Scandinavian Journal of Primary Health Care

ISSN: 0281-3432 (Print) 1502-7724 (Online) Journal homepage: https://www.tandfonline.com/loi/ipri20

Workload pressures in rural general practice: a qualitative investigation

Lisa Iversen, Jane C. Farmer & Philip C. Hannaford

To cite this article: Lisa Iversen, Jane C. Farmer & Philip C. Hannaford (2002) Workload pressures in rural general practice: a qualitative investigation, Scandinavian Journal of Primary Health Care, 20:3, 139-144, DOI: 10.1080/028134302760234573

To link to this article: https://doi.org/10.1080/028134302760234573

Published online: 12 Jul 2009.

Taylor&Francis
healthsciences

Workload pressures in rural general practice: a qualitative investigation

Lisa Iversen[1], Jane C. Farmer[2] and Philip C. Hannaford[3]

[1]Department of General Practice and Primary Care, [2]Department of Management Studies, [3]Department of General Practice and Primary Care, University of Aberdeen, Scotland, UK.

Scand J Prim Health Care 2002;20:139–144. ISSN 0281-3432

Objective – To examine whether there are workload pressures, as reported by healthcare professionals, which are unique to rural general practice.
Design – Semi-structured face-to-face interviews with staff from general practice teams located in different geographical areas.
Setting – The north-east of Scotland (Grampian).
Participants – 16 GPs, 14 practice nurses, 9 practice managers and 14 administrative staff from 14 general practice teams.
Main outcome measures – Recurrent themes were identified by the systematic analysis of interview transcripts.
Results – Workload pressures experienced at all locations included continual change, increased volumes of administration and dealing with rising patient expectations. Workload pressures particular to rural areas were long periods on-call and difficulties in taking time off from the practice, the "specialist-generalist" role of rural practitioners and feelings of responsibility, including a pastoral role within the community.
Conclusion – Although some workload pressures exist regardless of location, rural practices appear to have some unique difficulties. Solutions which help practices cope with change and demand will be useful to both rural and urban practices. Staff from rural practices, however, also need location-specific solutions, such as those for reducing stress from being on-call for prolonged periods.

Key words: general practice, pressures, qualitative, rural, workload.

Lisa Iversen, Department of General Practice and Primary Care, University of Aberdeen, Foresterhill Health Centre, Westburn Road, Aberdeen, AB25 2AY, Scotland, UK. E-mail: i.iversen@abdn.ac.uk

The paucity of research in the United Kingdom (UK) and Europe regarding rural general practice has been highlighted (1–3). One in-depth study of rural primary care in the north of England concluded that the work of general practitioners (GPs) in rural areas was different to that carried out by their counterparts in urban areas. In all aspects of workload examined, differences were greatest when considering the "remoteness" rather than "population density" definition of rurality; for example, when general practices are at a distance from other services such as secondary care services (1). Rural general practice was found to have particular characteristics, such as needing to be equipped to deal with emergencies, and having long periods on-call. Furthermore, rural general practice was found to impose social pressures on health care professionals and their families; for example, by long periods on-call. It was recognised, however, that rural practices are diverse and it was recommended that the generalisability of the findings be examined by research in other rural areas. Meanwhile, studies of stress in mainly urban general practice found that interruptions during surgeries, out-of-hours work (4) and poor time management (5) contribute to job stress and pressure.

The need for our study arose from discussions with rural GPs across Scotland. These rural GPs believed that urban GPs expressed their workload pressures in terms of patient throughput. Those in rural practice believed their workload pressures arose from other aspects of their job, such as having an in-depth knowledge of their patients and their families. They consistently stated that their work was "different" to that of their urban colleagues and that policy-makers insufficiently understood this difference. We aimed to investigate perceived workload pressures among general practice staff working in different geographical settings. Specifically, we sought to discover whether there are workload pressures that are unique to rural practices.

METHODS

Fifteen general practices within one health region in north-east Scotland (Grampian) were asked to participate in the study. The practices were purposefully selected so that: both rural and urban locations were represented; the practices had a similar number of principals; and that a geographical spread was achieved. Urban practices were located within the main city in the region (Aberdeen). Rural practices were more than 30 minutes drive from Aberdeen, excluding market towns. We focused on rural general practices but included urban practices of a similar size as a comparison group. This enabled us to explore whether differences found were due to rurality rather than other factors such as practice size.

Data collection: interviews

Data were collected using semi-structured interviews and an observation day in each practice. Both interviewers (LI and JCF) were from non-clinical backgrounds – health services research and information management, respectively. Interviews were held in the practices and recorded. Initially, practice managers (or, in practices without managers, the senior GP) were interviewed to establish a relationship with the practice and to gather information about its characteristics and organisation.

This initial interview enabled us to understand how the different professions in each practice related to one another on a daily basis. We then interviewed in each practice a GP, a practice nurse (where employed), a receptionist and a member of the administrative staff. These interviews focused on four key questions (Table I).

Observation days aimed to verify the information described by participants at interview. Since the first set of observation days did not provide any new information to that collected during interviews, they were held in five practices only, located in rural and urban practices.

Data analysis

Audiotapes of the interviews were transcribed verbatim. Data were manually analysed thematically using a grounded approach to the analysis (6,7). Recurrent themes were identified inductively through the systematic analysis of transcripts by LI. Once themes were developed, sections of transcripts were grouped together by theme. Relationships between major themes emerged. Transcripts were re-read to compare comments from participants across similar and different geographical settings. The influence of practice size was considered as a potential alternative explanation for our findings to that of geographical location. For independent verification, transcripts were analysed by JCF. Further verification was also achieved by sending a report of our findings to all the participating practices asking for notification of discrepancies. None was received; indeed some practices remarked that our analysis described well their perceptions about workload.

RESULTS

One practice declined to take part in the project. In total, 53 staff [16 GPs (12 men), 14 practice nurses (all women), 9 practice managers (1 man) and 14 administration staff (all women)] from 14 general practices were interviewed. Nine practices were rural and five were urban. The practices varied in their organisation, largely because of different practice sizes, history, personalities and available resources rather than a result of location per se. The main features of the participating practices are summarised in Table II.

Workload pressures common to both rural and urban practices

Although the main focus of this article is workload encountered in rural general practice, several pressures were mentioned regardless of practice location. Keeping up to date with structural change in the health service and its administrative procedures was perceived as being associated with increased workload in recent years. Requirements to maintain and distribute information to other agencies were thought to be time-consuming. The GPs thought that they spent around 2 h a day doing paperwork associated with running the practice, as well as an increasing amount for "social" reasons, such as insurance reports.

Changes in patients' attitudes and expectations were also common pressures reported by all professional groups. Some of the reasons given for these changes were highly publicised negligence cases and increased knowledge among patients about health matters. Some staff believed that practices had added to their workload by continually responding to de-

Table I. Second stage interviews: key questions.

Question	Purpose
Could you describe a typical day in your job?	To gain an understanding of workload and as validation for information gathered in initial interview. Although each day was likely to be different, the question was found to be a good way of encouraging participants to discuss their work.
What are the pressures in your job/what makes your job more difficult?	To identify pressures on work in different locations.
How do you keep up to date with professional developments?	A particular concern identified by previous consultation with practitioners.
What do you think would be the pressures in your job if you worked in an urban/rural practice?	To gain an understanding of professional perceptions of contrasts between work in different geographical settings.

Table II. Characteristics of participating practices.

Location	Practice characteristics
Rural (more than 30 min drive from Aberdeen excluding market towns) Total number = 9	List size from 600 to 5500, number of GP principals: 1–4, 3 practices with branch surgeries, 5 practices with practice managers, part-time practice nurses, part-time triple duty nurses[1]
Urban (all within Aberdeen) Total number = 5	List size from 1200 to 9700, number of GP principals: 1–6, 1 practice with branch surgeries, 4 practices with practice managers, part-time practice nurses

[1] A nurse who is a health visitor, district nurse and community midwife.

mand for appointments, initiating more surgeries and services.

Workload pressures in rural general practice

From the analysis, themes emerged which were described only by staff in rural practices. Many of the pressures identified were associated with geography and the distance of the practice from other services. The geographical area covered by practices could be considerable, in one case over 400 square kilometres.

The "specialist-generalist" role: For GPs a dominant source of pressure, was the need to be able to deal with anything and everything (such as minor surgery, accident and emergency work and dispensing) due to small practice teams and considerable distance from general hospital services: "*I have no opportunity … to delegate work that I consider is medical and hands-on clinical work. I do all the blood-taking, all the smears. I do all the minor surgery on my own. I do all the accident work …*" (GP; male).

The GPs most distant from the city remarked that although they might not always be as busy as their urban colleagues in terms of the intensity or volume of patients seen, they experienced other pressures produced by the unpredictable nature of their workload, such as the continuous need to maintain clinical skills that might be deployed infrequently.

On-call commitment: Rural practitioners, especially the GPs, had difficulties finding cover for heavy on-call commitments. Few of the rural practices included were members of out-of-hours cooperatives, mainly because of large distances from other practices or the large area covered by the practice. Where cross-cover arrangements had been tried, it was felt that these tended to disadvantage GPs from smaller practices. This usually led to the GPs reverting to covering only their own patients (i.e. being on-call more often but being less busy and having a more contained geographical area to cover). In itself, attending out-of-hours calls was not regarded as a pressure. Instead, pressures arose from the sustained periods on-call. Some participants reported never being able to relax fully: "*The main problem in this practice is our heavy out-of-hours work. I've been working a one in two rota for 25 years and I'd really like to stop … If you are up doing one call at three in the morning it's as bad as being up all night because you can't get back to sleep again. I think that affects the quality of care you can give if you are chronically tired …*" (GP; male).

"*Basically we are it (out of hours) … So I'm 14, 15 days on call without a break, which really you get used to, but you don't totally relax; you never know what could happen next. We don't actually have a lot of out-of-hours work to do but when it happens, it can vary from the mild to the completely dramatic*" (GP; female).

A large proportion of the health professionals interviewed identified difficulties in taking time out from the practice for holidays, professional development or other activities. The GPs who were single-handed had greatest difficulty. Formal professional development activities were not an option for some GPs. They believed learning was continuous through their contact with patients and through following their interests using CD-ROMs, textbooks and journals in their own time.

Often, in rural partnerships, a GP would cover for their absent partner, thus time for professional development activities away from the practice had to be carefully planned, and took place mainly at weekends. Consequently the GPs stated that they had to be certain that an organised postgraduate activity would be highly beneficial before they would commit time and money to it. Practice nurses, on the other hand, seemed more able to attend professional development activities: "*We are always offered training and all these courses and study days … The practice nurses in the area have been meeting. It's quite good to get together as a group because a lot of us, well I'm on my own. I think it's more difficult for me on my own*" (Practice nurse).

Only a few GPs found time to catch up with other GPs working nearby. Many thought that such profes-

sional isolation could be a barrier when trying to recruit doctors to rural practice.

Responsibility to the community and the pastoral role: Rural GPs expressed a strong sense of responsibility, almost a 'tie', to the community. This appeared to arise partly from the large distances to specialist services, which required rural health professionals to make carefully balanced risk assessments about whether to treat people locally or send them to hospital in the city. The GPs seemed to be particularly aware that their clinical decisions were very visible in the community. Other practice staff also expressed feelings of responsibility and "visibility" in the community. These feelings were linked with difficulties in escaping from a professional role: *"I would hate to live in the same place as the surgery. I mean I just went down at lunchtime … and actually I went to buy fruit and some jelly babies (confectionery) for the children's immunisations. I came out without the fruit because I got interrupted by this woman who came and asked me about meningitis vaccines"* (Practice nurse).

The twin burdens of responsibility and visibility were mitigated somewhat for some GPs by the value and respect given to them by the community. However, this could also have negative consequences, since patients were sometimes reluctant to make demands even when appropriate: *"… I mean people who have a heart attack and then apologise for phoning you – (I may say) look, don't apologise for things like this – you need to call me at home … (They might reply) oh, but I don't like getting you out of bed …"* (GP; male).

Related to the theme of responsibility to the community, many staff (not just the GPs) thought that the health centre was perceived locally as a 'community help centre': "*… people come along here – you get social work problems, they come with problems that would be better addressed to a minister, they come with problems that would be better addressed to a policeman, but they don't go to these places. Why don't they go? The social work department are not easily accessible. There's no lawyer here to take charge of things … so where do they go? They come here*" (GP; male).

"*There are circumstances – we are in the country. One woman her neighbour was threatening to shoot her dog so they wanted me to come out and sort out the problem*!" (GP; male).

"*… it's how people are – they'll actually go to their doctor because they are having – you know it's nothing to do with their health – well it's health but it's their personal life and they want someone to speak to and counsel them…. At least when we had this counsellor we had somewhere for them to go, now they just get referred … and (because) they don't want people to know they just come here*" (Practice manager; female).

Staff knew patients as neighbours and friends. Many interviewees mentioned that they spent time helping patients complete benefit forms and listening to problems. It was sometimes difficult for practice nurses to detach themselves from patients and their problems. The increased pastoral role of rural general practice was thought to be a consequence of the decline or absence of a range of support services available in urban areas, such as social services, voluntary agencies, the police force and the church.

Pressures stemming from patients' attitudes and high expectations were not unique to rural practice, but beliefs about which patients generated demand were. Some of the rural practice staff thought that incomers to the area were more demanding than indigenous local patients. Providing accessible medical services for commuters and their families was difficult due to surgery opening hours coinciding with commuters' work and travel time.

DISCUSSION

One of the strengths of our study was the iterative approach to data collection. Repeated visits to the practices, and the interviewing of different staff, enabled us to build rich pictures of the context within which participating individuals worked. Both interviewers were from non-clinical backgrounds. This was an advantage throughout the study. The interviewers approached the research without any preconceptions or personal professional experiences. Interviewees appeared to respond well to questioning, knowing that the researchers were not fellow health professionals.

A limitation of the study was its conduct in one region of Scotland – we do not know if the findings would be similar in other areas. The majority of those interviewed were women, yet most of the participating GPs were men. Thus, it was difficult to determine whether gender was related to workload pressures. The interviews with GPs tended to be longer and generated richer data than those held with practice nurses. It is possible that the practice nurses were not familiar with being asked to reflect on their jobs. When describing their workload pressures, both doctors and practice nurses compared themselves with other professionals outside of their own practice. Other staff within the practices were more likely to make comparisons in-house.

Our findings support the view that, "although most of the work of rural practitioners is common to colleagues working in non-rural areas, there is sufficient that is different to merit description and study" (8). A particular pressure of rural practice, which we

have termed the "specialist-generalist" role, has been described previously (1) and has been recognised by professional bodies (9). Others have described the non-medical or social nature of problems presented by many patients in rural practice, and the responsibility felt by rural GPs for problems which include social and pastoral dimensions (10,11). Although rural doctors may believe that their style of practice can be found in non-rural settings, they believe that the scope for implementing this style of practice may be more limited outside rural areas.

Prolonged periods on-call is a characteristic of rural general practice which has been found in other countries (12,13). This workload pressure may be less in urban areas, where locums are more easily available and where there are out-of-hours cooperatives. Difficulties in arranging time off from the practice were reported barriers to GPs attending organised professional development activities. Research investigating professional development events found that doctors from rural areas attended fewer educational meetings than those from urban areas, and that the location of the practice had a small, statistically significant, bearing on overall attendance at meetings (15). Examining GP preferences for the provision of postgraduate education, Kelly and Murray discovered that GPs attending continuing education events that used locums were more likely to be from rural areas than from urban locations (16). The majority of GPs in our study said they did not use locums or that they were reluctant to do so, which suggests that they were more likely to keep up to date with professional developments through reading or local meetings. Whether this style of professional development is effective is unknown.

Sutherland and Cooper identified a number of "role stressors" in relation to a GP's job, a few of which appeared unique to rural practitioners (being 'visible' in the community and the associated implications of making mistakes) (14).

High patient expectations was another stressor although not unique to rural practice. Other research has identified unrealistically high expectations of GPs by others as an increasing source of stress for GPs (17). The rural GPs interviewed by Rousseau and McColl believed that certain groups of patients were more demanding, namely incomers to the areas and temporary residents (1). These sentiments were echoed by interviewees in our study. Rural practitioners in other countries also appear to be challenged by high patient expectations (12).

This qualitative study has shown that there are workload pressures particular to rural practice. These included the specialist-generalist role of rural practitioners (and the associated problem of keeping up to date with a wide range of skills); heavy on-call commitments and difficulties in taking time off; feelings of responsibility to and a pastoral role within the community. Rural practitioners also experienced the work pressures that were unrelated to location, such as those associated with change and increasing administration. A mixture of solutions is needed to address these problems; some common to all practices regardless of location and some more specific to rural areas.

ACKNOWLEDGEMENTS

We thank all the general practices and their staff who agreed to take part in this study. All responses have been anonymised. This work was funded by a research grant from the Grampian Health Board.

REFERENCES

1. Rousseau N, McColl E. Equity and access in rural primary care: an exploratory study in Northumberland and Cumbria. Newcastle Upon Tyne: University of Newcastle upon Tyne Centre for Health Services Research, 1997.
2. Royal College of General Practitioners Scottish Council. Rural health care in Scotland – the future. A multidisciplinary conference; 1998 May 7–8; Dunkeld, Scotland.
3. Deaville JA. The nature of rural general practice in the UK – preliminary research. A joint report from the Institute of Rural Health and the General Practitioners Committee of the BMA. Powys: Institute of Rural Health. 2001: 104.
4. Cooper CL, Rout U, Faragher B. Mental health, job satisfaction, and job stress among general practitioners. BMJ 1989;298:366–70.
5. Howie JGR, Hopton JL, Heaney DJ, Porter AM. Attitudes to medical care, the organisation of work, and stress among general practitioners. Br J Gen Pract 1992;42:181–5.
6. Strauss A, Corbin J. Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park, CA: Sage, 1990.
7. Gantley M, Harding G, Kumar S, Tissier J. An introduction to qualitative methods for health professionals. London: The Royal College of General Practitioners, 1999.
8. Cox J, Mungall I. What is different about rural practice? In: Cox J, Mungall I, editors. Rural healthcare. Oxon: Radcliffe Medical Press, 1999:1.
9. World Organisation of Family Doctors (WONCA). Policy on training for rural practice. 1995.
10. Gillies JCM, Baird AG, Gillies EM. Balancing proactive and reactive care. In: Cox J, editor. Rural general practice in the United Kingdom. Occasional Paper 71. Exeter: Royal College of General Practitioners, 1995:15–8.
11. Horobin G, McIntosh J. Responsibility in general practice. In: Stacey M, Reid M, Heath C, Dingwall R, editors. Health and the division of labour. London: Croom Helm, 1977:88–111.
12. Bowman RC, Crabtree BF, Petzel JB, Hadley TS. Meeting the challenges of workload and building a practice: the perspectives of 10 rural physicians. J Rural Health 1997;13:71–7.

13. Cuddy NJ, Keane AM, Murphy AW. Rural general practitioners' experience of the provision of out-of-hours care: A qualitative study. Br J Gen Pract 2001;51:286–90.
14. Sutherland VJ, Cooper CL. Identifying distress among general practitioners: Predictors of psychological ill-health and job dissatisfaction. Soc Sci Med 1993;37:575–81.
15. Murray TS, Dyker GS, Kelly MH, Gilmour WH, Campbell IM. Demographic characteristics of general practitioners attending educational meetings. Br J Gen Pract 1993;43:467–9.
16. Kelly MH, Murray TS. General practitioners' views on continuing medical education. Br J Gen Pract 1994;44:469–71.
17. Sibbald B, Enzer I, Cooper C, Rout U, Sutherland V. GP job satisfaction in 1987, 1990 and 1998: lessons for the future? Fam Pract 2000;17:364–71.