Disrupting and Building a 'Sense of Community': A case study of the Northern Medical Program

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Abstract: Since the early 1980s, stresses associated with health care restructuring have led to concerns about long-term access to physicians in northern BC communities. The Northern Medical Program at UNBC was established to enhance the supply of physicians who want to live and work in northern BC. Previous research suggests that a strong sense of community among care providers can improve the efficiency and provision of health care services. However, it is unclear how changes associated with the implementation of the NMP have impacted the sense of community, through relationships and networks, of those physicians currently practicing in northern BC. Using key informant interviews with physicians in Prince George, BC, this paper explores how the NMP has impacted the sense of community amongst physicians by building or disrupting relationships and networks. While results suggest that relationships and networks have been disrupted in the short-term, the NMP has provided another venue for building relationships and networks to support the long-term viability of health care.

Keywords: social cohesion, social capital, health geography.

1.0 Introduction

Since the early 1980s, stresses associated with health care restructuring have led to concerns about long-term access to physicians in northern BC communities. UNBC's Northern Medical Program (NMP) was established to address these concerns. However, it is unclear how this program has impacted pre-existing supports, relationships, and networks within the physician community. Using an exploratory case study methodology, this paper examines how the NMP has impacted the sense of community amongst physicians in Prince George, B.C.

This paper begins by reviewing how a sense of community can influence the provision of efficient health care services. This is followed by a brief review of health care restructuring before describing the development of the NMP. To understand how this program may be 'building' or 'disrupting' a sense of community, a qualitative analysis of 25 key informant interviews was completed to explore changes in support, interaction, networks, and cooperation before and after the creation of the NMP.

2.0 Defining Community

A strong sense of community can play an important role in delivering services, particularly in places with constrained resources. There are, however, many definitions of community. For example, Tonnie's concept of gemeinschaft defines community as a close network of social systems where interaction is important (Cloke 1994). Similarly, communities may define "the social and spatial framework within which individuals experience and conduct most of their day-to-day activities… bound by a shared sense of belonging, and [how] the group defines a

distinctive identity for its members" (Halseth 1998, 43). In this paper, we use an interest-based definition of community to explore interactions amongst physicians in Prince George, B.C.

3.0 Building Sense of Community

Identifying how relationships and social networks are used to build trust and a sense of community helps to illustrate how social processes can impact the medical community's ability to respond to health care demands. This can be accomplished by exploring contributions to social cohesion and social capital.

Social cohesion is often linked to the extent to which a community responds collectively to stress (Reimer 2002). It is a process that is achieved through the development of relationships and social interaction. Social capital is both a producer and consequence of social cohesion (Schuller 2001). Social capital includes forms of participation, such as networks and trust, that facilitate cooperation between individuals and groups to achieve common goals (Coleman 1988; Keast *et al.* 2004; Mohan and Mohan 2002). Furthermore, a sense of belonging within the physician community develops through these forms of interaction, knowledge sharing, and professional support (West *et al.* 1999). Networks that evolve from cooperation are important for coping with the increased pressures associated with health care restructuring.

4.0 Health Care Restructuring

Service restructuring began in northern BC in the 1980s (Halseth *et al.* 2003; Northern and Rural Health Task Force 1995). Federal and provincial government policies were aimed at regionalizing services to reduce government expenditures for health care services over large distances and low population densities (Furuseth 1998; Halseth and Williams 1999; Hanlon and Rosenberg 1998).

At the same time, health care providers are becoming increasingly professionalized and specialized (Northern and Rural Health Task Force 1995, Struthers 1994), thereby limiting their ability to adapt to work environments that have limited human and financial resources (Campbell 2000; Delaney 1995). Health care professionals are also coping with increased service demands from an aging population (Hanlon and Halseth 2005). Support for health professionals, however, is often located in distant places (MacLeod *et al.* 1998). When combined, these issues can lead to physician burnout and out-migration from under serviced regions.

5.0 Background of the Northern Medical Program

In June of 2000, approximately 7,000 northern BC residents gathered at the Prince George Multiplex, the city's largest arena, in protest of their region's physician shortage (Snadden 2005). There was a call to 'train physicians in the north, for the north'. The hope was not only to train and recruit more doctors, but also to provide more professional opportunities to those already practicing in the region. Six months later, an agreement was reached to create a distributed model of medical education between the University of British Columbia, the University of Northern British Columbia, and the University of Victoria. The NMP represents the 'northern'

component of this agreement. By August 2004, the NMP had admitted its first students (Trick 23 January 2003). This first cohort of the NMP will graduate in 2008.

6.0 Methodology

The purpose of this research is to explore how the NMP has affected the sense of community amongst physicians in Prince George. This is the first step in a longer term monitoring of NMP impacts across northern B.C. Lessons learned can be used to refine the NMP and other distributed medical education programs.

Purposive sampling (Patton 1990) was used to select leaders or key physicians. Overall, twenty-five interviews were conducted. Individual interviews were conducted instead of focus groups in order to enhance the anonymity of participants. It is also hoped that individual interviews would improve the validity and reliability of qualitative data collected as they were less likely to be influenced by others' perspectives and thoughts (Yegedis *et al.* 1999). The interviews were conducted in person, and were recorded and transcribed.

Open-ended questions were asked about aspects of the practice environment before and after the creation of the NMP; pressure points and stresses in physician's professional life, and their involvement with the NMP. Qualitative analysis involved identifying, coding, and categorizing patterns and themes from the data (Hycner 1999; Patton 1990). Content analysis included attention to both latent and manifest information (Babbie 1979).

7.0 Results

7.1 Sources of Support

As suggested earlier, aspects of social cohesion (through interaction) and social capital (through trust and networks) play a role in developing and maintaining a sense of community and are important sources of support for physicians providing health care (Hollins *et al.* 2000; Joyce *et al.* 2003). Thus far, there is an absence of work examining how the development of a medical school impacts the sense of community, professional interaction, and support networks. Participants were asked to describe their professional support both before and after the creation of the NMP.

Before the NMP was developed, participants relied upon both formal and informal sources of support. Existing social cohesion networks were clearly important, as participants talked about how informal interactions with colleagues were critical for sharing information, obtaining advice, and offering support. Social capital is developed as people learn who they can turn to when needed. Informal interaction also helps to transfer skills and expertise amongst medical staff.

Formal sources of support identified by participants included organizations, such as the Northern Medical Society and the BC Medical Association, and formal referrals to specialists, locums, and departments and programs based in Vancouver. Through membership, formal organizations can develop bonding and bridging forms of social capital (Putnam 2001) as individuals belonging to

a particular network can mobilize their solidarity and reciprocity relationships. Through membership, such organizations also develop social cohesion as members congregate around a sense of shared values and a sense of belonging. Some participants, though, identified that lack of time and movements of physicians and specialists out of the community resulted in limited access to networks.

The creation of the NMP led to new sources of support and networks. Human resources improved as the NMP was successful at attracting new physicians and specialists. The NMP brought in new residents, and NMP staff provided logistical and technical support. New academic roles for general practitioners were accompanied by faculty development sessions. Informally, participants appreciated the ability to share stresses associated with teaching and benefited from available teaching support. The development of the NMP also led to closer cooperation between the medical community and the University of Northern British Columbia and UBC.

Meanwhile, the NMP has also produced a series of new challenges for the physician community. Workloads have expanded with new teaching and administrative duties. These new demands place limits on how physicians manage their practice or plan leaves and vacations. Levels and types of support also fluctuate during and between periods of teaching. It can be difficult to get other GPs to fill in for these periods.

7.2 Building Community through Professional & Social Interaction

In response to increased workloads and service demands, relationships and routine social interaction have provided a foundation to develop social cohesion and build networks that can help the physician community respond collectively. Participants were asked to describe professional and social interactions with their colleagues before the NMP began. In response, committee meetings, on-the-job activities, educational opportunities, and medical organizations provided focal points for physicians to engage in routine social interaction.

Informal social opportunities, such as dinner with colleagues or interaction in the doctors' lounge, provide venues to develop relationships and explore common values that can provide a basis for building a sense of community. Similarly, formal social opportunities, such as the Jasper retreat or Northern Doctors' Day, are driven by efforts to facilitate the development of relationships and networks that reinforce a supportive, collegial physician community. Networks that emerge from these social interactions can generate trust (social capital) that can be mobilized to help communities cope with stressful events.

As expected, new opportunities for professional interaction were created through the NMP. Examples include interacting with students and academics, teaching, and mentoring. Participants have also had an opportunity to interact with their colleagues through NMP committees, social events, and lectures. They have participated in problem-based learning groups, and there have been more organized rounds at the hospital to accommodate needs related to the NMP. These interactions have lead to the creation of new networks that have been mobilized to engage in joint problem-solving and education.

7.3 Building and Maintaining Cooperation

Changes in working environments can impact trust and a sense of community and may ultimately influence a physician's decision to remain in the community. Subsequently, participants were asked to describe changes in cooperation. Prior to the creation of the NMP, participants generally felt that there was a good sense of cooperation within the physician community. This stemmed from good working relationships between GPs and specialists, as well as the presence of a small, supportive collegial medical community. Like in most small communities, everyone knew everyone else.

In terms of coping with workloads, the use of networks with colleagues to exchange favours, as well as the high participation at meetings demonstrates the importance of mobilizing social capital in order to help alleviate pressures. In response to the 'crisis' in the health care system, the mobilization of networks and cooperation contributed to the success of the rally at the Prince George Multiplex in 2000. Furthermore, cooperation between the medical community, the hospital administration, the NHA, UNBC and UBC, the provincial government, and numerous communities around northern BC was instrumental to obtaining resources to support stability with the health care system and to develop the NMP.

Health care restructuring policies, however, strained many relationships. Prior to the rally, frustrations with limited resources, limited support, and policy choices led to adversarial relations amongst many health care groups. To complicate matters, sharing resources within the hospital was limited. Cooperation was also limited between hospitals as some were not willing to accept patients from Prince George Regional Hospital.

After the NMP was developed, cooperation shifted from rallying for support, resources, and establishing a new medical program towards teaching activities. The NMP created an additional venue for people to work together. Inherent components of social cohesion or interaction revolve around concepts of inclusion and exclusion (Bruce and Halseth 2001; Wall *et al.* 1998). Following the development of the NMP, physician inclusion in decision-making processes and on-going operations resulted in a sense of ownership that affirms their commitment to the program.

There was closer cooperation between physicians and colleagues at UNBC, UBC, and departments and programs based in Vancouver. Special clinic rounds were set up to cover the needs of medical students, and there was a push to improve the medical facilities to be a teaching hospital. In some cases, as relationships with new medical staff take time to develop, there is a perception that medical students have acted as a bridge between medical departments and disciplines. At the same time, the stabilization of human resources has enabled relationships to develop over time.

On the other hand, new 'growing pains' are emerging with an expanding medical community. In a larger medical setting, some physicians felt that it is easier for doctors to be anonymous. While some felt that there is a lower need to cooperate in a larger medical community, others were unclear about the individual roles of new staff. Fewer physicians are spending time in the doctor's lounge. Participants know fewer people than in the past. There are also challenges

interacting with new individuals due to completing schedules. People also focus on interacting with those in their own medical niche. Finally, interaction is influenced by differences between older and younger generations of GPs. In response, information and communication support, as well as continuing to provide venues for interaction with new physicians, specialists, and support staff will be important to provide a foundation for establishing relationships that can lead to future cooperation.

8.0 Conclusion

In summary, a sense of community can impact a group's ability to respond to stress and increasing demands for services. This paper has explored how the Northern Medical Program at the University of Northern British Columbia may have impacted the sense of community amongst physicians in Prince George, BC by building or disrupting relationships and networks.

While new roles, new staff, and expanding workloads have temporarily disrupted the sense of community, the NMP has provided another venue for physicians to build relationships and support networks. The NMP is fostering interaction amongst GPs, students, and academics. Through participation in the program and on committees, the NMP is broadening physician networks. Driven by a desire to see the NMP succeed, cooperation and trust amongst many health care professionals and groups have improved as people delivered on promises to develop and implement the NMP.

However, the NMP is just one part of a number of recent changes to health care in Prince George. Trust and a sense of community are also impacted by a lack of familiarity. In an expanding health care community, it will be important to ensure opportunities for social and professional interaction continue to exist in order to foster new relationships and strengthen support networks.

As distributed medical education programs work to build capacity and relationships within the medical community, other important lessons should be considered. Additional workloads from teaching both residents and undergraduate students every year may lead to physician burnout. Facilitating breaks from NMP duties will be important to ensure long-term commitment and participation in the program. Sufficient infrastructure and access to office space is also important to support physician participation. The next step for this project is to continue to monitor the impact of the NMP on northern BC and its physician community in order to ascertain if early impressions about the NMP will be lasting ones.

9.0 References

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