CHALLENGES CONFRONTING CLINICIANS IN RURAL ACUTE CARE SETTINGS: A LITERATURE REVIEW

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Aim: To present current expert thought surrounding the question of the challenges confronting clinicians in rural acute care areas.

Primary Argument: The aim of this review is to present current expert thought surrounding the challenges clinicians face in rural acute care areas in Australia. While several studies revealed challenges experienced by both metropolitan and rural health professionals, the information is very general in nature. Literature that identified challenges in rural acute care settings was scarce and concentrated mostly on nurses and occasionally doctors, and even less on allied health professionals. Most of the studies were conducted in either Canada or the United Kingdom.

Conclusion: Very little current research exists that describes challenges as perceived by clinicians in rural acute care settings in Australia. Findings of this review identify the need to further investigate challenges experienced by clinicians in rural acute care settings. Further research on this topic will provide balanced information to inform health policy development and recruitment as well as retention strategies.

Key Words: Acute care, challenges, rural, recruitment, retention, staffing.

INTRODUCTION

This paper presents a critical summary and analysis of current literature and expert thought in relation to the challenges clinicians face in Australian rural acute care settings. The review begins with an overview of rural health care followed by a description of current issues affecting rural clinicians. The term ‘clinicians’ includes doctors (general practitioners and specialists), nurses and allied health professionals. Definitions of rural and acute care follow later in this paper.

This paper builds on a previous study that investigated the challenges facing clinicians in acute care in metropolitan New South Wales (Parker, Giles & Higgins, 2008). In reviewing available literature, three main themes emerged. These were:

• Workforce issues;
• Professional development/professional isolation;
• Lifestyle factors.

These themes formed the basis for exploring recurring issues that affect how clinicians function in rural acute care settings. Subheadings throughout this review assist with structuring the expanse of literature that was consulted.

SOURCES USED IN THIS REVIEW

Databases searched to access information included, CINAHL (EBSCO), Meditext, Proquest, OVID, & Emerald. Websites accessed included the Joanna Briggs Institute, Cochrane Library, the Australian Institute of Health and Welfare (AIHW), Services for Australian Rural and Remote Allied Health (SARRAH), and the Australian National Rural Health Alliance Inc (ANRHI).

RURAL HEALTH

The literature clearly identifies that the profile of rural health in Australia reveals a picture of considerable inequity in access to health care when compared with the metropolitan profile (Wakeman, 2008; Commonwealth Department of Education, Science and Training [DEST], 2001). These authors contend that the context of rural health is geographically, sociologically and demographically different from metropolitan settings and that morbidity and mortality rates for rural and remote Australian residents are significantly higher when compared to those of their metropolitan counterparts. Wakeman (2008) argued that health determinants such as risk factors, health loss and mortality rates increase with remoteness and that rural accidents, isolation and poor availability of health services add to the profile of healthcare in the bush because the tyranny of distance makes health care services difficult to access.

The Australian Productivity Commission (2005) reported that a major theme in their study of rural health is the inadequate number of health professionals, especially general practitioners, medical specialists and allied health staff. The Commission’s findings indicate that apart from nurses, there were significant decreases in numbers of doctors, specialists and allied health professionals the further a community was from a major city. The Commission also found that the further away a rural health practitioner was from regional or metropolitan health facilities and professional support, the greater the requirements for a generalist scope of practice and application of independent judgment and decision-making.

Several studies identified professional, personal and social issues as reasons why doctors and specialists choose to abandon employment in a rural area, or not work in a rural setting at all (Allan & Ball, 2008; Alexander & Fraser, 2005; Full, 2001). The Productivity Commission (2005), however, also stated that rural and remote communities do not have the masses of population to sustain resident specialists or for meeting related infrastructure requirements. Indeed, the Australian Society of Anaesthetists (cited in Productivity Commission, 2005) stated that the consolidation of surgical and anaesthetic services in larger centres results in a far higher standard of health care (delivery) as health care professionals are able to maintain and improve their skills due to the combination of collegiate support, enhanced medical infrastructure and the high volume of service provided. However, the Commission identified that in lieu of the unavailability of some health services in rural areas, some services are provided by visiting health teams or via telemedicine.

Recruitment of overseas trained nurses and doctors has been an option exercised by Australian governments and rural communities in an attempt to overcome the shortages of specific groups of health professionals (NRHA, 2004; Han & Humphreys, 2005; Francis, Chapman, Doolan, Sellick & Barnett, 2008). However, issues such as community integration and meeting the professional and social needs of overseas trained personnel have been identified as ongoing challenges affecting long term retention of these personnel (Han & Humphreys, 2005; Francis et al., 2008).

In identifying challenges that clinicians face in rural health, Garling (2008) made a number of recommendations to New South Wales (NSW) Health to address disparities between metropolitan and rural health, and urged the Department to undertake those recommendations in an urgent and timely manner. In his report,
Garling contended that given the difficulties of recruiting to, and retaining health professionals in rural areas, there is a need for a new model of health to address the challenges. Amongst his recommendations were the removal of the rigid demarcation of what a doctor’s...and nurse’s job is and the institution of a...qualified nurse practitioner to (carry out the) many jobs once reserved for doctor’. This is supported by the National Rural Health Alliance (2005) which argued that the advanced practice nurse work in rural areas whether there is medical and allied health support available or not. The increased scope of nursing practice could result in a greater number of people receiving health care in the event that a medical practitioner cannot be recruited to a particular rural area. The desired outcome from Garling’s recommendations is better health for people residing in rural areas which results from a greater access to health care.

In an editorial highlighting discussion from the 10th Rural National Health Conference in Cairns (2010), Gregory (2009) lamented that since the advent of this Conference in 1991, themes in the recruitment to and retention of health care professionals in rural and remote areas have not changed. Two chapters important to this editorial included Overcoming disincentives in rural practice and Improving resource allocation and infrastructure. The latter not only refers to health professionals and health service infrastructure as resources, but also the maintenance of roads, public transport, telecommunications, and community and health service facilities. What becomes evident from this editorial is that despite generous resource allocation focused on attracting healthcare professionals to the bush, successful recruitment and retention have not followed.

The Australian National Rural Health Alliance (NRHA, 2004) contended that shortages in rural health professionals in Australia need to be considered and addressed within the context of the global situation. They describe how rural Australia is relatively well off in its distribution of health professionals compared with poorer nations. NRHA suggested that the canvassing of overseas trained doctors and nurses as a strategic plan for recruiting more health professionals to rural Australia, would only serve to further drain the country of origin of their already depleted human resources. Australia should try and solve the problem of addressing staff shortages using domestic resources.

THREE IDENTIFIED THEMES IN THE LITERATURE

1. Workforce Issues

The literature revealed several studies and reports on workforce issues in rural health settings, but relatively few linking this to acute care (NRHA, 2004; Lea & Cruickshank, 2005; Charles, Ward & Lopez, 2005). Due to the lack of acute care studies in rural settings, this paper also considered some studies outlining the challenges faced by metropolitan health professionals to compare them with those in rural settings.

Health professionals, particularly nurses and doctors, require a broad range of clinical skills to function and perform in rural health (Chater, 2008; Rosenthal, 2005; Montour, Baumann, Blythe & Hunsberger, 2009). Chater (2008) and Montour et al, (2009) found that although this presents challenges to working in a rural health care setting, both agree that the same challenges also held appeal to those health professionals who enjoyed the diverse range of clinical demands.

Of the limited literature available on challenges perceived by rural clinicians, a qualitative study provided an in depth account of the workforce issues identified by a cohort of twenty-one nurses from seven different hospitals in rural Canada (Montour et al., 2009). Recurring themes in workforce issues included concerns over organisational change and the increased requirement for nurses to attend to administrative responsibilities; the burden of rural nursing practice as generalist requiring a broad knowledge base; the concern about the increasing average age of nurses, with fewer new nurses to fill the places of retiring nurses. Bushy (2002, cited in Manahan & Lavoie, 2008) and Pong & Russell (2003, cited in Manahan & Lavoie, 2008) agreed that there was significant pressure on rural nurses to have an increased scope of practice as at times they may be the only available health professional for a given rural or regional area.

There is a growing body of evidence suggesting that generational differences in attitudes towards work exist (Wilson, Squires, Widgely & Tourangeau, 2008; Manahan & Lavoie, 2008; Montour et al., 2009). Research indicates that new graduate health professionals prefer to work in larger health facilities where they are able to choose specialised practice rather than to succumb to the generalist or the jack–of-all-trades role that is required of a rural practitioner (Montour et al., 2008; Rosenthal, 2005; Wilson et al., 2008). However, Hegney, McCarthy, Rogers-Clarke & Gorman, (2002) and Lea & Cruickshank, (2005) reported that new graduate nurses sometimes resigned from positions because of heavy workloads, inadequate postgraduate transitional support and the elusiveness of guaranteed permanent employment. Hegney et al., (2002) reported that the older generations of nurses were leaving because of factors relating to workplace management practices, the emotional demands of work, inadequate recognition by management of work performed, and remuneration that did not recognise levels of skills and experience. Interestingly, Charles et al., (2005) found that workforce issues for female general practice medical registrars are similar to those experienced by nurses. The registrars stated that negative aspects of working in rural health settings also included not enough available childcare services and their work being undervalued by their male peers.

Wilson et al. (2008) suggested that job satisfaction is paramount as a predictor of retention, and that recruitment strategies need to include reviewing specific aspects of overall job satisfaction to improve retention. However, there are persistent difficulties in recruiting to, and retaining health professionals in rural health care settings.

As rural health is a recognised specialty area, this needs to be reflected in the development of undergraduate curriculum (Hegney et al., 2002; Lea & Cruickshank, 2005). New graduate transitional support is a resource that is nonexistent in many rural acute care facilities. Strategies to recruit more staff to the bush have included introducing medical, nursing, and allied health students to rural settings as part of their clinical placements. Indeed, Courtney, Edwards, Sith & Finlayson,(2002); Schofield, Keane, Fletcher, Shrestha & Percival, (2009); and Lea, Cruickshank, Paladelis, Parminter & Thombery, (2008) all agreed that including a rural placement for students as part of their undergraduate training has been an effective recruitment strategy. Schofield et al. (2009) and McAuliffe & Barnett (2009) found that students from an urban background were more likely to seek employment in a rural setting upon graduation if a rural placement featured in their clinical practicum. Research indicated that if an undergraduate student originates from a rural background, this is highly likely to influence their decision to work in a rural acute care setting. While the studies did not make specific reference to recruitment of new graduates to acute care settings, it is not inconceivable that their findings relate to a variety of clinical settings in rural Australia, including acute care.
A study by Spencer, Cardin, Ranmuthagala, Somers & Solarsh (2005) found that the development of Rural Clinical Schools (RCSs) that offer third, fourth and fifth year medical students opportunities to rotate through medicine, surgery, general practice and psychiatry, and women’s and children’s health, has increased recruitment to rural Australia. However, Hayden & Long (2007) and Tucker et al. (2006) (cited in Schofield et al., 2009) state that a significant population of students are engaged in employment to support themselves while they are studying, and a rural placement would lead to a loss of earnings. Other financial disincentives include the additional expenses of travel, accommodation, and having to maintain the cost of accommodation in their usual place of residence. Students living and studying in metropolitan areas are at least in a position to continue employment whilst attending their placement. Accessibility to public transport, especially if students do not own or cannot drive a car, is another factor that makes living, studying and completing clinical placements in a metropolitan setting a more feasible and sustainable option.

2. Professional Development/Professional Isolation

Issues associated with access to professional development are frequently cited in current literature (McLeod et al., 2008; Grobler et al., 2009; Rosenthal, 2005; Hegney et al., 2002). Access to professional development is strongly linked to job satisfaction. In fact, a common theme arising from the literature was that doctors, nurses and allied health professionals are leaving the rural setting because of a lack of access to continuing education, leading them to feel professionally isolated. The Productivity Commission (2005) reported that access to (collegiate) support, infrastructure, caseload and training opportunities... is a significant factor which causes many specialists to relocate to or remain in larger regional centres and major cities. However, a questionnaire survey by Smith et al. (2008) profiling the rural allied health workforce in Northern New South Wales found that 70.6% of respondents (N = 225) were satisfied with the level of ongoing professional development.

The literature identified professional isolation as a significant challenge for staff in rural health care (Alexander & Fraser, 2001; Hegney et al., 2002). These authors described the overall quality of working life for health professionals in rural areas as challenging. Alexander & Fraser (2001) also asserted that a one-size-fits-all approach to professional development for doctors would not be appropriate as there can be significant differences in epidemiology and demographics between one town and the next. Hegney et al. (2002) found that for nurses, insufficient exposure to specialist areas of practice and limited access to other health professionals reduced advance practice nurses’ confidence in their roles. Charles, Ward and Lopez (2005) reported that general practice registrars expressed social and/or intellectual isolation, a deficiency in support networks, and difficulty in accessing continuing medical education due to long working hours, as negative aspects of professional isolation.

A study conducted by Mills, Francis and Bonner (2007) found that in the absence of a formally appointed clinical nurse educator, supervision and mentoring of new graduate nurses occurred mostly by accident and usually resulted from a critical incident. The researchers contended that ...retention rates of new or novice nurses could be improved if accidental mentoring was recognised and fostered by organisational leaders. However, a limitation of this study was that the researchers did not indicate the size or rural nature of the health settings in which they conducted their study. Nor did they indicate the extent of rural experience held by these accidental mentors to sufficiently supervise new or novice nurses.

3. Lifestyle

Bushy (2002, cited in Manahan & Lavoie, 2008) found that common themes relating to the challenges of rural lifestyle existed in Canada, Australia, and the United Kingdom. Little anonymity and the blurring of professional boundaries were aspects of employment in rural health frequently cited (Rosenthal, 2005; Manahan & Lavoie, 2008). Rosenthal argued that anonymity issues arose because of the degree of contact and familiarity that occurs in small communities, which can bring about role conflict for both health workers and patients. However, the literature also revealed that recognition of a health care provider also provided a sense of comfort and relief for the patient (Rosenthal, 2005).

The lack of anonymity experienced by health care professionals can extend to difficulties in maintaining private lives beyond the health care setting. Rosenthal (2005) points out in her discussion that other roles in the community such as a parent, spouse and church goer could influence how a community may perceive the credibility of a health professional. Mills et al. (2007) found that these aspects of a tight knit community could also dissuade new or novice rural nurses from continuing working and living in a rural setting. However, Charles et al. (2005) reported that, for general practitioner registrars, the sense of connectedness with the community facilitated more work within the hospital, and providing opportunities for whole and multigenerational care which they perceived as a positive aspect of working in a rural health setting.

Other lifestyle factors influencing recruitment and especially retention of health care professionals included opportunities for employment, and social and other infrastructure available for the spouse of the health professional working in rural health (Hegney et al., 2002). The literature identified that these are significant reasons why health professionals leave a rural area and move to a metropolitan centre. However, Lea & Cruickshank (2005) found that an important influence on retention was whether the spouse of the health care professional was employed as a teacher, farmer or with the police force within the rural community. Conversely, Hegney et al. (2002) reported that health professionals may come to work in rural areas not by their own choice, but if their spouse secured employment in a rural location.

CONCLUSION

This review of current and recent literature on the challenges of clinicians in rural areas suggests that persistent misdistribution of staff remains a significant workforce issue in Australia. Studies indicate that chronic shortages of rural nurses, doctors and allied health staff affect not only the availability of services to patients but also the quality of life of the health professionals who work in these areas. The literature identified three major interconnecting themes that are key influences in both the recruitment and retention of rural health staff. These themes are workforce issues, professional isolation and lifestyle factors.

Workforce issues that appear to affect practice include staff shortages and insufficient locum relief resulting in long inflexible working hours. This links to both lifestyle factors such as remuneration not being commensurate for service actually provided; insufficient privacy, and excess and excessive client contact due to minimal anonymity within the community; and to professional isolation issues including inadequate support for minimal mentoring. While some of these challenges are similar to those faced by urban health professionals, other issues are clearly unique to rural and remote settings. For example, the problem of spouses obtaining paid work is considerably more of a challenge.
outside large metropolitan centres.

On a positive note, some beneficial aspects of rural health practice do exist. For example, enhanced professional autonomy and a friendly, supportive, community-oriented lifestyle can be quite attractive to some professionals. The literature researched for this paper indicates that these benefits are being incorporated into strategies for recruiting health care workers to rural areas.

Limitations of this review are that the majority of published studies focus on challenges for rural and remote nurses and doctors only, with little attention to allied health professionals. Additionally, no Australian studies could be located that investigate acute care rural health challenges. All research involved primary health care or general hospital care, with the only available comparison being a Canadian rural acute care study. These gaps in the literature clearly highlight a need for further research to support planning for recruitment and retention of health staff, and to identify critical issues in rural acute care staffing. An appropriately focused Australian study may also contribute to the development of new health care models repositioning generalist practitioners in rural public health.

REFERENCES


