Chapter 9
Supporting rural health professionals and their families

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Learning objectives

- Describe the issues health professionals and their families face living and working in rural communities.
- Identify mechanisms for supporting rural health professionals and their families.

Introduction

Rural health services, providers and programs can have difficulty recruiting health professionals (Strasser et al 1997, Strasser 2000). Many Australian-trained health professionals are reluctant to work in the country because of their professional or employment aspirations, and those of their spouse or partner, as well as their children's educational needs (Strasser et al 1997, Wainer 2000). Overseas-trained clinicians have often been recruited to fill vacancies (AMWAC 2004, ARRWAG 2004); however, this solution brings its own problems. Clinicians from culturally and linguistically diverse backgrounds who are living and working in rural locations can face cultural dislocation as well as professional and social challenges, as can their families.

Political and economic changes in the past 20 years have significantly affected those living in rural locations (Twaddle 1996, Palmer and Short 2000, Rodger 2000): economic reform has resulted in less state assistance to rural and farm sectors (Haslam McKenzie 2000); essential services, such as banking have been withdrawn in many small towns (Tonts 2000); and rural hospitals have been downsized (Kamien 1998). These changes have implications for rural health professionals in terms of work demands and access to services and for their families in terms of employment, education and social activities.

Given the limited services currently available in many rural areas, rural clinicians often feel overworked, stressed and frustrated at the demands placed on them by community expectations and the effects of those demands on their own health, family life and leisure time. This is particularly relevant in smaller rural communities, where long, irregular

working hours are often the norm and locum relief is limited at best (Strasser et al 1997, Wainer 2000). Women generally like to have flexible working hours to meet the demands of their responsibilities at home and at work (Pringle 1998, Roach 2002, Wainer 2004). Some male GPs also support the notion of changing dominant ideas about work patterns to better reflect a work–life balance, and seek to apply them to practice (Wainer 2001, Young et al 2001).

The rural health workforce and their families need to be supported through the recruitment and settlement process. Good professional and personal networks, both formal and informal, can make all the difference to the attraction and retention of the rural health workforce.

This chapter uses three case studies to highlight aspects of the main issues facing rural health practitioners and their families: isolation, community expectations, needs of the family and of the health practitioner, and multiple roles. Each case study is followed by a brief discussion of the main issues it raises. In the Discussion section, we focus on the specific issues, relating them back to the case studies and also suggesting possible solutions.

Chapter 8 also discusses retention strategies, including the professional supports shown to enhance retention and sustainable health services.

Case study 9.1 Moving from town to country

My husband, a rural health worker, began working in Whytown one month before the family relocated from Adelaide. When we arrived we were surrounded by a smoky haze. Bushfires raged and a ghostly stillness swallowed our truck and belongings. We were hot and tired, the water was affected, folk in the region were distressed. It was a stark difference from the safe and familiar surrounds of home!

Our teenagers hung around the house, waiting with trepidation to find out whether they would be accepted by the locals. Kind people rang to welcome us to the town, despite the menacing dangers of the fire they faced.

I began to unpack. Boxes were everywhere. The things my four children needed — their things were, it seemed, nowhere. Paperwork was endless. Birth certificates, reports, business documents; all had to be found immediately, if not sooner. Teachers needed information.

My youngest went to primary school, my foster son to the local Catholic school and the two older children to the local high school. My Year 11 son faced his battles with assimilation — the city boy who was different.

The children networked, as did my husband. Soccer club commitments quickly accumulated for children and father. Many soccer parents were nurses, teachers, lawyers, doctors, and other professional people. The conversations began and boundaries faded (but diplomacy was required).

As this case study illustrates, relocating a family from a metropolitan capital city to a rural town is stressful. Professionals at specialist level are often recruited from cities, and they face many challenges, as do their families. For example, they may not be familiar with the cultural norms and expectations in rural areas — the networks, support structures, acknowledged power relationships and communication processes. The overall stresses of living in an unfamiliar place can be compounded by the cultural norms and expectations; everyone seems to know one another, overlapping relationships are common, confidentiality boundaries and health indicators are different, and environmental changes are ever present. At the same time, rural communities may have difficulty relating to new arrivals. Without support, it is difficult for newcomers to fit in and become part of the community. If they do not become part of the community, they will not stay long. Engagement with community in the processes leading to recruitment and their involvement in retention strategies augurs well for welcoming community participation.

Case study 9.2 Blurring the boundaries

Thank goodness the weekend is finally here. It is Saturday afternoon. Ayesha is out in the garden getting the potatoes planted at last and I am working on my tax return. Our friend Vivien rings and we catch up. We have not seen her for sometime. She then enquires if Ayesha is home. I say yes and Vivien asks if she could pop round to show Ayesha the X-rays of her daughter, Robyn. Robyn had a fall some weeks ago she explains, and her wrist is not improving. I tell Vivian that Ayesha is working in the vegetable garden and she assures me it will not take long and she will see me shortly.

Vivien arrives with both the X-rays and her daughter. I alerted Ayesha to Vivien's impending arrival and she has come in from the garden and cleaned herself up. Ayesha has seen Robyn for other injuries in the past. After examining Robyn's wrist and looking at the X-rays, Ayesha arranges to see the girl in her rooms on Monday. We have a cup of tea and then they leave.

This case study reflects the tension in a small rural community when the need for 'time out' intersects with community expectations that 'you are always on call', often resulting in disruption to the health professional's family life (Hays 2002b, Bourke et al 2004). Although the notion of continuity of care can be seen as an advantage by some health professionals (McAllister et al 1998, Hays 2002b), this case study also demonstrates the difficulties that can arise when professional and social boundaries blur, particularly when friends may expect special treatment (Ballarin 2005). Perceptions of 'living in a goldfish bowl' are common, as are difficulties negotiating professional and social boundaries.

Case study 9.3 Improving connections

'Whose turn is it to host the meal for the next specialist dinner?'

'I think it's me — I'll check that my husband can do the cooking. Who would you like to invite to come and talk to us?'

'Let's ask the dermatologist if he can talk to us about treatment of acne, eczema and psoriasis — I've had a lot of difficult cases recently.'

The specialist accepts and travels for an hour after work to talk to our local health professionals (doctors, nurses and other hospital staff) on skin conditions. He answers their general or case-specific questions. Then the whole group — the local team, their partners or spouses and the visiting specialist — adjourns for a sociable meal. Although there is some more 'shop talk', mostly we just enjoy being together away from work.

It was one of our nurses who came up with this idea. It works well and we run the sessions on alternate months, relying on the goodwill of specialists and spouses. Having an outsider come in to talk fulfils various needs for our health professionals; it provides them with relevant continuing education, interprofessional education sessions, a chance to get to know specialists and some social time together with colleagues. At the end of this particular evening, we thanked the specialist, and warned him about the corners and wallabies on the road for his journey back to the city.

This case study shows how rural health practitioners can be proactive in arranging activities that provide them with up-to-date continuing professional development, and an opportunity for off-duty socialising to network with specialists and other clinicians. At the same time, these activities can give the health workers' partners opportunities for social interaction.

Access to professional development is recognised as critical to rural practitioners. Professional associations and discipline networks as well as team-based initiatives offer opportunities for continuing professional development. However, such opportunities in the bush have been said to be limited and this has given rise to increasing online, web-based teaching and learning sites such as Telederm, which offers rural GPs online advice on diagnosis and management of skin disease, and Kidney Check Australian Taskforce (KCAT) (Kidney Health Australia), which provides online learning for health professionals.

Discussion

Various themes thread through the case studies, raising specific issues and reflecting the diverse contexts in which health professionals and their families live and work. Despite the problems, many local and overseas-trained rural health professionals feel that the rewards of living and working in a rural community outweigh the disadvantages. Opportunities for innovation in professional and social contexts abound, despite

constraints. This section focuses on the main issues and on solutions, relating the issues back to the case studies where relevant.

Research on recruitment and retention often centres on health professionals' relationships with the rural environment in which they live and work. For example, it examines issues such as the effects of isolation, the lack of services, and the limited professional, occupational and educational opportunities (Strasser et al 1997, Wainer 2000). However, where solutions focus on needs of individuals and their families, or on the disadvantages of rural 'space', they often fail to critically examine the issue within a broader social context. By analysing the relationship between structural factors and social practice, it is possible to expand the parameters within which to view the problem, and consider innovative solutions. This approach offers a more nuanced understanding of the complexity of recruitment and retention by demonstrating how structural issues (eg gender relations and political and economic factors) affect the choices, actions and expectations of rural clinicians and their spouses.

Providing support

The financial and social costs of moving are often significant and may create a stressful environment. As illustrated by Case study 9.1, the process of packing a family home can be time consuming, and emotionally and physically exhausting. Children's education is another major issue for families moving to rural locations. Factors influencing the settling in process are often complex and varied, and children and their parents can feel 'new' for a long time.

Support networks are important in making the transition to a rural location easier. Opportunities for new arrivals to meet people occur in different contexts, such as the children's school, community organisations and groups, or the workplace. Rural communities recruiting health professionals can actively facilitate such opportunities by inviting new families to social events soon after they arrive. Developing friendships is an important indicator of satisfaction and retention of health professionals and their families in rural areas (Hays 2002b).

Employment for their partners is also important in recruiting health professionals, as is the availability of accessible and affordable child care.

Support can also come from health professional organisations looking after the interests of their members. The Divisions of General Practice offer regional support for GPs; Services for Australian Rural and Remote Allied Health (SARRAH) offer support for rural allied health professionals; and Council for Remote Area Nurses Australia (CRANA) and Australian Rural Nurses and Midwives (ARNM) offer support for rural and remote nurses.

As Case study 9.3 showed, local solutions that draw the health team together but provide external input can be successfully arranged. Bringing in an external specialist obviates the need to travel (which means that the 'on-call' doctor would not miss out) and improves relationships with specialists to whom rural practitioners might refer clients.

Spouse and family

While the rural practitioner may have access to support and ongoing training through professional networks, their families do not have these networks readily or structurally in place. Support for the family occurs in a more ad hoc informal manner. To increase the likelihood of recruitment and retention, policy makers and rural communities need to consider support at structural and local levels. For example, policies and local communities that support the social integration of parents and children may increase the likelihood of staying.

Self care

Provision of ongoing care to rural practitioners requires changes to medical culture. Currently, the inability to cope is considered an unsuitable trait in the health profession where illness is seen as acceptable for the patient but inappropriate for the doctor, and therefore often resisted or denied. Forward planning to ensure rural practitioners have their own GP can be more difficult in a rural area; but, locating a GP in another town and visiting regularly for check-ups, screening and preventative medicine is a sound investment. Calling on immediate colleagues would then be limited to emergencies. A service such as the Bush Crisis Line provides a 24-hour telephone service, seven days a week, and contact with trained psychologists for rural practitioners.

Changing medical culture

Rural clinicians and their spouses potentially have the choice and capacity to resist structural limitations that conflict with their own interests. For example, as increasing numbers of women enter the medical workforce, female GPs are challenging the convention of long and irregular working hours, which were made possible for male GPs by the wife's role as the main caregiver in the home (Pringle 1998). That conventional model is particularly evident in rural general practice. However, today's female GPs may also take on the role of main caregiver in the home, and many are calling for revised work practices that will allow them to achieve a balance between work and home life (Witz 1992, Pringle 1998, Wainer 2000). Ongoing education and support in the health and community sectors on the importance of equity will ensure that issues of gender and equity can be identified, and processes are put in place to deal with them.

The on-call requirements of rural doctors are often a disincentive for their urban medical colleagues to make the move to the country. Collaboration between professional organisations and rural communities to reduce the on-call commitment would benefit specialists. This could be achieved by sharing of specialists from other towns or by giving part-time work (eg on-call once a month) to urban-based specialists wanting extra work. Giving urban specialists a taste of rural practice in this way may encourage them to be willing to take up rural practice full time.

Setting boundaries

Case study 9.2 focused on the issue of the health practitioner's multiple roles within the rural community. Multiple roles are not necessarily negative, but it is necessary to be aware of boundaries becoming blurred; for example when friends may also be clients.

Health professionals who set boundaries that are clearly communicated to clients and friends may be more likely to have uninterrupted time off. Peer support, whether informal or formalised through local professional groups, is another useful strategy for debriefing and discussing other ideas to manage this issue. Community education can also develop realistic expectations of the demands placed on health professionals and flag the need health professionals and their families have for a work–life balance.

If there is an unavoidable doctor shortage, rearranging work practices to use interprofessional teams for triage with a doctor on the end of a phone or support from a nearby town, would avoid compromising patient care. Educating the community and encouraging them (as well as the doctors!) to take more responsibility for preventative medicine would decrease work loads and improve outcomes. The strength of rural communities is in the practical support they offer, such as transport and meals in situations of crisis.

The united nations of rural practitioners

As had been mentioned throughout this book, rural health practitioners come from many disciplines and from many cultures and nations. In addition to professional support, ie training and development and locum relief, and family support, rural practitioners also need cultural support and orientation to the rural communities and also, at times, to our Australian health system. Recruiting health services, agencies and communities need to consider how best to introduce and support health practitioners with a different cultural background. Case study 3.1 introduced the interplay between the community and the practitioner, with both benefiting from diversity and engagement.

Key points

These case studies have highlighted difficulties working in rural communities and offered solutions that can contribute to rural practice as a positive experience. The case studies also highlight the need to address the difficulties at a policy level, as well as locally, if recruitment and retention rates are to be improved.

Important issues facing rural health professionals and their families include:

- Isolation — this can be geographical, social, professional and educational; solutions include community support, specialist availability, distance education and formal supports.
- Community expectations — this includes the expectation that health professionals are always available; solutions include community education to change the culture and expectations, and provision of affordable locums.
- Needs of families — these include issues such as employment, expectations of gender roles, child care and schooling; solutions include community support, peak

bodies or local 'champions' to advocate for spouses, flexible employment opportunities, tax-deductible child care and travel.

- Needs of self — this includes issues such as work ethic, pressure of community expectation and lack of free time; solutions include education for health professionals and the community on work–life balance and provision of affordable locums.
- Multiple roles — these blur professional and social boundaries; solutions include orientation that empowers health professionals to say 'no', community education and provision of affordable locums.

Recommended readings and resources

- Alston M (2005). Gender perspectives in Australian rural community life. In: *Sustainability and Change in Rural Australia*, Cocklin C and Dibden J (eds), University of New South Wales Press, Sydney, 139–156.

Alston discusses the different power and gender relations and identities in rural communities. The daily life practices tend to result in a hierarchical gender division of labour. Inattention to gender implications of living in a rural setting implicitly supports a pervasive masculine dominance.

- Palmer G and Short S (2000). *Health Care and Public Policy: An Australian Analysis*, 3rd edition, Macmillan, Melbourne.

The authors locate health care in a political–economic context and analyse public policy in Australia and the roles and implications of public and private health care models. Different models of health care are illustrated with examples from Australia and overseas. The authors reflect on the dominance of a biomedical model of health care in Australia.

- Pringle R (1998). *Sex and Medicine: Gender, Power and Authority in the Medical Profession*, Cambridge University Press, Cambridge.

This book is based on a study of female doctors living in rural and urban locations in Australia and Britain. It explores the role of female doctors and the impact they are having in changing the traditional focus and culture of the medical profession, not least their preference for working flexible hours. Pringle argues that, as a result, medicine 'is being called upon to restructure; effectively challenging the notion that medicine as an occupation requires a 'vocational commitment, a readiness to be available 24 hours a day, seven days a week'.

- Tonts M (2000). The restructuring of Australia's rural communities. In: *Land of Discontent: The Dynamics of Change in Rural and Regional Australia*, Pritchard B and McManus P (eds), University of New South Wales, Sydney, 52–72.

Tonts examines the effect on rural communities of socioeconomic changes in the last 30 years, where government policies have shifted away from sociospatial equity towards

those emphasising economic efficiency. This has led to a withdrawal of essential services in some rural communities, often compromising the identity and survival of country towns. These changes have had a major impact on the lives and wellbeing of rural people.

- Wainer J, Strasser R and Bryant L (2005). Strengthening the rural medical workforce: understanding gender. Paper to the 8th National Rural Health Conference, Alice Springs, Northern Territory, 10–13 March 2005, 1–11, CD ROM.

Given the increasing numbers of women entering the medical profession (over 60% of the 2002, and subsequent, rural registrar intakes), the authors argue the need to address the implications of this trend on the rural medical workforce. This study further examines the identified need for a more accurate understanding of a gender perspective in rural medical practice. Findings showed that strategies for sustainable rural practice for men and women included developing and implementing practices supporting flexible working hours.

Learning activities

1. You are in a small rural town with only one pub. You are out for a social drink after knocking off when you see a patient (whom you know to have alcoholic liver disease and with whom you discussed just that morning the need to stop drinking) knocking back his fifth beer for the evening. As a medical student visiting the town on a rural attachment, what do you do? As the patient's GP, what do you do?
2. You are a health professional in a small town and are doing the shopping on Saturday morning. A patient corners you by the sliced bread counter and starts to tell you about their breathing problems. How do you respond?
3. You are the community nurse about to leave town for your first weekend off in three months. Just as you are about to walk out the door, your colleague rings and tells you she's sprained her ankle and can't drive to be on call this weekend. How do you respond?
4. If you were moving into rural practice, what would you be looking for in a rural community in terms of personal and family factors?