‘Moving to the countryside and staying’? Exploring doctors’ migration choices to rural areas

Abstract

In this paper we bring together health services research, rural studies and migration research to explore the recruitment and retention of doctors to rural areas. We argue that to understand doctors’ job choices we need to understand their lives holistically - beyond solely their job. In doing this we consider why doctors move, but also why they stay in rural areas. To do this we draw on qualitative research with 56 doctors from primary and secondary care. We highlight how place-based factors are important to consider in moving beyond the language of ‘recruitment and retention’, as many of the issues facing doctors moving to, or staying in, rural areas are beyond the scope and influence of their jobs and the health service. With a demographic shift in general practice particularly, where many GPs are over the age of 50, specific pre-retirement migration habits are important to consider within wider research on demographic ageing in rural communities. Further, stressors such as the COVID-19 pandemic may have impacts on the migration decisions of future doctors’ training or career choices. This work’s contribution, thus, brings holistic place-based and interdisciplinary perspectives to bear on work otherwise influenced heavily by health and medical research and we argue that such dialogue with other interdisciplinary perspectives within rural studies is important in understanding professional migratory choices, particularly of doctors, to rural places.

Introduction

Rural migration research has a rich history, focused on urban-rural and rural-urban migration processes of people across the life course (see: Philip and MacLeod, 2018; Barcus and Halfacree, 2018). Considerations of pro-rural migration such as why people move to the rural (e.g. Ni Laoire and Stockdale, 2016), why people stay (e.g. Berg, 2020; Halfacree and Rivera, 2012), and the benefits and challenges associated with such migration patterns are well researched, covering topics such as affordability of housing (Taylor, 2008), associated processes of gentrification (Phillips, 2005; Smith, 2002), and community cohesion (Murdoch et al., 2003). One factor often explored as part of the decision-making process of migrants is local service provision (Bosworth, 2010), and the capacity of rural areas to provide services such as healthcare and
education to support an acceptable quality of life. Local service provision relies on the availability of a range of regulated and non-regulated trained workers, such as medical doctors, nurses and teachers, to deliver key services. However, many rural areas do not have sufficient numbers of or access to these workers. Yet, while these workers are often key to the creation of sustainable rural communities (Farmer et al., 2003), there is little focus within rural migration research on the movement choices of professionals (Although see Enticott, 2018 on international rural migration of veterinary professionals; Carson et al., 2017 on GPs in Australia).

Rural communities globally are seeing the challenges associated with reduced service provision in health, social care and education, often alongside demographic ageing, caused by ageing in place, the inward migration of older people to rural areas for lifestyle reasons either pre-retirement, or for retirement (Maclaren, 2018), and the outward migration of young people for education and/or economic opportunities (Ni Laoire & Stockdale, 2016). Such challenges are also exacerbated by difficulties in attracting professionals, particularly healthcare professionals (Weinhold & Gurtner, 2014).

This paper focuses on the recruitment and retention of doctors to rural areas in Scotland. The delivery of rural healthcare and the recruitment and retention of health care professionals has been extensively researched. People living in remote and rural areas face real and significant geographic and demographic difficulties accessing quality health and social care, difficulties which can have negative consequences for health equity and outcomes (Murchie et al., 2019; Weinhold & Gurtner, 2014; Cohen et al., 2018). Providing healthcare for people in remote and rural areas is a priority for the Scottish Government. However, to do so is challenging because of difficulties recruiting and retaining healthcare staff. For example, NHS Education for Scotland reported that highest medical and dental vacancy rates were in rural and remote NHS boards, including Highland (14.5%), Western Isles (25.1%), Orkney (17.4%) and Shetland, 39% (NHS Education for Scotland, 2023a).

Much of the research into this issue has been job or remuneration focused, with some wider consideration of personal factors like partner employment, schooling and housing. However, recent research has identified the importance of ‘whole of society’
World Health Organization [WHO], 2021) solutions to address the shortage of healthcare professionals in remote and rural areas.

Aligning these areas of research (rural migration and health services) may go some way to addressing two key research gaps in the literature: 1) the lack of focus on the migration choices of doctors and 2) the limited consideration of the wider migration determinants of an individual in response to the challenge of recruiting and retaining healthcare professionals in rural areas. In this paper we argue that to understand doctors’ job choices we need to understand their lives holistically - beyond the job. In other words, considering, as Halfacree and Rivera (2012) articulated, not just why people move, but also why they stay.

The paper begins by exploring rural migration literature from rural studies, rural geographies and associated social sciences whilst relating it to contemporary health services research. We note the importance of place (Maclaren et al., 2022a, 2022b; Malatzky et al., 2020) both in conversations about recruitment and retention of doctors to rural areas, and in relation to rural migration. We then discuss our methodology and the context of our research in Scotland. Our empirical sections are structured around connection to place, work-life balance, pre-retirement migration and changing contexts. The paper concludes by highlighting the importance of focusing on why doctors move and stay, rather than solely how they are recruited and retained. First, this will help to bridge the gap between rural studies and work undertaken in health services research contexts. Second, it will appreciate and reiterate the importance of ‘whole of society’ (WHO, 2021) solutions to address the shortage of medical professionals in remote and rural areas, which cannot lie solely in the sphere of responsibility of health service management.

Literature

Recruitment and retention of doctors to rural and remote areas is a global challenge (WHO, 2020, 2021): such struggles negatively impact and entrench existing health and social inequalities. As Malatzky et al. (2020, p. 1) argue, the “decisions about staying or leaving a health position – the retention of a health workforce – are informed by a myriad of highly interactive dimensions within personal, organisational, social and spatial domains” (See also: Bourke et al., 2012; Cosgrave et al., 2018; Cutchin, 1997;
Hanlon and Kearns, 2016; Kearns et al., 2006; Pierce, 2017). But this too affects people moving to rural or remote areas in the first place.

Research on rural migration typically revolves around the attraction of the countryside, in which juxtaposed visions of city and country life are held up as contributing to, and sustaining, idyllic representations of rurality (Bell, 2006). The rural idyll is suggested as a centripetal force (Cloke, 2003), a motivating factor for people choosing to move to rural areas (e.g., Halfacree, 1994; Jones, 1995; Valentine, 1997). Rural places as a construct are seen to be beautiful, to have recreation opportunities, to offer a better quality of life, and to have a nurturing and close community feeling (Bell, 2006; Key, 2014). These are often cited in the literature as being the reason why people move to a rural location. However, challenges around service provision such as the availability and accessibility of goods and services, schooling and medical care are also considered, often after the point of moving (Stockdale and Haartsen, 2018). Indeed, these aspects are interlinked: the very people required for these services to exist also need to want to live and work in these places. This is amplified in more remote areas as it becomes more difficult for professionals to provide services by commuting or visiting from other areas.

There is little explicit focus within rural migration research on the movement choices of professionals (although see Enticott, 2018; Carson et al., 2017). Whilst research may implicitly cover professionals, the profession is rarely the direct focus. The focus is instead on what keeps people in place (Lynnebakke & Aasland, 2022; Berg, 2020), understanding how a ‘sense of community’ factors into migratory decisions (Wolfe et al., 2019), why some families move and others do not, and the socio economic impacts of pro rural migration (McCollum et al., 2021; Kasimis et al., 2010). Research that factors profession in has focused on the working habits of different professional sectors, such as public or creative sectors, rather than the individual professions themselves (Sandow et al., 2019). Doctors’ migration stories present an opportunity to explore where a professional role intertwines with rurality, but also challenges notions that migration is solely based around lifestyle or financial aspects. Attending to doctors’ biographies reorganises our thoughts around migration, allowing us to examine doctors’ choices in light of understanding representations of rurality, whilst also re-examining the rural idyll in light of doctors’ own experiences. Recent research in rural studies within the social sciences, arts and humanities has focussed not just on
migration - the act of moving to rural areas – but also why people stay (Halfacree and Rivera, 2012; Barcus and Halfacree, 2018; Berg, 2020). The choices, ideas or imaginaries involved in someone moving may be very different from the reasons that they end up staying, or not, in a place. This underlies the importance of understanding someone’s lifecourse (Tyrrell and Kraftl, 2015). The lifecourse perspective has been outlined as important in population geographies owing to its relational capacity (Barcus and Halfacree, 2018) to understand lives that are inflected by social and cultural events and roles over time (Giele and Elder, 1998). Lifecourse approaches thus allow for context, relationality and understanding that lives do not necessarily follow clearly marked stages on a ‘cycle’, rather they meander, flow, change and evolve influenced by a range of personal, social, economic, political, environmental and phenomenological factors.

Research to date on recruitment and retention of healthcare professionals has primarily been within health services research. This work has focused on differences globally (WHO, 2020; Strasser & Strasser., 2020; Marchand & Peckham, 2017) but also across countries, considering differences within or between countries with high incomes (Holloway et al., 2020; Kaarbøe & Aars, 2023; Carson et al., 2017; Lee & Nichols 2014; Heilmann, 2010) or middle and low income (e.g. Honda et al., 2019; Uta Lehmann et al., 2008; Astor et al., 2005). Research has also considered the global migration of healthcare professionals, particularly doctors, often choosing to move away from resource constrained areas (Yeates & Pillinger, 2019; Chikanda, 2006; Farham, 2005; Eastwood et al., 2005; Marchal & Kegels, 2003). Our research speaks to the wider discourses around migration seen in high income countries with rural and remote regions such as in Australia (e.g. Makate et al., 2021; Lennon et al., 2019), the UK (e.g. Scanlan et al., 2018; Curran & Baker, 2016), Canada (e.g., Koebisch et al., 2020; Klein e al., 2009) and within Europe, particularly Scandinavia (e.g. Kaarbøe & Aars, 2023; Heilmann, 2010).

Thus far, specific research into why doctors, and other healthcare workers, move to or work in rural areas has kept focus on filling the job (see: Jones et al., 2019) and keeping the job filled, with less focus on the people doing the moving. The research has been dominated by seeing the job as the thing to explore and solve. This is understandable given it is the main factor that a health service can influence or have control over. Factors such as salary (e.g., Kaarbøe & Aars, 2021), training location and
future working intention (Carson et al., 2022; Makate et al., 2021; Scanlan et al., 2018),
the generalist vs specialist nature of rural vs urban care (Jones et al., 2019), specialty
rotations (Heilmann, 2010) have all been explored as answers to the issue of
recruitment and retention in rural areas. Opportunities for spousal/partner
employment, children’s schooling, etc. have also factored into this research (e.g.
Myroniuk et al., 2016; Cameron et al., 2012; Kearns et al., 2006; Mayo, 2004), and it
is not to say it is excluded, rather that, as the language of ‘recruitment’ and ‘retention’
illustrates (Maclaren et al., 2022b), the focus is on the job being at the centre of a
person’s life and identity instead of seeing that as a part of their whole.

The gap that has also been recognised in the research (e.g. Beccaria et al., 2021;
Kearns et al., 2006; Richards et al., 2005), is that associated lifestyles are as
important, and if not more so, in attracting professionals, including doctors, to move
and ultimately stay in rural locations. We draw together this research by considering
contemporary rural studies and geographical literature with health services research
into doctors’ migratory choices. We analyse a range of doctors’ experiences of moving
to remote and rural areas of Scotland, and consider how personal, professional and
place-based factors assemble, push and pull individuals into ultimately making
decisions about whether to move but also whether to stay.

**Methods**

The focus of this study was exploring and understanding doctors’ perceptions and
experiences of working in remote and rural settings of Scotland. It is part of a wider
mixed-methods programme of work in which service mapping and qualitative data
were gathered in support of this aim, and also to inform the design and content of a
quantitative tool looking at push-pull factors for recruitment and retention of rural
medical jobs.

This paper draws on qualitative data gathered from a series of interviews with 56
doctors. Ten participants were part of a service mapping exercise (reported elsewhere:
Authors., 2022a) to understand current recruitment and retention issues in the Scottish
context. These interviews also included discussion of those individuals’ biography, so
are included here. The other 46 interviews focussed on that doctor’s own biography,
experiences, and perceptions. Doctors were recruited through multiple channels,
including rural medical society email lists, and regional general practice contacts, and
snowball sampling (Crang and Cook, 2007). Those who currently worked in rural and remote settings were primarily recruited, but others who had worked or trained in similar settings and since moved elsewhere, and who had never worked in such places were also interviewed. The sample included doctors at various stages of their career, from those in the final years of their specialty training, to senior consultants and general practitioners (GPs), to those who described themselves as recently or semi-retired.

Interviews were framed as “conversations with a purpose” (Cloke et al., 2004, p. 149) and were semi-structured with some pre-determined questions. All interviews were conducted online or by telephone and began with an open invitation for the participant to tell the interviewer, in their own words, about themselves, their background and then their working life and career motivations to date, as a biographical narrative. Conversations were led by the topics brought up by the participant, with general themes, developed from the service mapping stage and literature, raised for discussion (if not spontaneously mentioned by the interviewee). This included subjects such as community and social life, housing, family, recreation, career motivations and futures. The timing of the interviews also gave an opportunity to consider the effects of the COVID-19 pandemic given that our research was planned prior to the pandemic, delayed because of it, and started amidst a UK lockdown in October 2020. Overall, our interviews sought to more fully understand the biography of the doctor to explore what attracted them, or not, to work in remote and rural places. All names used are pseudonyms as are place names where required because of small community size.

Analysis occurred iteratively as the research was undertaken to inform and refine further future interviews. Analysis was undertaken thematically and led by Author 1 and Author 3 initially who then refined themes in discussion with Author 2. Throughout the study, the wider research team was involved in analysis discussion with other members of the team. Interview transcripts, notes or coding led by Author 1 and Author 3 were circulated in advance of monthly team meetings, discussed at the meeting to consider and build themes and develop the iterative process of analysis. Similarly, we shared extracts with the project advisory panel, which included policy makers, clinicians and public representatives to gather multiple perspectives on our data and ideas. Drawing on these whole team discussions, Author 1 continued this analysis for
all interviews, again developing the coding framework both deductively and inductively. Key themes were drawn out and discussed and related to the literature.

**Connection to place**

**Lifecourse**

Moving and staying in a rural or remote place often relies on the capacity for an individual and/or their family to form connection to and with that place, whether the locality or the people who make the place (Berg, 2020). Socialities and physical aspects of place can have affective and emotional qualities that might be hard to articulate (Maclaren, 2018; Phillips, 2014) but are nonetheless important. Indeed, research has focussed on the various reasons for communities, and in particular people within a place, being the thing that keeps people in that place (Kanakis et al., 2019).

All UK graduates with a primary medical qualification can apply to the UK Foundation Programme (UKFP). This is a two-year programme of general clinical training in one of the UK’s 18 Foundation Schools, one of which is Scotland. Following successful completion of the UKFP, doctors can choose to apply for either a non-training grade role or a General Medical Council-approved specialty training post in one of 16 Postgraduate Deaneries. The duration of specialty training posts varies depending on the curriculum and is generally between two and eight years (NHS Education for Scotland, 2023b). For example, a GP who does not intercalate, does not take other opportunities (e.g., extra clinical placements or fellowships) or have career breaks, will take 10 years to become fully qualified from starting medical school. In both Foundation and specialty training posts, applicants can usually preference a particular training region. Following appointment, there is usually an option for intra-regional location allocation. For example, a successful applicant for the Scotland Foundation School might preference to be placed in a rotation involving a particular remote and rural location. However, while there are opportunities for choice, a trainee may not receive their first choice (or second, or third etc) for a particular programme, depending on the popularity of a given post, the nature of the post-appointment process and the ranking of an appointee. So, while there are opportunities for choice, the ‘system’ has a certain amount of locational influence, with most doctors unable to be assured of their training location at the point of initial application. There has been extensive
research on recruiting students into medicine from remote and rural areas, and on
having remote and rural placements in medical degree programmes, as there is some
evidence that it can prompt doctors to express a higher preference for those remote
and rural places throughout the training programme by creating connection to places,
as a way to address the challenges rural and remote areas have in recruiting. This
connection to place was something we explored in our interviews.

One key consideration in forming a connection to place is the stage in an individual’s
life course, with different personal circumstances acting as a catalyst for forming place-
based connections. Family circumstances were often a reason for doctors moving,
staying, or leaving, and, indeed, even when a role perhaps wasn’t ‘perfect’ or ‘ideal’,
benefits to personal and familial life were seen as extremely important reasons for
staying in a community, something that further reflects the literature the importance of
family in doctors’ decision making (e.g., Hays et al., 2003; McGrail et al., 2017). Having
children was also frequently highlighted as being helpful for integrating into a place,
due to the opportunities for connection and forming friendships:

But I think we were welcomed with open arms, [...] partly because we were a young
family and schools needed numbers, you know? Kids, I think, are always really
welcoming in a community...there were also other couples around our age with kids
around the same age, and that makes it a wee bit easier as well. I think if you’ve got
things in common with other people, it’s easier to put down the roots if you’ve got
shared interests. I think having kids makes it easier, you know? I think everyone kind
of acknowledges that, you know, you do get to know people quicker because you’ve
got the school gate and various activities and all the rest, you’re introduced to a wider
range of people and you’re meeting them in a setting other than in the role as the doctor
with the patient, you know? (Corrina, GP Partner)

Seeing the doctor as more than just a doctor is very powerful in making place in the
community for a doctor, and also for that community to make place for the doctor,
where school aged children are often a way to make those connections. Where this
can become more challenging is schooling. Whilst some more remote places in
Scotland are reasonably close to schooling options, the distance and travelling time
for school education, particularly for secondary education, can become a barrier to
remaining in very remote communities. However, for many rural doctors, the disruption
of uprooting their children from established school arrangements could be enough of a deterrent from enacting plans for moving elsewhere and therefore it becomes a strong connection to their current place, and a driving factor, or conversely a barrier, in making migration decisions:

Well, initially, the girls were at school, so that was the reason for staying, and the job was going well…I wanted stability for them…And I’d put down roots by then and got to know a lot of people locally… (Will, Single Handed GP)

Lifecourse and personal circumstances continue to shape these migration experiences (Tyrrell and Kraftl, 2015). For individuals who did not have young families or partners, the idea of moving somewhere remote, however, was equally challenging, as Charlotte articulates:

I certainly wouldn’t…, speaking as a young, single person…, I wouldn’t choose to move up to [a very remote place on the mainland] full time, because of, well professionally it would be isolating, and potentially not good for my clinical development. Also, I think socially, much as I absolutely love the area, great community, it would be pretty isolating as well. I consider [these mainland remote places] way more remote than [an island town] because [an island town], it’s like a city, it feels like a city, because it’s like there’s everything there, there’s like cinemas and theatre and the massive sports complexes, and good shops, and like everything you, you need, whereas you know, a lot of these remote communities, I appreciate you can’t change that, that’s just, that’s the way the remote communities are, but like they’re tiny and I think there wouldn’t be a potential to develop your social life there (Charlotte, Salaried GP)

For this doctor, at their life stage, the elements required to make a strong connection to place are not available in many rural and remote communities. They place more importance on the diversity of entertainment options in developing a social life and thus in forming a connection to place. This reflects wider literature particularly focused on women’s experience of work-life balance in rural locations (Baylina et al., 2017). While some rural spaces that are closer to urban centres may allow for a successful blending of the two, it highlights how physical distance and community are important to consider for many people when making their choices in achieving a balance between their work and life.
Whilst these examples show a snapshot of an individual’s perspective at a certain time, it is important to acknowledge that the feelings and choices of individuals are not static across their lifecourse and can change over a relatively short period of time. Indeed, Charlotte highlighted their changing thoughts on rural working:

> It’s funny actually if you’d asked me this question a year or two ago and you said there’s a job between [a city/town] and [remote rural place], like say 3 weeks in [the town/city], 1 week [remote], would you take it, if you’d asked me 2 years ago, I would probably have said yes, whereas now, I’m much more, I really value being in one place and having a base, so yeah, it’s interesting, my thoughts have changed somewhat on the matter (Charlotte, Salaried GP)

What is articulated here is an example of the need to understand not just people’s choices, but how they evolve over time. Berg (2020) and others (Halfacree and Rivera, 2012) have highlighted the importance of time and people’s choices around moving and staying. Charlotte presents an example of the challenge facing doctors who have recently completed speciality training, in this case as a GP, of finding a job they will like, contrasted with a desire to put down roots, ‘to have a base’. At this point in people’s careers, their life stage can have a huge influence in their decision making. One doctor might, by their own choice, consider moving, but the roots put down by their young family, or perhaps having purchased a property (although something noted to be difficult in rural communities in our interviews and more widely (The Scottish Government, 2023)), might foster a strong enough connection place that is an encouraging factor in deciding to stay. Whereas another doctor, without dependants and immediate partner connections, or a property might have been open to exploring other options, but as they move towards pre-retirement age might begin to want to put these roots down and thus become less able to commit to places where they might not be able to form connections beyond work.

**Historical connection**

Whilst different stages of an individual’s lifecourse can affect what is important to them in forming connection to place, so too can an individual’s biography. The initial connection to place is often anchored in the historical relationship an individual may have with that place (Maclaren, 2019). For example, those who spent their childhood
in a rural community are often more likely to return to a similar place later in their career (WHO, 2021).

I suppose the other factor is that my parents have had a holiday home … just down the road, for 35 years. This was our place to come on holiday. In fact, when I took the job, the only comment our eldest made was, “Well, where are we going to go on holiday then?” So we knew the area really quite well, it ticked all those boxes. (Grace, GP Partner)

The experiences of rural places are then more than just an experience but can be valued as an affective and emotional connection to place, creating within individuals the capacity to attach to places and be a motivating factor in their migration choices. Places then become relational and “[understood] as co-produced through their historical and contemporary connections, often with other places” (Andrews, 2017, p. 727).

**Place of doctor within the community**

Being the only doctor or one of just a few doctors in a community - a common experience in rural and remote communities - adds further complexity to the construct of connection to place.

How do you settle into a community, particularly if you’re only meeting people in that role, it’s really difficult. People then tend to see you as “the doctor”. That’s still a challenge, it’s not as prevalent here but even there, in a small community, you know, we used to call it the ‘Spar’[iv] ward round because people would come up to you in the aisles when you’re there with the two small kids and start talking about something completely inappropriate! You’re like, “I’ve got two sets of ears here, this is not the time or place, ring me tomorrow when I’m on duty or call my colleague!” Or people driving past you in the car and pulling up ahead of you and going, “Oh, could you book me in for an appointment on Tuesday?” (laughs) I don’t have the appointment screen in front of me, I haven’t the first clue, ring the practice! You know? (Corrina, GP Partner)

This creates a particular sociality for doctors in rural communities, which may become a defining factor in their connection to place. They may be unable to separate their identities as a person and as a doctor within that place. Indeed, this furthers Jervis-
Tracey et al.’s (2016) research in relation to statutory responsibilities of professionals in rural areas in Australia which included healthcare workers. The extent to which this becomes a challenge will depend on the community itself and how those living within the community relate to the doctor. In addition to challenges around identity, doctors present a further unique example within the context of a social connection to place, as Sophie articulates:

I think it’s a very difficult job, because I mean, you know, like the GMC say don’t they, don’t look after your friends and family, and I think there’s a good reason for that really, is because it’s very difficult, like, and you can’t live in a small community, and not be, become, you know, become friends with people, so then it, it’s so difficult to be rational then, you know, with people who you know well… I was just saying this to [my husband] this morning, that it’s a really, really difficult situation with GP’s in these communities, because I think the problem is, is I think you, it’s like to last, you’ve got to be part of the community, but then almost like you can’t be part of the community at the same time

(Sophie, GP Partner)

Professionally doctors are told not to treat their friends, or family, as patients. General Medical Council guidance advises “you must, wherever possible, avoid providing medical care to yourself or anyone with whom you have a close personal relationship” (GMC, 2020, p.8). However, for many remote and rural communities, that simply is not realistic, with some medical practices only having 200 people on their list. This can create additive stress in holding dual roles and maintaining confidentiality between the professional and the personal, in an environment that might not necessarily have a network of professional colleagues for peer support (See also Jervis-Tracey et al., 2016). One very important reason for staying, connection to people, then, becomes very difficult in a situation such as this or in a remote mainland location, where pushes and pulls to move or stay revolve around a doctor’s personal and professional life.

**Job and work-life balance**

The perceived ability to achieve a positive work-life balance is often a driving factor in the attraction of taking a medical job in a rural place. Coupled with idyllic notions of rurality including beautiful landscapes, recreation opportunities, close communities and an improved quality of life, a rural job can present an opportunity for both personal and professional balance. Halfacree and Rivera write about “the act of migration
[being] strongly underpinned by representation of a better life to be had in the countryside" (2012, p.93). In this section we explore how the search for ‘a better life’ and work-life balance impacts on doctors’ decisions to move and to stay.

One doctor talked about how moving to their rural role did meet their imagined aims:

the joys of working rurally, the small [general] hospitalvi, the close-knit team, the supportive environment, the links and relationships to patients, the being busy but not overwhelmed, have all been fulfilled (Freddie, secondary care consultant)

This experienced reality extends the concept of the rural idyll beyond notions of landscape and leisure to idyllic job satisfaction and is an example of an achieved imaginary. Indeed, this potential imagined job satisfaction is what attracted many people to a rural or remote role, as a reason why they might move:

A friend of mine had sent on the ad… I thought, “Well, this could be something that would meet some of our priorities,” in terms of working life and family life… So yeah, I think the attraction was… beautiful place, it wasn’t somewhere that we’d particularly visited or particularly had any connections to, but again, you know, rural coast and… more clinical support, different working environment. (Hazel, Salaried GP)

The environment of rural practices set within small communities, with GPs often living very close to their practice, and potentially being able to achieve a perceived improvement to their work-life balance was frequently cited as an attraction for rural working:

I had small children and I thought I should change my working life, my working pattern, that brought me to the positive things, I’m living in a village where I’m working, and I thought I’d, that’s what I grew up with, and I want to do that again, that I could see my kids over the course of the day, and that I could have lunch at home, and simple things, simple things which, which make a big difference to life of small children and I thought I will work probably quite a lot too, but I will do it in a way which will be very close to the family, and so I looked round for that, and that’s what I wanted to do, [Luke, GP Partner]

Beyond just the perceived benefits to family life, wider lifestyle considerations of leisure opportunities, the commute, the landscape - all elements that are part of the
representation of the rural idyll - were key factors in making the decision to move to and stay in a rural area:

I just kind of liked living somewhere that was... had the hills on your doorstep and you could go for a cycle out of your back garden and, you know, you don’t have to drive two hours to find a really lovely walk. You know, there’s hundreds just two minutes away. So that part of it, a sort of work-life balance side of things. And then I think it was probably also just that, again, work-life balance, so it’s that not wanting to spend an hour and a half sitting in my car driving in a line of traffic feeling like you’re just part of the rat race. (Sam, secondary care consultant)

All these experiences reflect wider migratory preferences, that a move to rural areas is as much about lifestyle outside of work as it is about the job. However, professional factors that feed directly into the idea of work-life balance contribute into the expanded notion of the rural idyll and are intertwined with the associated lifestyle and environmental factors that are linked with idyllic notions of the balanced life.

The challenge, though, for doctors in search of the ‘good life’ is that the current ‘crisis’ in recruiting and retaining healthcare professionals to rural practices can distort the potential for the balanced rural idyll. Workplaces, particularly GP surgeries, can have situations where success breeds success, with successful small groups developing a reputation as a ‘good place to work’, compared to others which over time have struggled to recruit or retain leading to ‘last person standing’ situations amidst increasing workloads. The positive professional factors that contribute to good work-life balance and job satisfaction do not exist across all rural practices and the recruitment challenge has created environments where a single GP has a high workload and no ability to switch off.

**Pre-retirement migration**

Pre-retirement migration has featured in rural migration literature, particularly within the Scottish context (Stockdale and MacLeod, 2013; Philip et al., 2013; Philip and MacLeod, 2018). This work argues that “older adults in the ‘preretirement’ age group, defined as those aged between 50 and 64 in the UK (Stockdale and MacLeod, 2013), account for a higher percentage of in-migrants to remote and peripheral rural areas” (Philip and MacLeod, 2018, p. 148). In our research we spoke to several doctors who fitted into this age category, with different motivations for relocating to a
rural area, from *empty nesters* who were no longer fixed to a particular place because their children had grown up and left home, to those who were at the end of their career and wanted a new challenge or change of pace. Many doctors fit with Philip et al.’s observation that “retirement is no longer the abrupt life event that it was for earlier generations […]. Rather, it is a fluid and transitional period of the life-course” (Philip et al., 2013, p.124):

> My wife was fully behind the idea... because, you know, on her reflections… it was not good for me carrying on working in England, so she was delighted when I decided to retire... to, to, to draw my pension and supplement it by working elsewhere. That said, (laughs) her, her trips to [the island] were infrequent because it’s a hell of a long way away. [But now] she’s the prime mover behind our attempts... ongoing at the moment to try and find somewhere to buy so we can stay here… We weren’t planning things to the extent of let’s go to [the island] and look for somewhere to retire. We came up here, realised that we enjoyed it at least as much as we were expecting if not more, so now we’re looking to maybe try and buy a property here if we can. (Daniel, GP partner)

The potentially negative elements of a rural move highlighted earlier, such as children’s schooling and partner employment, become less of a driving factor for those at a later point in their career, and the concept of the positive work-life balance and the imagined rural idyll loom larger in the decision-making process:

> So yeah… I just decided I didn’t want to spend the last few years of my career doing the same thing that I’d done before, knew that I wanted to live in [rural Scotland] … I think one of the things that finally got to me was I discovered we had I think seven consultants in the cardiac department [of my hospital in England], and I didn’t even know the name of four of them in the same hospital, and I should, I should be able to know the names of the people I’m referring patients to… [moving] just seemed it would be an interesting challenge. A completely different way of working from how I’d become accustomed to working in my previous job. (Gavin, secondary care consultant)

This is another example of where the stage of an individual’s life course can act as a catalyst for a move to a rural area, and where professional factors can be a driving decision, for a change in the lived experience of working life.

One initiative that some of the doctors interviewed were involved in was ‘Rediscover the Joy of General Practice’ (Scottish Rural Medicine Collaborative [SRMC], 2019).
This collaborative project between different Scottish health boards takes a flexible working approach to delivering general practice care in rural areas. GPs can sign up to work for short periods of time in different areas of Scotland, without having to permanently relocate. The program is actively aimed at “those considering retirement who would like to continue providing their skills and experience to the NHS” (SRMC, 2019, p.1).

I have only good things to say about [Rediscover the Joy] as a program … I think it’s a very clever idea because I think these people might otherwise have burned out and left general practice because on the whole, they’re around retirement age. So, it’s not cannibalising a resource that’s still being used elsewhere, it is using something that would otherwise be unused and that’s fantastic. The GPs love it and the practices get lots out of it. (Isobel, GP Partner)

Whilst the aim of the ‘Joy’ project is that doctors do not have to permanently relocate, for some it was a precursor to or a testing ground for a move to a rural area.

The pre-retirement considerations of doctors are a useful contributor to the pre-retirement migration literature, with professional factors layering over the established drivers of a perceived improved quality of life. The potential increased freedom available to those at this stage of their life course provides a way for individuals to open their eyes and minds to opportunities that may not have been practically available to them before, given constraints of family life and career development.

**Changing contexts**

Whilst the perception of the rural idyll may be an attractive driving force for medical professionals at various stages of their career to consider migrating to a rural area, it can be also be considered a façade for fragility, with inadequate local services, isolation, poverty and crime all masked by the bucolic view of the rural within the cultural imagination. The provision of remote and rural healthcare is an example of a service under stress, with recruitment and retention issues creating inequitable access to appropriate healthcare professionals across rural areas in Scotland. This contributes to a rural healthcare system that can lack resilience. The effect, therefore, of an external stressor to the system can be to exacerbate pre-existing issues within
healthcare delivery, all factors which can contribute to a doctor’s decision to move to, stay in, or leave a rural area.

Recent examples of external stressors are extreme weather events, such as storms leading to power cuts or cutting off transport links (e.g. the 2021/22 Storms Arwen, Eunice and Franklin), and the COVID-19 pandemic, both of which can put pressure on a fragile system. During this research, many of the doctors reflected on their experience of working during the pandemic and spoke to the increased intensity of the work and associated burnout, brought about by clinical changes and an increased workload. Some doctors, however, commented positively about shifting their focus, or gave examples of colleagues shifting their focus, to rural areas for work because of their contrasting experience of hospital medicine during the first year of the pandemic:

The reason for ending up in a remote and rural setting, that’s probably got more to do with more kind of recent events, global events that we’ve all sort of been living through recently. Obviously the coronavirus is what I’m talking about…I worked as a junior doctor through the first part of the pandemic and we had to make a choice early on there about where to move to, and there was really no question that I’d feel more comfortable working somewhere with a bit less people and a bit more space, and that’s why I basically ended up [on a remote island]. I’m actually really enjoying it here. In the middle of a pandemic, coming to remote and rural general practice, it almost felt like a, like a different world really, but it was a very welcome relief too, to what we’d been going through (Ryan, Specialist Trainee GP)

This doctor highlights what might be the start of a change within healthcare, where the pandemic has shaped realities for many graduate and postgraduate training experiences, and thus had an impact on their decisions moving forward. This however can be considered within the changing context an individual’s lifecourse where local circumstances at one point in time can influence the migration choices they make. For rural and remote areas that struggle to attract new doctors it may be an ‘opportunity’ to grasp as people perhaps consider their positions and futures. However, as one interviewee cautioned:

I mean, I don't know what it is like to be stuck in the city and those places but I'm not sure whether that is actually then really a career choice or whether that's not trying to get away from the pandemic and I’m not sure that really makes for satisfying jobs. So,
I think, you know, running away from the city I can understand but I think you have to be very careful on what you're letting yourself in to a remote and rural place. I think it's the way you are working here, is very different to a big hospital and, you know, just to get away from a virus it may make you very unhappy. (Eleanor, secondary care doctor)

The value in future research then returns to one of the key parts of migration research that the motivations for moving and staying are important (Halfacree and Rivera, 2012) and a continued emphasis is required in future research on longitudinal perspectives in understanding people's choices (Berg, 2020) and their wider migration patterns.

**Conclusion**

In this paper we have drawn on original empirical research to explore the reasons doctors have chosen to move and stay (or not), to rural areas. We have emphasised the importance of place in these decisions and how it is important to consider this in the wider context of moving and staying (Halfacree and Rivera 2012; Berg, 2020). Further we have highlighted how moving beyond just ‘recruitment and retention’ (See also Maclaren et al., 2022b) is important, as many of the issues facing doctors moving to or staying in rural areas are beyond the scope and influence of their jobs and the health service. Third, in the Scottish context particularly, there is a demographic shift in general practice where many GPs are over the age of 50, and thus are exhibiting specific pre-retirement migration habits, which are of note within the wider context of ageing migration research (Philip and MacLeod, 2018) and wider research on demographic ageing in rural communities as a whole (Berry, 2021). Finally, we have also considered the impact system stressors such as the COVID-19 pandemic may have had on migration decisions and may well have moving forward.

This work is important for several reasons. It expands the research on rural migration to focus on a specific profession, one vital to rural communities, that has specific migratory characteristics. Second, it takes forward Maclaren et al.’s (2022b) contention that a shift in focus from recruitment and retention, and the language of jobs, organisation, and work, is required, to understand why healthcare professionals move or not, or stay or not, in rural communities. Finally, this work continues to bring holistic place-based and interdisciplinary perspectives to bear on work otherwise influenced
heavily by health and medical research as well as such work into dialogue with other interdisciplinary perspectives within the *Journal of Rural Studies*.

As Berg’s (2020) work points to in line with others, rural migration “is not just a matter of home base relocation but is composed, experienced and then lived in complex and diverse ways” (Smith et al., 2015, p. 10; original emphasis). In the context of healthcare practitioners, in this case doctors, this is indeed true and even in many ways more so where a person’s choice to move and stay somewhere has a direct effect, potentially, on the health, wellbeing and sustainability of an area.

**References**


This research had ethical approval from the University [redacted for review anonymity] Ethics Review Board [redacted for review], as well as R&D approval from all Scottish NHS Health Boards ([redacted for review]

The nature of woman’s experiences in particular could be an area for further investigation. There is an increasing number of women going into general practice, with woman making up more than 50% of the GP workforce (Public Health Scotland, 2022). These figures show a steady rise in GP numbers, but fall in Working Time Equivalent going down. Whilst beyond the scope of this paper, work-life balance, rural General Practice and increasing female labour force will be an important avenue for future research.

In the UK doctors undertake undergraduate medical training followed by paid postgraduate training, first in foundation years (FY) and then in speciality training (ST). Speciality training lasts three years, full time, for GPs and between five and up to ten years, full time, for other specialities: https://www.healthcareers.nhs.uk/explore-roles/doctors/training-doctor

A GP list size refers to the number of patients registered with that surgery. Many places that have seasonal population changes for tourism reasons, with expanded list sizes during late spring, summer and early autumn months.

There are six rural general hospitals in Scotland: Balfour Hospital, Orkney; Belford Hospital, Fort William; Caithness General Hospital, Wick; Gilbert Bain Hospital, Shetland; Western Isles Hospital, Lewis; Lorn and Islands Hospital, Oban.