

ARTICLE

Understanding recruitment and retention of doctors in rural Scotland: Stakeholder perspectives

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Abstract

Recruitment and retention of medical practitioners is a challenging contemporary policy issue for rural areas. In this paper we explore this issue in the context of doctors in rural and remote Scotland, drawing on findings from a service mapping exercise into the recruitment and retention of doctors in rural areas, conducted by interviewing key stakeholders in the delivery of healthcare in rural and remote Scotland, most of whom combine clinical and organisational responsibilities. The aim of this paper is to understand the key issues, drawing on what the stakeholders see across the day-to-day delivery of their clinical roles and within the varied levels of the organisational structure of Scottish healthcare to which they contribute. Our findings build on a review of key literature of contemporary issues in rural Scotland, healthcare delivery in rural areas and wider international literature on recruitment and retention of medical practitioners. Our findings focus around three key themes: power of place; how people make place; and place and policy. In our conclusion, we argue that the importance of this stakeholder research is three-fold. First, that such insights from stakeholders are important in shaping and preparing for future research on the topic, particularly interviewing those currently working. Second, it adds to and echoes the growing body of literature globally focused on recruitment and retention by expanding on the Scottish context. Finally, it proposes that appropriate and effective rural proofing is important in the implementation of new policies where place-based challenges or differences can emerge.

KEYWORDS

doctors, qualitative, recruitment, retention, rural, Scotland

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1 | INTRODUCTION

Recruitment and retention of medical practitioners is a challenging contemporary policy issue across the world (World Health Organization, 2020, 2021). It particularly impacts remote and rural places, furthering existing health and social inequalities. The nature of place and place-specific differences across continents, countries and even communities means there can be no one-size-fits-all approach. In building on existing global evidence, we draw on research carried out in Scotland that aims to explore the recruitment and retention of primary and secondary care doctors in remote and rural areas, an area of focus also identified by the Scottish Government (2020). Here, we present findings from a service mapping exercise into the recruitment and retention of doctors in rural areas, conducted by interviewing key stakeholders in the delivery of healthcare to rural Scotland, most of whom combine clinical and organisational responsibilities. This service mapping is designed as a launchpad for future research and forms part of an ongoing project investigating recruitment and retention of doctors in rural and remote Scotland. The aim of this paper is to understand the key issues, drawing on what the stakeholders see across the day-to-day delivery of their clinical roles and within the varied levels of the organisational structure of Scottish healthcare to which they contribute.

The paper begins by situating rural Scotland alongside contemporary issues in rural studies, which includes healthcare inequalities. We then present the structure of healthcare delivery in Scotland and how this affects doctors in rural localities. We then review the international literature on recruitment and retention of medical professionals to rural areas, arguing that it has been a key area of research for a number of years but that conceptualising place as a way of understanding the issues is less developed. The methodological approach is then presented, involving an initial scoping review of grey literature to establish key themes, followed by a range of qualitative interviews with key stakeholders in remote and rural areas. We argue that these key stakeholders are well placed to contrast both what they see and experience in their daily professional and personal lives as practicing doctors, with how the various forms of governance and regulation impact rural practice.

We present our findings around three key themes: power of place; how people make place; and place and policy. In our conclusion, we argue that the importance of this stakeholder research is three-fold. First, that such insights from stakeholders are important in shaping and preparing for future research on the topic, particularly interviewing those currently working. Second, it adds to and echoes the growing body of literature globally focused on recruitment and retention, by expanding on the Scottish context. Finally, it proposes that appropriate and effective rural proofing is important in the implementation of new policies where place-based challenges or differences can emerge.

2 | LITERATURE REVIEW

2.1 | Situating rural Scotland

Understanding and defining rurality and associated place-based issues has been at the heart of rural geographical enquiry. It is understood that rurality is a contested concept (Cloke, 2006; Woods, 2011), around the utility of the term 'rural' (Hoggart, 1990). Scholarship has explored how rural can, and does, have diverse place-specific meanings and understandings, as a 'category of thought that each society takes and reconstructs' (Mormont, 1990, pp. 40–41). Within Scotland, rural encompasses a diversity of landscapes and communities, from lowland regions around the Central Belt, the highland mountains of the Cairngorms to the far reaches of the Outer Hebrides islands (Figure 1).

The Scottish Government (2018) defines rurality in Scotland as areas with a population of fewer than 3000 people. The level of rurality is then measured in relation to drive times to urban areas, designated as those with more than 10,000 people. Combining both these measures gives an eight-fold classification system of urban and rural areas within Scotland (Figure 2).

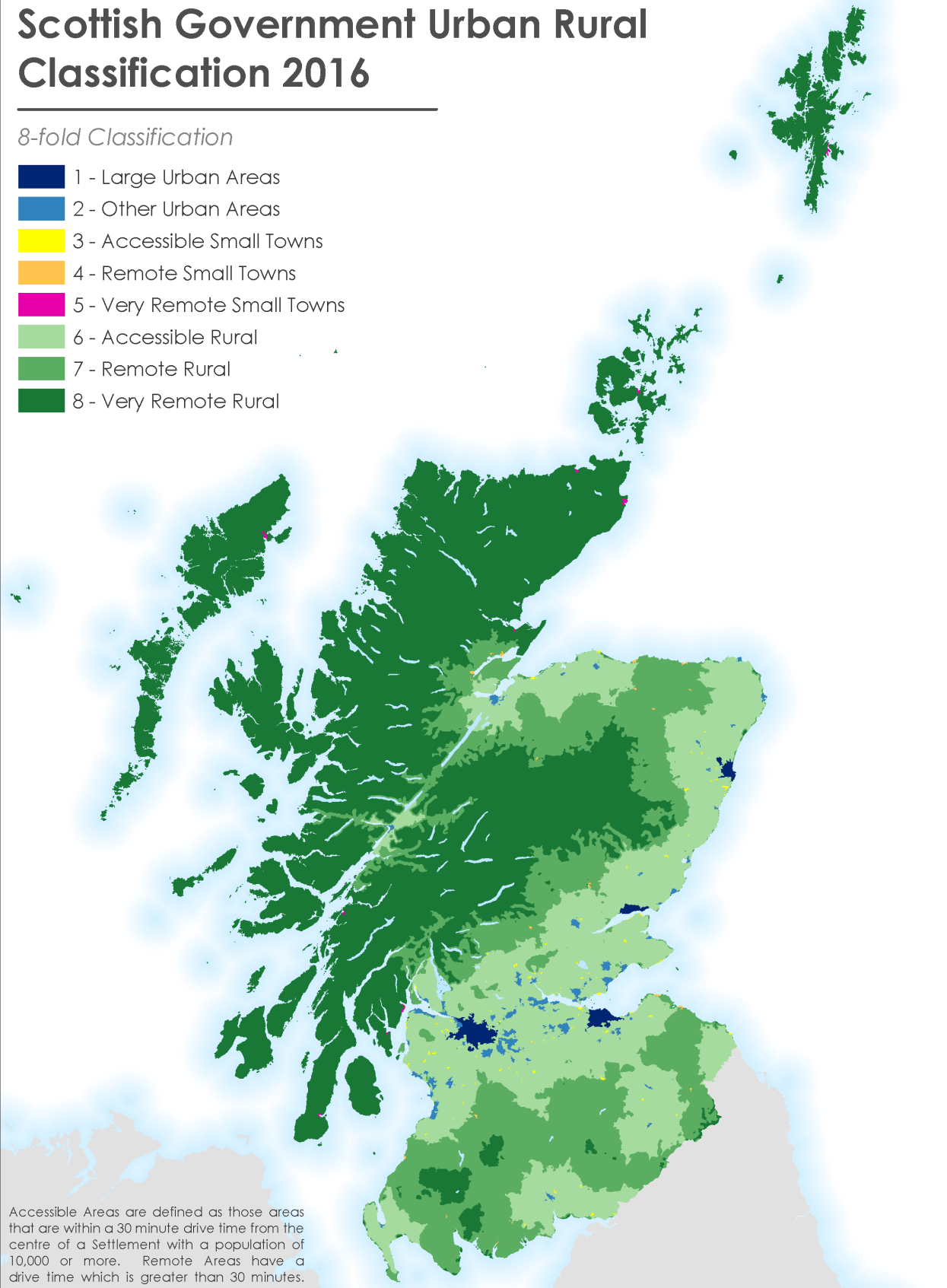
Figure 1 shows how the landmass of Scotland fits within this classification, visually supporting the fact that 98% of the landmass of Scotland is classed as rural (The Scottish Government, 2021b).

Rural research focuses on not just functional characteristics but 'the study of the processes through which rurality is produced, reproduced, and contested, and of the places and practices that are associated with "rural" ways of being' (Woods, 2009, p. 429). Rural research both globally and in the context of Scotland has burgeoned along lines of contemporary investigation as follows: migration (Ni Laoire & Stockdale, 2016), including in-migration of retirement and pre-retirement aged people (Philip & MacLeod, 2018) and out-migration of younger people for education reasons (Pedersen & Gram, 2018); ageing in rural areas (Scharf et al., 2016), particularly in Scotland (Maclaren, 2018); housing, including

Scottish Government Urban Rural Classification 2016

8-fold Classification

- 1 - Large Urban Areas
- 2 - Other Urban Areas
- 3 - Accessible Small Towns
- 4 - Remote Small Towns
- 5 - Very Remote Small Towns
- 6 - Accessible Rural
- 7 - Remote Rural
- 8 - Very Remote Rural



Accessible Areas are defined as those areas that are within a 30 minute drive time from the centre of a Settlement with a population of 10,000 or more. Remote Areas have a drive time which is greater than 30 minutes.

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Scottish Government
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FIGURE 1 Scottish Government eight-fold Urban Rural Classification 2016 (The Scottish Government, 2018)

Class	Class Name	Description
1	Large Urban Areas	Settlements of 125,000 people and over.
2	Other Urban Areas	Settlements of 10,000 to 124,999 people.
3	Accessible Small Towns	Settlements of 3,000 to 9,999 people, and within a 30 minute drive time of a Settlement of 10,000 or more.
4	Remote Small Towns	Settlements of 3,000 to 9,999 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more.
5	Very Remote Small Towns	Settlements of 3,000 to 9,999 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.
6	Accessible Rural Areas	Areas with a population of less than 3,000 people, and within a drive time of 30 minutes to a Settlement of 10,000 or more.
7	Remote Rural Areas	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more.
8	Very Remote Rural Areas	Areas with a population of less than 3,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.

FIGURE 2 Scottish Government eight-fold Urban Rural Classification. *Source:* The Scottish Government (2018, p. 5)

access to affordable housing (Dunning et al., 2020); and also healthcare and associated inequalities (International Labour Office, 2015). All these areas of focus are important issues in rural Scotland (Nimegeer et al., 2011; The Scottish Government, 2021b) and present areas where the experience of rural life can differ from that of more populated areas. This study focuses on one such difference, the crisis in recruitment and retention of primary and secondary care doctors in rural areas.

2.2 | Contemporary healthcare in Scotland

Primary care in Scotland is generally the first point of contact with the National Health Service (NHS)¹ and includes contact with family doctors/general practitioners (GPs), community nurses, dentists, opticians, pharmacists, occupational therapists, physiotherapists, and midwives (The Scottish Government, 2021a). Secondary care is primarily hospital-based healthcare provision, including emergency care services, outpatient/ambulatory services and inpatient treatment for health problems. Access to secondary care services is generally controlled by GPs. Tertiary care refers to specialist healthcare services that require higher levels of specialism in their delivery, generally located in regional centres in larger cities associated with medical schools. Since 2016, health and social care services have become increasingly integrated in Scotland (The Scottish Government, 2019).

Doctors, along with allied health professionals, are involved in primary, secondary and tertiary care delivery. In Scotland, the public organisation under which healthcare is delivered is NHS Scotland. Almost all secondary care doctors are employed directly by the NHS and some GPs may also be in salaried posts working directly for the NHS. However, most GPs, along with community pharmacists, optometrists and dentists, are independent contractors providing services to the NHS according to nationally agreed contractual agreements.

In Scotland there are 14 territorial (regional) health boards (Figure 3) alongside seven Special NHS Boards providing services on a national basis and one public health body. Regional boards are responsible for 'the protection and the improvement of their population's health and for the delivery of frontline healthcare services' (The Scottish Government, 2021a, p. 1) whilst the Special Boards and Public Health Scotland 'support the regional NHS Boards by providing a range of important specialist and national services' (The Scottish Government, 2021a).

As of January 2021, there were 922 general practices in Scotland with 5240 doctors (Information Services Division Scotland, 2021). General practices in Scotland are either run by the territorial NHS Health Board or, more commonly, run as a partnership where the practice has a contract with the NHS for the provision of healthcare services. Practices can range from city partnerships with practice populations of over 20,000 and up to 30 supporting GPs (and some even larger consortia), to small rural practices with only a few hundred patients and one or two GPs. Table 1 shows the spread of GPs across urban and rural Scotland.

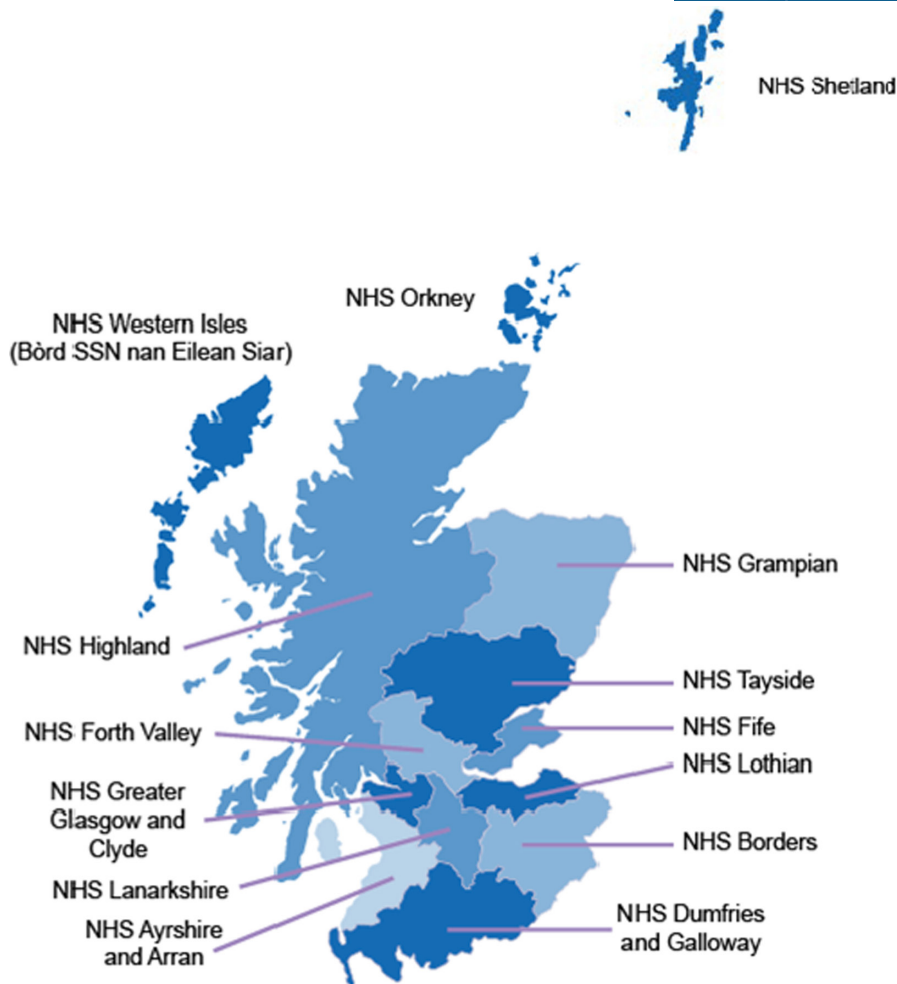


FIGURE 3 Territorial Health Boards, Scotland (adapted from Robson, 2016, p. 11)

TABLE 1 Scotland’s GPs, practices and practice populations by three-fold definition of rurality

	Three-fold	Number of practices	Practice population	Number of GPs
Rest of Scotland	1	742	5,232,132	4556
Accessible rural	2	71	313,919	304
Remote rural	3	109	229,221	380
Total		922	5,775,272	5240

Source: author (data source: Information Services Division Scotland, 2021).

Secondary care within rural areas is concentrated across six rural general hospitals,² which provide general surgical services and general medical services (The Scottish Government, 2008), and a larger number of community hospitals, usually run by GPs, which are smaller facilities providing varying levels of services depending on the location. A number of secondary care specialists travel out of their base hospital to support more remote and rural hospitals: for example, an oncologist based in a large urban teaching hospital might travel to a rural general hospital every month to follow up patients with cancer who live nearby.

Our research focuses on both primary and secondary care and the doctors delivering those services. The accessibility of primary and secondary care services for people living in rural areas is varied. Part of this issue comes down to staffing challenges in rural areas (World Health Organisation, 2020) and the associated recruitment and retention problems that compound and exacerbate other inequalities (Fecht et al., 2017; Jones et al., 2019). In Scotland, there is a ‘crisis’ in recruitment of doctors and in particular GPs (British Medical Association Scotland, 2016; Peterkin, 2019a, 2019b; Royal College of General Practitioners, 2016; The Scottish Government, 2020). Significant pressures have increased since the turn of the

century (Christie, 2001) with increasing intensity and complexity in GP workload amidst an ageing population and increasing difficulty in recruiting and retaining staff in the profession (Royal College of General Practitioners, 2016). From a UK-wide perspective, there has been a steady decline in the proportion of junior doctors aspiring to become GPs, falling from 77% in 2005 to 36% in 2015 (Lambert et al., 2017). Resource allocation to general practice is likely to have contributed to the recruitment crisis: within Scotland, the allocation of overall NHS resources to general practice fell between 2008 and 2018 from 9.8% to 7.75% (Royal College of General Practitioners, 2019). Furthermore, rural general practice was selectively disadvantaged by the 2018 Scottish GP contract which allocated substantial new resources to urban GPs while little or no additional funding was received by rural practices (Rural GP Association of Scotland, 2018). The most recent Primary Care Workforce Survey (Information Services Division Scotland, 2018) states that vacancy rates for GPs in the Western Isles and Shetland were the highest in the country (15.0% and 32.9% respectively), and the highest vacancy rates for consultants were generally in health boards with a more rural profile.

2.3 | Recruitment and retention

Understanding the recruitment and retention landscape for medical professions in rural places has been a burgeoning research area for at least the last 20 years (Strasser & Strasser, 2020; World Health Organisation, 2020, 2021) with research exploring various key features and challenges of recruiting rural medical staff (McGrail et al., 2017b; O'Toole et al., 2010; Verma et al., 2016; Wilson et al., 2009). This is alongside a wider call for consideration of the specific geographies of healthcare work itself (Andrews & Evans, 2008; Andrews et al., 2021; Connell & Walton-Roberts, 2015). Much of this work has been geographically focused, particularly in Australia, the United States, Canada, Japan, and New Zealand.

Place is not a new lens for research engaged within geography or health research more broadly (Andrews, 2019; Cummins et al., 2007; Kearns, 1993; Parr, 2002, 2004). Cutchin (1997) first noted the importance of place as a useful perspective in understanding challenges and solutions in doctor retention in rural communities, and more recent research in this area continues to draw on place (Malatzky et al., 2020). Our research takes forward the importance of a relational and holistic approach to the recruitment and retention challenge, where our argument is to appreciate the diversity of rural Scotland as 'informed by a myriad of highly interactive dimensions within personal, organisational, social and spatial domains' (Malatzky et al., 2020, p. 1; see also: Cutchin, 1997; Cutchin et al., 1994; Hanlon & Kearns, 2016; Kearns et al., 2006).³ We do this as part of a wider research project, by engaging with stakeholder views to present key findings that inform on the recruitment and retention landscape in rural Scotland for primary and secondary care doctors. We argue this is important for setting the scene of a recruitment and retention geography of Scotland's rural doctors, and second, it sets the groundwork for future development in this field to begin to effectively design and conduct research with doctors to engage with their own experiences, and perceptions of working rurally. Finally, our research provides further evidence for other parts of the UK, and across the world, with other perspectives to compare their own physical and social rural landscapes as well as wider political structures that all influence rural places.

3 | METHODS

The initial plan for this research was to adopt an ethnographic methodology with immersion in rural communities, in addition to interviews with a range of practicing doctors. However, the COVID-19 pandemic, and the associated restriction in movements, necessitated a methodological change to in-depth interviews via video call or telephone, following interrogation of grey literature and service data sources online. Interviewees were sought by purposively approaching people with appropriate roles and responsibilities in rural health care delivery, including both primary and secondary care, who worked in key places that could offer a breadth of perspectives on rural Scotland (e.g., island communities, remote rural, accessible rural, peninsula coastal and inland), and with a wide-ranging viewpoint from their additional positions beyond their professional practice, such as clinical or cluster (groupings of local practices) leads or various NHS board committee positions or medical professional body positions.

The sample comprised 10 senior doctors, six based in NHS Highland, and one from each of NHS Lothian, Orkney, Shetland, and Western Isles. These informants were chosen as they all had experience working across the range of locations across their careers, were involved in local medical committees, as well as holding senior leadership positions representing doctors across Scotland. The geographical variation strengthened the transferability of the findings. Whilst

10 interviews may seem a relatively small sample, in the context of remote areas with low population and few health services it represents a broad and information-rich sample.

Interviews were semi-structured with broad thematic topics for discussion developed from a review of existing related academic and grey literature research. Interviews were conducted as a discussion where the interview 'unfolds in a conversational manner offering participants the chance to explore issues they feel important' (Longhurst, 2010, p. 103). This was particularly important owing to the place-based nature of informant perspectives from across Scotland.

The interviews were transcribed verbatim, reviewed and then iteratively coded to identify key themes, supported by NVivo software. The framework for coding was developed both inductively and deductively. Analysis was initially structured around key themes from the literature (such as community, professional and personal support networks, the family unit), as these had been used to shape initial interview questions. Additional themes were developed from reading the transcripts and were added to the coding list (such as the importance of place and the impact of policy). This practice was iterative, through multiple readings and reflection with the materials and discussions with colleagues in order to analyse the data effectively and rigorously. As analysis progressed, we focused increasingly on the intersections between place, person, and profession, and how constellations of these factors play out in different contexts and different lives.

4 | POWER OF PLACE

Place forms an integral part of geographical enquiry (Cresswell, 2004) and indeed as a concept of use has grown amongst wider social sciences (Convery et al., 2012) and has become more important in health-related research (Kearns et al., 2006; Malatzky et al., 2020; Pierce, 2017) against a backdrop of health geographies (Andrews, 2019; Parr, 2002). Place as a concept then is what makes space meaningful, what brings it to life, what makes one space different from another. This difference of spaces has both been of use but also a challenge to those considering rural spaces. Whilst a country such as Scotland may define a high percentage of land as 'rural' space for example (see Figure 1), the differences all these spaces have are what makes them unique to those who live there, who visit or indeed migrate to a rural place.

As a concept, place mattered to those interviewed in the service mapping as a factor within their profession. It mattered in how they perceived their place to be in comparison to other rural places in Scotland, as Olivia⁴ described:

A lot of doctors prefer the centralisation and being near the bigger centres where you have access to more facilities and more support and more backup than they have in more remote areas, and I think there are a group of doctors who like places like the Western Isles or very, very remote, but we're not ... we don't offer that type of all-round expectation, we're sort of in the middle. So you're somewhat quite remote but you're not quite the all singing, all dancing you know: you do it all and you do all your own chest drains and saving lives in an island with only you and the sheep to help, so we're not quite at that level.

Or as Keith succinctly put it: 'It's not sexy enough to be an island'.

How a rural place is both experienced, but also perceived (a geographical imagination) is important to how well a place can recruit and retain staff. The challenge for recruitment is often to get people to physically experience a rural place both professionally and socially. Indeed, research from across the world has shown those who have experienced rural places, either through upbringing (Dowell et al., 2015) or education (O'Sullivan et al., 2018), are more likely to work in rural practice in later life (Holloway et al., 2020). This has led to changes in medical education (Hays, 2017; O'Sullivan et al., 2018) through the inclusion of rural placements, work that has been demonstrated in Scotland (Cleland et al., 2012; Wilson & Cleland, 2008).

This fitted with the responses during interviews where the theme of training emerged, with interviewees such as James discussing how the 'grow your own' philosophy, by training medical students (undergraduate placements or elective attachments) or having them for postgraduate training, was important as many of these people would come back and be a partner in a practice, or work in a hospital, as Sheena said:

I strongly believe that I should continue to be involved in teaching and giving young GPs and medical students and people—junior doctors as well coming up for taster weeks, I think we should be supporting these people to get a good experience of what general practice can be like in a rural area.

Indeed, such experiences can radically alter people's perceptions of a place, as Olivia noted about one trainee GP they had:

We had an ST1⁵ a few years ago, probably ten years ago, who ... it might not have been quite as long ago as that, but eight to ten years ago, who was placed here and he was so upset at being put somewhere so out... he thought it was the end of the earth up here, but he then came back as a partner. I mean he didn't want to leave once the ST1 six months was over, he didn't want to leave.

Professionally, then, the stakeholders outlined that rural practice can be extremely rewarding. However, if doctors do not get the opportunity to experience a rural or remote professional environment in their training, then the positive association with place is not created.

In addition to the importance of doctors experiencing rural spaces through their training, throughout the interviews another key theme that emerged was how 'people make places'. Interviewees cited two areas of importance when considering place: its effect on personal lives and its effect on professional networks.

5 | HOW PEOPLE MAKE PLACE

5.1 | Personal lives

When considering where to practice medicine, it is not just the experience or wish of the individual doctor that is a factor, but how a place may affect their partner and family:

Well one of our ... not our trainee coming in February but the one coming a year in February, he came up here ... he was actually working down in [a city] and he's from [the south of England] ..., he was working in [a city], came up here with his wife to do a locum [here] and she refused to leave! ... Absolutely loved it, so he's now bought a house up here, doing his GP training and he's going to stay up here. (Olivia)

Spousal preferences as well as personal preferences are thus important considerations in order to enhance recruitment and retention. These are key themes to be explored around why a place is attractive to someone and considered a preferred location (or not). This reflects the literature where family preferences, experiences and perceptions of moving to and staying in a rural community are important to a doctor's final decision on whether to move to a rural place, and indeed choose to stay (Cameron et al., 2012; Cutchin et al., 1994; Daniels et al., 2007; Hays et al., 2003; Holloway et al., 2020; Kazanjian & Pagliccia, 1996; Matsumoto et al., 2005; Mayo & Mathews, 2006; McGrail et al., 2017a; Myroniuk et al., 2016; World Health Organisation, 2020, 2021).

Partner job and family situation were extremely important in the context of what our respondents mentioned. Gillian discussed a colleague's job advertisements:

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

Bound up in such discussions of family life is the notion that doctors in rural areas are extremely valued, and part of the pressure of being a rural doctor, particularly in general practice, is how related and embedded in a community a doctor can become. Research in Scotland has shown how important professionals are to communities' sustainability by being linchpins

in networks whilst also contributing beyond simply medical and social services (Farmer & Kilpatrick, 2009; Farmer et al., 2003). This came across in the key stakeholder interviews, highlighting that doctors in rural areas often have to be advocates for their communities:

All the way through your career, you're always fighting to represent your community, your practice, your patients. I've got a word in my head that I can't quite grasp—advocacy, yes. You're an advocate for your community. I think that's quite a job, that's quite a responsibility. I'm beginning to feel, you know, 'Why am I fighting to do this when I'm perhaps going to be retiring in a couple of years?' And if I really want to keep working, I want to stick to stuff that I enjoy, I want to keep the joy in the work that I do, and if it starts to become a real drag, having to fight to do my job the way I want to do it, do I really want to keep going? I think that is part of the recruitment challenge. That's the retention challenge, really, isn't it? Just thinking, 'Do you know, I could really just jack this in tomorrow. I'm fed up with it being a struggle'. (Sheena)

Understanding why doctors leave rural areas, as well as why they stay, will be important to reflect on as workload and burn out are common themes in the literature. However, understanding that narrative in the context of place and how it may have changed or evolved over time to contribute to someone staying or leaving has wider potential to contribute to contemporary understandings of migration in rural studies amongst professionals (Halfacree & Rivera, 2012; Stockdale & Haartsen, 2018). This level of advocacy faced with an increasingly challenging recruitment and retention environment does ultimately put pressure on GPs and their own values both professionally and personally, as Sheena stresses above.

5.2 | Professional networks

Holloway et al. (2020, p. 3), in their recent systematic review of recruitment and retention, highlight the importance of not only the needs of family and personal support but also 'professional support' as a 'major driver' of recruitment and retention of rural doctors. The literature, they note, covers issues such as capacity to access training and (lack of) ability to take leave. Whilst similar themes resonated in our own key stakeholder interviews, just as important was the nature of networks and support, and what these meant for people's capacity to continue and deliver within their role:

I believe that Scotland is sufficiently small that ... and we have got really good clinical networks, so for example, the primary care leads which are the associate medical director with GP leads or ... and the primary care managers, we meet every two months for a day. The relationships that we have are very, very strong. So it's that kind of relationship where you can say the stupid thing, you can be upset, you can do whatever you need to be because you're amongst colleagues who will support you and they're friends as well as colleagues, so that's very, very powerful. (Edward)

Whilst networks exist, they can often require proactive people to maintain and cultivate:

Our practice manager, she's very, very keen to support the other practice managers across the county, she arranges get togethers, she arranges just catch up meetings but obviously over Teams now, but she's also very, very proactive. (Olivia)

Being a kind of young, enthusiastic GP, I set about trying to build relationships with people and did that with an education perspective. I reinvigorated the medical society meetings that had died a death years and years ago, and really that's ... I suppose that's why I'm now doing quite a lot of the roles that I am locally, because I have successfully developed good working relationships with all of my colleagues here ... And then taking that into a clinical lead role, trying to develop relationships with the health board and the local managers. But again, this comes back to recruitment and retention of staff because, in the time, even in the time that I've been here, I can think of five local area managers that we've had. Some of them have been utterly atrocious at being supported to develop relationships with the GPs, and I've tried my best to support them to take that approach, which they have been keen on, but the culture that we're trying to work in is broken and really didn't support that. (Gillian)

The value of networks then was both in the professional benefit from a practice and education perspective, but also more informally through feeling appreciated and being able to talk openly and honestly (Galbraith et al., 2020; Rogers et al., 2014). The value of networks and relationships is less then about what the original intention may have been, but rather the wider benefits of contact, support and camaraderie, even more so in an increasingly digitised communication world where meetings and work are conducted online.

The value of networks, relationships and collaboration has sparked some regional attempts at solutions to the recruitment crisis for general practitioners. ‘Rediscover the Joy of General Practice’, also known as ‘the Joy’ (Scott, 2019; Scottish Rural Medicine Collaborative, 2019; Scottish Rural Medicine Collaborative & NHS Highland, 2020) was frequently cited either as a success story or known to be one by those interviewed. The Joy was designed to address recruitment challenges experienced across NHS Highland, NHS Orkney, NHS Shetland, and NHS Western Isles, particularly in rural areas. It aimed ‘to support primary care in the Highlands and Islands, providing GP cover for practices, using flexible GP work placements, to places where the continuity of care has been difficult to achieve due to a shortage of available GPs’ (Scottish Rural Medicine Collaborative & NHS Highland, 2020, p. 1). It was particularly targeted at older GPs looking for time-limited and flexible generalist work. A key contributor to the success of the Joy was the emphasis placed on the importance of networks as an underpinning philosophy of this collaborative recruitment endeavour, in order to ‘create a sense of team and support through recruitment, regular VC & WhatsApp contact’.

6 | PLACE AND POLICY

The final theme from our stakeholder interviews was related to the impact of policy. Of particular note was the effect policies can have on rural areas, if rurality is not considered in the future. Rural areas were seen to develop their own place-based ways and, although commonalities can exist, the stakeholders emphasised the sentiments from a recent Scottish Government (2020) report that highlighted that ‘there is no “one-size-fits all” approach to implementation’ of policies (see also: ESPON, 2020). Indeed, as Sheena highlighted, ‘in rural areas, I think each [GP] practice tends to develop in its own particular way’. One key issue that has affected primary, but indirectly secondary care, in rural areas has been the new GP contract (The Scottish Government, 2017). Indeed, those involved directly with primary care each noted that the new contract had issues:

The new GP contract has been a bit of a destabilising influence on rural general practice and at the same time as having to run our rural practices in a GP-poor environment. (Sheena)

The 2018 Scottish GP contract (The Scottish Government, 2017), which aimed to decrease GP workload through the development of multidisciplinary team working and which allocated additional funding to practices with certain socio-demographic disadvantages, is an example of the need for and importance of rural-proofing policy (Shortall, 2008). Understanding a recruitment and retention landscape requires a relational understanding of place and the people who live there, as structural decisions can have tangible effects on the ground that manifest differently across different locations. The new GP contract was one such example our key stakeholders recounted here. The contract was met with active petitioning (Murphy et al., 2018) and lobbying against by those engaged with rural areas on the grounds that the new model for funding that would financially disadvantage rural general practice because substantial new investment was made almost exclusively to urban areas. As Edward outlines:

Why rural GPs were so upset by the new GP contract is they felt it didn’t value or understand what the work was that they do. So, I think for a policy point of view there has to be an understanding of what the extended role of rural general practice is, so it comes back to defining the core activity. But it’s about understanding what the activity is, why is rural general practice different, why is it about quality and not quantity?

Understanding what rural GPs actually do in their everyday lives is important when considering policy implications. This was particularly key when thinking about primary and secondary care beyond normal working hours, as the activities undertaken by urban based doctors and rural doctors can differ, as Rebecca notes:

I think the thing I find myself saying the most in meetings is one doesn’t equal one, which drives people bonkers, but we had a guy from [an accountancy firm] assigned to us to manage our [Out of Hours] redesign

last year ... so [accountant] from [their firm] would just say all the time, 'Sorry, the data does not support that. You've only got X number of cases or X number of whatever's happening, I've looked at the data', and I would be like, 'But what does that even mean, because you're telling me I've only had X ... five contacts', I said, 'But it could be five 20 second phone calls, it could be five 40-mile drives, one hour visits, a phone call, it could be a phone call then an appointment then an admission', I said, 'So one doesn't equal one'.

The key differences in delivering urban and rural care need to be taken into account in any policy consideration for national healthcare delivery:

Who is saying, 'Okay, can we make sure this document [Workforce Strategy for NHS Scotland] is rural proofed? Have we gone through it and said is this going to work in ...' even rural [East Lothian] as a starting point, but much more so is it going to work in Kinlochbervie, in the Outer Hebrides, on Arran, on Islay, in Dornoch and up in Wick? ... if we really want to make policy for anything work it has, we have to have a commitment to rural proofing, and yeah, okay, I'll sound like a stuck record at some point, but that's one of the messages that I still think that the Scottish government has not listened to. (George)

This concept of 'rural proofing' policy initiatives was a key frustration of the stakeholders.

7 | DISCUSSION AND CONCLUSION

This paper reports a study exploring contemporary issues around the recruitment and retention of doctors in primary and secondary care in remote and rural Scotland. The key findings of this paper centre around place and how place is central to people's experiences of rural medical practice. This paper presents three themes: power of place, how people make place and the importance of place within policy. First, the power of rural places in relation to recruitment and retention is in their perceived differences, both between rural places and in contrast to urban areas. The interviewed stakeholders repeatedly highlighted the importance of potential recruits to rural practice being able to experience rural places. Perceptions that individuals may have of rural places may be of the extremes, the remote islands, the remote highland communities, whereas Scottish rurality in its entirety is diverse and presents a diversity of experiences.

The second theme is how place affects the individual and how people make places, both personally and professionally. The study informants highlighted the importance of family within the decision-making process and the potential effects on partners and children of rural living. This supports the international literature, although is under-explored, and should be a prompt to further explore it within the Scottish context. The literature also presents issues with access to training and professional support as a factor in rural recruitment and retention. The study informants highlighted this but also discussed several positive examples where professional networks have been created and successfully maintained. Such networks do require constant maintenance and proactive individuals to continue providing the camaraderie and support that doctors are looking for.

The third theme considers the relationship between place and policy. The new GP contract within Scotland was offered as an example of the need to rural proof any policy interventions. A lack of understanding of the realities of rural medical practice by those designing and then seeking to implement a nationwide policy change has created an environment of frustration. Centralising services that allow for continuity of care in diverse rural and remote areas, remove both the capacity for doctors to enjoy their practice and deliver holistic continuity of care to their populations, whilst also removing work from surgeries in particular and thus reducing their financial viability. Place should matter to policy and central, national approaches to healthcare delivery are not in the best interests of remote and rural communities.

This study provides initial empirical data from a Scottish context of how place affects recruitment and retention of doctors in rural areas. This advances the discussion of place in recent literature focused on health workforce (Malatzky et al., 2020), continues the interest and importance in the places of work (Andrews & Evans, 2008; Andrews et al., 2021) and identifies key themes for further exploration within rural health research around place, offering the potential to advance the 'more progressive, transformative agenda in the field' that Malatzky et al. (2020, p. 2) imagine. The insights in this paper are important to consider in shaping further research and present a useful structure around which to design and then conduct interviews with a wider pool of doctors, from those currently working in rural practice, to those who have considered but decided against such a move. Such findings could give a picture qualitatively, of how doctors see working in rural Scotland, and could also provide the basis for research into

the decisionmaking process of those considering rural working, by prioritising the trade-offs that are part of such a decision. Such mixed methods data will be useful from a policy level in future planning for recruitment and retention interventions. One of the key findings from this research is the importance of place-based considerations in policy design in healthcare and future research should aim to support place-based interventions. The work underscores the importance of policy grounded in regional whole-system data, with the ability to be agile and inclusive of local contexts.

The well known and researched challenges rural areas face are clear to see here: connectivity, isolation, accessibility. These challenges are not exclusive to Scotland, but rural areas as a whole (World Health Organisation, 2021). Engaging with key stakeholders on healthcare recruitment and retention has shown that key themes can emerge from diverse rural experiences, but place and indeed specific rural places still matter. They are still unique in their own way, by the complex networks of people and politics that are thrown together. As Murdoch (2003, p. 274) noted 'there is no single vantage point from which the whole panoply of rural or countryside relations can be seen'. The relational entanglements of one aspect of a rural community, in this case around healthcare recruitment and retention of doctors, are clear to see and their link to wider rural challenges in Scotland whether housing, migration, education, services access or distance. So as Woods has argued:

The enduring significance of the rural therefore lies in its relationality. The rural is not a pre-determined and discrete geographical territory, and neither is it a fantasy of the imagination. Rather, viewed from a relational perspective, the rural comprises millions of dynamic meeting-points, where different networks, and flows and processes are knotted together in unique ways. These configurations are enacted through the everyday lives of rural people (and, indeed, the lives of non-human rural residents), and they are given meaning by the application of particular ideas of rurality. (Woods, 2011, p. 291)

The challenge for research into rural healthcare provision then is how can policy be made relational and how can place be made to matter at a policy level.

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DATA AVAILABILITY STATEMENT

Authors elect to not share data owing to sharing data potentially compromising privacy of human data, ethical standards or legal requirements. We have committed ethically to maintaining interviewee confidentiality.

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ENDNOTES

- ¹ Use of the NHS in Scotland is free at the point of use, including prescriptions, with only some costs associated with use of optometry or dentistry.
- ² The six rural general hospitals are: Balfour Hospital, Orkney; Belford Hospital, Fort William; Caithness General Hospital, Wick; Gilbert Bain Hospital, Shetland; Western Isles Hospital, Lewis; Lorn and Islands Hospital, Oban.
- ³ The literature we present here primarily engages with work focused on doctors, but there is wider recruitment and retention literature on medical professionals beyond solely doctors which is also an important part of the wider rural recruitment and retention story but beyond the limits of this paper (see, e.g., England, 2015; MacKay et al., 2021; Moran et al., 2020).

⁴ Any names that appear are pseudonyms to maintain anonymity in line with normal practices of ethical research.

⁵ First year of specialist training.

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