learned in the urban environment with an awareness of the “internal diversity of peoples in its communities” and acknowledgement of the realities of rural life; the “tyranny of distance” that continues to draw on a vital but increasingly scarce physical population (Denz-Penhey and Murdoch, 2007: p.7).

In light of research findings that provide rationale for the study of physician shortages (through the unveiling of factors such as reported unmet need by rural populations, high levels of stress experienced by physicians and immense organizational change to health care structures over the past decade that presents further challenges to remote communities) it is possible to examine closer scale factors that influencing physician retention outcomes. Within a review of this broader literature, several themes emerge as pertinent to the goals of this thesis, which enable a better understanding of the connection between physician retention challenges and the nature of the communities where those challenges are experienced. These literature findings include the notion of the place-based (local) self (Cutchin, 1997), the acknowledgement of the specific “rural community” knowledge base employed by physicians who stay in communities for more than
two to three years (Denz-Penhey and Murdoch, 2007) and the multiple social and professional roles fulfilled by physicians who practice medicine from a unique angle as visible and integrated members of a small community (Society of Rural Physicians of Canada, 2009). These three concepts provide the impetus for the following qualitative research methodology (Chapter 3) and data analysis (Chapter 4), which bring to light experiences of physicians in rural and remote communities as they experience place, make decisions about personal and professional activities and must ultimately determine whether they will further integrate or withdraw.
Chapter 3
Research Design and Methodologies

3.0 Introduction

As discussed in the preceding chapter, this thesis fills a gap in the literature pertaining to physician retention in specific underserviced regions of North America; specifically northern British Columbia. This chapter will explain the rationale for the methodology employed to gather empirical data used to address the impact of physician-community member interactions in small, isolated communities on British Columbia’s northwest coast. It will outline the methods used to create a place-specific analysis of positive and negative retention outcomes at the local scale including (1) a review of physician retention literature and (2) semi-structured interviews carried out with community members and local physicians on Haida Gwaii who have direct contact with health care delivery and island society and who can speak to the existing perceptions of roles fulfilled by community health practitioners.

As discussed in the literature review, scholarly research in the field of health service distribution in underserviced areas and related to practitioner retention identifies a need for further locally contextualized research in rural and remote regions of North America, and particularly Canada (Anderson and Rosenberg, 1990; Cutchin, 1994, 1997; Hanlon, 2001; Pagliccia et al., 1993).

Rosenberg and Hanlon (1996, p. 981-982) found that “…as populations become more dispersed and rural, physician services become more limited in quantity, and where they are located, the use of emergency services and admissions to hospital are likely to increase”. This places a significant burden on rural physicians and other medical staff who must treat patients in hospital emergency departments for non-acute, chronic and late-course illnesses that have gone
previously undiagnosed due to the lack of regular consultations with a general practitioner. Furthermore, this utilization behaviour impedes the development of physician-patient relationships, disrupts continuity of care and, importantly to small, underserviced communities in particular, places stress on local physicians working on a frequent “call” basis in rotation with the few other physicians in the same community. It is this stress that interacts with the high level of social visibility and community intimacy that has led to intense physician shortages in northern and remote locations (Thommasen et al., 2001; Wilson et al., 2005; de Maio, 2007). Retention of island physicians is viewed in the context of this study as heavily influenced by community expectations and support, environmental pressures and benefits. Outside of these experiential-place factors (which influence Cutchin’s (1997) notion of place integration), it is important to acknowledge the overarching influence of systemic, or occupational, stressors on medical professionals. These occupational stressors include staffing and call-schedules, the level of administrative support within the regional hierarchy of the Northern Health Authority, and a chronic shortage of available physicians who can share the burden of care in underserviced island communities.

In addition to the scholarly findings in this research area, the British Columbia Ministry of Health has expressed major concern over the lack of retention sustainability in areas that tend to be geographically distant from urban centres and major health care infrastructure (BC Ministry of Health, 2005). The Northern Health Authority, responsible for administration of health care services delivery in the north, is made up almost entirely of British Columbia’s ‘A’ and ‘B’-level RSA (Rural Subsidiary Agreement) designated communities (BC Ministry of Health, 2009). These communities share the characteristics with those discussed by Rosenberg and Hanlon (1990) which are often medically underserved.
3.1 Study Design

The study employed a cross-sectional, multi-case approach to identify themes from the study population responses. Purposive, theoretical sampling was used to draw out information from two distinct groups on the islands: physicians and community members knowledgeable about some aspect of health care delivery. Snowball sampling followed this initial population identification. Community members were able to recommend individuals on the islands who could speak to the themes discussed in the interview process. This was particularly useful on the islands, where community roles often overlap. For example, one community member is involved with ambulance services on the island, bringing her/him into direct contact with health care providers. The same individual holds a pastoral position in the community which provides him/her with a unique, multi-dimensional perspective of the relationships between medical professionals and the general island population.

Cutchin (1997) argues that previous research has focused primarily on retention as an outcome “without recourse to the social process that leads to it”. These ideas, Cutchin (1997, p.39) states, have been “infrequently” addressed in health services research and do not give sufficient weight to the influence of “emplaced transactions” that can change seemingly inevitable outcomes in the course of individual [physician] experiences. Cutchin (1994) also argues for the use of qualitative narrative to reveal the experiences that underlie retention behaviours by local practitioners, while acknowledging that this experiential narrative remains in flux as a function of the qualitative, emplaced research framework. Aside from the more commonly addressed shortage of medical graduates, lack of funding, lack of educational opportunities, geographic distance, etc. (Rosenthal et al., 2005) this study seeks to identify the emplaced social experiences through a deeper analysis of the perceptions and interactions that take place in small, remote communities where an unmet healthcare need has already been
identified and certain incentives, government initiatives, and educational programmes (as discussed in Chapter 1) have been established to little effect. This and similar studies must address or at least acknowledge how these narratives change due to myriad components (cultural, political, economic, ethnic, class and gender-based) but that a temporal continuity can be found in the processes of integration and effectively studied through narrative analysis.

This study employed multiple methods to collect data from community members and practicing physicians. A combination of purposive and snowball sampling allowed for data collection from a wide variety of individuals. Those involved both formally and informally with island health care delivery and organization as well as social support and general island community development and activities were sought as key informants.

Physicians currently practicing on the islands were identified using the publicly available British Columbia Medical Association (BCMA) physician database. They were contacted with an initial mail-out letter (Appendix 1) describing the research which was later followed up by telephone. Due to time constraints and significant travel considerations (ferry schedules and driving distances) between island communities, some physicians opted to provide their responses over the telephone, while others completed a mail-in survey identical to the in-person interview script. Twelve physicians practice on-island. Several of these physicians were taking time off or at their alternate “job sharing” practice sites off-island during the research period. Fifty per cent (n=6) of the total practicing island physicians (n=12) responded to the mailing and participated in the project, an encouraging number considering the number of physicians off-island during the interview.

Physician responses reflect the experiences of these two locations, primarily because only Queen Charlotte and Masset contain regularly staffed, 24-hour medical infrastructure (clinics, hospitals, and laboratory, rehabilitation and support services). However, weekly physician clinics
in Port Clements and Sandspit foster regular physician-community contact, which, along with the implications of a small total island population and high level of population interaction between communities, allows for inclusion of responses from the two smaller communities. Physicians commented on their experiences in these two smaller communities and with community member-patients who visit the two larger centres regularly for amenities, medical appointments, social, cultural, and recreational activities, and who may serve the physicians in a different capacity through business or service activities.

Interview questions differed slightly between physician and community member interview scripts; the main difference between the two was based on the position of the key informant. For example, community members were asked how they perceive the role of community physicians and asked to describe their perception of the community’s relationship with local physicians, while physicians themselves were asked to speak about their knowledge or perception of their role, place-experience and their level of visibility in the community. In general, questions ranged from opinion-based discussion of island communities, health care and social interactions, to more specific questions about physician visibility, activities and roles taken on by physicians and the relationship(s) between the general island population and physicians as both community members and health care practitioners.

3.2 Physician Participant Research Process

Recognizing the need for local-scale qualitative research in the field of physician retention factors and challenges, this thesis presents and analyzes in-depth primary interview data collected in the four island communities on Haida Gwaii. The analysis is a starting point for further research in communities that share similarities in their geographical remoteness, social heterogeneity and lack of adequate practitioner coverage. During the research interview process
in August 2008, key informants were asked a series of opinion questions (Appendix 4). The physician interview and questionnaire included questions related to the job and medical practice in general, such as: “Is there a particular type of person who you think best “fits” the requirements for successful, long-term medical practice on the islands?”, “What do you like about living and working in this community? What do you dislike?”; and related more directly to their experience in the community individually, such as: “As a physician in a small community, are you aware of any stereotypes or preconceived notions attached to you or your colleagues by the larger community?” and “Does the nature of your work impact your interactions with the local community? If so, how?”.

When possible, physicians were interviewed in-person and over the telephone. Several physicians were not available during the August interview period. These individuals requested a written questionnaire that they could complete and mail at their convenience. The research questionnaire provided followed the same format as the in-person interview script and used the same questions with prompts “built-in”. These were completed and mailed back by the physicians in September 2008.

3.3 Community Participant Research Process

Community members from the four island towns and villages, Queen Charlotte, Masset, Port Clements and Sandspit, were included as participants. Community members were contacted over the phone. These individuals have deep knowledge and involvement with formal and informal political and service organizations that contribute to island health care decision making and advocacy. Some of the key informant names were provided by word-of-mouth reference from fellow islanders. Political contacts included the mayor’s offices in Queen Charlotte, Port Clements and Masset as well as the elected representative of Electoral District ‘D’ (Sandspit).
Council members, health advocacy group members, emergency response staff, clinical nursing staff, health care administrators and clergy contributed to the community member respondent pool, a total of 12 participants.

Community members were asked many of the same questions as physicians related to general staffing and health care system characteristics on the islands; these questions targeted their perceptions of medical practitioners, while not assuming any deep knowledge of medical practice itself. Other community member interview questions included those related to the community as a “container” for the physician experience: “Do local communities have any responsibility to accommodate physicians and incorporate them into the community?” and “Do you think communities expect local physicians to be involved with activities outside of the health care setting?” (Appendix 4).

3.4 Data Analysis

In-person interviews were recorded digitally and transcribed verbatim. These responses were sorted to enable a conceptualization of ideas and themes using basic grounded theory methods. Sorted into three categories within each set of participant responses (physician and community), the qualitative data were used to illustrate the main findings of the research interviews, filling a voiced need in the aforementioned literature with a place-based analysis of physician and community interactions.

Key informant interviews provide the bulk of the data used for this study. The interviews were carried out in July and August 2008. They were digitally recorded and transcribed to produce approximately 110 pages of single spaced text from 16 interviews/questionnaires and 18 interview participants. Grounded theory methods were applied to these transcripts to produce themes and categories that are discussed in the later chapters (Crang, 2003). The data were
categorized using open coding to create a baseline set of common themes and contextualization of the ideas.

It is important to address the limitations of this study by identifying some of the gaps generated by the qualitative research design. Qualitative research methods as employed by this project provide a strong framework for the type of “grounded”, in-depth information sought (Crang, 2003). The results of the interviews have been compared against other sources of data: the related body of literature, print media and personal observation. However, reliability and limitations are inherent in this scale of study due to the time constraints of the researcher, the participants (particularly physicians) and the small sample size. The quality of the data has been maintained to the best possible standards, recorded both by hand and digitally, and transcribed twice with a final copy of the transcript verified by the research participants themselves. One hundred and ten (110) pages of single-spaced text were produced from interview transcripts and questionnaires. Three major themes were identified from the whole body of interviews and questionnaires, which led to the generation of several more specific themes. These are analyzed and discussed in Chapter 4: Results and Discussion.

Following the ethical guidelines set forth by Queen’s University and the Tri-council, data collection was successfully completed in August 2008 and the project goals were met. Through a topical literature review and the production of locally-based qualitative data, this thesis provides an in-depth view of practitioner staffing challenges experienced by rural communities. Data from this research thesis provides a glimpse of community-physician encounters that directly impact retention outcomes that are largely covered only at regional and national scales in the broader literature. The literature review brings to light the need for a better understanding of local factors leading to retention difficulty in small communities; in particular, the fluid nature of individual roles and identities that colour social interactions in geographically and socially close knit places.
The qualitative data operationalise these findings, which have so far been only theorized by health geography and community health researchers who study the retention of physicians and other health care workers.
Chapter 4

Results and Discussion

4.0 Introduction

Chapter 4 is separated into three sections which cumulatively analyse and discuss the data findings from participant interviews; Part 4.1.1 (Physician Participant Responses), Part 4.2.1 (Community Member Participant Responses), and Part 4.3.1 (General Findings and Place-Effects Contributing to Retention Challenges). These findings explore the nature of physician experiences and take a comparative view using the responses of community members to a similar interview script which explores social, place-based experiences and interactions between physicians and their communities. These findings are preceded by a general discussion of the operative setting and health care system structures that northern British Columbia physicians work within and which must be considered at a broader scale alongside the local-scale roles and expectations that are reported by both participant groups to impact physician stress and subsequent retention outcomes.

Northern Health remains the sole body responsible for physician recruitment and hiring, working with the College of Physicians and Surgeons to determine the scope of care provided by communities and regions. For example, Northern Health coordinates levels of care facilities are regulated to provide, determining whether services such as obstetrical or surgical care can safely be or needs to be provided on island (the former is
available in cases where the mother is “proven” and the pregnancy is considered low-risk; surgical care is only provided at regional centres, and most often in Vancouver).

Para-health organizations on island include the Healthy Humans program, the Hospital Days committee and a village sub-committee called the Health and Wellness Advisory Committee. The first offers opportunities to fund programs that are a complement to, but non-traditional in, healthcare, and is run by volunteer community members. The second group functions to organize and promote Hospital Days, an annual community event that draws community members from across the islands in support of various fundraising initiatives for the Queen Charlotte Islands General Hospital (QCIGH). The final group, the Health and Wellness Advisory Committee (HWAC), is most directly involved with the political side of health care on island, gathering input from community members in Queen Charlotte and acting in an advisory capacity to Northern Health. Members of HWAC are designated to take information to Northern Health and disseminate information from Northern Health back to the community. This initiative began in October 2003 as provincial restructuring led to the dissolution of the local Community Health Councils and to a more regionalized health care administration structure (of which the Northern Health Authority was established) centred in Prince George.

4.1 Physician Participant Interview Results

Physician responses emphasize work arrangements and call schedules as the major contributors to burnout and as a common source of frustration (Table 4.1). These factors are the first trigger for what results in a failure to retain these professionals in a small community. The second major factor, stated in the literature and by community members and physicians alike, is the availability of amenities, employment and social support for family members of physicians,
particularly spouses (as discussed in further detail in Chapter 3). However, in considering the case of single physicians, while they do express difficulty when seeking partners in the community and do miss the close social network that a family would otherwise provide, family-related factors are obviously not of equal importance. Finally, the issue of “physician-as-community member”, or the physician-citizen, emerges and is expressed by feelings of belonging, sense of place in the surrounding community, comfort with social interactions and satisfaction with the nature of social activities. While these may take a longer time than the first two examples to manifest in retention behaviours, the eventual outcome is either long term retention in the best case scenario, or, in the worst case, a burnt-out physician who leaves the community regardless of pay, workload or scope of practice.

4.1.0 Physician Respondent Profiles, Experiences, and Views of Island Retention Challenges

The physician respondents for this project had been on island between 1 and 18 years. The physicians from Queen Charlotte had generally practiced longer and planned to stay longer than those from Masset. Several longer-term physicians had made plans to stay indefinitely; these individuals had already lived and practiced on island for over 5 years. Of the six physicians, two cited financial incentives (base pay or financial bonus) as an attractor to practice on island. All physician respondents said that they made an active, autonomous decision to locate on the island; one reported that there were “80 positions available on Health Match” but that he “wanted to live on the coast”. This physician reported that a signing bonus was useful, but the location was the ultimate decision-making factor as it allowed him to pursue outdoor interests such as fishing. All physicians mentioned at some stage of their interview that the wage made the less positive aspects of the job more bearable. In addition, all physicians reported that the pay and contracted employment structure of their positions were part of their decision to practice on
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<td>Isolation/Distances to major centres/urban amenities</td>
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<td>Outdoor activities (fishing, hiking, kayaking)</td>
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<td>Community infrastructure &amp; attractiveness (architecture, maintenance)</td>
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<td>Amenities (pool, gym, community centre)</td>
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<td>Cultural activities (music/arts, fairs, Haida events, clubs, sports)</td>
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<td><strong>Work-Related Factors</strong></td>
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<td>Challenging medicine</td>
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<td><strong>Colleague support (between physicians)</strong></td>
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<td>Perceived quality of care (i.e. time spent with patients)</td>
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<td><strong>System/Administrative Factors</strong></td>
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<td>Teaching opportunities (UBC/UNBC medical faculty positions)</td>
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<td>Administrative structure (Northern Health Authority, College of Physicians and Surgeons)</td>
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<td>Availability of specialist consultation</td>
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<td>Level of access to off-island critical care beds/patient transport services</td>
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<td>Learning/skill development opportunities (CME availability)</td>
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<td><strong>Social/Community Characteristics</strong></td>
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<td><strong>Community behaviour towards physicians (boundaries)</strong></td>
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*BOLD indicates focus of study*
island. One physician reports that he “should have” come later because at the time he arrived on island the pay was “peanuts”. The physicians, contractors to the Northern Health Authority, earn a set salary, which was cited as a more desirable arrangement than the fee-for-service system in effect at other locations.

When asked about other benefits or factors involved with the physician’s decision to locate on island, responses included community characteristics, work schedule, style of practice, lifestyle and the geographic setting (rural/outdoors). Doctors reported that they knew they would have access to outdoor recreational activities such as fishing, hiking, and kayaking. A physician lists “the beauty of the islands” as one of the main reasons for choosing their community as a practice location. Scope of practice and work environment were the main reasons provided for locating on island, cited equally between physicians from both Masset and Queen Charlotte. Specific elements of the job itself included the opportunities to practice rural and aboriginal medicine, the full spectrum of care (in-patient, emergency and clinic), the collaborative atmosphere, the diversity of medical conditions, and knowledge of other physicians already working on island. Several physicians who worked on the islands as a component of their medical school training returned for locum positions during their residencies following completion of their training.

Physicians in Queen Charlotte and Masset are general practitioners and cover both clinic and hospital facilities. In Queen Charlotte, the patient load ranges from 2700-2800 patients, approximately 900 patients per physician. There are currently only three full-time physicians in Queen Charlotte. These are supported by a group of locum physicians, on short term contracts with Northern Health. The situation in Masset is similar, with a group of locum physicians providing support to the full-time equivalent (FTE) physicians at that location. Physicians are on a 1:3 call schedule. This “busy and tiring” schedule consists of doing “call” every third day for a
full 24 hours, and every third weekend for 48 hours. On this rotation, they cover “everything from ER to OB”, “psychiatric care of acutely unwell patients”, in addition to dealing with addictions, palliative, geriatric and other in-patient care. While physicians in Queen Charlotte stated that they currently have a “full roster” of available physicians for “call”, it was also repeatedly stated throughout other sections of several interviews that a fourth FTE position was required to loosen up the call rotation and provide respite for the three current FTE physicians.

In addition to covering the call schedule, physicians work in the day-clinic doing general consultation for 10-12 hours, with patients for approximately 20 minutes each. In this setting, physicians have more regular non-acute contact with the patient population. Part of their job is to provide prenatal care, work at clinics in the two smaller towns (Masset physicians in Port Clements; Queen Charlotte physicians in Sandspit), provide phone follow up to patients as needed and take part in chronic care information/management sessions with groups of patients diagnosed with conditions such as diabetes or heart disease.

Physicians reported that practice-sharing has been a major benefit and one of the main reasons some were able to stay as long as they have. This arrangement consists of three physicians covering a two-physician position, or two physicians sharing one position. This allows them to have some respite from the grueling call-schedule, take time off for personal travel, and take part in continuing education or to work in other communities in a similar position. This was repeatedly cited as a way for physicians to maintain the intense work habits required of them while on island, knowing that they will have an extended period of relief at the end of one or two months on duty. One physician reported that at times in the past she/he has been “the only regular, full-time physician” and was completely supported by locums. At the time of the interview, the positions created by Northern Health were all filled, but physicians believed that a fourth position (which could be filled by multiple individuals in a job-sharing arrangement) was
required to bring the current workload to a level that was manageable. Another physician states that when she/he arrived on island (1991) “the workload was manageable”, but now it is “barely do-able”. Job-sharing is the only reason, she/he states, that the roster in Queen Charlotte is still full and that they have experienced relatively good retention for the past several years.

4.1.1 Physician Opinions of Community Expectations and Social Interactions

Physicians who have remained in the community long term (>3-5 years) reported a strong sense of belonging, called the islands “home” and had invested significantly in the social reproduction of place. They take part in community events, own property, have friends outside of the medical community and have found ways to offset the challenges of a demanding workload. These individuals report that they experience a high level of social visibility, but explicitly state that this is a positive aspect of their life on the island. These individuals enjoy the sense of accountability that this lack of anonymity affords and felt that it helped them become better physicians.

Physicians were asked to discuss the elements of living and working in the community that they liked and those they disliked. Most responses were a combination of factors related to the community/natural setting and the characteristics of their workload. Physicians “liked” most aspects of community. One physician stated that she/he enjoys “Haida culture, the exposure to cultural practices” and “outdoor activities” and “living in a beautiful setting which is largely untouched”. Related to the work, she/he also appreciated the “challenging work” and the overall contract schedule (“working 6 months a year”). The drawbacks are equally balanced between work-related and availability of amenities: “being on call is tough and exhausting, the office …is inefficient”. She/he continues to state that because …. is “very remote…some things are not available, such as good fruit, snowboarding and rock climbing…it’s rainy and cold. A LOT!”.
Another physician includes non-work-related factors as her/his “likes”; “people and outdoor activity” are the most positive elements of working on island. Under dislikes, she/he discusses four major stressors related to his job as major drawbacks:

First, the large number of dependent personalities; second, low, decreasing access to needed MedEvac’s [sic]; third, the increasing amount of PAPER [sic] workload required by government bureaucrats for patients…forms; and fourth, the higher than average number of folks resistant to proven prevention and treatment strategies.

A third physician lists as positive factors those which fit within the work sphere: fascinating medicine and “the continuity of care is great”. Her/his dislikes are related “social/work boundaries”; the challenge of making a clean cut at the end of the work day from a patient population that is often one and the same as the community into which they immerse themselves on time off. One of the other physicians refers to the community in both her/his likes and dislikes:

I like the sense of community and belonging. I like the lack of anonymity that makes pretense impossible. These are positives, as well as the blend of people from many different backgrounds, beliefs, (cultural, political, social) all having to get along in a small, isolated setting. My dislikes…mostly the lack of resources and amenities, such a pool, ice rink, theatre, music, etc.

These responses reflect the later comments of another physician related to the way that she/he approaches her/his work; the close-knit nature of the place creates a certain level of accountability that would not exist in a more urban region. This physician is one of the only respondents who had a positive view of the “lack of anonymity” that pushes her/him to maintain a high level of clinical skill and professionalism at all times, both in and out of the clinical setting. Last, a physician emphasized that she/he came to the island to enjoy the natural environment as well as to support a colleague who was already practicing in …: “I wanted to live on the coast…I knew [Dr.] Smith* (name changed) and I wanted to come and provide support for her/his and her/his activities on island. I like fishing, boating, there is a pool*”. This respondent states, though, that
it is hard to live in the same small community with “jerk patients – the ones who corner me in public upset that I haven’t followed up with them or called them with test results”. The social aspects of life in a small town as a physician were a source of strain over the long term.

Physicians generally felt that their expectations of the islands and of the basic requirements of practice were in line with their experiences upon arrival. They report that the best support and “catalyst” for integration upon their arrival to both Queen Charlotte and Masset was found in the professional community itself. Most respondents reported that their colleagues were vital to orienting them to the place itself, the pace of the work schedule and the social aspects of the community. There is a small, close knit group of physicians which seems to provide an element of social safety within a generally close knit, familiar community overall in both major communities. Respondents stated that without the professional and social support of their medical colleagues, they “would not be here”.

The community’s role in facilitating physician integration was not reported when asked directly about “who” helped them adjust and become integrated. However, throughout their responses, physicians reported that they felt at home in the community, that they took part in community activities that were important to their sense of belonging and which brought them closer to the people and the place in which they also practiced medicine. One of the physicians stated that she/he enjoys the community in general, but “the ongoing overall excellent sense of community, professionally, is what has kept me here”.

When asked whether the community or their work were more influential in their decision to stay on island, physicians did not readily separate the two, but instead stated that they were both important and that they “overlap and integrate” too much to think about in isolation. One physician stated that “if the work is not manageable, it doesn’t matter how good the community is”. All other responses echoed this sentiment, emphasizing, however, that the work and the
community were too integrated to separate in making a decision to stay or leave. Another physician stated that the islands were “home” and that if the work became unmanageable she/he would remain on island, but seek locum practice opportunities elsewhere. This indicates the greatest level of integration by a physician, who, as a professional, has extensive opportunity to practice elsewhere, but has chosen to stay in the community regardless of the work situation (or in spite of it) and sees herself/himself first as an islander.

Physicians were asked to consider their level of visibility and how they are viewed by the community at large; whether there were any preconceived ideas or notions that they felt had been attached to them in their time on the island. This was to determine whether people viewed them holistically (as community members who happened to practice medicine), or compartmentalized into their medical role to the exclusion of the rest of their activities and identities. This was also intended to determine whether people in the community expected that physicians would naturally take part in activities that are similarly “altruistic” alongside their position as health care providers. Generally, physicians felt that they were seen differently by the community, and that there were certain stereotypes attached to them. This was partly attributed to the fact that in such small communities, everyone is known, and therefore even if the image of a physician is standard across all health care regions, whether suburban or rural, the stereotypes have more power over the physicians’ living situation, their families’ interactions with peers and colleagues and their ability to function normally in the day-to-day course of their time spent off duty. All physician respondents reported that they were highly visible in the community, that there was a lack of anonymity and that “more people know my name than someone in a less public job”.

One physician reported that there is a sense that “perhaps we work less than we do and don’t provide as good care because we are doctors here [instead of in a larger place]. Another physician commented that “many urban GP’s have expressed that they would be terrified to work
here” because of the lack of anonymity and the level of involvement they feel a small community would have towards their doctors. A third physician believed that physicians are “possibly” viewed by some in the community as being “in a higher socio-economic group, with the ascendant stereotypes thereof”. However, this respondent also found a positive aspect to the familiarity inherent in practicing and being integrated into a smaller community:

We’re on first name basis with patients, so I think we’re less on a pedestal because we have that level of familiarity. It makes us more effective if we’re here for a long time and we get to know people well. It allows us to be more time effective. I don’t have to dig through paperwork to find the right chart; don’t have to take long interviews for history, information, etc.

One of the other physicians noted that there are certain areas where unfounded associations are made between people who practice medicine in the community and the common “image” of a physician, but states that other than “a few” problematic examples of this, “I generally feel that people treat each other on an even footing here regardless of the job title or social standing”.

The implications of this high level of visibility weave themselves into every area of island physicians’ lives, whether in terms of their practice and the way they think about their patients or in how they conduct their personal lives outside of the clinical setting. According to all respondents, there is a tendency towards exercising caution in public life and one’s behaviour. One physician reported that she/he has to be calculating about where and with whom she/he spends personal time: “I have to be careful about choosing friends and placing trust in others…I tend to “unwind” or “let loose” with select people only”. This respondent felt she/he has been able to “keep work separate” and has not yet found that there are negative impacts of her/his work on her/his community interactions.

In the responses by the other physicians, most state that they struggle to find a separation between their work and the rest of their lives. One physician felt that she/he has found it essential to refuse to answer medical questions in social settings in order to preserve a sense of normalcy in
his interactions with the community; “you have to place firm boundaries”. Another physician slowly detached herself/himself from the social environment, where he is “hound ed” by patients in social or community settings. Detaching from the community has meant more time in the outdoors and travelling, which is a positive experience for the respondent, but which is likely not contributing to her/his overall integration into the community beyond the enjoyment of the outdoors. A third physician stated that it is impossible to be a doctor in …. and have a work/life separation. She/he has to edit her/his personal behaviour in the community: “I have to “behave” more….I may choose to not misbehave in certain situations; there’s a certain decorum I have to follow. In the city you can do what you want and no one will know about it”. Another physician interpreted the implications of her/his visibility in terms of the way she/he practices medicine and, similarly to one of the other physicians, in the way she/he conducts herself himself in social, community or political settings. Her/his integration into the community is evident in her/his desire to be actively involved in issues that affect the islands but her/his awareness of the more negative implications of being part of a close knit place where roles often overlap and personal associations are not easily forgotten:

I feel a need to stay a bit detached in order to keep perspective and the ability to treat any and everyone equally...especially around contentious issues which divide the islands, I feel very leery to speak out to avoid alienating people who might need me for medical care now or in the future.

This respondent also expresses having difficulty finding a balance between being protective of her/his identity, energy and self, and building relationships in order to remain involved with the community. She/he states that while community involvement is highly rewarding and energizing, “I tend to be a bit reticent to form friendships and acquaintances for fear of being placed in a given clique or camp”. 
One of the physicians expressed the view that she/he was “once more involved” but now has had to withdraw from community activities to preserve what is left of his personal time. Because of staffing difficulties and the expectations this respondent perceived are placed on her/him and other physicians to be involved with extra-professional activities, she/he stated that she/he is now simply “trying not to get burned out”. She/he stated that “depression is a problem for other doctors who have worked here or in similar locations” and that this is a danger for those who do not preserve their time off and use it to recharge and escape from the demands of being a public figure. She/he continued, stating that because she/he is going to “try to get out of this in 5 years” she/he is now “withdrawing from activities…this work and lifestyle takes a toll on my health and fitness, on personal relations, especially with a family”.

Cutchin (1994) describes community investment and involvement by physicians as key to their development of a sense of belonging and ownership, and subsequent integration. This idea informs the next set of questions posed to physicians regarding the specific activities they are involved in and how these activities have impacted them and their experiences as island residents. First, physicians were asked to name and discuss any activities or roles they have taken on as community members. Physicians named such activities as being a member of a community sustainability committee, a leader in the local branch of the Sierra Club, a bicycling group member, yoga instructor, and choir master, among other musical activities. One physician writes a regular column related to health and the local environment in a regional newspaper. The physicians were unanimous in their agreement that these activities “very much” enriched their lives and deepened their sense of place on the island. However, when asked “would you consider these activities to be integrated into your role or sense of identity as a physician?” the responses were varied.
Three physicians reported that they did feel that their extra-professional involvements were attached to their role as health care providers. One physician who teaches hatha yoga classes in Masset, attaches her practice and instruction to her general role as a promoter of healthy lifestyles, whether she is viewed as a physician or a yoga instructor; she states that yoga complements her medical practice as “a great adjunct to holistic health care”. Another physician stated that she/he finds her/his musical activities integrated into her/his role as a health care provider, but that “time is never adequate to do justice to it!” A third physician replied “yes and no”; that she/he may be first identified as a physician when taking part in an activity, but that this is not directly tied into her/his role as a practitioner. The physician, who writes a newspaper column and is part of the local Sierra Club, sees the newspaper as tied to her/his role as a physician because it is directly related to medicine, but does not believe that her/his outdoor involvements with the Sierra Club are connected to her/his role or identity as a local physician. Considering the question further, she/he says:

I don’t know [if these activities are connected]…perhaps there’s an expectation that as a physician we may be part of [volunteer activities like these]…that I’m one of the “pillars” of the community. As part of a community of professionals, I suppose we’re expected to be in the public eye.

She/he does not view these involvements as a negative impact on her/his practice or her/his community experience whatsoever, stating that she/he finds “these activities sustaining and not draining”. As stated earlier, this physician chose to practice on the islands partly due to the many outdoor opportunities available. By taking advantage of these whenever possible and being involved with similar community activities, she/he has actively reinforced the elements of her/his experience that contributes to long term satisfaction and continued retention. The initial attraction to the islands by this individual was informed by an accurate knowledge of the positive and negative aspects of the islands before arriving. This was followed by not only pro-active
personal involvement by the respondent and her/his family in the positive aspects of the setting upon arrival (community groups, professional connections and recreational activities, to name a few) but also a careful, calculated management of the negative aspects of living and working in a small, close-knit town. This “management” of the environment includes the respondent’s choice to separate her/his personal and professional lives through residential relocation outside of town (to a smaller, adjacent island near town). This physician’s retention may be attributed to this interplay of awareness and timely environmental adjustment decisions which mitigate some of the immediate stressors of life “in a fishbowl”.

Physicians were subsequently asked to discuss whether they felt that any roles or other community activities they participated in impeded time or resources they needed to devote to work-related activities such as conference attendance, reading articles, skill upgrades, etc. The responses were mixed; three physicians reported “no”. They emphasized that the time for work and professional development is “fixed”. Two physicians responded “yes”. One of them had experienced immense difficulty in the past with the demands of the community and volunteer roles in contrast to the time he needed to spend on her/his job. Her/his past experiences have brought her/him to a point where she/he has made decisions to withdraw, stating “I don’t let them detract from my practice now; I could only participate in community activities if I went to part-time”. Contemplating this question further, she/he adds:

They don’t teach about this aspect of [rural practice] in medical school. They don’t tell you about the various demands, the bureaucracies, the role of the College (BC College of Physicians and Surgeons). They don’t prepare you to be a parent, have kids, have a marriage. You have to learn your own way and learn to create boundaries.

Based on the next question, “do these activities impede time spent with family or at leisure?”, respondents were unanimous in their agreement. They reported that they had to make an active
decision to block off their personal time or work and community commitments would detract.

One physician commented:

Traditionally, you were taught to put medicine first. Medical practice always came before family, before your personal life. You can’t say no. Things have changed now but the demands are all still there and it is possible to get sucked into all of that.

Her/his analysis agrees with the comments of the other physician respondents who state that they struggle to find a balance between their perceived duty to be involved with community and their quality of life with their families or personal respite time. Another physician stated that she/he has had a fairly positive experience so far, because her/his involvement in activities is part of her/his own life already. Another physician had similar feelings about her/his involvement in the community, stating that “some volunteer activities are leisurely” and that her/his family can take part together. She/he stated, however, that there are other non-leisurely commitments that tend to detract from time off-duty while on island; “I have to limit these to protect what little personal time I have….much is done in my “time off, thanks to job-sharing”. This respondent is referring to the job sharing arrangement she/he is in with another physician, during which she/he passes over responsibilities for the single FTE position to a colleague and is able to take 6 to 8 weeks off at a time to travel, take care of her/his other commitments and also pursue interests on island that are not feasible while on the call rotation. Without having the long-term respite provided through job-sharing, this respondent did not see how she/he would be able to contribute at all to island activities and develop her/his interests outside of work. This is also the time when she/he participates in conferences, reading and other modes of professional development.

4.1.2 Physician Perceptions of Selves and their Role(s) in the Community

When asked whether the islands had experienced difficulty retaining physicians, the physician-participants were unanimous in their agreement. They reported that retention had
always been a challenge across the islands, but particularly for the community of Masset. One physician stated that while there is currently a “full roster” of physicians, “there have been years in succession where I have been the only regular doctor in this [south end] community” with only locum physicians available to fill the rotation. In contrast with the other participants, this physician has over 10 years experience practicing on the islands. Two other physicians similarly reported that there has been difficulty retaining physicians, but that compared to Masset, Queen Charlotte has had relatively little difficulty filling the number of available FTE positions. A fourth physician suggested that there has been a significantly different experience on the south end compared to the north end, noting that “there has been general stability of physicians over the past 25 to 30 years, with some turnover”. Practice sharing is argued to have been “a major contributor to lack of burnout/turnover....”

Masset physicians report acute problems with maintaining a regular roster of physicians in the north end community. This is attributed to long hours, the remote location, in part, and what retention has taken place is reported only be due to the current retention benefits supplied by Northern Health. Without these the retention benefits “we would have total turnover”. This physician stated that even with benefits such as increased vacation time and salary, “the current [physician supply] is very fragile” and she/he is “barely more satisfied with the general situation”…“the money doesn’t make you happy or more satisfied”. Given previous comments about the positive aspects of the challenges of covering more aspects of practice, one physician paradoxically also included the “broad scope of practice” as a possible deterrent for long term retention in her/his comments.

Community members and physicians were asked the same question about the characteristics of physicians who have been retained long term in order to identify whether these individuals shared common traits that enabled them to integrate into the community, adjust to the
workload and transition into rural/remote practice successfully. Adventure, autonomy and courage were repeatedly brought up as essential to requirements for island medical practice. One physician stated that in order to integrate and enjoy island medicine “you have to be adventurous, independent, skilled, a team player and grounded”. This was reinforced by the rest of the physician respondent group, who combined clinical ability with personal traits as essential qualities for retention. Another physician emphasized, on the one hand, that physicians must have “strong clinical skills”, be “adventurous and courageous” while also being an “outdoor enthusiast”. A slight variation on this theme was that physicians should be “autonomous, comfortable with uncertainty and adventurous”. The paradox of scope of practice also appeared in the responses to this question where one of the physicians commented that “those who want to practice the full scope (and something beyond!) of their training” will enjoy island practice. Yet another physician argued that this type of practice “seems to attract MD’s with a perfectionist streak due to the ability to spend more time per patient”.

Collaboration and collegiality are themes that also ran through the responses of each physician. One of the physicians stated that she/he came to the island to support someone else who was already practicing on island. Her/his preparation from previous rural experience (through upbringing and professional practice) reflects in her/his statements that while the salary is good, the ability to take advantage of the outdoors, be a team player and work in support of the other physicians is the key to coping with the more negative aspects of the job, such as community demands and a stressful workload.

Physicians listed two overarching influences on practice location decision. The first was work-related. Each respondent voiced pay arrangements (non-fee-for service) and challenging medicine as positive, but the intense call schedule and lack of training opportunities as drawbacks. The second element in making a practice location decision (in this case, to work on
the islands) was related to place. Under the general theme of the community, they named factors such as “sense of community”, “interesting culture”, “the natural environment and outdoor opportunities”. One of the physicians articulated the importance of community level involvements as positive factors in her/his decision to stay:

Quality of experience in the outdoors [is important to me]. The feeling in the community is important, and that’s hard to detail, but it’s a culmination of factors…including architecture, the pride people have in their community. That shows in the various community groups; how committed people are to improving the community.

Another physician noted that the community “has everything” but that the positive elements of the community cannot be enjoyed when the work schedule is overly demanding. These contradictions weave themselves into most questions about community factors. Often, the communities themselves are the positive side of the physicians’ experiences, but they do not have the time to enjoy opportunities, or to take advantage of what amenities are available for themselves and their families.

Over time, physicians generally did not find that their ideal practice situation had changed, although they did report that the things they enjoyed about island medical practice were increasingly unattainable due to increasing workload pressure. A physician stated “I have past experience in a rural area, so I knew what to expect” in terms of workload and community. Another physician reported that as she/he has spent more time on island, despite the increased workload “things have gotten easier, how I’ve learned to manage [work] has changed”. A third physician noted that “as workload has increased, and as I’ve aged, I have less time and energy to enjoy life here outside of work”. Her/his ability to be involved with the community and enjoyable activities has become increasingly limited, which is cited earlier in this section as a reason that she/he might pursue other work opportunities while maintaining an island home. A fourth physician reported that while her/his expectations continue to be met, she/he is limited in
her/his ability to pursue continuing education training, and this is a drawback to his experience as an island general practitioner.

Physicians were equally split regarding their ability to balance between work demands and outside commitments, including community involvement. While one physician, a relatively new island practitioner, stated that she/he has found a balance due to her/his “personal approach to life”, the remaining respondents had only conditional positive responses to this question. For example, one physician stated that she/he is able to manage workload alongside personal and community commitments, “but only through practice-sharing; without taking every third month off I would not find the work sustainable”. This is echoed by another physician, whose work and personal commitments “tend to be unbalanced”, in favour of work. She/he continued that “it’s hard on my home life…without kids I can work full time, with kids, it’s not sustainable”. One of the physician who has completely removed herself/himself from most activities and voluntary roles in the community, stated that “the problem is call”. He argued that the nature of the community’s health care demands, misuse of the emergency room for non-emergency issues, and the subsequent lack of nursing support for decision-making which leads to frequent calls after midnight, leads to unsustainable sleep deprivation and poor quality of life while on personal time. He stated that nurses should be better equipped to deal with patients who present with non-acute issues in the emergency department and that physicians have a lack of control of issues such as these (staff training and support) because they do not have control over the structure as they would if they had private practices and therefore “control over who we work with”.

Since all staff are hired by Northern Health, physicians and nurses, many of whom are short-term locum practitioners, work within a transient pool of professionals and lose the sense of confidence in their peers’ knowledge experience. This holds particularly true for Masset, where recent staffing has been dependent on short-term physicians and nurses who do not have the same
sense of ownership and familiarity that they would as community residents and core-team members.

This question was answered similarly by all physician respondents, and immediately turned to staffing and call-shift demands, which they report takes an immense toll on their ability to function outside of the work environment. When asked to comment on the differences between work/life balance in the island and in a larger community, The physician who reported having found a balance, speculated that even though a larger community practice would involve fee-for-service (and therefore a busier practice) and a larger, busier emergency room, these would be mitigated by having “more doctors on call and less number of call shifts”. All physician respondents reported that they would be doing less call in even a slightly larger community, as more doctors would be available for rotation, meaning that instead of a 1/3 call schedule, they would operate on a 1/6, or less. Another physician argued that physicians in a larger community “wouldn’t work 60 hour weeks and would likely not be doing emergency and hospital care”.

These scheduling issues tie directly into the ability of a physician to integrate into the broader community in which they practice. Without appropriate time off to re-charge and “sharpen the saw”, physicians are unable to invest into community activities that the literature and this study’s participants reported improves overall retention experiences in small communities. Therefore the cost of adding a fourth FTE to what is currently a 3-physician (though filled by more, through job sharing) roster is justified in the long-term as a positive outcome of better rested, more involved and therefore-more-likely-to-be-integrated-and-invested rural/remote physicians. By maintaining a strong core of physicians, what uncertainty does exist within the usual staff rotations, or the odd locum nurse or physician, is offset by the stability of the existing team. This is a positive feedback cycle that continues to feed those in place, and
which is a major attractor to a physician considering a long-term job arrangement in a place like Queen Charlotte or Masset.

The physicians stated that they appreciate having more time to see patients in the clinic without getting overwhelmed. One physician suggested that she/he had more time for her/his patients because she/he is familiar with their cases and as a member of the community-at-large; “I don’t have to dig through paperwork to find the right chart, don’t have to take long interviews for history, information…” This is a positive aspect of the close knit nature of island communities, where the familiarity between the physician and their patient population fosters relationships that benefit patient care and ease the production and administration of patient records, follow-up care, and so on.

However, physicians also emphasized that the creation of personal boundaries is vital to remaining effective as practitioners and staying “sane” in their day-to-day lives outside of the clinic. While they enjoy the close knit atmosphere of the islands, the high level of visibility experienced by physicians is a detriment to their ability to enjoy the outdoors, to foster friendships and to establishing themselves into the social fabric of their community apart from their role as health care practitioners.

4.1.3 Systemic and Occupational Stressors Contributing to Local Retention Challenges

Support for acute case transport was another major theme physicians identified as a current source of stress. One physician insisted that improved access to off island facilities for serious cases is needed; “the government has to improve access to critical care beds, surgical facilities and MedEvac crews”. This shortfall affected her/his ability to use what little time off she/he has while on the call rotation because it cuts into her/his scheduled days off if she/he must follow a case through until it is resolved or a transport is arranged; as she/he states:
I have to spend 36 hours at a bedside of a ventilated patient while waiting for a bed/transfer and then go back to the clinic…this is not sustainable. This is an extreme example, of a milder, yet common, problem here.

Another physician similarly responded to the stress of a lack of external, systemic support for urgent cases. She/he stated that Northern Health needs to “make patient transfers out to secondary and tertiary care centers - what the province calls BC’s Centres of Excellence - more friendly”. Her/his reportedly stressful work experiences at the time of the interview were indicative of this struggle, as she/he was in the process of providing care for two highly unstable patients, awaiting availability of specialty care spaces, on top of her/his regular clinical duties and coverage of the emergency department. She/he stated that she/he is “continually experiencing hassles, delays and problems trying to transfer out patients with conditions that [this] hospital is not supposed to deal with”. This concern exhibits the perceived lack of control that island physicians have in terms of the limits to their skills and scope of practice, mainly related to factors that are out of their control:

Northern Health, the College [of Physicians and Surgeons] and the government dictate what responsibilities hospitals have and what their scope is…we can’t perform surgeries, complicated obs/gyn, et cetera - but then they have to follow through and support this. If they say we can’t do certain things, that’s fine, but they have to facilitate and support doctors better when we try to work within this system and send people to the appropriate care facilities in Prince George or Vancouver.

Finally, physicians identified job sharing arrangements as vital to their continued employment on island. All physicians interviewed were involved with a shared FTE position arrangement that provided them with the time off they needed to maintain the busy call schedule and provide an acceptable level of patient care. They cite the need for Northern Health to remain open to job sharing and to add an additional physician position to both Queen Charlotte and Masset to facilitate retention.
Physicians had mainly organizational suggestions to the issue of retention improvement. However, job sharing arrangements are touted as one of the best ways the physicians found to mitigate the detrimental effects of their call schedule on island. All respondents listed this as one of the solutions to retention difficulties if an additional position could not be added to ease the burden of call on their personal time, sense of well-being and minimally acceptable quality of life.

Relief from the one-in-three (day) call schedule was argued by physicians to be a requirement for easing stress on every part of their lives; in the clinic and in turn, and home and in the community. This relief was most often suggested in the form of an additional doctor; a fourth full time equivalent position in both communities, which currently only have three positions allotted, not including locum relief. A typical comment heard was:

We as MD’s have been aware that full time practice here is NOT sustainable with the present 3 MD rotation. On-call relief or a fourth MD position would eliminate or decrease the necessity for practice sharing/splitting that we currently rely on to gain the needed time off that is otherwise unavailable.

Other benefits to a fourth FTE position mentioned were improved capacity of current staff in order to complement the physician cohort and greater dispersal of the responsibility of care. A physician argued that nurses need to be better trained and entrusted with more responsibility in order to improve their ability to manage basic emergency department presentations without depending on the physician who may have been on call for a 48 hour weekend slot:

We need to intake and create more positions for nurse practitioners. For call-outs [to physicians on call], we need to give more responsibility to the nurses in hospital, give them latitude for decision making power, responsibility, broaden scope of their practice. Otherwise they are calling to ask if they can administer Tylenol and this disrupts my sleep for several hours and subsequently affects my performance at work the next day.
4.2 Community Member Participant (CMP) Results and Discussion

4.2.0 Community Member Profiles and Perceptions of Physician Retention Challenges

Community member participants (CMPs) were drawn from a number of fields and areas of expertise in both Masset and Queen Charlotte. They often suggested colleagues on island who were similarly involved with health care, who were deeply involved with community initiatives or who could speak in more detail to questions in the interview script. CMPs were not solely those involved with some aspect of health care. However, a trend emerged during the research process wherein those who were involved with one area of community leadership were generally versed in the historic experiences of the community’s health care system, with advocacy or health organizations and were in close contact informally and through political or organizational channels with health care providers and administrators.

CMPs were involved with organizations dealing with public and private sector initiatives, health care provision, village politics (elected representatives) in both incorporated and non-incorporated communities, environmental interest groups, education, and spiritual care. Most of the individuals had involvement with and working knowledge of the local health care environment and the social construction of their immediate communities. This allowed them to comment on the relationship between the larger community and the physicians as representatives of the group that physicians encounter both inside and out of the clinic on a day-to-day basis. Allied healthcare providers included any individual in the area of nursing, clinical administration (under
Northern Health), emergency response, long-term care provider, healthcare technology (laboratory and x-ray), etc.

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<thead>
<tr>
<th>Community Member #</th>
<th>Category of Community Involvement</th>
<th>Length of Island Residency (years)</th>
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<tr>
<td>1</td>
<td>Political &amp; environmental</td>
<td>30</td>
</tr>
<tr>
<td>2</td>
<td>Political &amp; healthcare advocacy</td>
<td>33</td>
</tr>
<tr>
<td>3</td>
<td>Allied healthcare provider</td>
<td>8</td>
</tr>
<tr>
<td>4</td>
<td>Healthcare advocacy</td>
<td>33</td>
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<tr>
<td>5</td>
<td>Spiritual care &amp; allied healthcare provider</td>
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<td>12</td>
<td>Political &amp; healthcare advocacy</td>
<td>34</td>
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Most CMPs did not have any direct involvement with physician hiring but were either involved with organizations that make health care changes that affect physician experiences in the workplace or had influence and experience with a broad range of people in the communities where physicians took part in social interaction outside of the workplace. They were well equipped to comment on the social environment inhabited by island health care practitioners and the cultural and social norms that impact day-to-day interactions in the four island communities.

The islands fall within the jurisdiction of the Northwest Regional Hospital District (NWHRD), which, through tax dollars, provides approximately 40% of the funding for all infrastructure projects in the region. This has a trickle-down effect on how programs are run because they are often “facility-oriented” according to one community respondent. These programs may find some overlap with the expressed needs of the community through HWAC,
and may influence staffing through HWAC’s advisement of community and health care practitioner satisfaction with the availability, location and status of island health care infrastructure. According to one CMP, HWAC may also address specific issues or events that impact islanders, acting “either proactively or reactively” to improve management of and response to the issue at hand by the community, health care personnel and the health authority. Another CMP notes that the issues range from broad discussions surrounding the location of a new south end hospital facility (currently under construction) to the increase in ferry fares and the challenges faced by islanders who need to travel to Vancouver and Prince Rupert for essential specialty care.

HWAC can communicate with local politicians who, in turn, have access to decision-makers or higher level government bodies, to access care for specific medical cases, to make available off island long term care beds, or to garner attention from regional and provincial bodies towards issues such as the acute physician shortage around 2002. In that case, physicians and community members came together to protest the dependence on locums and the immense burden placed on the few remaining FTE physicians who were stretched to the limit. HWAC became an important liaison between the community and Northern Health during this period, as one CMP commented, they worked “from all different aspects and angles; we’re rural and isolated communities and because you need to take a ferry to go see a specialist we worked with Northern Health to find ways of bringing [physicians] here so that we’re not always trying to send our people out”. HWAC, according to one CMP, is usually attended by the chief of staff (at the hospital) or the site manager, who keep board members well informed on recent care initiatives and broader developments in health care or regional issues. HWAC informs the village council of the major points and makes the best case they can for various actions, based on opinions from expert contributors including health care users and contributors. HWAC also meets with
Northern Health and “tries to represent the people of Queen Charlotte to the health authority as best we can”. The people of Queen Charlotte include the physicians, according to the CMP, who emphasized that doctors operate as independent contractors to the health authority and have a vested interest in the well-being of the community. The CMP continued, arguing that HWAC provides a counterpoint to often overlapping political and healthcare interests and priorities; while “there is no decision making on health operations…if there are concerns, such as like last year, in determining where we are going to locate the new hospital…our job was to make the best case we could to Northern Health”.

Political figures on the islands take part in province wide initiatives aimed at improving rural medical care in particular. A CMP respondent discussed these efforts, citing a 2007 conference in Vancouver focused on improving physician retention, acquisition and referral during which policy makers and rural physicians gathered to discuss the aspects of British Columbia’s physicians’ salaries, benefits, educational programs, etc., that worked and needed to be enhanced, as well as the elements that needed to be discarded. Physicians and community members, including political figures, are involved with an island health fair every other year which brings the two groups together on broad health matters and community health; “the doctors usually participate, and not in their capacity as physicians, but bringing to the table everything they are involved with outside of their professions that helps promote healthy living”.

CMPs had a good general understanding of the healthcare structure in operation and the roles of island physicians. CMPs were asked whether the islands had experienced difficulty retaining the number of needed physicians. They were unanimous in agreeing that this was the case, although they also agreed with the physician respondents that there had been very different histories and experiences over time (currently more stable than in the past) and between Masset and Queen Charlotte. One CMP stated that the situation “off and on over the years…right now
we have a real solid core group”. Another CMP commented that they have “been doing well down here in Queen Charlotte over the last, well, pretty much since I came here [8 years]…."

The respondent attributed the recent stability to the fact that doctors have been able to participate in job sharing arrangements and the ability to “switch one another off, which provides them opportunity for getting off island”. Another CMP commented that the nature of the professional lifestyle, transitioning from an intensive, often urban educational and social environment where training takes place, to the rural setting, is fraught with difficulty that can explain much of the lack of retention in rural areas such as the islands:

Retaining any professional in an isolated community has challenges, based on remoteness; not everyone is capable of living on the islands where we are. It can be very expensive to travel on and off…very limited social activities, unless you’re interested in the outdoors, limited supply services, no big outlet that people rely on, and it’s difficult to entertain the spouses of professionals here…the person you have “retained” is going to be under pressure to move all the time if the family is not happily engaged here.

Community members did not see the lack of some health services as a negative aspect of their lives, but simply as a challenge:

They evacuate any serious cases off island immediately because they don’t have the resources, equipment, technical support, and it must be challenging for docs who perhaps have the ability to do far more than they’re capable of doing here because of the restrictions. Those things are certainly not ever going to be here because we’re a community of just 5,000 people total. There’s two hospitals, and you know, that type of equipment would serve 50,000 people in the lower mainland, so why would they do that [treatment] here? All those kinds of issues come to bear heavily on physicians and what they can do with what they have.

Another CMP commented that the physicians currently practicing on island are “really committed to dealing with small communities and overcoming the fact that you don’t get the exposure…you’d get in a larger area”. Another respondent similarly commented that retention challenges arise when a doctor “wants to be busy and have lots of patients…I know of doctors who come here who only want to work half time”. This comment from a north island CMP,
contrasts sharply with the expressed concerns physicians have over only being able to find respite in job sharing, but being otherwise fully engaged in their medical practice on island. It suggests a misunderstanding of the short-staffed rotation and intense schedules physicians work within even while sharing an FTE position. Similar statements to this CMP’s imply that community members, particularly on the north end, are not fully aware of the full patient load carried by physicians and the inability of most practitioners to balance life and work. It does, however, confirm one north island physician’s suspicions that the community perceives that “we don’t work as hard as urban docs”.

4.2.1 Community Members’ Knowledge and Perceptions of Physician Integration Experiences

In response to the question ‘Do local communities have any responsibility to accommodate physicians and incorporate them into the community?’ CMPs were mainly affirmative, and had two major categories into which they placed this responsibility. The first is related to the amenities, infrastructure, programs, and events that a community could provide; the “material goods” that could cushion and support a physician and/or their families arriving from a more urban setting. One CMP stated that communities, and particularly leadership at the local and regional level, needs to understand physicians as much as physicians need to research and familiarize themselves with their practice destination before arriving:

Usually physicians and their families are very education-oriented, so opportunity is important. And then so are all the [things] people take for granted; a ball diamond, tv channels…as you get more and more remote, some of these are difficult to do but can really pay off. Physicians are health aware, so you have to examine the community and ask, ‘do you have walking trails, what happens at the school gym or rec centre?’ You know, these are attractors.

The second category of accommodation that CMPs identified was related to the daily reception of physicians in social situations and the ways that community impacts the level of
integration sought and experienced by physicians. CMPs generally felt that communication and social boundaries had a major impact on the experiences of local physicians and that, in particular, island residents had a clear responsibility to respect physicians’ personal time. A south island CMP discussed the impact of social interactions on physician retention as compared to material factors provided by the community:

I would expect things like [giving physicians] privacy make a difference in their quality of life; respecting that they’re off shift when they’re off shift, those kinds of things. One would expect that the system would already be providing adequate housing compensation, but the community itself could really be involved with improving their interaction with physicians. It’s difficult…you can’t dictate common sense. It’s very difficult to instill in people.

Appropriate social functioning by community members was best when the community had a sense of the responsibilities and commitments that fill physicians times, such as call schedules and the low physician to patient ratio that exacerbates visibility in a small community characterized by ubiquitous social transparency regardless of one’s profession or role. One CMP commented that they understand physicians’ reluctance to integrate socially due to the many factors involved with their practice, stating, “I had a conversation with a doctor who expressed concern [she/he] had with being on call so much…the demand on the physician is such that they have no relief, and so they burn out and they don’t have time for recreation or vacations”. This CMP later on related the level of integration with the physician’s ability to practice effectively, stating that patients are “more likely to open up” if they know the physician and see them as a “real person…then s/he has insight into your case that someone else just doesn’t have”.

Several community members immediately identified social interactions and the collective responsibility of communities to “increase the liveability” of the islands for their doctors. A CMP in Queen Charlotte emphasizes this idea, stating that “the community needs to recognize challenges that doctors face and realize that they have a role to play in the ability of a community to secure and retain physicians”. Another CMP mentioned the “non-monetary things”, apart from
government-provided financial benefits, that she/he believed would “substantially improve retention in island communities” if attended to. The non-monetary factors included, according to the CMP, the communication and creation of clear boundaries, and the awareness of community members of the impact of “casual conversations, chance meetings and social occasions” used inappropriately as a time to ascertain medical information from off-duty physicians. Many community members likened physicians to police officers on island; a group that experiences similar visibility on and off-duty and has a high level of contact with island residents. The community member summarized the impact of a community’s ignorance of work/life boundaries in terms of the effects on the population as a whole:

   if [physicians] try to ignore people and say ‘I’m not working and don’t want to hear about it’, they’re frowned on, but most people don’t realise that they don’t want to bring their jobs home. We have to go out of our way to make it a more liveable experience…professionals come here to a remote area to provide service and the experience they have affects each person here in one way or another eventually.

Another CMP noted that the communication of boundaries has to be enforced by residents and physicians alike, stating, “people have to remember that if they are not in the doctor’s office they need to not start talking about [their] health care and the doctors have to remind people of that periodically too…they just have to quietly and firmly remind people, and say, ‘I’m sorry, come to the office, make an appointment, and we’ll talk about this’”.

Some CMPs expressed a concern that physicians who do not have a positive experience may “not belong” and state that “doctors come here who want to be here, to be remote”. This does not agree closely with other statements by community members or physicians, as it places the burden of experience directly on the physician, their expectations, and their histories. Both respondent groups listed the characteristics of the place itself, its remoteness and setting, as a particular draw and a retaining factor; however, the expectations or lack of knowledge about
small community living was less clear to individuals new to the islands, and was the major source of stress, superseded only by short-staffing issues that impeded the quality of life of on-call practitioners.

A small number of CMPs did not believe the community had a responsibility to participate in the incorporation of physicians. When they were pressed for detail on who was responsible, hospital staff, community boards (such as HWAC) and political figures were most often listed, and modes of integration were mainly the first “material” category; fishing trips, barbeques, etc., with no mention of the social implications of living in a small community or being visible outside of the workplace.

CMPs were asked to discuss whether they are aware of expectations placed on the local physicians by island residents to be involved with activities outside of the healthcare setting. Most CMPs replied that they did not think there was any overt expectation, but that it was hoped for and appreciated by the community. Whether this “hope” is expressed and articulated in a manner that creates pressure for physicians is reflected in the responses of the physicians themselves, who, as discussed earlier, did have a sense of obligation to the community outside of their formal duties. One CMP commented that if any expectation exists, it is the same hope for volunteerism and involvement that any other resident would experience. The CMP stated that they “don’t know that people expect [involvement by physicians] more than they would of any other community member, but those who do things may have a negative view of those who don’t”. Another CMP stated that “the general public doesn’t [have any expectation towards physicians] understand that it isn’t just the clinic hours, but it’s also rounds at the hospital, call hours when you can’t be more than so many minutes away from the hospital…people just don’t get that”. A third community CMP seemed to condition the integration experience of the physicians on their willingness to be involved, stating that “involvement may not be expected, but
it’s appreciated…no one wants an aloof doctor”. She/he continued to say that the physicians benefit by becoming involved; that “the more the doctor gets to know the community the more information they have, and they can basically put their finger on the pulse of the community”. This respondent believed that communities will be less inclined to extend themselves if they are not approached by incoming physicians; voicing concerns over physicians becoming “recluse”.

Most respondents recognized that scheduling does not make it easy for physicians to engage with their communities, but as discussed by a CMP, “people respect someone who is aware and involved…physicians play a very important role as examples and when they take part in something, often with their families, it really adds to their life and it changes the community”. This was the common response from community members, who realized that physicians are “very busy”, but who believe the community hopes for and notices when they take part in various activities and issues that are separate from their work.

CMPs were asked to discuss perceptions that the community has of its physicians and whether they believe these are attached to expectations or preconceived notions about a physician’s role. Respondents felt that physicians were generally very well regarded, highly valued, that their skills and strengths are recognized by the community and that physicians complement each other as part of a strong team in an otherwise challenging practice location. One CMP believed that people treat physicians in a certain way because they know they are “well educated”. Another CMP agreed with this statement and stated that “[physicians] are being held to a higher standard [than others] in the community…I think we should judge people for who they are and what they do on an equitable level and yet that doesn’t happen”. Other CMPs stated that they expect a doctor to fulfill the role of the “traditional country doctor”, although they acknowledge that “perhaps this has been idealized”. These respondents stated that some community members expect physicians to “do house calls when we have a very capable nursing
staff who already do that”. A CMP stated that physicians in small towns face a unique challenge in social and clinical settings due to the fact that physicians are expected to know everyone and be able to engage on a variety of levels with their patients:

It’s hard for a small town doctor because the community expects them to know their individual medical issues, really know them… each practice has about 1200 clients, although maybe only 500 are moderate-to-heavy users of the system, that’s still a lot of people to remember. As a community member I’m only having to remember those 5 doctors, so it’s easy for me, but there’s a major expectation that doctors are supposed to know everything and everyone.

Other CMPs believed that the perceptions of the community are largely dependent on the personality of the physician themselves. This determines whether an individual is community oriented, according to a CMP who remembered the farewell party for a physician who had practiced for over 10 years on the island:

[She/he] was hugely community oriented, so when we had a going away farewell gathering, it amazed me in attending how many lives were affected by this individual beyond her being a physician. I think rather than anyone having a set perception it depends on [physicians] individually and how long they’ve stayed. We’ve had people who signed up for full time but only stayed 8 months, and there was really no integration into the community during the time those individuals were here.

Physicians who have committed to long term practice tend to be seen in a more favourable light than those who are on island for a short term locum posting; as one community member stated, “there’s definitely an idea that locum doctors aren’t very good or as good, because obviously they don’t know all this [personal] information about their patients”. This implies that particularly in a small community setting, regardless of the technical skill of the physician, their relationships with patients and knowledge of the social dynamics of families and communities on island have an impact on the perceived quality of care that they deliver.

Physicians in both communities at the time of the interviews, however, were highly regarded by all CMPs. A CMP stated that physicians are “good listeners and have time…or they make the
time”. This CMP continued, emphasizing the benefit of long term integration into the community for both the clinical practice and the community; “They have a high degree of compassion, because they know the people they’re dealing with and they know the impact of tragedy; I think they’re highly aware of that here and really step in”. Another CMP reflected on the same positive dynamic resulting from a close relationship between physicians and their communities, stating that “the person who’s in touch with the environment of the community has this insight that an urban doctor coming in isn’t aware of, who wouldn’t be quick to pick up on some of the chronic issues or some of the other issues that show up, like a falling [logging] concussion”.

When asked whether physicians are “more visible to the general population on a day-to-day basis” the CMPs agreed unanimously; however, some believed that all members of the community experience visibility due to the small populations of each island town. One CMP believed that “people know who they are, but in a small community, that’s true of anybody”, while another stated that “everybody’s quite visible, but [physicians] in particular are held in high esteem and they are noticed”. Only one community member, directly involved with healthcare provision, believed that physicians are not as visible, stating that “these guys are pretty invisible; dress in regular, informal clothes and drive mid-class cars. However, it’s a small population, so it doesn’t take long to know everyone”. This sentiment generally makes sense alongside the remainder of the CMP responses, as island physicians share a similar lifestyle, behaviour and dress as the general community, and generally “blend”. However, as noted earlier in the results, the nature of their profession leads to characterization of the physicians based on educational attainment, perceived social standing and the nature of their relationships with a large proportion of residents, regardless of their otherwise similar lifestyle and day-to-day behaviours.

This high level of visibility has implications for the way that physicians function in public, whether it involves editing behaviours, avoiding certain social situations where they feel
they might be sought out for medical information or where they feel a situation might impact their
ability to practice medicine with a reasonable level of neutrality. This was voiced as a concern by
several physicians who avoid political involvement as much as possible in order to remain
unbiased in their delivery of medical care and to maintain positive, open relationships with
patients who may need to access services at any time and have little choice as to the physician
who provides those services.

CMPs felt that physicians’ visibility had the potential to be both positive and negative, but generally discussed the benefits of being known in the community because of the support available in a small town to those who are open and receptive to it. One CMP stated that visibility “depends on the doctor and the situation, but if you’re reasonably competent and polite people will notice and it will strengthen your practice”. Another CMP stated that physicians are easily recognized and there is always the chance of medical questions in the grocery store, not to mention that any misbehaving will get back to the [physicians]”. The most concerning implication voiced by the physicians is the tendency to isolate themselves when the pressures of work combine with extra-clinical stressors. A CMP involved with politics and widely involved with the community stated that physicians “have really been badgered in the past and this makes them not want to be seen outside of the clinic, and this leads to isolation”. Physicians “can’t hide, you can’t get away even on your day off because people will phone you, they know where you live and you’re never really off call”, a CMP added.

This leads to a difficult decision-making point by physicians. On one hand, these responses suggest a need to create a safe space outside of the workplace, which physicians do by choosing to interact socially with only a select group. On the other hand, physicians have a better chance of remaining in long-term practice if they become involved with some aspect of the general community that fosters a sense of ownership and investment, but which will expose them
to a variety of individuals who may not have the wherewithal to respect the physician as a neighbour and community member as opposed to simply being their doctor. A CMP stated that the visibility of practitioners is generally “positive for the community and, by and large, negative for physicians…because of the lack of autonomy they can’t enjoy things a lot of us take for granted”. Another CMP stated that the situation is similar to someone who is in the RCMP or a firefighter; “everyone knows what you do and it’s a very important position, so that changes the dynamics a bit in any situation, of where [physicians] fit in the social structure”.

As was noted by physician respondents, CMPs voiced awareness of difficulties faced by physicians when the physician-patient relationship deteriorates. The effects of a physician’s visibility on clinical practice are most difficult to negotiate when a negative outcome occurs in the medical setting, impacting the relationship of the physician and that patient or their family in the community setting; as one CMP stated:

[Physicians] get to know so many people, which is nice in some aspects, but if somebody thinks [their doctor] hasn’t treated them right or thinks the doctor didn’t do what they were supposed to or they wanted them to they’re not going to be happy with them…you hear things, of course. People that are unhappy say things, people that are happy don’t say things. Sometimes doctors, I think, get bashed when they shouldn’t.

Another CMP stated that the worst possible outcome for a physician in a small community is “if something goes wrong with a patient and it’s taken very personally by the family…and this has happened in the past”. In addition to the difficulty this would present for those residents, both the physician and the patient sharing the same small community, highly visible physicians have a difficult time when struggling through any personal issues that arise, when they need help and support but have a limited social network. One long-term CMP stated that “in their own personal lives…and for anyone in the community, really, it’s tougher to have personal problems when you’re in a place like this and you don’t have the support. I would imagine it would be their colleagues that would be there, not the community at large”. Both scenarios, the case of the poor
physician-patient relationship and the situation of a physician struggling with their own set of
issues, reinforce the need for a steady, core group of individuals, physicians or other reliable
confidantes with an understanding of the context and the need for discretion. When asked
whether this is true, a CMP stated that “the continuity is so important, you have to have a full
complement of physicians for these situations, it doesn’t work if they are surrounded by locums”.

On the opposite end of this spectrum, is, however, the situation when the strong
physician-patient relationship, combined with some level of knowledge of the patient outside of
the clinical setting, enhances the delivery of care. One CMP stated that she/he experienced better
care for an injury that required she/he be sent off island; she/he commented, “as a patient,
knowing them helps; when I was hurt they really advocated for me and took care of me and that
wouldn’t have happened just anywhere”.

Respondents were asked to discuss characteristics of the islands and island communities
that they believed helped physicians become integrated into the place (either Queen Charlotte or
Masset, depending on the respondent’s location of residence). In general, respondents listed the
openness of island communities, the relative ease of familiarizing oneself with people in the
community, and the strong core group of physicians, nurses and other health care personnel who
welcome incoming physicians. The desire to maintain health care services in their current form
is a priority cited by most respondents. One CMP stated that there is a “sincere desire to have our
hospital here…to maintain a first tier health centre” and another CM echoed this, saying, “the
community here is very interested in giving physicians a positive experience so that they do stay”.

This positive experience manifests itself differently between Masset and Queen
Charlotte. In Queen Charlotte, there is a clear emphasis placed on first, the desire and priority to
maintain current health services and staffing capacities, and this is followed by the provision of
programs, groups, infrastructure and a general recognition of the needs of, and demands on,
physicians and their families. In Masset, there is also a strong sentiment towards creating a warm environment for physicians, helping them and fostering a sense of community, as a north-island CMP stated, “everybody needs help at some time” and “the community looks out especially for people the community really needs, such as physicians”. They place an emphasis on cultural awareness activities for physicians to familiarize them with local aboriginal customs or natural attractions and pastimes. The Old Masset village council (the band council for the north island Haida clan) according to one CMP, “organizes cultural events, clam digging, so doctors can get to know what it is we do here, and they can find out what lifestyle means here, and get involved quicker”. This CMP continued, stating that the community hopes this will lead to retention of physicians by giving them a picture of the benefits and practices of island life: “all of this is with the expectation that if you nab someone that way, they will want to stay”.

This is a common belief among many of the respondents, who put considerable thought and planning into the initial attraction efforts, hoping that these will foster an appreciation on the part of the physicians for the potential experiences they can look forward to once they establish themselves on island. While these initial activities do capture small town ambience, hospitality and sense of partnership in community, they may also act to reinforce the community’s image of a physician as “other” and suppress the authentic interactions that are important to physicians becoming community members themselves. In Queen Charlotte, similar activities are organized for physicians, mainly by hospital staff and community leaders. In addition to these, there seems to be a clear emphasis on the importance of working to keep infrastructure, programs and organizations in place to support professionals and their families, as one CMP stated, “it is helpful to have a variety of community organizations or even informal groups, like the Sierra Club, arts, maybe a variety of educational opportunities and some sports, both for physicians and for their kids”. Queen Charlotte’s more stable physician situation cannot be ascribed to the
existence of more programs or events, but these factors, combined with the different historical experience on the south island, has provided a clear advantage to the development of a well-retained cohort of current general practitioners. One CMP stated that “we are very motivated to have health care professionals stay here [in Masset]” but that despite their best efforts, “Queen Charlotte’s hospital is more stable because they have a very different history and have been able to build on that”.

One possible dynamic in Masset, as opposed to Queen Charlotte, is the increased isolation of the community (compared to the busier south island) combined with a very strong sense of interdependence between community members. This may lead to a high level of social interaction and desire to be involved with the physician, to include them and be included, and to impose unknowingly a lifestyle onto a practitioner who is simply too exhausted or busy to be as integrated as the community would hope. A CMP in Masset states that “we have more than one role in our communities, we can’t wear just one hat, and it takes a different mindset to come be a doctor in a remote area and live amidst that”. The practitioner who is able to stay on island must be either well prepared to engage on a variety of levels with the community each day, or find ways to exit the social “theatre” without completely disengaging from community involvement.

A CMP on the south island discussed the general awareness of the community (Queen Charlotte) pertaining to physician schedules in relation to their level of involvement in “extra-curricular activities”; “physicians work extremely long hours here and I think probably the exhaustion of it at times is the limiting factor. And they do 1/3 call, so it’s hard when you’re on, you can’t do a lot of planning”. Another CMP similarly commented that it might be a difficult transition for physicians who “come from a vibrant urban setting, where if you want to do anything you can and you just go do it, to a place where you have to plan your spontaneity”.

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CMP respondents were asked to discuss the level of involvement, or the type of “voice” that they think local residents should have with physician hiring and health care decision making in general. This was asked, in part, to determine the community’s level of awareness of current hiring practices, of the organizations in place to carry out advocacy, and of the balance carried out by community politicians to support professionals and infrastructure while also acting on behalf of citizens when services were not felt to be adequate. CMPs believed the current hiring arrangement with Northern Health was sufficient and were happy with the physicians on staff. However, they believed that they had a right to become vocal when they were not able to receive care or felt that the local physicians were not able to provide care due to higher-level decisions that are ill-fitted to the geographic and social situation on the islands. One CMP stated that community members “have every right to say ‘this is not adequate, we are not being served well’” and that people did step in several years ago:

   This was what was going on with a revolving door policy a few years ago when we really didn’t have enough permanent doctors in place…it was a very bad situation. The doctors were saying it and the public was saying it; ‘we are being shoved to the back of the class and being told to be quiet’. The doctors were protesting it alongside the community, because for them, say somebody like me needed physiotherapy, they can write on the chart “needs physio” but they’re not enabled to do anything past that to take care of their patients.

In this case, the relationships between community organizations, local residents and physicians, enabled a conversation and heightened the mutual understanding of a situation that equipped both groups to speak to the higher-level decision makers and create positive change in the local health care environment and the way services are organized and delivered. CMPs on the south-island were generally well aware of the groups in place for such action and advocacy, including HWAC, and at other times, the hospital board. CMPs on the north end did not mention the health advisory boards, but were vaguely aware of groups that advised Northern Health, physicians and hospital site managers when concerns were raised by the public. On the north island, there was, however,
a strong movement by community leaders to mobilise efforts independently from Northern Health to build a new hospital, with the hope of creating infrastructure that physicians and nurses would want to work in.

4.2.2 Community Member Perspectives on Physician Roles and Community-Physician Relationships

CMPs were asked whether there was a type of person who they believe “best fits the general requirements for successful, long term practice on the islands?”. Three general categories were mentioned; previous knowledge and reasonable expectations of rural and island life, strong general practice skills, and appreciation for the outdoors and the isolated setting of the islands themselves. While most CMPs immediately listed “the outdoors” as a needed interest, the “material” factors gave way later in their responses to social and skill-related factors that included commitment to general practice, flexibility, compassion, level-headedness and the ability to be assertive. CM respondents also mentioned family structure and spousal support as major factors “built in” to the type of person who would choose to remain on island for over three years. One CMP even mentioned that having a spouse “who is not in the medical field is a plus, because of the varied work schedules…I’ve seen it [when both spouses are in healthcare] and it does not work so well”.

Material factors were commonly noted by both physicians and community members as being an important gateway to deeper integration into the community. One CMP stated that the physician, and their families, if applicable, should like the outdoors and “take advantage of the kinds of infrastructure that is available here” and does not believe that the skill-set or the physician’s personality is as important to considering the likelihood of that individual’s retention:

One would expect that any qualified physician would be able to provide the actual care needed, so I would look more at overall social structure of the family than at the technical
requirements. It’s nice to have family doctor who is compassionate and cares and is thorough, but you can get a guy that’s gruff and has no personality and you think he’s a bit of a jerk but if he fixes your ailment and tends to you properly then really that’s what you need.

Another CMP stated that physicians who have stayed on island “really enjoy an active lifestyle, because there’s lots to do, between kayaking and hiking, fishing, et cetera.” This CMP continued, “I don’t think there’s enough for a highly urbanized person because we just don’t have the things or facilities of a larger place”, which concurs with the statements of another CMP who mentioned that the islands are not the right place for a physician who “needs to be entertained”. Successfully dealing with the high level of community interaction and the lack of immediately available entertainment is possible for a physician who does not have a rural background, according to most CMPs. A CMP suggested that “a rural background can help because they’d have an understanding of the social situations that can develop” but emphasized that there is “no reason someone from an urban background can’t come here and be successful, because attitude and personality count”. Another CMP involved with health care agreed with this statement, arguing that physicians do not necessarily have to be from rural backgrounds, “although they might adjust more quickly”. Physicians, a CMP stated, need to realise, and perhaps be informed by the community leaders or hiring boards in advance, that “everyone’s going to know your business”. She/he continued, “if you’re not an outdoor person and you expect to have amenities like opera and live theatre you’re going to have a tough time…on the other hand I’ve met people who grew up in the city and absolutely love it here and wouldn’t want to be anywhere else. They’ve adjusted to the fact that everybody knows you”.

CMPs who were more directly involved with health care tended to name factors that related to practice habits and experiences as opposed to social and place-based interactions. One such CMP stated that a person is a good fit for island practice if they are “quite flexible and
independent, a very good generalist and able to provide care beyond what would be expected of an urban GP”. Only later on did this CMP mention the outdoors as a possible attractor to island practice. Individuals working closely with health care on island placed a high value on the physicians’ ability to be proactive; this affects their social interactions, their practice and time management in clinical setting as well as their ability to obtain upgrading and CME training to improve their skill level constantly. CMPs listed the lack of training opportunities as a source of stress for a physician, which aligns with the statements of physician respondents. One CMP involved with emergency response noted that “there are significant challenges for our doctors, who may not feel that they are keeping up with the times”, practicing in a medically heterogeneous environment where one procedure, technique or piece of equipment is used a few times a year. Two CMPs (A and B, below), both involved with healthcare and interviewed together, discussed the challenges they perceived are experienced by both the community and by physicians who practice within a transient staffing pool as they navigate a diverse set of medical presentations:

CMP-A: that’s got to be discouraging for a talented physician, to come here and have the skill but not have the facilities at their disposal. I think a community would get behind a doctor who was committed to stay, but we’re so used to having doctors on a revolving door basis that the community is…they’re not sure how to engage.

CMP-B: Doctors and nurses seem to come here on a revolving door basis

CMP-A: Yeah, that the community isn’t used to [having a regular doctor] anymore and almost has to be trained in doctor support and a doctor has to train a community about what to expect from them.

Another CMP stated that “you need to tell people what they’re coming to” and emphasizes the need for Northern Health and island communities to be honest with incoming physicians. This respondent commented that those who choose to stay on island made their decisions carefully and integrated slowly are now “involved…they care”. She/he continued, citing instances of
physicians who currently practice and are deeply committed to both their medical positions and their communities,

if they’re not interested in the great outdoors, if they can’t entertain themselves, if they want to go to the cinema, it’s not going to work here. But if they like to go fishing, and if they want to maybe get a boat or join the art community…its pretty hard to be totally distant in a small town so you just need to be realistic about what you’re coming to and whether you’re willing to try [to be involved].

To determine whether there was a real or perceived expectation on the part of community members towards physicians, CMPs were asked to consider and comment on the job-related responsibilities of a physician in a small community. This question was followed by another query as to the separate functions of physicians in professional, social, and community contexts, asking “aside from professional commitments, do you think physicians on the islands have any other responsibilities as community members?” The first question was largely descriptive, and unless the individual was directly involved with medical services, was expected to be highly speculative. This speculation, however, is the root of how communities perceive and view the physicians in their towns, so was seen to be useful in determining levels of understanding and awareness and how or whether, this translated into social behaviours and expectations of physicians outside of the clinical context.

CMPs stated that they personally considered physicians to be free of expectations for service once they left the clinic; “when they’re off duty they shouldn’t be expected to provide any more of a role in the community than you or I or the next person”. This CMP added to this idea later on in the interview, stating that everyone in the community should participate in “whatever would help make this a better place to live…it’s an expectation of anyone who wants to be part of the fabric of the community”. However, this project identified physicians as a highly visible group and questions whether this visibility lends itself to a targeting of the physicians, as opposed to other residents who are less known, to take up informal and formal roles in the community on
top of a heavy work schedule, which is ultimately unsustainable. Another CMP added that
“people want [physicians] to be involved, but when you look at the hours of commitment that
physicians have, I don’t think you should expect anything else from them”. This trend, the
acknowledgement of both expectation by community and yet voicing the immense burden on
physicians in the workplace, is repeated throughout the interviews when CMPs are asked about
external pressure on physician residents.

Another CMP remarked that physicians have been involved in the past, and the current
roster of FTE physicians is quite involved and are “seen” out in the community at events or as
members of various committees and boards. This, the CMP said, might foster expectations by the
community towards all physicians, which is a difficult situation for newer physicians unfamiliar
with small town dynamics in general and the heavy schedule and broad scope of practice in
Masset and Queen Charlotte.

Some CMPs felt that there were certain stereotypes attached to physicians on the island.
One CMP commented that they believe “a doctor has to commit for a certain amount of time with
the realization that [they] are not going to have regular hours whenever [they] want, [they’re] here
for the people’…going back to the old country doctor”. The CMP stated that physicians “have to
be well versed in all aspects of the community and medicine, or be willing to become [well
versed]. It be idealized, but it’s necessary”. Another CMP directly involved with health care
confirmed that this is a prevalent viewpoint from the community and that it has impacted some
physicians as they socialize or interact with the community outside of the clinical context. While
most CMPs are supportive in positive ways to current and incoming physicians, there has been a
lack of awareness about appropriate social conduct with physicians that leads to self-isolation by
doctors. Another CMP commented that physicians are constantly navigating a “social gauntlet”;
whether they have developed a “thick enough skin for that kind of daily barrage” of social
recognition is the key to whether they will be able to sustain a life in a small island community.

She/he continued:

I’ve seen it happen where someone finds out there’s a doctor in the room and they immediately tell them their problems. I don’t think the [doctor] can say no to that or stay away from that…they get buttonholed all the time. It’s not just here [that it happens], but it’s isolating them a lot and it is really harmful in the long term.

A CMP commenting on the involvement of physicians versus the community as a whole stated that “all community members have a responsibility to be aware and use their skills to contribute…hopefully this will include the physician and their family and they’ll be involved in all aspects of community life, which will feed back into their interactions”. A CMP also commented that physicians have tried in the past to be involved but she/he is not sure whether this comes from a community request or because physicians tend to respond to expressed need where they have an applicable interest or skill. She/he stated,

all community members should be actively involved in their community; I think a doctor has no higher responsibility than anyone else, but the same small group of people always volunteer here and they get burnt out after a while…based on my own stress level, doctors might not want to get involved in too many things.

Another CMP echoed the earlier statement towards the physicians’ tendency to be involved with a variety of extra-occupational activities tied in with their personality type and the profession they have chosen; she/he commented that physicians “I think they are the type of people who get involved…it’s a small place and I think it’s refreshing for them to interact on something other than ‘being a doctor’”. Physicians have tended to depend highly on each other as support in the workplace and as a social network, according to both physicians and CMPs. As one CMP stated, “they’re it; they’re the most important part of the puzzle and they need to be true generalists in a place like this. They work together and they deal and they call upon one another”.

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A positive aspect of the high degree of interaction between community and healthcare professionals is the way in which both can advocate for the other. CMPs referred to instances where physician wages and benefits were threatened and local politicians stepped in to defend the way physicians have organized themselves (job sharing) and to defend the uniqueness of the solutions in light of the complex needs of island communities themselves. Island communities and physicians worked together in the past to negotiate broader health care changes from regional and provincial authorities. These relationships reinforced the positive, attraction factors that have kept the current complement in practice on the islands, particularly on the south-end (Queen Charlotte).

CMPs, for the most part, expressed lack of awareness about activities that are included as a physician’s “professional responsibility” and those that fall outside of their contract with Northern Health. One CMP stated that lobbying for improvement of staffing, facilities and equipment has been taken on by island doctors, and she/he stated “I don’t see these people being involved “as doctors” I see them being involved as community members who also happen to be [physicians].

Physicians take part in a variety of recreational, artistic and community development-related activities. One CMP stated that physicians are “pretty much involved in any organization” suggesting that the community may perceive a higher level of interaction by physicians than the physicians themselves report. This may lead to unreasonable views by the general population of the time physicians have available in social settings and activities and have led to the creation of high expectations for practitioner involvement. CMPs also believed that some of the physicians’ involvements in complementary or educational health care activities are separate from their work (including such activities as chronic care support, group leadership and community health fairs) when in fact these are included as part of their workload atop clinic and
hospital coverage. These are built into the community health program as one of the “models of primary care”, whereby physicians can meet with a larger patient group at one time for a single issue (such as diabetes management). These roles can, and do, overlap with the physicians’ separate activities relating to the promotion of a healthy lifestyle and as one CMP stated, their efforts to “try to extend the idea of recreation for people in the community…they live by example”. There is a point where physicians are not able to be involved, as members of HWAC, for example, as one south-island CMP stated, due to conflict of interest issues which have been ironed out over time and as the whole community learned “there are definite lines that can’t be crossed”. Apart from this, physicians have been widely involved with “everything from political office, to the school board, which is entirely in their right and not related directly to their profession”.

Respondents were asked to consider whether they believed the island physicians are equally, more or less integrated into the community compared to other island residents. They believed that in general, physicians were more integrated. This was due to two main factors. The first was the high level of contact that individual physicians have with the community at large. The second has to do with what the CMPs stated is related to their personality and their ability to multitask and get to know people inside and outside of the clinic. The first factor, the base contact, is highly related to their visibility in the community and the level of involvement and integration that community residents perceive physicians have simply based on recognition and reinforcement of the physician’s familiar face. Physicians reported that they were often approached by people who assume that the physician is on a first name basis with them, when in fact they may only remember vague details of that individual. Physicians who are able to compartmentalise part of their lives may have a more positive community experience because they do not carry clinical “baggage” into social situations. As one CMP stated, “I think it has to
do with fulfillment. One doctor keeps certain parts of his life really, really separate, and some
doctors need that to be able to focus”. However, such compartmentalisation may also impede the
familiarity that community members reported is the benefit of knowing their physician outside of
the clinic. They stated that being treated as a whole person with a level of trust reinforced through
various positive community interactions and mutual awareness is a positive experience for both
physician and patient (a sentiment that is agreed upon by the physician respondents).

A CMP stated that simply “having a wider range of contact with the population than the
average person every day” influences integration. Another disagreed with this general idea,
stating that “you could have an extroverted logger who will get to know everybody on the
weekends and you’ll have an introverted doctor who never gets to know anybody even though
[she/he] sees them all…it really depends on the character”. This statement captures the second
factor considered by CMPs to indicate integration; whether the character and personality of the
physician are such that they prioritize community involvement. A highly integrated physician
who can remain on the islands must have the desire to develop friendships and partnerships in
town and be able to do so without impeding their mental and physical health (e.g., while on call)
and while maintaining clinical responsibilities and identity as a physician and confidante during
work hours. CMPs did not believe that physicians have a choice in balancing these spheres of life
on the island; one CMP stated that “some people can sit and watch TV and not be involved, but
because physicians are so highly visible, they don’t have that choice, they are really out there
contributing to the community”.

After discussing the relationships between community members and physicians as
community members, CMPs were asked whether they were aware of the level of stress or burnout
experienced by island physicians, and whether they knew of factors involved with this stress.
The major issue raised by CMPs were directly related to the hours worked and the “rough”,

“busy”, “intense” call schedule of one-in-three days, and one-in-three weekends on-call, which is set up as such because of the small number of physician positions available (though all are presently full).

The schedules island physicians are forced to manage is a major factor in their reported levels of stress and can lead to poor retention. However, earlier retention research (Cutchin, 1997; Pathman et al., 1996; Selznick, 1992) focused on the need to examine the social factors that strain physician-community relationships, resulting in burnout and the loss of practitioners who were satisfied with rural practice and could otherwise have been retained. CMPs directly involved with health care delivery listed the various administrative challenges that create difficulty for physicians, such as the lack of control over their practices. One CMP discussed the workload and office pressures, stating, “Inefficiency [is an issue]; if they had a private practice, they could address it, but they can’t here. Because they’re on a contracted payment scheme they are…well, everybody’s an employee”.

CMPs had a good sense of the specific factors involved with physician schedules and responsibilities. They realised that physicians are on call “twenty-four-seven” for days at a time, and that they have to be careful not to over commit socially, risking exhaustion amidst their clinical and call responsibilities. However, CMPs also alluded to the challenges physicians face related to their lack of autonomy. One community member stated that “in a larger centre [physicians] can walk out the door and be off-shift; here, they can’t necessarily do that”. Making similar comparisons to general practice in a larger centre, CMPs commented on the different, more connected and personal care they receive from their island GP versus an off island practitioner in a large community. One CMP stated that “it’s more stressful being here because of the fact that there’s more ownership of your patient’s issues, versus a city where you have such a huge volume every day and you probably wouldn’t know [your patient] outside of the office.
door”. A CMP stated that “a remote doctor doesn’t necessarily care more than an urban doctor, but it’s a different kind of caring”. A CMP commented on the experience of a physician who is no longer practicing on island, who reported that between their urban practice and their island practice, the latter was more stressful because of the “sense of responsibility for so many aspects of your patients’ life, because they spent so much more time together in every context”.

CMPs supported job-sharing for this reason, as physicians had such an intense schedule and a heavy burden of responsibility in the community and as practitioners. CMPs stated that job sharing provides a respite from the “nose to the grindstone” type of practice on the island. A CMP commented that at one time “it was the docs who had to cover it all, diabetes, mental health and addictions, etc.; they were on twelve month rotations and people did get burnt out in the early days”. Another CMP stated that “in larger centres someone is on call, the rest of them are off doing whatever they want to do. And that often isn’t available to the physicians in small communities”. Job sharing enhances the ability of local physicians to improve their practice as well as disengage from the social “scene” for a period of time, as one south island CMP stated:

> there’s a certain amount of social isolation that does happen because [physicians] know so many people and people know so much about them, but there’s also that isolation from their peers…if they can get away and keep themselves up professionally it is a huge benefit for us here on the islands and for their sanity. If you don’t practice your skills on a regular basis, then you do feel like you’re losing them.

Job sharing, while only one part of a larger solution needed to improve retention, has made it possible for physicians to practice on the islands permanently, easing some of the challenges related to schedules, a slim physician roster and the social dynamics inherent in small, isolated communities.
4.3: The Importance of Place for Rural and Remote Retention

Within the medical geography literature, *space* is historically conceptualized as a medium for the contraction and transmission of disease, the determination of etiologies and ecologies of disease (Meade and Erickson, 2005). These are determined through quantitative location analysis and spatial analysis (Meade, 1980). More recently, literature has acknowledged the impact health care systems and neighbourhood effects (e.g., on various dimensions of healthcare inequality within regional and local populations) (Meade and Erickson, 2005). These non-medical place-effects and the social determinants of health that dictate the construction of place are important to gaining an accurate understanding of health care and health care access inequalities. In particular, the acknowledgement of unique place interactions allows for a better informed approach when creating strategies to mitigate challenges faced by widely dispersed rural populations and administrative bodies such as the regional health authority.

The place effects of medical practice in rural and remote locations, and in this case on Haida Gwaii, cannot be understated. Experience is vital to understanding the operational and experiential impacts of a locale on the community and individual. A qualitative framework allows the historic, social, political and cultural spheres to be considered alongside respondent experience and structural realities embedded in the delivery of health care and the structure of the health care system. These factors, already complex and unique, reveal themselves in more complex and function limiting ways on the Islands. Isolation, remoteness, social connectedness and medical complexity interact
to create an environment that challenges the most prepared, experienced and adventurous physicians. Distance between island communities, weather conditions, cost of living, socio-cultural factors must be taken into account by physicians hoping to practice on the islands and should be openly communicated by organizations conducting physician recruitment.

Because of the close-knit nature of each island community (within and between communities), physicians interact as both health care providers and community members. A tension emerges when the formal role they play in the clinic bleeds into the informal activities they take part in as local residents. Levels of integration into the community are an outcome of the comfort a physician has creating boundaries in certain situations and opening up as an individual to facilitate bonding with the community in other situations. Physicians frequently reported their discomfort with boundary setting in social situations and felt the need to create a physical separation from the community. This took place through job-sharing, living in isolation from the island community where they practiced or both. In one sense, this active separation allowed physicians to interact with the community at will and to be involved with select activities without “burning out”. In other cases, the chosen mode of physical separation led to a feedback cycle that further isolated and disconnected the physician from the community.

Lee et al. (2009) propose the use of systems thinking as a way to understand and decrease physician stress, emphasizing that the personal, occupational and health care system interact with each other to compound stresses of an already challenging job. This thesis proposes place as a component of each system; whereby personal levels of stress
are dictated by rural/remote community effects (which can be mitigated by active planning or reactive response once the stress has manifested itself in other systems making up the physician experience). Following from this, occupational stresses may be impacted by rural place-effects such as distance to tertiary care centres, lack of colleague support and the sense of “overlap” between the occupational and social settings. Finally, system stressors are exacerbated in rural and remote places by the lack of tacit exposure to other practitioners and facilities, which bolster practitioner confidence, experience and ease referral processes for patients. These interactions are not available to the rural practitioner. In addition, local practitioners have trouble accessing decision makers at the regional and provincial level when scheduling, patient transfer processes and remuneration are unsatisfactory. To deal with high level system-structure issues, physicians in small communities are forced to use personal time or the short time spent with patients.

As Cutchin (1997) notes, the need for in-depth qualitative analysis is revealed in the embedded relations between communities and the various landscapes that influence lived experiences; he states that “a rural community has an important historical dimension…the various historical situations and events that have come to bear on any rural place and community set them apart from others”. Masset and Queen Charlotte have experienced very different retention outcomes for two major reasons. The first is their remarkably different historical development, even over the past 30 years. History has played a major role in the reportedly more challenging experiences of physicians in Masset and in the more positive and stable experiences of physicians in Queen Charlotte.
According to one CMP, “the level of stability is different” between the two communities and has led to a tangible deterioration of atmosphere in Masset. Masset struggles with acute physician shortages where Queen Charlotte has experienced “relative stability” over the past eight years. A CMP in Masset commented that “we don’t have a well established team here that has worked together for a long time (as they have in Queen Charlotte).” She/he remarked that a major reason for the lack of stability is directly related to the recent history of the town and transition from a military town to one that is dependent on resource extraction and a slowly-growing tourist industry:

Our hospital only been public for 10 years. Prior to that it was run by the military, so we don’t have the same stable work force [as Queen Charlotte]. Even if someone came here right when we opened our doors, maybe there would be a slightly better situation, but it’s a big thing to get 5 year people here. We [in Masset] don’t have the same sense of community within the medical field, and the effects of that trickle down to doctors…you don’t know who you’ll be working with.

Distance, or relative isolation, quite simply, is the second major factor involved with Masset’s difficult professional retention situation. The north-end community is approximately 1 hour and 45 minutes away from Queen Charlotte and is a socially distinct community from those on the south end in terms of its recent development and its aboriginal community. The community is characterized by numerous empty buildings, remnants of the former Canadian Forces presence; and experiences regular closure of amenities that the dwindling tax base cannot afford to maintain. The town is aesthetically a “shell” of its former self, and despite having a strong and close-knit core community, respondents from both groups (physician and CMP) reported that there is no comparison to the more nested, architecturally pleasing, amenity-rich south end. The Haida clan on
the north end, most of whom live in Old Masset (on-reserve) are less socio-economically advantaged compared to the more politically involved and historically wealthy clan located in Skidegate, adjacent to Queen Charlotte. Finally, the south end acts as a major transportation gateway, and while Masset has an airport with semi-regular service to the mainland, it does not have the same level of access to cultural and human capital as the southern island communities. The south island contains government and support services for industrial and resource-related operations, is in close proximity to the world-renowned Gwaii Haanas World Heritage Site and these have culminated in the building of a relatively stable professional and service economy that fosters involvement and integration by physicians and other residents.

These two factors are not complete explanations for the particularly poor retention outcomes in Masset, but do explain some of the operational challenges that impact daily life activities and satisfaction with the community. Social and physical isolation were reported by Masset physicians and acknowledged by community members, indicating that where Queen Charlotte has worked to maintain basic infrastructure and create a physically liveable space, incremental improvements can make a difference for physicians who are aware of the general demands of small town practice. Creating and supporting opportunities for families seems to have paid off on the south end. Masset, due to unchangeable historical and environmental realities, must act even more aggressively to make positive inputs where there currently exists a feedback system of environmental and socio-cultural draws on the community-related factors that can improve retention.
It was difficult to separate physicians’ reported problems of structure and work-related stresses from their responses about the community impacts on their experience. Both are considerable sources of strain at different points in time for the physicians. This thesis focuses on the latter, and therefore the research integrates the organizational, or occupational, stressors as partial outcomes of the community or place-based characteristics. Overall, the island has few regular physicians; experiences immense isolation that can be made worse by inclement weather; unique health issues between the aboriginal population needs (e.g., a higher use of the local hospital by the Haida community for geriatric and long term care) and local dependence on high-risk resource industries; increasing addictions, particularly on-reserve; and a strong physician familiarity with, and ownership of patient issues. These factors are tied in with the physician’s position as integrated community members; they are uniquely bound to the place in both a community and medical context. Higher-level administrative challenges lead to outcomes, such as bed closures or scarcity of MedEvac crews for patient transport, that only act to exacerbate local realities. Community-related stress has the potential to compound clinical, job-related aggravations. This diminishes the quality of life for a local physician over time, particularly when they are not prepared for the non-medical demands of small town life.

Island physicians see themselves as highly integrated and do not consciously separate themselves from the rest of the community when directly asked how they were viewed. Those who had been on island for a long period of time, though had actively created physical separations and had to pick and choose activities to be involved in at the
community level. Long term physicians found ways to escape while remaining on island in order to create boundaries and find respite from the constant visibility in town/at the beach, and so forth.

Despite the higher level of visibility, being more familiar with patients on a day-to-day basis has brought the physicians down off the “pedestal” that they might otherwise occupy in the eyes of the public, and more into the realm of neighbours and caregivers. Several physicians reported that this familiarity lends a measure of accountability and accuracy to their practice because people know who they are and they know who people are both inside and out of the clinical setting. Community members reinforced this idea, stating that they find comfort in the level of care they receive because of the close relationship they have with their physicians outside of the clinical setting. Physicians were seen as community caregivers in a different way than would be seen in a larger community.

Physicians constantly re-encounter the relatively small patient population that does not respond to commonly accepted and easily implemented advice from the local physician, who must later deal with the outcomes of their patients’ lack of response in the form of more acute treatments and corrective action. One example of this might be exercise, weight loss or dietary changes needed to avoid onset of diabetes in the aboriginal population, already at-risk for adiposity and diabetes mellitus.

As reported in the Physician Results section (4.1), physicians found that the lack of anonymity instilled in them a sense of accountability which had the effect of improving their practice and led to a heightened sense of professionalism at all times, in
both the clinic and the community. This continuity between personal and occupational roles is shared by all members of the community regardless of profession; most island residents work with or serve each other, providing amenities and services, and interact with each other on a daily basis both personally and professionally. While not always positive, these interactions are what mend and tear the social fabric of island communities. The lack of anonymity might be positive to some, but highly negative to others, particularly those in social service positions where neighbours and friends become clients and share vulnerable information on a regular basis. In the medical context, most peers and relationships emerge after the physician has established a patient load, amplifying the need for physicians to tread carefully in social situations, set boundaries and maintain a level of social neutrality with the knowledge that their skills could be called on by any community member at any time.
Chapter 5
Conclusion

5.0 Interfacing Identities and Problems for Retention: The Physician-Community Member on Haida Gwaii

Using qualitative analysis, this study generated and reinforced basic concepts of physician retention issues found more generally in the current body of literature, particularly querying the community-influenced experiences of physicians in small, close-knit communities. Setting this study in a local, isolated region allowed for the issue to be contextualized, provided more nuanced responses than might be available from national healthcare databases such as the Canadian Community Health Survey or from studies focusing on purely quantitative analysis of stress factors for rural physicians. Within the qualitative framework, health care practitioners and community members who live and work in close proximity in remote geographic settings provide responses to questions that connect the occupational demands of medical practice with the social and cultural factors that influence physicians’ work and personal environments.

Participant responses in this thesis contribute to the body of knowledge within a number of disciplines, including geography, medicine, sociology and anthropology. The goals of this project were to first query the amount of stress that physicians attribute to their social environment, and second, to determine the acuity of the surrounding community in terms of their influence on physician experiences outside of the clinical environment. This research identified multiple layers of connection between physician participants and their community. It revealed that there is no discrete boundary between the two areas of life for a physician, and often, for their family. The interviews allowed for an in-depth analysis of retention challenges on the islands;
within each community and with a view to the symbiotic relationship between island communities and their residents as a cohesive whole. The analysis brought forth major themes that highlight the difficulties physicians face not only in their medical practices, but as highly visible social service providers in a tightly-knit community setting.

Lee et al.’s (2009) three systems may be expanded to include place-based stress factors built-in to account for the pressures of a rural or remoteness on physicians who must negotiate the stresses of personal, occupational and systemic factors in a small community and within the larger health care administrative region. However, the findings also repeatedly demonstrate the vibrant and irreplaceable qualities of life in a small community that enhance and support physicians’ lives not only as health care practitioners but as community members. It is the balance between these two sets of place-based factors that this thesis demonstrates can lead to positive retention outcomes in remote health care delivery areas.

5.1 Limitations

Several limitations were present in the course of planning and carrying out the research process. First, the number of physicians available to interview was small in absolute terms and in relative terms compared with the number of community members interviewed for the project. This was mainly due to the core motivation for this research, the many draws on physician time and resources in an isolated practice setting. Several physicians were away from the island as part of their job-sharing arrangements. While 50 per cent of the practicing physicians ended up contributing to the study, of these, several were only able to complete written questionnaires once they found free time between clinical and personal responsibilities. These questionnaires, while helpful and identical in substance to the in-person as interview script, provided less-detailed, less-
nuanced responses than was possible with the face-to-face exchange between researcher and interview participant.

Also in relation to the physician participant responses, the timeframe of the research process did not allow for a retroactive screening of physicians who had already chosen to leave the islands for practice elsewhere; it would have been very useful to the aims of the study to focus on the differences between so-far successfully retained physicians and those who had not been retained. Finally, a retroactive comparison between the attributes of physicians who had formerly practiced (long-term versus short-term) would enable a strong final conclusion about potential to retain physicians who currently practice on island and who provided largely speculative responses about their location choice intentions in the future.

Limitations within the community participant population are related to the information not included in this examination. First, only community member participants (CMP) in leadership or health care related positions were recruited as initial participants; and due to the use of a snowball sampling technique, these individuals usually referred their peers or other well-known community members as potential research participants. The inclusion of general community participants would allow for a closer examination of the expectations of the public towards physicians, where the current participant cohort is already highly aware of physician-community interactions at a broader social scale, are involved with advocacy to promote community health care and act in relationship with the broader political and health care apparatus; factors that are not the reality for many island health care users.

This thesis was limited in its ability to identify locations and place names when discussing interview data and findings because of the high level of visibility of physicians and community members in general regardless of occupation. Due to the risks associated with identifying occupations, roles or places of residence, participant identities were masked and
identifying information was removed. The responses of physicians, in particular, were more specific and nuanced than is represented in the final text due to the high likelihood that their roles, activities or experiences could be linked to their individual identities. This information may have proven useful for making more detailed comparisons between Queen Charlotte and Masset, physician-community relationships and community dynamics that greatly impact retention differences between island communities but the ethical guarantees made to the participants outweighed these considerations.

Finally, due to ethical considerations and research scope, this study did not target the aboriginal population as research participants. This group would be valuable for understanding many of the cultural considerations and differences between the Haida and non-Haida populations in terms of their service usage, their conceptualization of health and illness which contributes to unique views of “ideal” characteristics of health care providers, and finally, the unique perspectives of what it means to be “distant”, rural, and remote. A future study might take the aboriginal component into consideration in isolation from the other limitations discussed here, to capture an important component of the health care user population tended by physicians in northern British Columbia.

5.2 Practitioner-Community Preparedness and Integration Essential for Long-Term Retention

The main differences in how physicians are viewed by the community versus how physicians view themselves emerged primarily in the community-influence-related responses of both groups. Because physicians and CMPs reported similar characteristics in the “ideal” recruit for long-term retention on the islands and CMPs seemed to be well aware of the medical demands on island practitioners, it was the community-influences on physicians that were more
prominently misunderstood by the community. Physicians reported the lack of boundaries as a major source of pressure. CMPs expressed high levels of physician participation in the community but also voiced concern over negative physician-community interactions and the lack of privacy of physicians, indicating that community and health care leaders must proactively improve the awareness of communities struggling to retain practitioners while preparing physicians for this reality. This begins with communication between physicians, health care recruiters and community leaders at the beginning of the practice location choice process. In combination with rural residency programs and job-sharing arrangements which provide exposure to and respite from rural and remote practice settings, there is potential for improved retention through higher levels of awareness on the part of both physicians and their patient populations. It should be followed by formal and informal “education” of the public as stated by both participant groups to articulate when certain conversations and behaviours are and are not appropriate. Improving the community’s awareness of draws on physicians’ time and energy has the potential to ease interactions, reduce practitioners stress, strengthen physician-patient relationships and allow for integration of physicians. This subsequently has been shown in this thesis and elsewhere in the literature in other settings (Cutchin, 1994; 1997; Thomassen, 2001) to improve the chances of retention and continuity and quality of care on island, while also guarding otherwise-satisfied physicians from over-exposure to social pressures that detract from their experience and lead to a spiral of burnout and self-isolation.

The intersection of physician and community life comes to bear visibly on the currently precarious retention outcomes on Haida Gwaii, reflecting nuanced relationships between health care providers and their patients in communities where individual roles overlap into several “life” areas beyond the formal medical space. These interactions indicate that a need exists for a medical apparatus that is not only culturally and socially responsive to the patient
population, but which acknowledges the immense demands placed on physicians in these places and supports their unique role in the community. Not just passive experiences of place, these resilient interactions are based on relationship, action and personal investment, on the part of both community and physician participants. These values underpin the physician experience, leading not only to the success stories found in this project, but to the willingness of residents and physicians to work together towards improvement of their communities in situations where there seem to be more challenges than successes.
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Appendices
Appendix 1: Physician Participant Letter of Information

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August 5, 2008

Dear Dr. XXXXX,

As a Master of Arts candidate at Queen’s University and a resident of Queen Charlotte I am carrying out research to assess the role of local family physicians in small and/or isolated communities in Northern British Columbia. I would greatly appreciate your involvement in this project as a key informant. The research is being carried out with health care practitioners and community leaders throughout the Islands with interviews taking place from August 5-20, 2008. The results of the interviews will be used for the completion of my Master’s thesis. The main objectives of the study are to:

1. Assess the expectations that community leaders (speaking on behalf of the community at large) have of the physicians working and living in the local community and their evaluation of the kinds of activities they currently see physicians taking part in outside of their formal clinical roles.

2. Assess the roles fulfilled by physicians in the community, according to their own report of work-related duties and informal community activity, carried out away from the health care setting.

3. Determine whether a discrepancy exists between these two groups that would suggest why physician retention in Northern British Columbia has continued to present a significant problem, particularly for small, remote communities.

This information may be shared with the local and regional healthcare and policy communities. It is hoped that the research will contribute to a better understanding of the unique role(s) that physicians play in small communities and present potential solutions to the multidimensional problems of physician retention in remote locations throughout British Columbia and Canada.

The discussion will take approximately one hour of the participant’s time. Neither you nor your organization will be named in any research outputs. This study was approved by the Queen’s University General Research Ethics Board on August 4, 2008.

If interested, please review the attached letter of information and contact me at your earliest convenience to indicate your willingness to participate in this study. My local contact information may be found below.

Thank you very much.

Sincerely Yours,

Catherine Fraser

Queen Charlotte: (250) 559-8730
Appendix 2:
General Letter of Information

You are invited to participate as a key informant in a research project titled: “Determining the Relationship Between Non-Clinical Demands and Physician Shortages on the Queen Charlotte Islands”. The research is being conducted by Catherine Fraser, MA Candidate at the Department of Geography, Queen’s University, Ontario.

The main purpose of this study is to assess the role of the physician in a small community from two perspectives; those of the physicians themselves and those of community leaders with in-depth knowledge of the local community and the unique social environment of the islands.

The research will involve a series of interviews with general practitioners and with community leaders involved in community politics and/or civic organizations. These interviews will explore whether there is a difference between the physicians’ expectations of their role as a health provider in a small community compared to the perceptions and expectations that the community itself has towards local physicians. These questions will help determine whether physicians are prepared for the unique position they hold in small, close-knit and isolated practice settings. The overall goal of the thesis is to determine what pressure (if any) communities place on physicians practicing in the local area.

Interviews are anticipated to be approximately one hour in duration. There are no known physical, psychological, economic or social risks involved with the participation in the research. Participation in the project is completely voluntary and you are free to withdraw at any point. Should you choose to withdraw, the researcher will erase all information which you have contributed to the study. You can choose not to answer any question(s) with which you are not comfortable.

The interviews will be audio-recorded. After transcription, I will send you a printed copy of the interview and you will be free to amend or delete any or all of the comments you made before I begin the analysis of them. All information will be kept confidential by not revealing your real name or any specific information that would allow identification by those familiar with the study area or the local health care community. The interview material will be kept on a password protected computer and destroyed after seven years. There is no remuneration provided for participating in this research.
Your participation is greatly appreciated. Any complaints or queries regarding the nature or manner of research can be forwarded to the following persons/bodies:

Researcher: Catherine E. Fraser  
Ph: 613 533-6000 ex. 75732 (Queen Charlotte: 250-559-8730)  
E-mail: 6cf16@queensu.ca  
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Research Supervisor: Dr. Mark Rosenberg  
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Kingston, Ontario, Canada K7L 3N6.

General Research Ethics Board Chair: Dr. Joan Stevenson  
Ph: 613 533-6288  
Email: chair.GREB@queensu.ca  
Queen’s University, Kingston, Ontario, Canada K7L 3N6
Appendix 3

General Consent Form

Determining the Relationship between Non-Clinical Demands and Physician Shortages on the Queen Charlotte Islands

Participant Name: _______________________________

☐ I have read the Letter of Information and have had all questions regarding it answered to my satisfaction.

☐ I am aware of the aims of this research project titled “Determining the Relationship Between Non-Clinical Demands and Physician Shortages on the Queen Charlotte Islands” and of the nature and extent of my involvement.

☐ I am aware that I can contact the researcher, Catherine Fraser, the research supervisor, Dr. Mark Rosenberg, or the Chair of the General Research Ethics Board regarding any complaints or queries with respect to the research:

Researcher: Catherine E. Fraser
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General Research Ethics Board Chair: Dr. Joan Stevenson
Ph: 613 533-6288 chair.GREB@queensu.ca
Queen’s University, Kingston, Ontario, Canada K7L 3N6

☐ I am aware that my participation is completely voluntary and that I am free to withdraw from the research at any point of time.

☐ I am assured that the researcher shall protect the confidentiality of my identity by not using my name or any other identifying information in the research findings and by keeping the raw data on a password-protected computer.

Name: ________________________________

Date: ________

Signature: ________________________________
Appendix 4:
Sample Interview Questions

Physician Participant:

1. How long have you been in [community]?
2. Can you please tell me how you came to practice on the islands?
3. What factors were involved in your decision to practice in [community]?
4. Was this an assigned posting or did you make an active decision to locate in this area?
5. Was a financial incentive or other benefit involved in your decision to locate here?
6. If actively chosen, why? What factors were involved in the decision?
7. Approximately how long do you plan to stay on the islands?
8. What would be your ideal place to practice or what are the conditions you would consider ideal in making a practice location decision?
9. Has your experience on the islands altered this ideal over time?
10. Can you describe your…(professional role/job description, caseload, number of patients, time spent with patients)?
11. What were your expectations of the job before arriving in [community name/hospital]?
12. What were your expectations of the islands and this community before your arrival?
13. How close have your expectations been to the reality? How have they differed?
14. Has your role here changed from what you expected? If so, how?
15. In what ways do you think your position here different from a similar position in a larger community or city? Do you think your job would be different in a large city and of so, how?
16. Are you involved in any voluntary community organizations or committees that you would consider to be part of your role or identity as a community physician? (other activities might include community building or development, health promotion initiatives, recreation, etc.)
17. If so, would you consider these roles reasonable alongside your formal workload in terms of time and resources required?
18. Do these activities contribute to or detract from your practice or from the time you spend taking care of professional commitments (conferences, reading, upgrading, etc.)?
19. Do these enhance or detract from time spent with family or at leisure?
20. Why do you think it has been difficult for [community] to retain the number of needed physicians?
21. Can you provide any suggestions from your experience as to how organizations and/or communities can better retain health care professionals on the islands or in a similar location?
22. Are there any ways that physicians should specifically prepare for practice in a place like [community]?
Community Member Participant:

1. How long have you lived on the islands?
2. How long have you been involved with your organization and what is your role?
3. Are you or your organization involved at any level of health care or the physician hiring process? If so, how?
4. Have the islands had difficulty retaining the number of needed physicians? If so, why?
5. What, if any, do you think are the responsibilities of the community in accommodating a physician, incorporating them into the community, etc.?
6. Thinking as a citizen, a community leader and patient can you tell me if there is a particular type of person who you think best “fits” the requirements for medical practice on the islands?
7. Aside from hospital and clinical commitments, what do you think are the responsibilities of a physician in an island community?
8. How do you think local physicians are perceived by the communities they work in?
9. Do you think the local community might expect local physicians to be involved with activities outside of the health care setting [hospital/care center/clinic]? (For example, any kind of health related-organization, sports, arts, etc.)
10. Do you think that the nature of the physicians’ work impacts their interactions with the local community or residents positively or negatively? (For example, avoiding certain situations because of concerns over confidentiality/sensitive information/stress etc.)
11. What characteristics of a small town (such as those on the islands) and its residents would you say enable physicians to become integrated into the place?
12. Are there any factors that might deter them from deeper community involvement?
13. Would you say that the physicians here are more or less integrated into the community than the average island resident? Why (and how)?
14. Can you think of any examples of how local physicians have played a role in activities or even taken leadership apart from their professional responsibilities?
15. Do you think the role of a physician in an isolated community involves different responsibilities than would be involved with medical practice in a larger city? (For example, thinking about the characteristics of a larger place, its proximity to other places and the expectations of that kind of population towards their physicians?)
16. Do you think that physicians on the islands experience higher rates of burnout or stress than would physicians in larger centers? Why or why not?
17. Do you think the public (on the islands) is able to engage with policy and hiring decisions in an effective way?
18. What amount of involvement should the community have with administrative decisions and the supply of health care providers?
19. Can you provide any suggestions on how small communities can improve their retention of health care professionals (and perhaps their families) at the community level?
20. Are there any other ways that community engagement or participation could improve the situation of physicians working and living in island communities?
Figure 1

Map 1 – Queen Charlotte Islands/Haida Gwaii
Figure 2
Map 2 – North Coastal British Columbia