

New Partner Recruitment to Rural Versus Urban Ob-Gyn Practices: A Survey of Practicing Ob-Gyns

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Abstract

Purpose: The purpose of this pilot study was to investigate the recruitment efforts of practicing obstetrics and gynecology (ob-gyns) from rural and urban practices.

Method: The authors surveyed practicing ob-gyns from 5 states in the Pacific Northwest in 2016 about their background, practice setting, practice profile, partner recruitment, and retention.

Results: Seventy-three patients completed the study (53.2% response rate). Thirty-seven percent of respondents work in an urban practice and 43% have a rural practice, with the remainder in a suburban setting. A majority of the respondents attempted to recruit a new partner in the past 5 years. Respondents were most interested in experience and diversity in new recruits. Urban respondents, however, were more interested in hiring those with specialized skills ($\chi^2 = 7.842, P = .02$) than rural providers who were more interested in partners familiar with their community ($\chi^2 = 7.153, P = .03$). Reasons most often cited to leave their practice were reimbursement, limited social/marital options, and workload, other than rural providers who more often also cited lack of access to specialty care ($\chi^2 = 13.256, P = .001$). Rural providers were more likely to cite marital and family status as an advantage to recruitment, whereas urban and suburban providers were more often neutral.

Conclusions: Reduced access to care has led to significant health disparities for women living in rural communities. Understanding which providers are most likely to be successful in these settings might help preserve access as our health-care systems evolves.

Keywords

rural health, practice management, community health, access to care, primary care

Introduction

Significant health disparities exist among various US populations, with rural Americans, in particular, more likely to have reduced access to care leading to higher rates of smoking, higher death rates due to cancer, and lower rates of breast cancer screening.¹⁻⁴ Contributing to rural health disparities is the difficulty recruiting and retaining health-care professionals in these settings.⁵ Many factors influence practice choice, but thus far medical professionals appear to work in rural areas due to preference for a smaller community, return to one's hometown, or because they participated in a rural training program.⁶⁻⁸

The American College of Obstetricians and Gynecologists has acknowledged the significant health disparities for women living in rural communities due to reduced access to care.^{2,5} As obstetrics and gynecology (ob-gyn) has been steadily changing to a predominantly female workforce, it is unclear

how this shift has impacted recruitment and retention to rural practices.⁹ The purpose of this pilot study was to compare the perceptions of a specific subset of practicing ob-gyns from rural and urban practices in their efforts and opinions on recruitment and retention of new partners.

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Methods

Sample and Study Design

The sample used for this study consisted of practicing University of Washington School of Medicine (UWSOM) ob-gyns courtesy faculty in the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) region.

A letter introducing the study was sent to 155 individuals with a subsequent online questionnaire consisting of 30 questions (see online appendix). For those who did not respond after 3 e-mail reminders, a paper survey with a postage-paid envelope was sent.

Data Analysis

Statistical analysis was performed using IBM SPSS Statistics 24.0 (IBM Corp, Armonk, New York). For the purposes of data analysis, the responses “minor barrier” and “major barrier” were combined and considered to be a barrier, while the responses “minor advantage” and “major advantage” were combined and considered to be an advantage. In addition, the variable for practice location was condensed from 6 categories to 4: “urban, inner city” and “urban, non-inner city” were combined into “urban,” while “mid-sized town” and “rural” were combined into “rural.” χ^2 tests were performed for comparative analysis, and analysis of variance tests were used to compare group means of continuous variables. Results were considered statistically significant at $P < .05$.

Results

Response Rates

Sixteen providers were excluded for not having a correct address and 2 had left the state, leaving 137 eligible participants. Of the remaining 137, 73 participated in the online or paper survey, for a 53.2% response rate.

Demographics and Practice Profile

The respondents represented rural and urban practices from across the WWAMI region (Figure 1) and are characterized in Table 1. Providers who practiced in rural locations were more likely to practice general ob-gyn as opposed to specializing in either obstetrics or gynecology alone ($\chi^2 = 17.666, P = .007$).

Partner Recruitment Within WWAMI

The majority ($n = 62, 84.9\%$) of respondents reported being involved in decisions to recruit or hire partners. Most respondents ($n = 44, 71.0\%$) have attempted to recruit in the last 5 years and 17 (27.4%) were actively recruiting. Over half of respondents ($n = 34, 54.8\%$) would hire part-time employees and 50 (80.6%) replied that they would hire non-MD providers of women’s health care. Overall, when hiring, the respondents look most for experience ($n = 29, 46.8\%$) and diversity ($n = 23, 37.1\%$); however, when stratified by practice location,

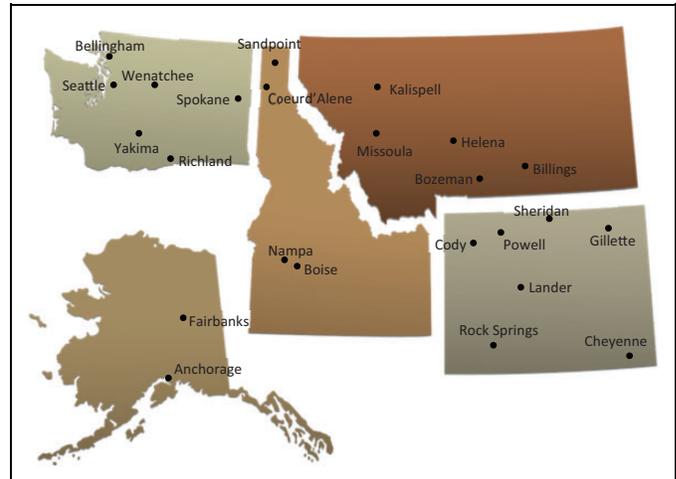


Figure 1. Washington Wyoming Alaska Montana and Idaho (WWAMI) practice region.

respondents who worked in urban areas were more likely to look for a new partner with specialized skills (eg, minimally invasive surgery; $\chi^2 = 7.842, P = .02$), while respondents in rural areas were more likely to look for partners who are familiar with the community ($\chi^2 = 7.153, P = .03$). Barriers to recruitment to rural practice were single recruits ($\chi^2 = 10.025, P = .04$) and lack of specialty care access ($\chi^2 = 15.614, P = .004$), while living space was more likely an advantage ($\chi^2 = 11.035, P = .03$). Married recruits were more likely to be viewed as an advantage for rural providers than urban or suburban providers ($\chi^2 = 7.129, P = .03$).

Reason for Leaving Practice

Table 2 summarizes the reasons the respondents felt a partner would leave their practice. The only significant difference was that, in rural practices, it was more common for a partner to leave their practice due to a lack of specialty care access” ($\chi^2 = 13.256, P = .001$).

Discussion

The American health-care system is in the midst of a sea change. The impact on patient access is likely to be felt most keenly in rural and smaller community practices where there is little buffer to sudden changes in provider volume. This is particularly true of ob-gyn providers because they bridge the boundary between primary and specialty care so there is often only capacity for a few providers in these communities.

The WWAMI program at the UWSOM was established to address health provider shortages in the predominantly rural northwest.^{10,11} Although WWAMI encompasses over a quarter of the land mass of the United States, it includes only 3.3% of the population and has been chronically short of primary care providers.¹¹ It was hypothesized that exposing medical students from this region to rural and general practice, as opposed to urban inpatient care, would encourage them to return to

Table 1. Medical Provider Demographics Subdivided by Practice Location.

| Demographics | Overall, % ^a (n) | Urban, % (n) | Suburban, % (n) | Rural, % (n) |
|---|-----------------------------|---------------|-----------------|---------------|
| Gender | | | | |
| Female | 31.5 (23) | 12.9 (9) | 5.7 (4) | 12.9 (9) |
| Male | 65.8 (48) | 25.7 (18) | 11.4 (8) | 30 (21) |
| Mean years in practice, range | 19.063 (0-42) | 21.537 (0-40) | 13.385 (3-30) | 19.613 (1-42) |
| Race/ethnicity | | | | |
| American Indian or Alaska Native | 0.0 (0) | – | – | – |
| Asian | 4.1 (3) | 0 (0) | 4.2 (3) | 0 (0) |
| Black or African American | 0.0 (0) | – | – | – |
| Hispanic or Latino | 2.7 (2) | 1.4 (1) | 2.4 (1) | 0 (0) |
| Native Hawaiian or other Pacific Islander | 0.0 (0) | – | – | – |
| White | 91.8 (67) | 36.1 (26) | 16.7 (12) | 38.9 (28) |
| Type of medicine practiced | | | | |
| General obstetrics and gynecology | 78.1 (57) | 21.1 (15) | 18.3 (13) | 39.4 (28) |
| Obstetrics only | 5.5 (4) | 5.6 (4) | 0 (0) | 0 (0) |
| Gynecology only | 13.7 (10) | 11.3 (8) | 0 (0) | 2.8 (2) |
| Practice location | – | 37 (27) | 17.8 (13) | 42.5 (31) |
| Type of practice | | | | |
| Ob-gyn partnership/group | 46.6 (34) | 14.1 (10) | 12.7 (9) | 21.1 (15) |
| Hospital or clinic | 20.5 (15) | 9.9 (7) | 1.4 (1) | 9.9 (7) |
| Multispecialty group | 15.1 (11) | 5.6 (4) | 2.8 (2) | 5.6 (4) |
| Solo private practice | 8.2 (6) | 2.8 (2) | 1.4 (1) | 4.2 (3) |
| Other | 8.2 (6) | 4.2 (3) | 0 (0) | 2.8 (2) |
| Type of call shifts | | | | |
| In-house | 14.1 (10) | 7 (5) | 4.2 (3) | 2.8 (2) |
| At-home | 29.6 (21) | 9.9 (7) | 5.6 (4) | 14.1 (10) |
| Both in-house and at-home | 47.9 (34) | 15.5 (11) | 7 (5) | 23.9 (17) |
| Do not take call | 8.5 (6) | 4.2 (3) | 1.4 (1) | 2.8 (2) |
| Number of hours of clinical work per week | | | | |
| Over 60 | 19.2 (14) | 11.1 (7) | 3.2 (2) | 7.9 (5) |
| 51-60 | 21.9 (16) | 6.3 (4) | 6.3 (4) | 12.7 (8) |
| 41-50 | 17.8 (13) | 12.7 (8) | 1.6 (1) | 4.8 (3) |
| 31-40 | 19.2 (14) | 3.2 (2) | 4.8 (3) | 14.3 (9) |
| Less than 30 | 9.5 (7) | 4.8 (3) | 3.2 (2) | 3.2 (2) |

^aBased on sample size of 73 respondents.

Table 2. Top Reasons a Partner Would Leave the Practice.^a

| Reason | Overall, No. (%) ^b | Urban, No. (%) ^c | Suburban, No. (%) | Rural, No. (%) | P Value |
|--------------------------------|-------------------------------|-----------------------------|-------------------|----------------|---------|
| Reimbursement | 24 (44.4) | 8 (14.8) | 8 (14.8) | 8 (14.8) | .101 |
| Limited social/marital options | 26 (48.1) | 7 (13.0) | 4 (7.4) | 15 (27.8) | .096 |
| Work load | 28 (51.9) | 13 (24.1) | 5 (9.3) | 10 (18.5) | .331 |
| Malpractice risk | 2 (3.7) | 0 (0.0) | 0 (0.0) | 2 (3.7) | .247 |
| Lack of specialty care access | 14 (25.9) | 0 (0.0) | 3 (5.6) | 11 (20.4) | .002 |
| Quality schools | 5 (9.3) | 2 (3.7) | 1 (1.9) | 2 (3.7) | .989 |
| Living space | 1 (1.9) | 1 (1.9) | 0 (0.0) | 0 (0.0) | .421 |
| Patient population | 7 (13.0) | 2 (3.7) | 2 (3.7) | 3 (5.6) | .810 |
| Cost of living | 9 (16.7) | 3 (5.6) | 1 (1.9) | 5 (9.3) | .631 |

^aPhysicians who ranked this reason in top 3, stratified by practice location.

^bBased on those who are involved in hiring decisions (disregarding practice location and excluding missing data).

^cn based on those who are involved in hiring decisions, as well as answered the questions "In your opinion, what are the top 3 reasons a partner would leave your practice?" and "Which of the following best describes your practice location?" Fifty-four respondents for each.

practice in their home states. When assessed in 1999, between 41% and 51% of students were returning to home state, higher than the national average, and 55% had entered a primary care residency. This model is being applied at the residency

level as well.¹² Several studies have been done to characterize workforce issues in rural regions, but few in ob-gyn.

With this pilot study, we sought to compare the impressions of practicing ob-gyns on their ability to recruit and retain

partners to their rural or urban practice in order to identify factors that might predict a successful or unsuccessful transition from residency to rural practice. Malpractice and debt burden have not been seen as a barrier to practice location for ob-gyns as opposed to family physicians.^{7,13} Providing obstetrics care for family physicians and ob-gyns significantly increases total workload including hours, outpatient visits, inpatient care, and calls.¹⁴ Physician job satisfaction is significantly associated with age and specialty as well as job factors such as colleague support, income satisfaction, work control, and patient relationships.¹⁵

Although overall our respondents shared more than differed in their opinions on recruitment and retention, there were some important differences. In particular, marital status appears to be a key issue for rural providers. Urban providers appear more interested in partners with specialized skills, while rural providers attributed lack of access to specialty care as a key reason for a partner to leave their practice. Rural providers are more interested on those with familiarity with the community and tend to continue general practice, whereas urban providers are more likely to drop either gynecology or obstetrics. Although minimizing social limitations in rural areas is impractical, graduates and rural practices should consider the issue in their plans along with an awareness of practice style when there is a lack of ready access to specialty care.¹⁶

The primary strength of our study is that it reflects the opinions of actively practicing ob-gyns across a large portion of rural America (see Figure 1). The majority of the respondents have recruited a partner recently within the past 5 years, making these opinions a contemporary reflection of the current workplace in the rural northwest. Although a clear limitation of this study is the relatively low response rate, it is in keeping with other work on this topic. Second, because the population was chosen due to an existing relationship with the UWSOM, their opinions may not be generalizable both within and outside the region. Third, the survey (online appendix, attachment 1) is not a validated instrument that may impact interpretation, especially in terms of rural versus urban location, as this was self-reported as opposed to objectively determined. Fourth, the respondents are predominantly white, and therefore, it is difficult to know what the experience would be for a minority provider or recruit to this region regardless of urban or rural location. With those limitations in mind, we feel these results do, however, contribute to our nascent understanding of ob-gyn workforce issues in rural America.

In the future, we will be studying the experience of new hires, and in particular those of minority graduates, to determine what aspects they found most challenging and rewarding in adapting to active practice in the WWAMI region. As we adapt to the changes in health care, it will remain important to follow these vulnerable communities for changes in the issues impacting practicing ob-gyns so as to preserve access to care for women.

Authors' Note

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Declaration of Conflicting Interests

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Supplemental Material

Supplementary material for this article is available online.

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