

# “There’s nobody else here, right?”: Concertive Control in Rural Health

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## Abstract

Rural communities present distinct healthcare disparities, including a higher risk for comorbidities, lower socioeconomic status, and a higher hesitancy towards medical care, compared to their urban counterparts. Current research focuses on the lack of personnel and physical resources in rural areas. However, this paper proposes an alternative approach to studying rural healthcare. Concertive control explores how self-managed teams create management structures that are more restrictive than traditional, vertical management systems (Barker, 1993). Eight providers were interviewed to probe their phenomenological lived experiences. Three themes emerged from iterative coding: investment, out of your comfort zone, and nobody else. We conclude that rural communities deserve acceptable healthcare from providers who understand the unique facets of rurality. Current solutions, such as telemedicine and loan repayment programs, do not offer equitable or sustainable options for rural communities and do not consider the controlling gaze of these rural communities revealed by providers.

*Keywords: Rural disparities, Provider perspectives, Concertive Control, rural South, Community impact.*

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In the United States, 46 million people, nearly 20 percent of the population, live in rural areas (FDA, 2021). The dearth of physicians working in these regions evidences the lack of healthcare resources available for rural communities. Only 11 percent of American physicians practice in rural areas (Jaret, 2020), up from nine percent in 2000 (Rosenblatt & Hart, 2000), but still an alarmingly low percentage. Focusing on the location of this study, 78 of North Carolina’s 100 counties are rural, having a population density of 250 people or less per square mile (NCRHA, 2022). Since 2005, 195 rural hospitals have closed nationwide, with 12 being located in North Carolina (Cecil G. Sheps Center, n.d.). Nevertheless, there is limited research on why healthcare providers choose to stay in rural medicine despite known limited resources. One explanation is the development of concertive control structures (Barker, 1993; Barker & Cheney, 1994; Papa et al., 1997). This project explores the relationship between rural providers and their communities and the impact of concertive control on these providers’ decisions to practice rural medicine.

## Literature Review

Exploring concertive control in rural healthcare requires a look at concertive control, along with barriers and initiatives.

## Concertive Control

In organizational communication, scholars often define control through an organization’s structure and dissemination of power (Mumby & Stohl, 1991). Whereas bureaucratic organizations are controlled by a higher up managerial team and normative control stems from covertly imposed values, self-managed work teams rely on decentralized power and shared decision making (Tata & Prasad, 2004; Barker, 1993). Barker (1993) elucidated self-managed work teams in modern organizations. He outlined three phases of concertive control, a “form of control more powerful, less apparent, and more difficult to resist than that of the former bureaucracy” (Barker, 1993, p. 408). First is consolidation, where a group distinguishes ideals to facilitate self-management. Next is the creation of normative rules, where guidelines emerge based on group norms. Third is the stabilization and formation of rules. Here, the group evolves from rules-based norms to structured, fixed rules (Barker, 1993). By the end of these phases, the group has become more controlling than a typical hierarchical management system.

We maintain that rural communities exhibit characteristics of self-managed teams, and the scope of concertive control can be extended to a community level. Williams (1993) explains that working-class communities create culture through their

emphasis on “neighbourhood, mutual obligation, and common betterment” (p. 9). This project applies these principles to rural communities, proposing that the creation and reinforcement of norms in rural areas are reliant on reciprocity and connection. These norms then become stable, explicit rules that are enacted through communication, resulting in the presence of concertive control.

Research has illuminated problems recruiting and keeping rural physicians (Nielsen et al., 2017). Much of this research details the lack of physical resources, including medical facilities, funding, and specialists. Little research focuses on the relationship between rural physicians and their communities, including concertive control (Barker, 1993). Even recent research (Larsen & Tompkins, 2005; Ormes & Ziemer, 2019) does not extend the concept beyond self-contained organizations, except Gibbs et al.’s (2022) theorizing of concertive control in online communities; but Gibbs et al. do not include studying broader communities as proposed by Papa et al.’s (1997) research with the Grameen Bank.

### ***Concertive Control and Identification***

Papa et al. (1997) examine how identification functions in concertive control. For concertive control to evolve, each group member must identify with other members and group values. Papa et al. (1997) describe how Grameen Bank workers’ organizational identification led to acceptance of more restrictive control systems by outlining two paradoxes: the paradoxes of control and sociality. Workers believe they have freedom because they have control over their work, but they experience more restrictive working conditions. Bank workers find fulfillment helping poor Bangladeshis, but work requirements are brutal. In essence, bank workers are surveilled by two organizations – one formal in the Grameen Bank and the other more informally and invisibly (Foucault, 1979) in the organizing enactment activities (Weick, 1979) of loosely conglomerated centers in the community. The connection between the Grameen workers’ fulfillment, identification with other workers, and acceptance of restrictive working conditions offers a foundation for examining similar connections in rural healthcare, where organizing may be understood in terms of the community itself (see Farmer, 1999). This project extends the scope of Papa et al.’s (1997) work, viewing the community as an organization versus examining an established company like the Grameen Bank.

### ***Rural Healthcare Barriers***

Prior rural healthcare research is centered on the physical barriers present for rural communities. Coombs et al. (2022) explore barriers present in Montanan healthcare through interviews with rural providers. The two most relevant themes were (1) a barrier exists between the rural identity of patients and receiving healthcare and (4) time and resource constraints. Rosenblatt and Hart (2000) connect specialization and managed care to nationwide rural physician shortages. They offer three solutions to address disparities in rural medicine: advancing educational initiatives that encourage rural practice, reimbursing physicians who offer rural services, and creating government programs that provide rural services. Nielsen et al. (2017) examined health disparities in rural Missouri. They attribute the shortage of rural providers with a lack of training in rural medicine, noting 99% of residency programs are in urban areas. Chipp et al. (2011) specify commonalities among practicing physicians in rural areas, including providers’

descriptions of how patients approach them for advice outside the medical setting.

### ***Rural Health Initiatives***

Solutions to previously mentioned barriers have hinged on monetary incentives to recruit physicians to rural and underserved areas. Nationally, physicians can apply to the National Health Service Corps’ (NHSC) Loan Repayment Program, which repays up to \$50,000 in loans to physicians who agree to practice in an approved NHSC site for two years. In North Carolina (where the current project is based), the Department of Health and Human Services’ (NCDHHS) Office of Rural Health incentivizes physicians practicing in rural communities through the North Carolina Loan Repayment Program (NCLRP), which offers physicians up to \$100,000 towards student loans for a four-year rural commitment (NCDHHS, n.d.). However, current literature suggests that loan repayment programs do not result in providers continuing to practice rural medicine once their obligation has been fulfilled (Russell et al., 2021).

Using the existing literature regarding systemic barriers and impacts of concertive control, we pose the following research questions to understand the lived experience of rural healthcare providers:

- **RQ1:** How does a rural community function as a self-managing team from the lens of concertive control?
- **RQ2:** How does identity affect a provider’s decision to accept harsher working conditions in rural areas?
- **RQ3:** How does community dependence affect providers’ acceptance of working conditions?

## **Methods**

### ***Participants/Co-Researchers***

After obtaining IRB approval, this project used a phenomenological approach to explicate the lived experiences of rural providers (Faulkner & Atkinson, 2024; Glesne, 2014; Patton, 1990). The lead author recruited co-researchers via email from rural areas in North Carolina through snowball sampling (Glesne, 2014; Patton, 1990; Penrod et al., 2003). Co-researchers were practicing (both allopathic [MD] and osteopathic [DO]) physicians and physician assistants (PAs). The lead author grew up in a rural Oklahoma county and experienced firsthand the informality that exists in rural healthcare, with her provider of over 15 years serving as her sixth-grade Sunday school teacher. She initially envisioned a career in medicine before pursuing communication studies. The second author has roots in central Appalachia, also a region with limited healthcare options. His dissertation investigates the concepts of unobtrusive control in the region.

### ***Procedure***

Because of co-researchers’ demanding schedules, the lead author conducted both in-person and Zoom interviews from November 2023 – March 2024, using a semi-structured guide (Patton, 1990), asking the same questions in each interview with additional probing questions as participants’ narratives dictated. The importance of each participant feeling comfortable divulging sensitive information was central to this study, so researchers utilized an individual interview strategy to be cognizant of anonymity concerns. Authors utilized the term “provider” to add a further layer

of anonymity by not distinguishing between MDs, DOs, and PAs. Interviews were recorded and transcribed using Microsoft Word Dictate, then manually checked for accuracy. Overall, 200 hours of fieldwork observation and interviews produced 67 single-spaced transcription pages.

## Results

Eight providers were co-researchers: 2 MDs, 2 DOs, and 4 PAs. Areas of practice included family medicine, emergency medicine, and pediatrics. Length of practice varied from less than three to 20+ years. The authors coded interviews separately using values coding as suggested by Manning and Kunkel (2014), examining how “value systems operate in a social system by analyzing attitudes, values, and beliefs” (Faulkner & Atkinson, 2024, p. 80). Authors then engaged in multiple rounds of collaborative coding to synthesize resulting themes (Tracy et al., 2024). In response to research questions, the following themes materialized from co-researchers’ lived experience narratives:

In response to RQ1, a theme of Investment emerged. Investment to and in the locale is central to the experience of the rural community, a phenomenon guarded by natives to prevent weakening of community bonds (Syrek, 2009). As Provider A maintained, “people like it when their doctors live in the area . . . patients ask me where I live, because they want to know how invested are you?” This provider explained she “wanted to be the person that ran into patients in the grocery store”, exemplifying the mutual belief of providers being community members. Provider C, who is not local, also sensed community surveillance: “I don’t live here. . . Patients have asked me . . . where I live, and, you know, are you from around here.” Echoing Procter (1990, 2004), the rural community views this investment as a rhetorical act through which social community is created and recreated. Providers sense this intrinsic surveillance narrative (Foucault, 1979), presuming and expecting connection, as the expectations are embedded “in the social fabric” of our communities (Foucault, 1982; Barker & Cheney, 1994, p. 39). The ‘social fabric’ demonstrates the first step of the development of concertive control structures, manifesting itself in mundane communicative occurrences, like Provider H’s affirmation that providers should be “a part of the community, part of their fabric.” Co-participants’ responses showcase the presence of understood ideals with the purpose of self-management. Both providers and patients expect a personal and professional relationship, demonstrating concertive control consolidation (Barker, 1993).

In response to RQ2, the theme of Out of Your Comfort Zone emerged. Provider D maintains rural conditions are “a good challenge, because it pushes you out of your comfort zone a little bit. It’s rewarding and I think that’s . . . kind of what it’s all about.” The identification with the rural community discussed for RQ1 unobtrusively trains (Foucault, 1979) providers to accept working conditions foreign to their urban colleagues. Provider B, who described herself as “almost overly involved in [her] community”, has worked “every Saturday since April of ‘21”, except for one Saturday to watch her son graduate from college. When speaking about time off, Provider B explained that “it’s hard to take vacations, because . . . if I’m going to take a vacation, they just close the clinic”, and Provider F corroborated this by stating she receives calls from patients when she takes time off around Christmas. The

second stage of concertive control is exemplified through these narratives, with a normative rule being that providers should be available whenever needed. Rural providers must work as bricoleurs to create something from nothing (Baker & Nelson, 2005; see also Haider & Cleaver, 2023; Shafaei, et al., 2023); yet the resulting ‘something’ remains constrained by environmental factors. Provider F commented that those factors are “kind of the restraints in rural medicine that you won’t get other places because . . . they won’t go or they fall through the cracks.” At times, the rural “won’t go” is a function of rural resilience (Ballard-Reisch, 2010; Okamoto, 2020), but constraints remain (Bell et al., 2024). Care is compromised, as Provider B stated, “the standard of care is dramatic between rural and urban. . . . [local] infant mortality. . . . It’s the same as Bangladesh.” While such constraints go unrecognized by patients, providers are acutely aware and frustrated by administrative answers. As reassurance for rural practice, administrators offer comforting statements to providers like “Don’t worry. If anything bad happens, they’ll just helicopter them out” (Provider B). Provider B offered a narrative that defies administrative excuses:

*I had 27-week twins... They needed to be in a NICU... I got both of them intubated . . . [they were] too little to breathe... so I was just holding their tubes in with my gloved hands . . . waiting for the helicopter to come. . . . Helicopter doesn’t [sic] fly in thunderstorms. So . . . we were waiting on ground transport... so it was hours and hours I had to keep the 27-week-old twins alive.*

Certainly, value-laden premises (Barker, 1993) of health professions contribute to providers’ persistence working through barriers, but the power of concertive community expectations creates an additional layer of responsibility (Mumby & Stohl, 1991).

In response to RQ3, the theme of Nobody Else emerged. Provider B explained that she “sort of [feels] obligated to keep taking care of [her patients]”, because “there’s nobody else here, right?”. Due to rural communities’ demographic profile, there are additional barriers to care, including lack of public transportation and, more gravely, limited specialists. Provider D explained she has, “to act like whatever kind of specialist I was trying to refer to”. When describing rural primary care, Provider E stated that he is, “the specialist for everything until [he] can’t anymore”. This community and professional dependence prompted Provider H to spend nearly a decade working with a local initiative that provided uninsured individuals with care outside normal business hours. She was asked if she would, “be interested in helping in this clinic”, but the underlying question was, “would [she] be interested in staying till midnight” once a week. She chose to add this additional responsibility because her supervising physician “was pretty much doing that clinic by himself”.

These provider experiences illuminate the final stage of a community-based concertive control system. Whereas Barker (1993) described organizational workers creating a “communal value system that eventually controls their actions through rational rules” (p. 435), our co-researchers are immersed in pre-existing value systems that demand expertise, loyalty, and time. Their medical training provides connection to the Hippocratic Oath (Kopel, 2022); more demanding is one communicated through a community-

derived concertive control apparatus where providers are trained and surveilled (Foucault, 1979) in what is expected of a rural provider. They are watching; the community creates Foucault's (1979) Threefold Disciplinary Apparatus: Hierarchical Observation, Normalizing Judgement, and Examination. The community provides surveillance from above (Hierarchical Observation), the individuality-focused rural culture works from an initial premise of equality to homogenize what is expected (Normalizing Judgment), and the community gaze is a ritual that normalizes the expectations of rural providers (Examination; see also Papa et al., 2006). The community expects the provider to be perpetually available, knowledgeable, and personal. While these expectations might be present in suburban and urban practice areas, they are magnified in the rural, because "there's nobody else here, right?" (Provider B).

## Discussion

Much healthcare research highlights a limited scope of systemic problems plaguing rural areas, including a lack of funding, resources, and rural-focused medical training. Practicing medicine in rural communities can be rewarding—despite harsh working conditions. By shifting the focus from systemic problems persistent in rural healthcare to examining how identity with a rural community shapes rural physicians' experiences, proactive initiatives can be created to enhance rural healthcare. Identified struggles from these physicians' experience can be removed, because the underlying causes of stress in rural medicine can be understood more fully. The conditions expressed through provider interviews echo Grameen Bank fieldworker Antiquar Rahman's question – "How can I let down . . . the poor people we serve? (Papa et al., 1997, p. 231). The community identification (Burke, 1969) of rural providers interviewed is strong, as providers maintain "it is unreal the personal and professional fulfillment that you get from connecting with the community" (Provider H). The community functions much as Barker's organizationally located self-managed team (Barker, 1993; Barker & Cheney, 1994; Barker & Tompkins, 1994); the community exerts concertive control more exacting than a provider's professional standards or organizational responsibilities.

## Conclusion and Limitations

With the continuing and increasing need to recruit healthcare providers to rural areas (see Bell et al., 2024; Nye Barton, 1982), current incentives need to be examined and improved. Loan repayment programs are becoming more accessible for providers who want to practice rural medicine (see Daniels et al., 2007; Gillette et al., 2022; Kaplan et al., 2020; Opoku et al., 2015; Watanabe-Galloway et al., 2015), but the absence of medical schools and residency programs in rural areas remains, although some have developed rural residency or post-graduate programs (Butler et al., 2021; Casapulla & Longenecker, 2023; McGrail et al., 2023). More medical schools and residency programs need to be located in rural areas, because the personal identification with rurality highlighted in this project is a powerful driving force for practicing rural medicine.

The limitations of this study include the location of participants, methodology, and focus on primary care. Because this study took place in North Carolina, the findings exemplify the lived experiences of rural providers in central

North Carolina. Further studies can be conducted that look at rural providers in other regions, including the Great Plains, West, and Midwest. While qualitative methodology aligns with prior research on concertive control, it does not allow for generalizability. We did not interview specialized physicians, so further research could be done to examine how the experiences of rural specialists compare to primary-care providers.

Rural communities deserve access to healthcare equivalent to that which is available in suburban and urban settings. In attempts to improve rural healthcare availability and delivery, it must be acknowledged that concertive control functions to enculturate providers to stay and become part of the community – or they leave. This project extends the scope of concertive control, highlighting the presence of concertive control in rural medicine and explicating how identification and community dependence push providers to accept difficult working conditions. To loosely paraphrase a former NFL great, rural healthcare practice is not for soft people.

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