

## To stay or not to stay: the role of sense of belonging in the retention of physicians in rural areas

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### ABSTRACT

Rural communities across the circumpolar region and worldwide perennially suffer from physician shortages despite decades of attempting targeted strategies for recruitment. Particularly in rural Canada, financial incentives have attracted but not retained a medical workforce. Although the importance of social connection or belonging is a long-established source of well-being, such information has not infiltrated the dialogue or action on physician retention in rural areas. A physician's sense of belonging, arising from that emotional need for social connectedness, is built via bilateral active efforts at community engagement, reciprocity, social integration of family and workplace collegiality. Links between rural upbringing, rural training opportunities and subsequent rural practice likely rest upon fostering this sense of belonging. Policymakers and recruiters might consider how to help physicians adapt, "fit in", and consider they have "come home" when they venture off to rural settings. Empowering the community to be involved in the recruitment and retention of rural physicians may also be effective. Perhaps this approach would better address the age-old battle to retain physicians in rural Canada and around the world.

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### Text

*If you build it, they will come, but will they stay?*

Across countries, retaining physicians in rural and remote settings is an age-old battle that is yet to be won. Limited access to medical services contributes to poorer health and well-being of rural populations relative to their urban counterparts, especially for Indigenous populations living in rural communities who also face socio-economic disadvantages [1,2]. Rural hospitals perennially suffer from understaffing of physicians.

Across the circumpolar region, the recruitment and retention of rural physicians continues to be a struggle that has met with varying degrees of success. North America (USA and Canada) has lower density of rural physicians than the Nordic countries, whereas Russia reports a paradoxical situation of high physician-population ratios but a chronic physician shortage, especially general practitioners (GPs) in rural areas [3,4]. The largest disparities between "north" and "south" are observed in the Northwest Territories and Nunavut (Canada), and in Greenland [3]. Some countries have introduced educational and financial initiatives to lure GPs to rural areas [5]. For example, in 2012, Russia introduced the "Rural physician" initiative [4]. Other

places, especially the Nordic countries, have tried to fill the shortage by employing foreign-born physicians or itinerant GPs [5–7]. However, this poses a challenge to ensuring continuity of care and culturally competent care, as visiting doctors may have limited knowledge of local conditions, and clinical communication is often filtered through an interpreter, especially for Indigenous populations [3].

Financial incentives have been the standard strategy used to attract physicians to rural areas of Canada, sometimes providing good optics of short-term recruitment but doing little for long-term retention [8]. Further, despite decades of offering rural electives for medical students, rural tracks within medical school and rural residency programmes (often referred to as distributed education), which are evidenced to be effective to some degree, the issue of an underserved rural physician workforce has not abated [9]. Fewer than 10% of physicians (primarily general practitioners) currently serve rural and remote areas of Canada, despite these settings being where more than 20% of the population live [8]. The turn-over of that 10% is high, with many physicians leaving after a few years to seek opportunities in urban centres.

What is it that motivates a rural physician to stay or not to stay? Several theoretical models have been

proposed to explain the retention dilemma. These include the classic “push and pull” model, Cutchin’s model of security, freedom and identity, as well as Goertzen’s “4-legged” kitchen stool model that considers balance in different aspects of the physician’s life [10,11]. Of limited relevance are individual circumstances as outlined in Maslow’s Hierarchy of Needs – physiological needs, safety, freedom and financial/job security [10]. However, Maslow also describes the importance of loving and belonging. “Sense of belonging” refers to the human need for social connectedness [12]. It is what makes an individual feel like an “insider” and can arise from, for example, being greeted by name, having a say in community affairs, being able to participate in local groups and activities and more. A narrative review of circumstances that help develop interest in, recruit and retain rural primary care physicians found that when physicians are integrated into their workplace and community, that is, when they feel “at home”, they are more likely to stay [13]. For a few, rural settings have always been “home” but for most, formation of connections – whether these arise from shared social identities (e.g. race, religion), values or interests – is key. The process of connecting can take time and initiative for both the physician and the community. It is facilitated by a physician’s intentional effort to join with and become part of the community.

Developing a “sense of belonging” requires reciprocity between the physician and the community. Rural medicine is challenging, often pushing physicians to practice beyond their comfort zone and be self-reliant. However, feeling that their hard work and efforts are appreciated by community members provides physicians with strong motivation to stay [1]. This appreciation can take the form of gifts, verbal feedback, public acknowledgement, expressing trust, community support for medical facilities, nominations of physicians for awards and hospitality towards the physician’s family. All reinforce a physician’s sense of having a meaningful community role and of making a difference, in turn fostering a sense of altruism, responsibility, and a commitment to serve the rural area.

Social integration of partner and family augments rural physician retention. Many physicians will value social, recreational and employment opportunities for family as well as quality education and childcare, all of which build that sense of belonging [13]. Partners and children tend to broaden a physician’s social circle as their activities provide opportunities to meet and connect with others. A meta-analysis of qualitative studies from Australia and Canada showed, not surprisingly,

that physicians with families who are content in a rural community are more likely to stay [1].

While rural upbringing or familiarity is often identified as the strongest predictor of rural practice, this also is likely about sense of belonging [7,10]. Community integration and feeling “at home” is more of a given with proximity to family or social ties, familiarity with a region, and comfort with a rural lifestyle [10].

Sense of community extends to the workplace, where the collegiality of colleagues reduces professional and personal isolation. In a positive work environment, rural physicians will share the workload, seek advice from each other, make flexible after-hours coverage arrangements, debrief after difficult situations and make group decisions [1,14]. Strong peer support in a small rural group practice brings friendship, pride and loyalty, all of which motivate retention. Aside from local colleagues, a positive relationship with urban specialists is also vital in reducing professional isolation and nurturing responsibility towards a rural community. These specialists are the ones who receive a rural physician’s referred patients, provide advice by phone during emergencies and extend emotional support to rural physicians in low-resourced centres in times of great stress. Therefore, when an urban specialist has a pleasant demeanour, understands the conditions under which rural physicians work, and respects a rural physician’s clinical and social knowledge about their patients, it facilitates open communication, boosts confidence, and augments a sense of advocacy in rural physicians towards their community and patients [15].

Of note, there is evidence that sense of belonging, both professionally and socially, also motivates medical students, especially those from urban centres, to choose rural practice after experiencing community-based rural placements or integrated clerkships [16]. Concern about the health inequity faced by rural populations, engagement in local activities and appreciation received from the local population will transform a rural placement into an experience of living in and being welcomed by a host community. Preceptor role modelling, mentorship, informal socialisation opportunities with colleagues and the experience of being part of the medical team are further attractions [16].

Financial rewards have not sustained a long-term medical workforce in rural areas around the world. Recruitment of foreign-born doctors and short-term GPs is also not a sustainable solution, with many physicians migrating to urban centres after a few years [7]. Although the importance to one’s satisfaction and well-being of belonging is well known, links between that sense and physician retention in rural areas are relatively unexplored. Nevertheless, there is evidence that individuals who relocate to rural

communities for work but fail to develop social supports feel lonely and isolated, and eventually leave regardless of the financial benefits of staying [17].

Alongside financial incentives and other recruitment strategies, policymakers and recruiters might consider how to help physicians adapt and “fit in” to rural settings. This could include aiding family integration, eliminating barriers to community engagement by promoting work-life balance, showing appreciation for physicians, and nurturing relationships between rural and urban colleagues to reduce professional isolation. This aligns with the World Health Organization’s recommendations for non-financial incentives including professional support and networking, improvements to living conditions and work environments, and public recognition events [2]. However, it is also important to have members of the community involved in issues that affect them [17]. Communities possess the local and historical knowledge to plan a well-tailored intervention [17]. Empowering members of the community to play an active role also fosters a sense of responsibility and commitment to the successful recruitment of health workers and their integration into the community [17]. In a study by Cosgrave et al., some of the strategies formulated by two rural communities included forming a liaison committee involving all stakeholders, developing information packages for prospective physicians, developing a welcome process that helped physicians and their families settle in, addressing the quality and appropriateness of housing, and considering spouses’ education and employment needs [17].

Finally, a personal reflection. We two authors – a medical student and a family physician of more than 40 years – separated by decades, culture and hometown (Toronto, ON versus Iqaluit, NU) find common ground and social connection in our shared values and love of the north. This melting away of apparent differences is just what we see as the key to helping “outsiders” become “insiders” in the rural communities they are drawn to and making those communities “home”. We might then end the age-old battle against a chronic shortage of rural physicians and ensure equitable access to health services for all people regardless of location.

### Contributors statement

Both authors jointly contributed to the conception and design of the work. AM drafted the manuscript, and SPP revised it. Both authors contributed to final edits and agreed to be accountable for all aspects of the work.

### Disclosure statement

No potential conflict of interest was reported by the author(s).

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