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**Gender-Related Factors  
in the Recruitment of  
Generalist Physicians  
to the Rural Northwest**

by

Kathleen E. Ellsbury, M.D., M.S.P.H.

Laura-Mae Baldwin, M.D., M.P.H.

Karin E. Johnson, M.S.

Susan J. Runyan, M.D., M.P.H.

L. Gary Hart, Ph.D.

**WUWAMI RURAL HEALTH  
RESEARCH CENTER**

**UW** University of Washington



School of Medicine

Department of Family Medicine

## ABOUT THE CENTER

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The WWAMI Rural Health Research Center (RHRC) is one of six centers supported by the Federal Office of Rural Health Policy (FORHP), a component of the Health Resources and Services Administration (HRSA) of the Public Health Service. The major focus of the WWAMI RHRC is to perform policy-oriented research on issues related to rural health care. Specific interests of the Center include the training and supply of rural health care providers and the content and outcomes of the care they provide; the availability and quality of care for rural women and children, including obstetric and perinatal care; and access to high-quality care for vulnerable and minority rural populations.

The WWAMI Rural Health Research Center is based in the Department of Family Medicine at the University of Washington School of Medicine, and has close working relationships with the WWAMI Center for Health Workforce Studies, Programs for Healthy Communities (PHC), and the other health science schools at the University, as well as with other major universities in the five WWAMI states: Washington, Wyoming, Alaska, Montana, and Idaho. The University of Washington has over 25 years of experience as part of a decentralized educational research and service consortium involving the WWAMI states, and the activities of the Rural Health Research Center are particularly focused on the needs and challenges in these states. The WWAMI RHRC also works closely with the associated Area Health Education Centers.

The Rural Health Working Paper Series is a means of distributing pre-publication articles and other working papers to colleagues in the field. Your comments on these papers are welcome, and should be addressed directly to the authors. Questions about the WWAMI Rural Health Research Center should be addressed to:

L. Gary Hart, PhD, Principal Investigator and Director  
Roger A. Rosenblatt, MD, MPH, Co-Investigator  
Denise Lishner, MSW, Associate Director/Editor  
WWAMI Rural Health Research Center  
Department of Family Medicine  
School of Medicine  
University of Washington  
Box 354696  
Seattle, WA 98195-4696  
E-mail: [wwamirhrc@fammed.washington.edu](mailto:wwamirhrc@fammed.washington.edu)  
WWW: <http://www.fammed.washington.edu/wwamirhrc/>

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## ABOUT THE AUTHORS

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Kathleen E. Ellsbury, MD, MSPH, is an Associate Professor in the Department of Family Medicine, University of Washington School of Medicine.

Laura-Mae Baldwin, MD, MPH, is an Associate Professor in the Department of Family Medicine, University of Washington School of Medicine.

Karin E. Johnson, MS, is a Predoctoral Research Associate in the Department of Family Medicine, University of Washington School of Medicine.

Susan J. Runyan, MD, MPH, was a Rural Health Fellow at Tacoma Family Medicine at the time of this study.

L. Gary Hart, PhD, is Director of the WWAMI Rural Health Research Center and Professor in the Department of Family Medicine, University of Washington School of Medicine.

# Gender-Related Factors in the Recruitment of Generalist Physicians to the Rural Northwest

Kathleen E. Ellsbury, M.D., M.S.P.H.

Laura-Mae Baldwin, M.D., M.P.H.

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L. Gary Hart, Ph.D.

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## Abstract

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**Purpose:** This study examines differences in the factors female and male generalist physicians considered influential in their rural practice location choice and identifies the practice arrangements that successfully recruited female generalist physicians to rural areas.

**Method:** This cross-sectional study was based on a mailed survey of generalist physicians successfully recruited between 1992 and 1999 to towns of 10,000 or less in six states in the Pacific Northwest.

**Results:** Responses from 77 men and 37 women (response rate 61%) indicated that compared to men, recruited women were younger, less likely to be married, had fewer children, and worked fewer hours. Women were more likely than men to have been influenced in making their practice choice by issues related to spouse/personal partner, flexible scheduling, family leave, and availability of child-care. Women were more highly influenced by the interpersonal aspects of recruitment. Commonly reported themes reflected the respondents' desire for flexibility regarding family issues and the value they placed on honesty during recruitment. Men and women were equally likely to consider community factors, practice content, practice partner compatibility, and financial issues. The most common methods for obtaining information about practice opportunities were personal networking, prior training experience, recruiters, and outreach by medical practices; many respondents located the practice opportunity on their own. It is very important in recruitment of both men and women to highlight the positive aspects of the community and to involve and/or assist the physician's spouse or partner.

**Conclusions:** Rural communities and practices recruiting physicians should place high priority on practice scheduling, spouse/partner, and interpersonal issues in the recruitment process if they want to achieve a gender-balanced physician workforce.



## Introduction

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The growing proportion of women in medicine threatens to exacerbate the ongoing shortage of rural physicians (Rosenblatt & Lishner, 1991). Women, who gravitate toward primary care specialties (American Medical Association, 1990, 1992, 1994, 1996, 1999), are less likely than men to practice in rural areas (Baldwin et al., 1995; West et al., 1996). Among recent medical school graduates tracked by the American Medical Association (AMA), women comprise 19 percent of the urban but only 13 percent of rural generalist physicians (Doescher et al., 2000). Since rural areas rely mainly on primary care providers for health care (Doescher et al., 2000), the recent increase in numbers of women in medical training is likely to have a significant impact on the supply of medical providers for rural areas.

The availability of female providers is important in health care delivery for a number of reasons. Many patients, especially women, prefer female providers for certain types of medical care like prevention (Delgado et al., 1993; Lurie et al., 1993), some types of cancer screening (Fidler et al., 2000), and female adolescent health care (Kapphahn et al., 1999). In addition, female physician availability correlates with the frequency of preventive services offered to women (Bertakis et al., 1995; Lurie et al., 1993). One review of the importance of gender in the physician-patient relationship concluded that female physicians are more likely to address psychosocial issues than their male counterparts (Roter & Hall, 1998).

The literature regarding recruitment of physicians to rural areas describes features of rural practices and communities that physicians find attractive and unattractive, and characteristics of physicians who choose rural practices (Fryer et al., 1997; Magnus & Tollan, 1993). Some studies provide guidance to those involved in recruitment (Anderson et al., 1994). However, few studies describe the actual recruitment packages that attract male and female physicians to rural areas or systematically ask for rural physicians' advice on recruitment strategies. This study investigates factors female and male generalist physicians considered influential in their choice of a specific rural practice location and identifies the practice arrangements that were successful in recruiting female generalist physicians to rural areas.

## **Methods**

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### ***Study Population***

This cross-sectional study profiles male and female physicians recently recruited to small rural communities in the Pacific Northwest. The study population was selected from all generalist physicians indicated in the AMA Directories (American Medical Association, 1990, 1992, 1994, 1996, 1999) whose preferred mailing address was in nonmetropolitan statistical area towns of 10,000 or fewer population between 1992 and 1999 in the states of Alaska, Idaho, Montana, Oregon, Washington, and Wyoming. The selection of towns was based on 1994 census data (U.S. Census Bureau, 1994; U.S. Census Bureau, 2000). For the purposes of this study, generalist physicians included general internists, general pediatricians, family physicians, general practitioners, and obstetrician-gynecologists. We reviewed AMA data (American Medical Association, 1990, 1992, 1994, 1996, 1999) for 1992, 1994, 1996, and 1999 to identify generalist physicians newly recruited to these small towns over that period. Each year's data represented physicians for whom information was available as of June of the publication year. Our study sample included those newly recruited generalists who were still practicing in these towns according to the 1999 data. This particular study group was selected to provide information about recent influences on rural physician recruitment, based on the experiences and responses of successful recruits. In the sample population, gender was inferred from physician first and middle names. We included all listed generalist physicians who met inclusion criteria. The inferred gender of respondents was verified by an item on the questionnaire itself.

### ***Survey Instrument***

A four-page survey instrument included several question types. We listed 27 influences on recruitment and asked subjects to rate the importance of these influences (1 = not important, 2 = somewhat important, 3 = very important). There were several open-ended questions, asking subjects to list the three most successful strategies and three least attractive aspects of their recruitment, and eliciting three pieces of advice subjects would give to those involved in recruiting rural physicians. In addition, the questionnaire elicited descriptive information about the arrangements in the practices that the subjects ultimately chose, as well as standard demographic information. A pilot survey was sent to 30 family physicians in another state. Minor wording changes were made in the instrument, based on comments obtained during the pilot survey. The questionnaire was mailed to the study sample in the winter of 2000. To improve response rates, three mailings about one month apart were conducted.



## ***Analysis***

Responses to scaled questionnaire items were analyzed using SPSS 6.1 for the Power Macintosh®. Responses were stratified by gender as well as examined for the entire study population. Categorical responses were compared using Chi-square tests. Mean ratings for continuous responses were compared using T-tests for independent samples. Responses to open-ended items were coded using qualitative analysis methods with independent coding by two individuals, with a third coder resolving disagreements (Glaser, 1992).

## **Results**

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### ***Response Rate***

A total of 423 rural generalist physicians (311 men and 112 women) met our initial study sample criteria. Based on information provided by the postal service and returned surveys, we excluded from the denominator 20 physicians who were not providing patient care, were retired, or were deceased, and 95 who had not actually been practicing in the rural Northwest or for whom the AMA data provided an incorrect address that we were unable to update. We conducted a survey of randomly chosen nonrespondents to determine what percentage met our study criteria. Of those contacted, 27 percent had moved out of the study area, were no longer practicing, or were unreachable and presumably never received the survey. We used this result to further adjust the nonrespondent rate by 19 percent, resulting in an overall response rate of 61 percent (70% for women and 58% for men). The response rate by state ranged from 53 percent in Oregon and Montana to 72 percent in Alaska.

The study population was further refined to exclude 1 physician who was an emergency medicine specialist; 11 who had been in practice in that location for 10 or more years, and thus had not been recently recruited; and 23 who were recruited to their rural practices through a loan repayment program or as an obligation to a scholarship program. The latter group was excluded because their practice location choices may have been influenced by very different factors than physicians not so obligated. A total of 114 physicians—77 men (68%) and 37 women (32%)—returned the survey and met inclusion criteria.

## ***Demographics***

Respondent demographics are shown in Table 1. Compared with their male counterparts, rural female generalists were younger, less likely to be married/partnered, had fewer children, and were more likely to have completed residency more recently.

## ***Practice Characteristics***

Current practice characteristics of respondents are shown in Table 2. Respondents practiced in one of six states in the Northwest, and 79 percent were family or general practitioners. Men were more likely than women to be family or general practitioners. Only 19 percent of the respondents were in solo practices. While not statistically significant, there was a trend for women to be more likely to practice in multi-specialty groups rather than single specialty groups. The majority of respondents' incomes were based on salary, and 52 percent of respondents were employed rather than self-employed or partners in a practice. Men and women did not differ significantly with respect to practice organization, proportions of income based on salary and production, or likelihood of being self-employed or partners in their practices, as opposed to being employed.

## ***Recruitment Characteristics***

Aspects of the recruitment process are shown in Table 3. Forty-one percent of respondents had been in training and 36 percent in another type of primary care practice prior to entering their current practices. The rest provided ambiguous responses (e.g., "staff physician," "locum tenens," "physician employee") or had been in other types of positions such as medical director, critical care, or emergency medicine. Women reported that they had spent fewer years in their previous practice and were significantly more likely than men (52 vs. 24%,  $p < .05$ ) to have had a partner/spouse looking for work when considering their current practice. The majority (54%) of respondents to a question about outreach to the spouse/partner reported that the community provided no assistance to the spouse/partner. The most common type of assistance provided was finding employment (28%) and social involvement (19%), with no significant difference by gender of physician recruit. Men and women did not differ with regard to description of or perceived fairness of the recruitment negotiation process nor their negotiation behavior. Women were more likely than men to have discussed part-time work (38 vs. 14%,  $p < .05$ ) and family leave benefits (15 vs. 4%, but not statistically significant). The most common methods of obtaining information about the practice opportunity (not shown in a table) were networking (20%); professional experience (e.g., during medical school

or residency) (16%); recruiters (14%); and outreach by medical practice (13%). Many respondents had sought out the practice on their own.

### ***Practice Arrangements***

Practice arrangements related to scheduling issues and benefits are shown in Table 4. Among the 91 subjects who answered questions related to total work hours (direct patient care plus other professional roles), 22 percent—16 percent of men and 34 percent of women—worked fewer than 40 hours per week. A minority 42 percent—52 percent of men and 21 percent of women—worked more than 50 hours a week (not shown in a table). The mean number of hours per week for the respondent group as a whole was 43 hours in direct patient care (44.4 for men, 38.5 for women,  $p < .05$ ), and 3.5 hours in other professional roles (4.2 for men, 2.2 for women,  $p < .05$ ). Regression analysis showed marital status and number of children were not predictive of number of hours worked for either men or women (not shown). Responses to items about recruitment package details showed an average after-hours call load of 8 weeknights per month and 28 weekend days per year (no significant differences between men and women). Physicians who worked more hours per week also tended to spend more hours on call, regardless of gender (not shown). There were no significant differences between men and women with regard to insurance and retirement benefits offered when respondents were choosing their practices.

### ***Responses to Open-Ended Questions***

Responses to open-ended items regarding aspects of the recruitment process are summarized in Table 5. The most frequent type of comments, in descending order, were related to:

- (1) Community-related factors, e.g., setting, economic base, population characteristics, schools.
- (2) Facility/practice (more influential for men; ranked second for men and fourth for women), e.g., practice structure, work schedule.
- (3) Colleagues, e.g., competence, skills, personalities, level of trust.

The most frequent reasons for not choosing other practices overall were related to community, colleague, and facility/practice, in that order. However, men ranked facility/practice as more influential than colleagues, while women placed negative practice and financial arrangements before facility and practice as reasons why they did not choose other practices.

Recruitment strategies respondents thought to be most successful were, in descending order:

- (1) Good interpersonal communication (especially for women: 44% offered such a comment vs. 31% of men,  $p < .05$ ), e.g., friendliness, level of interest shown by those involved in recruiting.
- (2) Highlighting the positive aspects of the practice, e.g., conveying a sense of priorities, flexibility in scheduling.
- (3) Offering financial incentives, e.g., salary, benefit, and loan forgiveness.

For women, highlighting the community was given more often as a successful recruitment strategy than financial incentives. Among the comments provided regarding the least successful recruitment strategies, the most common type of comments, were:

- (1) Poor interpersonal communications, e.g., lack of interest shown toward potential recruit, high-pressure sales techniques.
- (2) Unsatisfactory financial offers.
- (3) Poor recruiting style, e.g., disagreements among practice partners during meetings, inadequate efforts to show candidate around the community.

Women mentioned unattractive structure or content as often as they did unsatisfactory financial offers. The most common kinds of advice to others trying to recruit physicians were:

- (1) Cultivating good recruitment relationships (especially for female recruits: 63% of them cited such comments vs. 33% of men,  $p < .05$ ). A common theme in this category related to honesty and integrity regarding the workload and professional climate and follow-up on promises. Other common examples of advice offered, especially by women, were the need for involvement of the spouse and family and flexibility regarding scheduling.
- (2) Offering attractive practice arrangements, e.g., balance between professional and nonprofessional life.
- (3) Emphasizing the strengths of the medical community, e.g., putting recruits in contact with key medical leaders, highlighting autonomy of

the rural practice, and emphasizing the availability of backup support, as well as offering attractive practice arrangements.

Of these five categories of advice, women discussed financial incentives and a good medical community the least but also recommended emphasizing the qualities of the community and involving the family/spouse.

In the section of the questionnaire listing specific influential aspects of recruitment (summarized in Table 6), the most influential factors for the respondent group as a whole related to community setting/recreation and practice relationships, variety, schedule, and content issues. Women were more likely to consider the following factors as very influential during recruitment: flexible scheduling opportunities ( $p < .0001$ ), opportunities for spouse/partner ( $p < .01$ ), and availability of child care ( $p < .01$ ).

## **Discussion/Conclusions**

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In this regional study of all AMA-listed, newly recruited physician generalists to small towns in the Northwest, women were significantly more likely than men to attribute more importance to opportunities for their partner/spouse, the availability of childcare, and temporal factors like flexible scheduling and part-time work. These results parallel those of past research showing that women in rural practice are more interested than men in opportunities for their spouse/partner (Spenny & Ellsbury, 2000). Similarly, women in academic medicine tend to have personal partners of similar educational levels, to move to accommodate partner career relocation, and to carry the major responsibility for household management (Levinson et al., 1989). In addition, general practitioners' job dissatisfaction correlates with conflict between professional and personal life (Rourke et al., 1996), an issue that flexible scheduling and availability of childcare would partially mitigate. Past studies have found a close association between gender and preferred practice arrangements. Women in rural practice are significantly more interested than men in flexible hours (Forti et al., 1995; Riley et al., 1991; Spenny & Ellsbury, 2000; Vanselow, 1990).

In our study, it was difficult to measure the difference in recruitment packages in terms of "time off" since many of the respondents in this study were self-employed and thus would likely have considerable control over their schedules. Women did work fewer hours than men overall (41 vs. 49,  $p < .002$ ) and were less likely than men to put in extremely long hours. Women were more likely than men to rank flexible scheduling and part-time schedules as more important, and their

reported work hours reflect this. An unexpected finding was the prevalence of part-time schedules among recent rural recruits, especially women. While the majority worked at least 40 hours per week, a significant proportion (22%) of respondents, 24 percent of women and 16 percent of men ( $p < .01$ ), were working fewer than 40 hours per week. One study in Quebec found that between 1978 and 1988 the number of total hours worked per week decreased by two hours for younger physicians and male physicians but did not decrease for female physicians. This study also found that the ratio of female-to-male hours increased among general practitioners and pediatricians but decreased among internists and obstetricians, suggesting that the gender-related "convergence" in hours worked is specialty dependent (Dedobbeleer et al., 1995). It appears that many rural practices are able to provide a significant amount of flexibility in scheduling.

Several other factors may discourage women, more than men, from joining a rural practice. These include negative collegial interactions (Ramsbottom-Lucier et al., 1995), limited free time, limited cultural amenities (Pathman et al., 1996), and cultural, social, and professional isolation (Vanselow, 1990). Comments from respondents in our study reflected many of these same concerns. Responses to open-ended items about attractions and deterrents to choosing a practice and successful/unsuccessful recruitment techniques revealed that interpersonal factors, both within the practice and among community members, were very important in the recruitment process. Factors such as relationships with practice partners and variety of clinical experiences were important for both men and women.

Interviews were conducted with seven key informants intimately involved in physician recruitment in the Northwest. These interviews confirmed the need for more women in rural practice, and their perceptions that women were much more interested than men in flexible scheduling options and opportunities for spouse/partner.

Although this study showed no correlation between gender and the influence of practice choice on the opportunity to do clinical procedures, others have concluded that women are relatively less interested than men in doing procedures (Bertakis et al., 1995).

Attention to acquainting the potential recruit to the strengths of the community and practice, as well as creating supportive practice arrangements, both financial and administrative, are very important. A surprising number of comments described awkward recruiting techniques that undermined the practices' and/or communities' recruitment efforts. Women, in particular, valued interpersonal communication as a successful recruitment strategy.

The limitations of this study include the small number of respondents, especially women (and the associated lack of statistical power), the regional nature of the study, and reliance on respondents' recall of reasons for past decisions. At the same time, this study surveyed the universe of physician generalists recently recruited to practices in the rural Northwest. The AMA database indicated a number of newly recruited physicians who, according to our follow-up, were not practicing in these rural towns. It is possible that those inaccuracies in the database also led to under-ascertainment of recruited male and female physicians in some of the small towns we studied. Just under 40 percent of physicians did not respond to our survey. While we would have preferred a higher response rate, there is no reason to believe that nonrespondents, in aggregate, would respond differently from respondents. Unfortunately, we were unable to include physicians who considered small-town practices but opted for practices in larger communities and those who did locate in rural areas but left their practices by 1999. It would be of great interest in future studies to survey these populations. Despite the study's limitations, its findings contribute to the understanding of an issue likely to assume more importance as women comprise increasing proportions of physicians completing residency training.

In summary, our findings suggest that with careful preparation and coordination of recruitment plans, communities, practices, and recruiters can improve their chances of successful recruitment for rural practices of a gender-balanced mix of generalist physicians. Efforts to encourage more women to enter rural practices will fall short if practice models attractive to women are not offered and if recruitment methods and packages do not accommodate and attract women and their families. Communities are more likely to successfully recruit female physicians if they address spouse/partner, childcare, and scheduling issues during the recruitment process and if they strive for effective interpersonal communications regarding important aspects of the community and practice. While such factors are also important for men, they may be more influential for women.

Recruitment is only the first step in ensuring an adequate rural workforce of both male and female providers. Equally important is retention of providers once recruited, which requires further study so that rural areas can identify the features that will maintain a gender-balanced provider workforce.





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**Table 1:** Personal and Training Characteristics of Rural Generalists Successfully Recruited to Rural Northwest, Compared by Gender

Characteristic	All Respondents (N = 114)	Men (N = 77)	Women (N = 37)
Mean Age (years)	43.7	45.2	40.6**
Married/Partnered	85%	94%	68%***
# Children at Home when Respondent Entered Current Practice:			
0	47%	38%	65%*
≥ 2	40%	47%	24%*
Mean # of Children	1.3	1.5	0.7**
Year Residency Completed:			
1995-98	21%	18%	28%
1990-94	39%	34%	47%
1980-89	29%	32%	25%
1970-79	7%	11%	0%
1960-69	4%	6%	0%
Mean year of completion	1989	1987	1992***

\* p < .05 (difference between men and women).

\*\* p < .01.

\*\*\* p < .001.



**Table 2: Current Practice Characteristics Among Rural Generalists Recruited to the Rural Northwest, Compared by Gender**

Practice Characteristic	All Respondents (N = 114)	Men (N = 77)	Women (N = 37)
	%	%	%
<i>Location of Principal Practice, by State:</i>			
Alaska	15	20	5
Idaho	15	16	14
Montana	21	18	27
Oregon	16	14	19
Washington	19	18	22
Wyoming	14	14	14
<i>Current Medical Specialty:</i>			
Pediatrics	5	4	8
Internal medicine	9	8	11
Obstetrics/gynecology	8	4	16
General practice/family practice†	79	85	65*
<i>Practice Organization:</i>			
Solo	19	20	19
Single-specialty group	47	51	38
Multi-specialty group	27	23	35
Employed, other	7	7	8
<i>Income Basis‡:</i>			
Mean proportion salary based	56	56	57
Mean proportion production based	44	44	43
<i>Employment Status:</i>			
Self-employed or professional partner	48	49	46
Employed	52	51	54

\* p < .05 (difference between men and women).

\*\* p < .01.

\*\*\* p < .001.

† 5% of men were GPs and 0% of women.

§ 8 missing observations.





**Table 3: Aspects of Recruitment Described by Rural Generalists Successfully Recruited to the Rural Northwest, Compared by Gender**

Aspect of Recruitment	All Respondents (N = 114†)	Men (N = 77)	Women (N = 37)
	%	%	%
(1) Position Prior to Current Practice:			
Training	41	40	43
Another primary care practice	36	40	27
Another type of position	23	20	30
(2) Mean Number of Years Spent in Previous Practice	4.8	5.8	2.8***
(3) Partner/Spouse Looking for Work when Considering Current Practice	31	24	52*
(4) Efforts Made to Recruit Spouse/Partner:			
Assistance finding employment	28	26	31
Social involvement	19	22	13
Little or no effort made	54	52	56
(5) Respondent Description of Negotiation:			
Accepted what was offered	51	51	53
Negotiated for more but ended up accepting what was originally offered	9	7	13
Negotiated for more and ended up with more than originally offered	38	41	31
Negotiated for more but ended up with much more than originally offered	2	1	3
(6) Ratings of Fairness of Practice Package:			
Not at all fair	9	8	9
Moderately fair	45	40	55
Very fair	47	51	36
(7) Discussed Working Part Time	22	15	38*
(8) Discussed Family Leave Benefits	8	4	15

\* p < .05 (difference between men and women).

\*\* p < .01.

\*\*\* p < .001.

† Missing observations: 11 for #2, 31 for #3, 13 for #4, 5 for #5, 9 for #6, 4 for #7, 7 for #8.



**Table 4: Practice Schedule and Benefits Offered to Rural Generalists Successfully Recruited to the Rural Northwest, Compared by Gender**

<u>Practice Arrangements</u>	<u>All Respondents (N = 114†)</u>	<u>Men (N = 77)</u>	<u>Women (N = 37)</u>
(1) Hours per week in direct patient care (mean)	43	44	39*
(2) Hours per week in other professional roles (mean)	3.5	4.2	2.2*
(3) Total hours per week (mean)	46	49	41**
(4) Week nights on call in typical month (mean)	8	8.4	7.9
(5) Weekend days on call per year (mean)	28	28.2	28.3
(6) Offered disability insurance	44%	45%	40%
(7) Offered health insurance	77%	78%	74%
(8) Offered retirement plan	58%	58%	57%

\* p < .05 (difference between men and women).

\*\* p < .01.

\*\*\* p < .001.

† Missing observations: 19 for #1, 31 for #2, 19 for #3, 8 for #4, 11 for #5, 1 for #6, 2 for #7, 2 for #8.



**Table 5: Most Frequent Comments Regarding Recruitment from Generalists Successfully Recruited to Rural Northwest, Compared by Gender**

Recruitment Comment Type	Proportion of Respondents Mentioning Factor, Listed in Order of Percentage of All Respondents Mentioning		
	All (%)	Men (%)	Women (%)
<i>Top Reasons for Choosing Current Practice Over Others (112 respondents):</i>			
Community related	83	86	78
Facility and practice related	31	34	25
Colleagues	27	25	31
Content and structure	17	12	28
<i>Top Reasons for Not Choosing Other Practices (81 respondents):</i>			
Community related	67	70	59
Colleagues	33	30	41
Facility and practice related	27	32	19
Practice arrangements	23	15	41*
<i>Most Successful Recruitment Strategies (74 respondents):</i>			
Good interpersonal skills	61	52	82*
Effectively highlighting practice	30	31	27
Financial incentives	26	27	23
Highlighting community	23	21	27
<i>Least Attractive Aspects of the Recruitment Efforts by Communities or Practices Considered (45 respondents):</i>			
Poor interpersonal relationships	42	46	33
Unsatisfactory financial offer	27	27	25
Poor recruitment style	22	24	25
<i>Advice for Rural Practices Trying to Recruit Physicians (84 respondents):</i>			
Cultivate good recruiting style	42	33	63*
Offer attractive financial package	33	40	17
Offer attractive practice arrangements	27	28	25
Emphasize good medical community	27	30	21
Emphasize qualities of community	19	17	25
Involve family/spouse	13	8	25

\* p < .05 (difference between men and women). Chi-square comparing percentage of each gender mentioning each influence as opposed to other influences.



**Table 6: Factors Successfully Recruited Rural Northwest Generalists Rated as Very Important in their Recruitment, Compared by Gender**

Factor	All Respondents (N = 114†)		Men (N = 77)		Women (N = 37)	
	% Rating Item Very Important	Rank	% Rating Item Very Important	Rank	% Rating Item Very Important	Rank
(1) Good relationship(s) with practice partners	80	1	76	2	88	1
(2) Variety of clinical experiences offered	78	2	83	1	68	3
(3) Attractive physical setting	69	3	72	3	63	6
(4) Recreational opportunities	67	4	70	4	61	7
(5) Reasonable call schedule	63	5	61	5	69	2
(6) Opportunity to practice general obstetrics	60	6	57	8	65	5
(7) Access to high quality hospital	58	7	60	6	53	9
(8) Opportunity to control work environment	56	8	54	9	59	8
(9) Wide range of clinical procedures	55	9	59	7	44	13
(10) Opportunity to provide a needed service	50	10	51	10	49	11
(11) Potential to have a full patient schedule	49	11	51	11	44	15
(12) Opportunity to perform Cesarean section	45	12	43	13	50	10
(13) Good relationship(s) with hospital administration	44	13	45	12	43	16
(14) Access to high quality consultants	41	14	42	14	38	18
(15) Other family-related issues (e.g. good school system)	40	15	39	15	44	13
(16) Flexible scheduling opportunities (e.g. part-time, flexible hrs)	38	16	25	17	66***	4
(17) Opportunities for spouse/partner‡	34	17	26	16	58**	12
(18) Attractive benefits package	24	18	22	18	27	21
(19) Opportunity to teach	21	20	17	21	29	20
(20) Community efforts to recruit spouse/partner‡	22	19	17	22	39	17
(21) Proximity to extended family	20	21	18	20	24	22
(22) High income potential	18	22	20	19	15	26

Factor	All Respondents (N = 114†)		Men (N = 77)		Women (N = 37)	
	% Rating Item Very Important	Rank	% Rating Item Very Important	Rank	% Rating Item Very Important	Rank
(23) Opportunity to take a leadership role	17	23	16	23	19	24
(24) Opportunity to repay educational loans	16	24	16	24	15	25
(25) Family leave opportunities	13	25	9	26	23	23
(26) Proximity to urban area	12	26	13	25	10	27
(27) Availability of child care§	10	27	3	27	33**	19

\* p < .05 (difference between men and women).

\*\* p < .01.

\*\*\* p < .001.

† Missing values: < 10 for #1-5, #7-11, #13-14, #22-23; 11-20 for #15-16, #18-19, #21, #25-26; 20 for #17, #20.

‡ Out of respondents indicating they were married/partnered.

§ Out of 51 respondents indicating they had children living at home and to whom the question was otherwise applicable.



## Previous WWAMI Rural Health and Health Workforce Research Center Working Papers

The WWAMI Rural Health Research Center was established in 1988. The WWAMI Center for Health Workforce Studies was established in 1998.

1. Hart, L. Gary; Rosenblatt, Roger A.; and Amundson, Bruce A. Is There a Role for the Small Rural Hospital? January 1989.
2. Hart, L. Gary; Rosenblatt, Roger A.; and Amundson, Bruce A. Rural Hospital Utilization: Who Stays and Who Goes? March 1989.
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4. Nesbitt, Thomas S.; Rosenblatt, Roger A.; Connell, Frederick A.; and Hart, L. Gary. Access to Obstetrical Care in Rural Areas: Effect on Birth Outcomes. July 1989.
5. Schleuning, Dianne; Rice, George; and Rosenblatt, Roger A. Addressing Barriers to Rural Perinatal Care: A Case Study of the Access to Maternity Care Committee in Washington State. October 1989.
6. Rosenblatt, Roger A.; Whelan, Amanda; and Hart, L. Gary. Rural Obstetrical Access in Washington State: Have We Attained Equilibrium? January 1990.
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9. Hart, L. Gary; Pirani, Michael; and Rosenblatt, Roger A. Causes and Consequences of Rural Small Hospital Closures from the Perspectives of Mayors. September 1990.
10. Welch, H. Gilbert; Larson, Eric H.; Hart, L. Gary; and Rosenblatt, Roger A. Readmission Following Surgery in Washington State Rural Hospitals. January 1991.
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16. Hart, L. Gary; Pirani, Michael J.; Rosenblatt, Roger A. Rural Hospital Closure and Local Physician Supply: A National Study. December 1991.
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18. Hart, L. Gary; Robertson, Deborah G.; Lishner, Denise M.; Rosenblatt, Roger A. Part 1: CEO Turnover in Rural WAMI Hospitals. Part 2: Rural Versus Urban CEOs: A Brief Report on Education and Career Location Patterns. August 1992.
19. Williamson, Harold; Hart, L. Gary; Pirani, Michael J.; Rosenblatt, Roger A. Rural Hospital Surgical Volume: Cutting Edge Service or Operating on the Margin? January 1993.
20. Rosenblatt, Roger A.; Saunders, Greg; Tressler, Carolyn; Larson, Eric H.; Nesbitt, Thomas S.; Hart, L. Gary. Do Rural Hospitals Have Less Obstetric Technology than their Urban Counterparts? A Statewide Study. March 1993.
21. Williamson, Harold A.; Hart, L. Gary; Pirani, Michael J.; Rosenblatt, Roger A. Market Shares for Rural Inpatient Surgical Services: Where Does the Buck Stop? April 1993.
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