ORIGINAL ARTICLE

Systemic challenges and resiliency in rural family practice

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Abstract

Introduction: The objective of our study was to understand how Canadian rural family physicians (RFPs) define and use resilience strategies to maintain their roles as generalists and resist burnout, while also understanding how organisational supports and systems may play a role.

Methods: This was a qualitative study of RFPs with at least 1 year of experience working in rural Canada. Data were collected via semi-structured, in-depth interviews using a grounded theory approach. The participant recruitment process involved purposive and theoretical sampling, and was stopped when theoretical saturation was reached.

Results: RFPs identified the following five themes related to resilience: (1) powerlessness, (2) strained work/life balance, (3) colleagues as supportive or straining, (4) living under the microscope and (5) compassion fatigue or empathy. Strategies to enhance resilience were identified at personal, community and organisational levels by participants.

Conclusion: Enhancing RFPs' awareness of the specific individual and organisational strategies, as well as system-oriented solutions to maintain resilience, is of benefit to RFPs and rural and remote communities across Canada.

Keywords: Burnout, generalism, resilience, rural family practice

Résumé

Introduction: Notre étude avait pour objectif de comprendre comment les médecins de famille en milieu rural canadien définissent et utilisent les stratégies de résilience afin de maintenir leur rôle de généraliste, et de résister à l'épuisement professionnel, tout en comprenant le rôle des systèmes de soutien et organisationnels.

Méthodes: Il s'agissait d'une étude qualitative menée auprès de médecins de famille en milieu rural ayant au moins une année d'expérience dans les régions rurales du Canada. Les données ont été recueillies dans le cadre d'entrevues approfondies semi-structurées à l'aide de l'approche de théorisation ancrée. Le recrutement des participants comprenait un échantillonnage dirigé et théorique, et a pris fin lorsque la saturation théorique a été atteinte.

Résultats: Les médecins de famille ruraux ont identifié les 5 thèmes suivants reliés à la résilience: 1. Impuissance, 2. Équilibre tendu entre la vie professionnelle et la vie personnelle, 3. Collègues qui soutiennent ou causent du stress, 4. Une vie à la loupe, 5. Fatigue de compassion et empathie. Les stratégies visant à rehausser la résilience

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ont été identifiées comme personnelles, communautaires et organisationnelles par les participants.
Conclusion: Il est bénéfique aux médecins de famille en régions rurales et dans les communautés éloignées du Canada de rehausser leur prise de conscience quant aux stratégies individuelles et organisationnelles, et aux solutions axées sur le système pour maintenir la résilience.

Mots-clés: Résilience, généraliste, épuisement professionnel, pratique familiale rurale

INTRODUCTION

Rural family physicians (RFPs) play a crucial role in providing healthcare to 6 million Canadians living in rural areas. To serve the needs of rural Canadians, and provide care closer to home, practitioners often embrace a generalist philosophy of broad-based medical care, which typically involves a greater scope of practice, services and procedures that may be found in urban family medicine.[1,2] However, RFPs often work in resource-limited areas and are susceptible to burnout (defined as feeling stressed, exhausted and unhappy). This can be caused by factors including work overload, isolation, high-stress loads or work dissatisfaction, among others, and results in the intent to leave rural practices.[3-5] While burnout is common among medical professionals, those working in rural communities are likely at a higher risk.[4,6] Consequently, RFPs may resort to restricting their scope of practice or leaving their practice altogether, exacerbating physician shortages in these communities.[6,7] The current demands on RFPs related to COVID-19 have caused an additional strain on an at-risk group of providers, increasing the urgency of understanding factors that may prevent burnout.

One of the key elements in preventing burnout in medical practice is resilience.[8] Resilience is 'the dynamic and evolving process of developing positive attitudes and effective coping strategies that enable physicians to rebound from adversity and overcome challenging circumstances'.[9,10] Studies have previously assessed the relationship between resilience and burnout in different countries globally;[11-26] however, the interplay between resilience and scope of practice has not been studied in detail. Our study aimed to further the understanding of how RFPs in Canada define and use resilience to maintain their generalist scope of practice. As rural practice offers unique challenges and opportunities, we hypothesised that these may uniquely influence the resilience strategies used, as well as the challenges faced by RFPs in maintaining their resilience.

METHODS

RFPs with at least 1 year of experience working in four regions across Canada (Atlantic, Central, Western and the Northern Territories) were recruited via e-mail. A recruitment e-mail was sent through the Society of Rural Physicians of Canada's RuralMed listserv. In our study, two sampling strategies were used. Purposive sampling[27] was used to select participants from a variety of rural and/or remote settings, with a different range of experiences, administrative systems or workplace structure, age and gender in order to reach the deepest understanding of resilience strategies and barriers. The second sampling strategy was theoretical sampling, which is based on 'a way of collecting data, and deciding what data to collect based on the theory and categories that emerge from your data'.[28] Such sampling ended once theoretical saturation was reached.

A grounded theory approach involving theoretical sampling, developed by Strauss and Corbin,[28] was used to explore the challenges and strategies to develop resilience among RFPs. Grounded theory involves the derivation of theories based on collected data, rather than starting with a hypothesis. Data were collected via semi-structured, in-depth interviews. Interviews lasted approximately 45 min and were recorded digitally. The interview guide included questions on the definition of resilience, challenging experiences, health well-being, coping strategies and background. Data were analysed based on three coding strategies of grounded theory, namely open, axial and selective coding.[28] In our study,

participant validation was conducted by involving participants in the process of theory construction to enhance the credibility of our results.

The study was reviewed and approved by the Health Research Ethics Board of the Memorial University of Newfoundland.

RESULTS

Theoretical saturation sampling was reached after the inclusion of 12 participants; however, data collection continued for a total of 14 participants to confirm no further data collection was necessary. Participants ranged in age from 35 to 75 years, with 50% identifying as women. There was a range of 1–30 years of experience in rural practice.

Rural physicians' definitions of resilience

Study participants' understanding and definition of 'resilience' in the workplace ranged from the ability to bounce back and survive, to creating strategies for getting through stressful circumstances [Table 1].

Resilience factors influencing the scope of rural practice for rural family physicians

From the interviews, the following five themes were extracted, which relate to RFPs' resilience: (1) powerlessness, (2) strained work–life balance, (3) colleagues as supportive or straining, (4) living under a microscope and (5) compassion fatigue or empathy.

Powerlessness

Almost all participants viewed their respective administrative systems as barriers which, instead of facilitating workplace processes, created challenges for RFPs. Participants felt that their deep understanding of patients' issues and needs was not considered by the system, when issuing policies and rules, and was harmful to their resilience. Consequently, the only options participants felt they had was to 'choose to accept it or choose to walk away'. Most physicians felt valueless and powerless; one of the participants described a 'moral outrage' due to a lack of consultation by the administration regarding hospital issues.

'I worked extremely hard to try and be included in the loop and try to find out what's going on, and the decisions keep getting made without any of us …. I would say those things are the kinds of things that hurt my resilience'.

Providing equipment in remote areas was one of the principal challenges for all rural physicians; however, issues were amplified for participants working in Indigenous communities. The ongoing impact of colonialism resulted in a wide range of difficulties for participants serving in these regions.

'Trying to advocate and find services for Indigenous people in remote areas with really ongoing colonialist practices is the biggest challenge. It's everything from equipment to staffing to properly trained nurses to proper space in which to work and to bring learners'.

Powerlessness occurs not only from being forced to obey strict rules that have already been put in place without consulting physicians but also by being surrounded by a lack of rules. Rural physicians also have additional duties (e.g., mentorship, teaching and committee membership), most of which involve unpaid work.

'It seems like every hospital committee needs a physician representative, and there's only a limited pool of physicians. So, all of us have to wear a hat, whether it be leading the family health team, being the chief of emerg, being the chief of obstetrics, being the chief of palliative care, being the clinic lead, the family practice in town, the utilisation committee, the informatics committee, the lab committee, and the vast majority of that is all unpaid work'.

Strained work/life balance

Some participants felt that resilience could be built and practised through engaging in different challenges, specifically in the workplace. In addition, some believed that being a rural

Table 1: Resilience definitions by rural family physicians

'The ability to continue ahead in the face of adversity'
'The ability to return to whatever situation they were doing before and still have the energy to do the work'
'The ability to work long term in a chronically underserviced area and finding that work-life balance despite pressure to always work more'
'The ability to survive and your ability to bounce back'
'Having coping strategies to live through stressful and challenging situations well'
'The ability to sort of bounce back from stressors or difficulty'
'Toughing things out without killing yourself in the process'

physician provided them with the opportunity *'To understand people and humanity. In a lot of ways, it affords me the opportunity to experience kinds of events and trials that a lot of people will never have to experience'*. However, rural physicians are usually forced to manage a broad array of duties and night shifts due to a lack of staff and supplies. This traps them in a blurred zone between life and their job or, as one of the participants states: *'I think this job will completely devour a person if they let it'*, or, as another participant states, *'time can be your time in medicine but can be stolen completely'*. Most participants believed they experienced more guilt compared to their urban counterparts.

'In a big city hospital, patients die? If somebody dies, they die on the whole team. The blame gets spread out. In rural practice, people will come in critically ill at night, and they will die on you alone and feelings of guilt can be overwhelming'.

Lifetime trauma exposure in rural areas pushed some participants to restrict their scope of practice.

'I stopped doing a big part of my practice, which was maternity care, and in actual fact, this coming fall I am closing my practice. I'm burnt… you just cannot do it anymore'.

Colleagues as supportive or straining

Most participants considered talking to and debriefing with their colleagues as a supportive strategy when facing a challenging and stressful workplace. This was a factor that reduced emotional exhaustion, particularly when there was a lack of judgement on the part of those asking questions or looking for assistance. Even in circumstances where a physician may have to go through a legal process because of allegations of medical error, they may keep working in the same hospital, and with ongoing support of colleagues during the process, before any resolution.

'We all support each other and have created a team kind of environment where there's no hesitation to go to one of the colleagues and say 'you know what, I don't know what to do in this situation, or even to say 'I don't know if I have made a mistake here, can you help me with that', there's no judgment'.

Unfortunately, others indicated that colleagues may be a source of stigmatisation and exclusion. Questioning medical decision-making through the professional review of cases may strain the support network for RFPs.

'I've had a couple times where I've had my medical decision making questioned…at the end of the day they agreed with my management. But just the fact that they pulled my file and went through that case …made me a lot more concerned about what my colleagues are thinking about my medical practice… so now I'm probably a lot more aware that my colleagues are watching me'.

Beyond this, the daily life of physicians gets more complicated when the physician is a victim of workplace violence, or, as one of the participants calls it, the 'toxic environment'. This situation may worsen if the health system does not intervene.

'Some colleagues are the source of the bad experiences, where I've been targeted by colleagues for financial purposes, I've been targeted by the spouse of colleagues because she's the manager of the office. Where other physicians were being bullies, and the hospital absolutely backed them up, and I was the victim of institutional bullying'.

Living under a microscope

Working as a physician in a small community and being known by almost everyone left participants with nearly nowhere to go without crossing paths with patients and their families. Some indicated that counselling services played a critical role in relieving stress and anxiety. However, using such services was stigmatised since, in small communities, citizens might recognise and gossip about them.

'Where there's even just that much more stigma that maybe you're willing to accept the counselling services, but you don't want your friends or your patients or other people seeing you access those services'.

In addition, some participants stated that they avoided seeing a counsellor since they were part of the same care team.

'If I was looking for a counsellor, it's a little bit awkward. I find most people in town go to the family health team, but that's not an option for me because I work with them'.

On the other hand, some participants found local medical associations and counselling services significantly helpful and supportive.

Compassion fatigue or empathy

Demonstrating empathetic care requires physicians to listen, understand and communicate

with patients to show respect and support. However, most RFPs, specifically those who serve in Indigenous communities, continuously deal with compassion fatigue and emotional exhaustion due to limited skills in emotional regulation and boundary setting.

'Moral fatigue and moral insults that they take in the medical profession just affect them that much, they're not as able to …detach themselves'.

Almost all participants believed that *'empathy means I have to carry your burden all the time'.* They contested and struggled to fit into two different worlds: one with a high degree of resilience and the second with a high degree of clinical empathy.

'Having compassion and having empathy allows me to keep my resilience. I know I have burnout, or if I'm feeling overwhelmed, when I lose my compassion for other people, and therefore los(e) my resilience to practise the way that I think is ethically and morally sound'.

One participant compared the process of recruiting rural physicians with special forces, to illustrate the importance of training during medical education to prepare RFPs for serving in remote areas.

'… If you look at some other high-intensity things. they're pretty extreme, [such as] the training of … elite soldiers …one of the first things they do is they try and break them mentally….. they actually intentionally structure their application process and their whole training process to look for that moral resolve and that's certainly not something that's even thought of or discussed in medical education applications'.

Resilience strategies to support maintaining the scope of rural practices

Throughout our study, participants suggested different strategies and interventions related to: (1) personal, (2) community and (3) organisational levels to support their rural practices [Figure 1].

Some participants described the strategies they applied while struggling with powerlessness, work/life balance, and living under a microscope [Figure 2].

DISCUSSION

In our study, several themes emerged which inform strategies to enhance resilience of RFPs.



Figure 1: Resilience strategies to support a broad scope of practice, as identified by rural physicians.

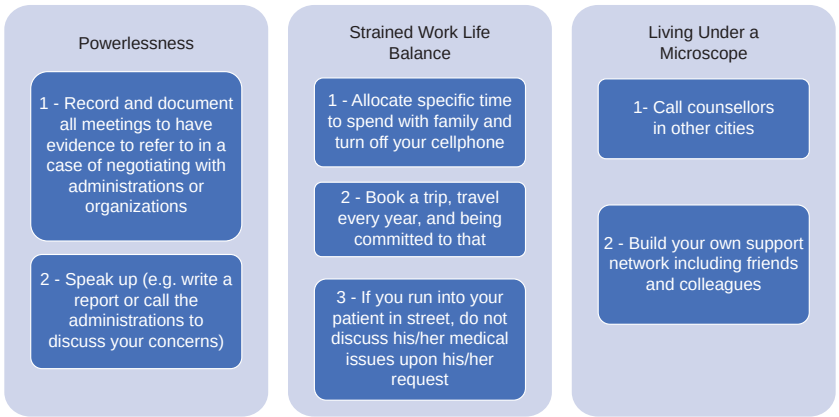


Figure 2: Burnout mitigation strategies related to administration, work-life balance and living under the microscope.

While there is commonality with themes found in the literature on factors influencing resilience, our study demonstrates ways in which these manifest that may be unique to RFPs. Interestingly, most physicians offered individual solutions to enhance their resilience, whereas factors of most concern involved an interplay of the physician and their organisation, their colleagues and their community. The results of our study are consistent with other studies that reveal the critical role of health-care organisations on the well-being of physicians.[29-33]

Addressing powerlessness, in the face of rules that do not consider the physician's experience or, in environments lacking clarity and direction, requires partnerships with RFPs. Expectations for RFPs to assume multiple leadership roles due to limited physician resources must be approached in a manner that allows them to provide expert guidance to various committees while allowing them to fulfil their clinical duties. It must also recognise the time commitments required. Such an approach would empower physicians and improve their resilience.

It should not be surprising that many participants identified a strained work-life balance as a challenge, and this issue has previously been noted in the literature.[30,34-38] While emigration and retirement have been mentioned as options for achieving a balanced lifestyle previously, participants in our study suggested a different approach by setting boundaries and expectations.

There is abundant literature supporting the critical role of physician peer support in mitigating professional challenges and decreasing burnout.[30,39-41] Our study highlights that successful teams, in which colleagues support each other, enhance the resilience of RFPs and help support generalist practice.

While there is existing literature on the stigma associated with seeking treatment,[31,42,43] 'living under the microscope' is a particularly unique challenge for RFPs. Virtual care or telemental health should be considered, and organisations may consider establishing partnerships that would facilitate the provision of primary and mental healthcare, even across jurisdictional boundaries.[43] Rural organisations and training programmes should consider incorporating elements that address the unique challenges of RFPs in maintaining resilience in their local communities, so physicians are well prepared for rural practice.

Finally, our study noted some of the challenges experienced by RFPs in delivering healthcare in Indigenous communities, through a system that is built on structures that have harmed and do not represent Indigenous peoples.[44] The impact of colonial structures and attitudes on the health system in Indigenous communities was a source of frustration and powerlessness for some participants, and echoes the experience of many Indigenous peoples in Canada.

Limitations

Even though the results of our study are based on the lived experiences of RFPs across Canada, the present study also has some limitations. Our study's small sample size, while adequate for thematic saturation, may limit the relevance to certain contexts. Specifically, hyperlocal factors, as may be found in many rural and remote communities, may not be captured through our thematic analysis. This limits the generalisability of the study's results.

Future research

Several areas warranting greater exploration emerged as a result of this study. Participants identified challenges unique to working in Indigenous communities due to ongoing colonial health-care structures in place. The present study reinforces the need for implementation of the Truth and Reconciliation Commission Calls to Action on Health (18–24) to de-colonise health-care delivery to rural Indigenous communities, working with Indigenous peoples to ensure equitable and culturally appropriate approaches are embedded at all levels.[44] While previous research has highlighted Indigenous community experiences of fundamental systemic racism and a system that devalues First Nations health and wellness,[45] a more detailed exploration of provider and community perspectives, and solutions, is warranted. In addition, participants identified systemic challenges in maintaining resilience, while often relying on individual strategies to enhance resilience. An in-depth exploration of the systemic factors effective in enhancing resilience in rural areas would be of great value for administrators and health-care regions looking to support their

physician workforce. Finally, many residency programmes have started to integrate resiliency training into their curricula. However, it is not known how well they have linked these to the true challenges to resilience which RFPs face in practice; exploring resident preparedness would be of great value in enhancing the resilience of future RFPs.

CONCLUSION

Enhancing awareness of the individual and organisational tools that can be used to maintain resilience is likely to benefit RFPs, and thereby many rural and remote communities across Canada. RFPs, in comparison to previously studied groups of physicians, face some unique challenges with powerlessness, strained work/life balance, collegial support, living under the microscope and compassion fatigue. Although the strategies suggested by RFPs in our study are centred around physicians rather than the health-care system, system-oriented solutions are undeniable parts of effective improvement interventions. To strengthen ongoing generalist care to rural Canadians, training programmes, communities, and organisations must consider how they, too, can enhance the resilience of rural physicians.

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