Practicing With the Urban Underserved

A Qualitative Analysis of Motivations, Incentives, and Disincentives

Lawrence B. Li, MD, MPH; Scott D. Williams, MD, MSPH; Debra L. Scammon, PhD

Objective: To investigate the personal characteristics and professional experiences of medical providers working with medically underserved urban populations.

Design: Focus groups of primary care providers.

Setting: Public and private clinics in Salt Lake City, Utah, in which the providers had ongoing relationships with medically underserved patients.

Participants: Twenty-four providers (11 men and 13 women), including 12 physicians (three family physicians, seven pediatricians, and two psychiatrists), one dentist, three physician assistants, and eight nurse practitioners participated in three focus groups.

Main Outcome Measure: Interpretative analysis of verbatim quotations regarding personal beliefs, feelings, and practice experiences.

Results: Participants revealed a strong sense of service to humanity and pride in making a difference. They thrive on the challenge of creatively dealing with their patients' complex human needs with limited health care resources. Factors critical to survival in an urban underserved setting include a hardy personality style, flexible but controllable work schedule, and multidisciplinary practice team. The camaraderie and synergy of teams generate personal support and opportunities for continuing professional development.

Conclusions: Increasing the numbers of health care professionals wanting to work with the medically underserved may be facilitated through refining admissions criteria to schools for health care professionals to include values and personality characteristics, emphasizing within curricula the important skills and practice styles necessary to work with underserved patients, and ensuring that underserved practice environments provide support through multidisciplinary teams and structured work hours. These potentially effective approaches could increase success in recruiting and retaining health care professionals to work with medically underserved patients.

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ACCESS TO health care has worsened in recent years, especially reaching crisis proportions for medically underserved populations. One critical component of the access solution is establishing an infrastructure of appropriately trained health care providers in the appropriate locations.

Several factors help to explain why few health care providers practice in medically underserved settings. Typically, medical school provides students with subspecialty-dominated curricula that affirm the value of academic careers.[1] The historical legacy of the pioneer frontier and Protestant work ethic in the United States have contributed to the contemporary belief that those who are socially disadvantaged are somehow morally and socially less worthy. Thus programs for the medically underserved do not appear to be expressions of a normal, pervasive social responsibility.[2] Programs for the underserved are associated with a loss of professional status among physicians serving other segments of the population.[3]

Underserved practice settings are placed at a further disadvantage by the increased competition for graduating primary care residents from health maintenance organizations (HMOs) and private practices with attractive salary and benefits packages. In family practice alone, there are currently six to 10 job openings for every graduating resident, double the

See Practice Commentary at end of article

From the Department of Family and Preventive Medicine, University of Utah School of Medicine (Dr Li), the Division of Family Health Services, Utah Department of Health (Dr Williams), and the Department of Marketing, University of Utah David Eccles School of Business (Dr Scammon), Salt Lake City.

METHODS

Focus group interviews were chosen as a means of engaging participants in interactive exploration of issues related to their common experience of working with the underserved. Focus group discussions have the advantage of member comments stimulating contributions by others. With skilled focusing of the discussion by the moderator on key issues, a predetermined range of issues can be explored in depth by the group.

Focus group participants are not selected to be representative (in a statistical sense) of a particular population. Rather, they are chosen because of their knowledge in the area of interest. Our participants were chosen because they had prolonged experience with different underserved populations. Our interest was in the experiences and perceptions of urban providers practicing in a setting in which they had an ongoing relationship with and commitment to an underserved patient population. Providers from a variety of professional training backgrounds who worked in public and private clinics in Salt Lake City, Utah, were contacted to participate.

Three focus group sessions with urban providers were conducted between February and May 1992. All sessions were conducted by us. One of us (D.L.S.) had extensive prior experience in focus group moderation and conducted the first session and trained the other two investigators (L.B.L. and S.D.W.). At the start of each session, appropriate explanations of study purpose and use of data were provided. Participant consent forms to tape record the discussion were obtained. The sessions all followed the same basic interview guide; however, subsequent sessions explored in more detail issues that needed further clarification. Each session was attended by all of us, with one facilitating the discussion and two recording the discussions and taking process field notes. Immediately following the focus group, a brief questionnaire was administered, and participants received movie tickets as a token of appreciation for their participation. The information from this questionnaire allowed us to characterize our groups with some basic demographic and background information.

Of the 81 providers invited to participate in the three focus groups, 24 providers were able to participate. **Table 1** lists the five basic types of organizations in which participants worked, and **Table 2** lists all the participants and their demographic data by each focus group. Group 1 included nine providers, six men and three women, representing the specialties of dentistry, psychiatry, family practice, and pediatrics. Group 2 included four providers, three men and one woman, in the specialties of family practice, pediatrics, and psychiatry. Group 3 included eight nurse practitioners and three physician assistants. Nine of this group were women and two were men. The 24 participants ranged in age from 32 to 70 years (mean, 42.1 years). They were predominantly non-Hispanic, white (23 of 24; one was Hispanic), balanced in gender (13 women and 11 men), and married (21 of 24). Thirteen participants had children (range, one to five; mean, 1.3). Only three participants had service obligations for educational loans. The range of days spent practicing with the underserved per week was 0.5 to 5 (mean, 3.3). The number of all patients seen per day ranged from five to 70 (mean, 23). As shown in **Table 3**, participants were diverse in their educational debt, income, and type of community of origin.

Collectively, our informants had experience working in a variety of medical settings (with patient populations other than the underserved), including private practice, academic medical centers, and HMOs. In the following section, we present three key themes that emerged from the focus group discussions. These themes reveal a high level of consensus across groups and across individuals. The breadth and length of experiences of our informants' working with the underserved contribute to the reliability of our findings.

Analysis of data from focus group discussions involves reviewing transcripts of the sessions to identify key themes that emerged during the discussions. These themes

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demand of just 2 years ago.[4] Among physicians overall, about one quarter to one third do not provide services for the poor.[5]

The primary care physicians who are willing to practice in underserved areas encounter more challenging patient populations, including individuals who lack financial access to health care, have minority sociocultural beliefs and practices, require more than the usual amount of physician effort, and have insufficient resources. Such challenges include human immunodeficiency virus–positive patients, pregnant teenagers, and substance abusers.[6] Providers at community mental health centers and other underserved settings frequently deal with dissatisfying work conditions such as busy schedules, inadequate time for continuing medical education, inadequate administrative support, and poor financial and organizational stability. These conditions result in burnout, low retention rates, and rapid turnover.[3,7,8]

Despite these trends, there is a cohort of providers who choose to practice in medically underserved settings. This group includes physicians in rural practices and in the US Public Health Service, Washington, DC, including the subdivisions of the National Health Service Corps, the Indian Health Service, and rural practices. Studies have shown that osteopaths, minority physicians,[9-11] and physicians with training in primary care (general internal medicine, primary care pediatrics, and family practice) choose to practice in underserved communities more than other groups.[12-14] Other groups associated with longer retention in underserved settings include older physicians and physicians with group or team experience. Women may be attracted to underserved settings for the convenience of regular hours, weekend freedom, and salaries (vs fee for service).[3]

Recruitment and retention studies of providers working in underserved settings have typically used quantitative analyses of physician databases[3] or large surveys.[15-21] Although these investigations have identified some statistically significant relationships between providers' personal characteristics and practice choices, overall the data provide only a limited understanding of the experiences of health care providers choosing to work in medically underserved settings. The lack of sufficient explanatory depth to comprehend providers' experi-

are then interpreted through an iterative review of relevant literature and analysts' judgment. Results are not definitive conclusions, but rather often are well-articulated questions. A well-focused group discussion can help the researcher formulate artful questions for future research.

With this process in mind, each focus group tape recording was transcribed. One of us listened to each tape to ensure accuracy of transcription. Observer notes were also checked against the transcriptions. These notes were extensive and comprehensive. Checks revealed a high level of accuracy and completeness. Using both session notes and audiotape voice identification, individual passages within each transcript were numbered to represent a contribution from a different speaker. For example, section 2.34 represents the contribution by the 34th speaker in the second focus group session. Participants were given disguised names using a coding scheme that allowed easy identification of the agency with which each participant was affiliated. We identified five basic types of organizations and assigned each a letter (for example, community health centers were coded "C"). A complete list of organizations and corresponding letter codes is given in Table 1. Participants who worked for a particular type of agency were then assigned first names that began with the same letter and preserved the informants' gender. Throughout the text, quotations from the discussion are identified by these disguised names. For example, "Michael, MD, 40M" designates a 40-year-old male physician working with a mental health organization.

The first step in the data analysis was to examine the transcript of the first session, searching for both emerging and underdeveloped themes. Thus, the first discussion guided the refinement of the probes for the following sessions as well as provided a framework for analysis. Later sessions were also analyzed individually before a synthesis was attempted. Owing to technical problems, portions of one focus group session were not recorded. For these portions, investigators used their collective field notes to arrive at consensus of discussion content. Thematic meaning was believed to be accurately captured, although verbatim quotations were not available.

As the analysis proceeded, each of us independently read and analyzed the transcripts, noting important themes. Once themes were identified, we searched each transcript for representative quotations. The identified verbatim comments representing each theme were categorized and sorted with the help of the internal numbering system. Interrater reliability among us was not formally measured, but there was substantial agreement in categorization between pairs of us. If there was not consensus, we discussed the meaning of the passages and together decided how to classify the quotations.

Through multiple readings of the transcripts, the themes were refined, and quotations epitomizing the essence of the themes were selected. To illustrate the richness of the discussions in both breadth and depth, we have chosen to illustrate some themes with single quotations that capture the theme well, while for others we have provided multiple quotations to demonstrate the nuances contained in the transcript. We have been careful not to include any themes for which negative cases were discovered or that were raised exclusively by one type of provider. Because of the volume of data obtained in this study, only those findings judged to expand knowledge of practice decisions and experiences of providers working with the underserved are discussed.

All three investigators participated in every phase of data analysis. The diversity of their backgrounds helped to ensure triangulation in interpretation of the data. Two of us (L.B.L. and S.D.W.) are physicians (family practitioner and pediatrician, respectively) with postbaccalaureate public health and research fellowship training and extensive practice experience with the medically underserved. The other (D.L.S.) has a background in health care marketing, particularly focusing on providers' and patients' perceptions of health care provision. Two of us (D.L.S. and L.B.L.) had previous qualitative research experience (with focus groups and ethnography, respectively).

ences, values, and the perceived benefits and costs of their practice decisions leaves medical trainees, educators, and policymakers with limited ability to implement meaningful changes aimed at increasing the number of providers willing to practice with the underserved. For example, the association that rural or minority students are more likely to practice in areas of physician shortage does not really provide health system planners with a true understanding of why rural or minority individuals choose to practice in these areas. Similarly, further in-depth information is needed for medical school admission committees to identify which particular prospective rural or minority students will elect careers in underserved areas. This information can help curriculum committees to grasp what medical training experiences will positively or negatively influence these individuals' interest and help administrators to know what particular community, office practice, and health system factors will help to recruit and retain such individuals.

The purpose of this study was to better understand career choices and practice experiences of health care providers who currently work with underserved populations. Our interest is not just in describing these individuals, but in understanding their perspectives on practice with the underserved. What are their personal beliefs and characteristics, professional attitudes, behav-

Table 1. Focus Group Participants and Name Codes List

Type of Organization (No. of Participants)	Letter Code	Names*
Community health center (5)	C	Craig, Charlie, Carl, Claire, Casey
Local county health department (6)	L	Lois, Linda, Laura, Lisa, Lucille, Lena
Mental health organization (2)	M	Mark, Michael
Private practice (2)	P	Patrick, Peter
Specialty program for Homeless (2) Maternal health (4) Indian health (1) Children's special health (2)	S	Sam, Sheila, Seth, Sally, Sarah, Sybil, Sonja, Stuart, Suzanne

**Assigned names are fictitious and reflect only the gender of the participants and the types of organizations in which they worked.*

Table 2. Focus Group Participants

Name*	Degree	Age, y/Sex
	Focus Group 1	
Craig	DDS	41/M
Lois	MD	33/F
Mark	MD	50/M
Patrick	MD	70/M
Peter	MD	42/M
Sally	MD	36/F
Sam	MD	50/M
Seth	MD	48/M
Sheila	MD	37/F
	Focus Group 2	
Carl	MD	37/M
Charlie	MD	41/M
Michael	MD	40/M
Sarah	MD	35/F
	Focus Group 3	
Casey	PA	42/M
Claire	PA	32/F
Laura	NP	43/F
Lena	NP	33/F
Linda	NP	35/F
Lisa	NP	37/F
Lucille	NP	50/F
Sonja	NP	37/F
Stuart	PA	38/M
Suzanne	NP	62/F
Sybil	NP	42/F

**Names assigned by letter code are described in Table 1.*

Table 3. Demographics of Focus Group Participants

Demographic Characteristic	No. of Participants	Category
Educational debt for middle-level providers	3	None
	8	<$24 000
Educational debt for physicians	2	None
	9	<$24 000
	1	$24 000 to $50 000
	1	$50 000 to $75 000
Salary for middle-level providers	8	<$40 000
	3	$40 000 to $60 000
Salary for physicians	5	$40 000 to $60 000
	3	$60 000 to $80 000
	3	$80 000 to $100 000
	2	$100 000 to $120 000
Type of hometown	6	Rural area
	4	Small town
	3	Medium-sized town
	8	Suburb
	3	City

iors, and experiences as a group? What are the factors that contribute to development of this special interest? Do providers identify common traits in their different underserved patient groups? What particular rewards or challenges do providers face in these settings? Do these providers use a unique style of practice specific to this setting? Discovering answers to these questions potentially could be valuable in developing effective strategies for recruitment and retention of providers interested in working with the medically underserved and planning curricula to ensure that providers are adequately prepared to enter practice with the underserved.

RESULTS

EMERGENT THEMES

One of the most powerful findings from the three focus group discussions was that the team of health care professionals who provide care to the underserved appears to be the glue that keeps the system together. Thus, we begin our analysis in the first section by exploring the personal and professional identities of these providers—their views about humanity, personal values, and self-images. In the second section, we look at the preferred practice style of these providers and aspects of their work with the underserved that enable them to deal with patients and colleagues in their preferred ways. In the third section, we focus on the rewards that these providers find in their work with the underserved and the opportunities that they see in these settings.

Other important emergent themes included observations about the systems of health care provision, political and social support, and medical provider training. These are addressed elsewhere (S.D.W., L.B.L., D.L.S., Kim A. Segal, MPH, unpublished data, 1992).

PERSONAL AND PROFESSIONAL IDENTITY

The most dominant theme emerging from what providers said influenced their decisions to dedicate at least some of their practice to underserved populations is the personal and professional identities of the health care professionals who participate in this arena of medical care. These providers' beliefs about human rights, backgrounds, experiences, and resulting personal values both push them toward practice with the underserved and away from more mainstream practice.

There was a high level of consensus among focus group participants about the right of the underserved to have adequate health care available. This conviction appeared to be rooted in a deep philosophical orientation toward humanity and the notion that, for many underserved, their plight was not their fault. As one informant commented:

> A recruit asked, "How is it working with all these indigent patients?" . . . as if there's something wrong with being poor . . . Is it considered your fault, like you could have helped it, or does it go back to the middle ages where, if you were a good person and God liked you, you made money? It was only if you did something wrong that you were poor and bad news happened to you (1.60, Lois, MD, 33F).

Although there are undoubtedly many factors that lead to such accepting and caring views about the underserved, an important one appears to be providers' exposure to underprivileged people while they were growing up. This exposure, however, appears to have two very different aspects. The first relates to personal experi-

ences that give providers an empathic ability to identify with the underprivileged. Some informants felt very comfortable with their patients, as if they knew them:

I came from an underserved population, going to west-side schools, knowing the people in the neighborhoods, the circumstances, and the language. I understood and knew all this. So it was very comfortable. I wasn't stepping into an alien culture or situation. It was just what I knew (1.41, Sally, MD, 36F).

The second aspect has to do with never having experienced negative encounters with underprivileged people and thus never developing a bias against the underprivileged that would prevent them from including such individuals within their practices:

Going back to childhood . . . we always felt fairly well off . . . It was certainly never a stigma to be poor or to not be able to buy things that other people buy . . . We didn't have an inner-city population. We didn't have a lot of minorities. So . . . I grew up without a lot of negative connotations for people who are now considered underserved (1.40, Lois, MD, 33F).

Experiences from the past affected not only our informants' attitudes toward working with the underserved, but also affected them in more general ways that contributed to their nonconformity and activism. In fact, many participants attributed their attraction to working with the medically underserved to childhood and adolescent experiences, especially to exposure to strong family role models. For others, a more general immersion in activist communities, such as Boy Scouts of America, a politically active community, or religiously oriented service, was believed to have contributed to this value orientation. For others, their experiences with mentor physicians working with medically underserved patients contributed to their own desire to serve less advantaged populations.

Informants believed that these influences contributed to their view of themselves as caring, compassionate nonconformists:

I was a kind of wild, crazy hippie, really politically left, a child of the 50s and 60s, and this just seems like the progression of where my life was heading. I was never going to put on a three-piece suit and have a briefcase and do that number (3.82, Stuart, PA, 38M).

This deeply held self-image is compatible with serving the less fortunate. By meeting the health care needs of the indigent, our informants meet their own needs for serving humanity.

Several comments suggest that this self-image is so strongly held that our informants wanted to dissociate themselves from the image they held of providers in private practice:

I don't know if I'll ever do private practice full-time—I certainly doubt it. Part of it is an identity thing. I don't really identify, I don't feel like I could identify myself with other people who are strictly in private practice. I just don't feel like I fit the mold (2.34, Michael, MD, 40M).

Informants' comments suggest that their personal and professional identities affected their choices to practice with the underserved. Our participants see themselves in a position to help the underserved by taking on challenges that not all providers would tackle, using a specific, unique practice style.

PREFERRED PRACTICE STYLE

Practicing medicine in their own way was manifested by our informants taking a holistic approach to providing health care. Such an approach enables them to deal with the comprehensive problems of their patients in creative and innovative ways. Many of our informants also felt strongly about the value to both themselves and their patients of working as part of a team of health care providers. These two features of practice style are elaborated to demonstrate the richness of the discussion in the focus groups.

Although our informants had experience working with different groups of patients, a common feature of their experiences was the complexity of problems faced by their patients, made even more difficult by the lack of resources. Because these patients have few or no medical, financial, or social resources, these providers believe that it is challenging to intervene simultaneously across all of these dimensions. Dealing comprehensively with the medical and social needs of their patients frequently meant that providers incorporated cultural, social, emotional, economic, and political factors as they attempted to improve their patients' health status. This need for attention to multiple facets of the presenting health problem was discussed by all provider types, but especially poignantly by nurse practitioners. Dealing with patients in a holistic psychosocial manner requires flexibility, creativity, and innovation. Both physicians and nurse practitioners felt very satisfied when this was successfully accomplished:

Being creative is a spiritual endeavor for people who do this, because that's part of what it's all about—how you can piece together something that needs to be highly individualized. You try to get people to fit categories, but then many times you see how you can get the categories to fit people. The people are very different in many respects, and it satisfies in me a need to seek novelty. In a private setting, you can get very focused. I've worked in a free-standing urgent care center. You can be in there and deal with that single focus problem, and then say goodbye. You know people who come in there using those chief complaints to really cover up many other things. You get sucked into it because of the insurance system. But at least in my work setting, it's an opportunity to be creative in a holistic way with a summary of problems that you need to prioritize with the patient and look at as a way to empower and enable that family to be able to go out and do that for themselves (1.24, Seth, MD, 48M).

It was a real growth experience. I was forced to be creative with minimal resources, working with schools and seeing patients in different settings. Now that I'm in private practice, these things are regarded as not being cost-efficient compared to in my previous work, when I had a sense of what needed to be done (2.23, Michael, MD, 40M).

We are barraged with the comprehensiveness or the pervasiveness of family problems. An example, today we saw a number of single parents involved with children not doing very well in school. They did not have the extended family resources and other social supports that others would utilize (1.17, Seth, MD, 48M).

Their problems are so complex. I walk into homes on home visits—and I have no idea where to start—where there are sick kids and dirty kids and disorganized homes and abuse and safety hazards. I like the idea of being able to help them simplify, prioritize, and choose one thing that they can be successful at (3.35, Lena, NP, 33F).

I have a holistic view. I see people as physical beings with emotional sides and intellectual sides and spiritual sides and social sides and relationships. I have a hard time just compartmentalizing. I can see different components that are contributing to one problem. If I just try to work with one problem in this population, you're unsuccessful a lot of times (3.16, Lena, NP, 33F).

Even routine problems with established treatment plans presented interesting challenges because of the unique circumstances of the patients. Providers also described feeling challenged because a visit with an underserved patient could not be managed the same way as a visit with a private practice patient. Providers must anticipate what might interfere with their patients' compliance with their recommendations. Working with underserved patients offered the opportunity for these providers to be creative and innovative. Many find this challenging and rewarding:

Nurse practitioners have a little bit more of a holistic approach to patients. The population that I deal with in particular needs a lot of teaching, a lot of reinforcing of things. I feel more satisfied and better about myself doing this particular job than I would if I was out in private practice. And maybe I'm feeling altruistic . . . but I still feel it's okay (3.26, Suzanne, NP, 62F).

A well-child visit is not the same as it is in private practice. The issues are totally different. When the kids are living with their parents and five other people in the house, the parents can't let the child cry through the night because so and so has got to get up. You just don't say, "Go home, and in order to get your kid to sleep through the night you do A, B, C, and D." It makes a big difference when working with this group (3.27, Sybil, NP, 42F).

Providers contrasted this with their perception of private practitioners who work in group practice as essentially working alone despite covering call for other practice members:

I see people in private group practices. They're so busy they hardly see each other. The one is covered from the other one, and they don't sit down and talk a lot about things (2.50, Charlie, MD, 41M).

To our informants, the value of the group in private practice is its structure, whereas in the setting of practice with the underserved, the value of the group is the team functioning.

For many participants, working together with their colleagues as part of a well-functioning team is seen as a particularly unique and important feature in their practice with the underserved. Interdependence among group members facilitated greater communication and group synergy. Informants relied not only on team members performing their individual roles, but also on their willingness to share responsibility:

My partner is a family nurse practitioner. We only overlap 2 days a week. When she's there, everything seems to go a lot easier just because there are two of us. So if 80 people come that day, we handle it. We'll laugh through it, and we trade a lot of things. I really notice it when I'm out there alone, like today. I just got my head staved in today. I left thinking, "God, I wish [she] was here" (3.141, Stuart, PA, 38M).

The dynamics of a well-functioning team mean that members truly work together by sharing multiple points of view and decision making. Participants like knowing that they have a sounding board for consulting about difficult problems. Backup was particularly important to the middle-level providers, giving them greater self-confidence. Having ancillary staff (eg, social worker or psychologist) on the teams also gives participants the freedom to admit that they do not know all the answers and the willingness to ask for help from specialist team members:

We have a fortunate circumstance to be involved with the team. A physician is not the head of the team. It's supposed to be an egalitarian operation with psychology and nursing and social service and other medical specialties that are engaged as they need to be to be able to look at the whole child (1.17, Seth, MD, 48M).

For individual providers, teams also provide camaraderie, support, and nurturing, which is perceived as critical to both their survival in stressful practice settings and long-term satisfaction and continued commitment to practice with the underserved:

The people that you have an opportunity to work with are an attraction to practice with the underserved. In our clinic system, we have about 23 providers, and it's split about equally between midlevel practitioners and primarily family practice docs. I think that one of the main reasons that we have a significant lack of turnover in our system is because the interaction is so good between the midlevels and the physicians (3.31, Casey, PA, 42M).

We hold each other in high regard. When a couple of my long-term partners left last summer, particularly one that I helped train who was my partner for 5 years, I mourned his leaving for a couple of months. I'm over that now. But these relationships are just so rich. I think that's very important, the ability to enjoy what you're doing and be inspired by your coworkers (2.48, Charlie, MD, 41M).

Working with others also provides perspective. Colleagues are available to ventilate the frustrations and stresses of working with underserved populations, an essential process for dealing with burnout. As one informant said:

It helps you redirect. Sometimes when you get frustrated, it's because you're not seeing something, and if you start telling it to someone else, and then they say, "Whoa, I think you're going kind of overboard on this," then you can refocus and say, "Maybe I am being kind of heavy on this, and I'll just pull back for awhile" (3.145, Lena, NP, 33F).

Working with this kind of a population, you need someone to blow off steam . . . Otherwise you take it home. You don't shut the door (3.143, Suzanne, NP, 62F).

In the preferred practice style of our informants, each element appears to hold benefits for both patients and providers. Importantly, the team structure, formal and informal roles, and lines of communication are perceived to enhance the team's effectiveness. Members truly respect each other's clinical contribution and interper-

sonal and organizational skills in responding to the big picture of the patient's situation. When this is possible, our informants believe that their patients are better served, and this knowledge adds to their job satisfaction.

REWARDS AND OPPORTUNITIES

In addition to the professional challenges that provided satisfaction, informants cited other rewarding aspects of their work with the underserved. Benefits include having a positive impact on their patients' lives, having professional opportunities to continue learning, working in environments that met practical considerations for flexibility, and balancing family and professional roles.

Consistent with our informants' attribution of their motivation to practice with the underserved in part to a deeply held service ethic, providers believed that they were making a difference. By having a positive impact on patients' lives, providers reinforce their sense of self and live as the selves they most want to be. In many cases, the care provided by our informants is likely to be the only health care available for these patients. Providers noted that their patients seem to be very appreciative of what is done. These providers gain a lot of satisfaction from providing this unique service:

> This person isn't going to doctor shop and go to the next place or the next place or the next place. If they don't get what they need from you in your particular situation, they're not going to get it from anyone. So it does make a difference (1.14, Sally, MD, 36F).

> I'm a nurse practitioner . . . I do care with juvenile detention . . . doing something for people that can use my services. There are a lot of people who are willing to work with middle class and upper middle class . . . there are very few people who are willing to work with the underserved people (3.6, Suzanne, NP, 62F).

One private practitioner who provides services to patients covered by Medicaid commented:

> I like to think that I get the same satisfaction from all of my patients. But I guess, to a certain degree, I think that the medically underserved appreciate it a little bit more. They enjoy my medical care, and I enjoy giving it to them (1.11, Peter, MD, 42M).

Our informants genuinely liked their patients and bonded with their practice populations and individual patients. The closeness of the relationships between providers and their patients means that both enjoy the interactions. In some cases, these interpersonal relationships affect patients' lives, which in the long run may affect their health status. Interpersonal relationships can also make a difference in the providers' lives:

> Yesterday I got a phone call from a semiliterate patient, a nice gal with an eighth grade education level . . . [She asked,] "How are you? I heard about what happened." She was referring to a young patient of mine who had recently died in a labor and delivery setting. I could hardly talk to her. I was so overcome that she was really concerned about how I was doing with that. So I have just a very rich support system from patients and colleagues. It's really nice to have that in working through this particular period of my life. It would be hard to give that up (2.42, Charlie, MD, 41M).

Some of the enjoyment that comes from working with the underserved is attributed by informants to the rich mix of cases in their practice. They found this diversity to be challenging, stimulating, and personally rewarding:

> I really enjoyed the ethnicity and diversity of the Southeast Asian population. Their cultural differences were so fascinating. I would not have experienced this anywhere but at the clinic (3.32, Sonja, NP, 37F).

Working with the underserved forces providers to redefine what it means to have an impact or be successful. Informants have learned that it is the little things that count:

> You have to concentrate on the little things. You get disgusted with patients' attitudes, but you learn not to let them bug you. They are that way for a reason. Some patients are always angry; they make me feel responsible. I understand that better now (2.26, Sarah, MD, 35F).

> I don't expect [patients] to walk out of here and change that behavior, but let me just plant the seed for [them]. Maybe it will sprout a year from now (3.30, Stuart, PA, 38M).

Defining what it means to have an impact carries over into other aspects of practice with the underserved. Learning to set limits, not be judgmental, be clear on goals, and value one's contribution to patient health care in terms of long-run outcomes appear to be key coping skills. With the tension of constantly being asked to do more for their patients, there is a fine balance for providers between feeling positively challenged and frustrated or overwhelmed:

> In taking care of these folks . . . if you have prejudgments or expectations of them, you're going to be disappointed. You have to lower your expectations and be pleasantly surprised when things work out well (3.74, Casey, PA, 42M).

Another type of reward available to many of our informants arises from the ways in which they can manage the practical aspects of their work, such as schedule and career flexibility, and avoid less desirable administrative tasks and paperwork. Even strategies for dealing with these issues had to fit within the philosophical perspectives of these providers.

Especially when comparing their situations to their perceptions of providers in private practice or HMOs, participants expressed satisfaction at being paid a salary, with less pressure to generate high patient volumes or to be concerned about billing. Although in their minds these providers earn lower incomes than they might in private practice, HMOs, and academic medicine, this is not an important issue. Providers believe that this arrangement gives them the freedom to be truly responsive to their patients' needs:

> I don't personally like the idea of my motivation to be money-oriented, for example, thinking, "Well, I have to see so many people in so much time to make so much money to meet so many bills." I do like the idea of not looking at somebody and having a dollar sign saying yes or no to what I do necessarily. I prefer to look at what they need and then try to match resources, within reasonable limits (3.35, Lena, NP, 33F).

My own experience and that from recruiting other physicians

is that money is not an issue. The important things are feeling a positive sense of challenge, practicing high quality of work, and having enough time off (2.8, Carl, MD, 37M).

Flexibility and autonomy appear to be necessary elements in the equation for practice with the underserved. The pressures of working with the underserved are great; providers are inexperienced at juggling the competing demands on their time. Participants described having control over their work hours (eg, working only 2 days per week or an 8-hour shift) as being extremely important to help balance the demands of working with very sick, needy, and resource-poor populations. Other components useful for setting boundaries on one's practice included acceptable call schedules, liberal vacation time, and time off for other activities. Balancing career with flexible part-time work conditions was described as being particularly important for both women and retired providers to allow enough time for family and meaningful work while simultaneously avoiding unwanted administrative paperwork.

The opportunity to continue to learn from their fellow providers was seen as a real benefit by these informants. Professionally, working in a multiple-provider setting offers opportunities to interact with peers, bounce ideas off others, and get feedback. These opportunities were seen as unavailable in some other practice settings.

The extrinsic motivation of money appears to be less important to these providers than the intrinsic motivation of a challenging job, which they believe that they are competent to tackle. From informants' perspective, the flexibility that their positions afford them professionally and practically, the learning, professional teamwork, and social interaction provided by their clinic colleagues, and the complex and dire needs of their patients outweigh the disincentives of lower pay and less professional stature among colleagues in nonunderserved practice settings.

COMMENT

The nature of qualitative research is to identify emergent themes and then explore these further through other literature that discusses these themes. This exploration can add richness to the interpretation of themes, especially when it delves into previously unconnected domains. Through the use of qualitative research, we have been truly able to get to know our participants. We have explored with them the reasons why they made the choice to practice with the underserved and what that choice has meant to them in terms of their professional and personal lives. Their comments make the statistics previously reported in the literature come to life. Deeper meaning was revealed with regard to important personal and developmental influences on the values and attitudes of our participants. Insights were gained about the intrinsic rewards of practice in underserved settings, advantages of egalitarian provider teams, and benefits of structured and controllable work assignments.

In interpreting our data, we relied on diverse literature sources to help us to fit our findings into a broader picture of these providers. We are left with a portrait of providers choosing to work with the underserved as hardy, resourceful, optimistic, and idealistic yet vulnerable individuals. Although it may be possible to continue to attract more health care professionals with these personality and value profiles into practice with the underserved, it is critical that they be protected. They are vulnerable financially. They face trade-offs of lifestyle and family demands. Most importantly, they face burnout from dealing with the complex problems of their patient population with only minimal resources at their disposal. As one informant described:

> I feel fatigue trying to do as much as I can with as little as possible on a constant basis. The organization can't afford to hire staff. I am even looking in the drug cabinets and using drugs with past expiration dates because that's all there is. Over time, there's a cumulative effect. With everyone else doing the same after awhile, it feels like a heavy cloud descending over the organization. It's like pouring your life energy into a black hole. When am I done at the end of the day? The patients' needs can take every ounce of energy from you. It takes diligence to set your own limits (2.25, Carl, MD, 37M).

If we do not want to lose the idealistic individuals who are attracted to practice with the underserved, then every effort must be made to make their practice environments as supportive and developmental as possible. Many of the valued aspects of practice with the underserved revealed by our informants are not expensive in the sense of requiring capital investments. Environments can be molded by the people in them through the relationships they forge and synergy they generate. These opportunities must be cultivated.

Turner[22] has defined the term *communitas* as a social antistructure that frees participants from their normal social roles and statuses and instead engages them in a transcending camaraderie of equal status. Our informants describe a similar social organization at their workplaces, with an egalitarian team structure in which a nurse practitioner or social worker might emerge as the leader instead of a physician. Team roles were determined more by individual strengths and skills than by preexisting status. In the constantly challenging underserved practice settings, *communitas* also provides significant support for our informants.

Our participants approach their practice with the underserved with a positive, "can do" attitude, finding their everyday encounters challenging rather than frustrating, their patients interesting rather than difficult, and their own effort as having an impact rather than going unobserved or unappreciated. They embody a personality style of hardiness described by Kobasa et al[23] as a composite of commitment, control, and challenge. Persons with high levels of these traits have high curiosity about the meaningfulness of life, believe and act as if they can influence the events of their experience, and regard life changes to be the norm and a stimulus to growth. These two themes revealed by our data—*communitas* and hardiness—suitably characterize individuals who provide health

care to the underserved. Our data also enable us to formulate some recommendations about how to match the right providers to the right settings to enhance the availability of care to the underserved.

RECOMMENDATIONS

If the goal of health system reform is to ensure universal access to care, it may be fundamentally more important to influence providers' attitudes toward working with the underserved than to focus exclusively on restructuring financial access. Identifying and enhancing inherent rewards of working with the underserved and cultivating positive attitudes toward them appear worthwhile. It is possible that under proposed health system reform plans, a different group of providers may be working with the underserved in the near future. These new providers may well have different needs and perspectives.

Our informants are hardy individuals who believe that they are in control of their professional lives (most of the time), are very committed to what they are doing, and thrive on challenge. If access to health care is to be achieved for the underserved, the supply of providers who have the characteristics that make them hardy must be enlarged. More individuals with these characteristics should be recruited into the medical professions, trained to deal with the situations they are likely to face in practice with the underserved, and supported in a practice environment in which they can function optimally.

RECRUITMENT

Our informants exhibit a number of values and personal characteristics in common—especially their caring for humanity, backgrounds, and personal values. If these can be better understood and defined, recruitment practices of schools for health care professionals might be well served to include such factors as part of their screening criteria. If more applicants with these values and personal characteristics could be recruited into schools, less emphasis on persuading students and residents to choose practice with the underserved might be required. These characteristics are very similar to those of medical students selecting family practice.[24,25] After admission, students could also receive career counseling that compares their personal values with profiles of health care professionals working in medically underserved settings.

CURRICULA

Although curricular issues were not a major focus of our study, informants spontaneously offered several viewpoints in their discussions that are worthy for further consideration.

Our provider participants largely attribute their motivation to the intrinsic rewards of providing needed care and close personal relationships with their patients and fellow providers. We speculate that further articulation of these intrinsic rewards and identification of ways in which they can be achieved could potentially enhance the training curricula of health care professionals and possibly influence more trainees to practice in this setting.

In their work with the underserved, provider informants used certain personal skills that traditionally have not been emphasized in health care professional and postgraduate training curricula. It is possible that inclusion of training in these skills in the formal curricula could provide students with the abilities both to practice well and reap the inherent rewards of being able to respond competently to the needs of the underserved. These abilities include individual skills for dealing with ambiguity and being self-reliant, resourceful, creative, and holistic when working with patients' complex human problems. Team skills that could be developed include working together to provide coordinated care and recognizing incremental small changes in patients' health behavior as well as long-term outcomes.

The decision to practice with the underserved appears to be influenced by providers' attitudes toward the underserved as patients. The undersupply of providers willing to work with the underserved is in part related to an aversion to practice with the underserved, based on lack of information or misperceptions about what the underserved are like as patients and human beings. As far as this is true, exposure through work with such patients may facilitate the development of positive attitudes and appreciation for the rewarding relationships possible between provider and patient. Changes in training curricula for health care professionals to include more exposure to racially and culturally diverse populations, low-income families, and patients from rural and inner-city settings may increase the number of providers choosing to work in these underserved settings. Exploration of the processes by which attitudes about the underserved are formed and the people and experiences that affect these attitudes should prove fruitful.

RETENTION

Creating and maintaining environments supportive of the providers dedicated to caring for the underserved is also important. We discovered several aspects of our informants' practice environments that enable them to cope with the demands of practicing with the underserved. Flexibility and the establishment of boundaries on their practice appear to be very important to our participants.

Our informants found a great deal of satisfaction in working with teams of health care providers. Consideration of the dependencies and interpersonal interactions within these teams should be a top priority when structuring work environments for professionals dealing with the underserved. It seems worthwhile to explore the ways in which team support can work to reduce stress and avoid burnout among providers practicing with the underserved.

An issue for future research is the impact that team structure and team roles have on the team's func-

tioning, both formal and informal. What are the impacts on providers and patients when hierarchical structures are abandoned in favor of structures that result from situational needs and individual competence? How can the impact on quality of care and provider satisfaction be assessed?

Facilitating a practice style in which the focus is on problem solving within the big picture and the highest priority is placed on patient needs (rather than productivity measured by number of patients seen) appears to be desirable. Our informants valued being able to decide how much time to spend with patients and how to proceed with caring for them. They valued being able to treat patients in a holistic manner.

Our informants provided insights pertaining to recruitment, training, and retention issues, and their comments have led us to make recommendations with regard to each of these as a means of enhancing access of the underserved to health care by increasing the supply of providers working with them. Our informants described practice environments in which coping mechanisms were built into their jobs. They appreciated having organizationally imposed limits on the time spent in practice with the underserved. Limited call schedules, liberal vacations, and even opportunities for continuing medical education provide a respite from the pressures of this practice. Working together as a team provides both professional support and personal nurturing. One wonders, however, about the extent to which such coping mechanisms are necessitated by the problems created by a two-tiered system of haves and have-nots and the financial (and thus resource) constraints connected with providing care to the have-nots. The real challenge may be not to ensure that such coping mechanisms are present for providers working with the underserved, but rather to correct the system, thereby removing the need for such coping mechanisms.

A limitation of this study is the small number of informants interviewed. On the basis of personal knowledge, we believe that our participants are more likely to be more altruistically involved in their work than the nonparticipants. Another important limitation is attributional bias, as discussed by Pathman and Agnew.[26] Participants' telling of their stories and insights may not reflect a true factual cause-and-effect relationship of their motivation or their behaviors based on their personal characteristics and experiences. The ideas presented here typically emerged from participants' spontaneous statements, not from direct inquiry or weight of evidence. We cannot determine how commonly or strongly held these perceptions are among other providers working with the urban underserved. These are fertile areas for further research. The demographic survey is a self-report questionnaire to provide some profile of our participants. Although the sample size may be appropriate for qualitative thematic generation, it is too small to attempt any meaningful analysis, correlation, or inference from the survey data.

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Correspondence to Department of Family and Community Medicine, University of Utah School of Medicine, 1C26 SOM, 50 N Medical Dr, Salt Lake City, UT 84132 (Dr Li).

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