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ORIGINAL ARTICLE

Leadership in rural medicine: The organization on thin ice?

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Abstract
Objective. To explore the personal experiences of and conceptions regarding leading rural primary care in Northern Norway. *Design.* Qualitative content analysis of focus-group interviews. *Setting.* Lead primary care physicians in the three northernmost counties. *Subjects.* Four groups with 22 out of 88 municipal lead physicians in the region. *Results.* Three main categories were developed and bound together by an implicit theme. *Demands and challenges* included the wide leadership span of clinical services and public health, placed in a merged line/board position. Constraints of human resources and time and the ever changing organizational context added to the experience of strain. *Personal qualifications* indicates the lack of leadership motivation and training, which was partly compensated for by a leader role developed through clinical undergraduate training and then through the responsibilities and experiences of clinical work. In *Exercising the leadership*, the participants described a vision of a coaching and coordinating leadership and, in practice, a display of communication skills, decision-making ability, result focusing, and ad hoc solutions. Leadership was made easier by the features of the small, rural organization, such as overview, close contact with cooperating partners, and a supportive environment. There was incongruence between demands and described qualifications, and between desired and executed leadership, but nevertheless the organization was running. Leadership demonstrated a "working inadequacy". *Conclusion.* Under resource constraints, leadership based on clinical skills favours *management by exception* which, in the long run, appears to make the leadership less effective. Leadership training which takes into account the prominent features of rural and decentralized primary care is strongly needed.

Key Words: *Clinician, focus-group interviews, physician leadership, rural primary health care*

Rural primary care facilities in Norway provide comprehensive clinical and public health services. Most facilities have teams of 2–5 physicians and an equal number of support personnel. One physician has the lead role, often in a merged line and board position, with clinical work as the major task.

The context for rural medical services entails small organizations, long distances, qualified human resource constraints, and a wide span of tasks undertaken by few people [1–3]. These conditions have an impact on leadership.

It is widely accepted that primary health care depends on the competence of its administration and leadership to deliver quality services. National and international policy documents state that governance and leadership of primary care need to be improved and that health reform policies are dependent on this improvement [4–7].

Undergraduate teaching in leadership in Norway's medical schools is still fragmented with one out of four schools providing training above the minimum. The speciality in public health requires six days of leadership training and general practice requires only two days. The public health speciality is steadily losing ground as the number of new candidates does not keep up with those leaving the specialty [8,9].

Changes and successful improvements in health services are dependent on trained leadership, but often rural municipalities have no other choice except to employ physicians without such training [10].

Research on leadership in rural health care is scarce, with most studies originating in the nursing profession. An Australian study of leaders in rural nursing units comprised certain key challenges, such as role complexity and the lack of relevant training

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Leadership in rural medicine has not been much studied. This does not reflect its importance for delivering quality services.

- There is incongruence between demands, qualifications, and practices of leadership.
- The rural context forces the use of less effective leadership styles.
- The improvement of this leadership must be built on training tailored to the setting and must be rooted in clinical practice.

and support [11]. Finnish health centre studies emphasize the need for effective management to solve problems of information exchange and collaboration, physician shortage linked to management, and management differences between large and small health centres [12–14]. More research-based knowledge is needed to define the role of rural lead physicians and to provide a basis for training. This study aims at exploring this group's experiences of, and conceptions regarding, rural medical leadership.

Material and methods

A qualitative approach using focus-group interviews was chosen, as the dynamics of these groups facilitate interaction between the collective experiences, knowledge, and opinions of participants [15–17].

Participants

Lead primary care physicians in North Norway were invited to participate. Four groups were purposely planned to cover all three counties. Experienced and inexperienced physicians were included. The invitation covered study background, questions to be discussed, confidentiality, and practical issues. A total of 22 (25%) self-selected, lead physicians out of 88 were included, four females and 18 males, corresponding to gender distribution in the region. The groups had three, four, six, and nine participants. An additional 10 (three females) physicians responded positively but could not participate for practical reasons and one male expressed no interest. The participants' experience of medical leadership ranged from a few months to 30 years.

Group interviews

Semi-structured interviews were undertaken. The discussions followed an interview guide (Table I) and lasted 1–2 hours. All discussions were led by JH, a practising GP with long leadership experience in the region, and an assistant. The interviews were taped and transcribed verbatim and were judged to provide sufficiently rich and varied material for the analysis.

Table I. Key questions.

Key questions in interview guide:

- *Tell us about your work as a lead physician.*
- *What are the important elements of the lead role?*
- *What leadership behaviour and tools are you practicing and using?*
- *What conditions are needed for improvement of the leadership?*

Analysis

The verbatim transcribed interviews were analysed using qualitative content analysis [15–18]. The texts were initially read to become familiar with the content. Meaning units were then identified, condensed, abstracted, and labelled with a code. Based on their similarities and differences, the codes were first sorted into preliminary subcategories and categories, and then, after continuing comparisons, into definite ones. Finally, after reading the categories as a whole, a general theme emerged [17] (Table II).

Codings and categorizations were first made individually by the two authors, and then tried and decided upon in cooperation. The theme was the fruit of a discussion continued throughout the later part of the process.

Results

Three main categories with subcategories, reflecting the experiences and conceptions of the participating lead physicians, were developed: *Demands and challenges*, *Personal qualifications*, and *Exercising the leadership*. These categories were held together by the theme "*Working inadequacy*".

Demands and challenges

The leadership span. The leadership had a wide span, covering both clinical services and public health:

> *I think very few are able to be a GP, a line manger, a public health officer, influence upwards and downwards at all levels in the municipality … very few can manage that…. (Gr1p8)*

Resource constraints. Resource constraints affected leadership. Patients and calls had first priority. Major concerns were time and vacancies. Vacancies resulted

Table II. Content analysis *example* matrix.

Meaning units	Codes	Subcategories	Categories	Theme
" I want me out of line eadership… that is not doctor work"				
"..too much demands from my superiors in the line."				
	Line/board position			
"..I want to be at the level where things happen. Up there, in the board, NOTHING happens.."		The leadership span	Demands and challenges	
"I think very few are able to be a GP, a line manger, a public health officer, ….very few can manage that"				Working inadequacy

in more calls and clinical work and less time for leadership:

> *… leadership, clinician, public health officer AND the BIGGEST problem …we have no time to do all this. It is just not possible. (Gr4p21)*

> *… the time available is extremely dependent on how many doctors present … short periods I am alone… (Gr2p5)*

Time shortages tended to make even major decisions half-hearted and last-minute:

> *… what should be my most important job; to push our services forward, create something new, that I have to do by a "heel kick"…. (G2p14)*

Organizational impact. The lead physicians felt municipality reorganization often increased the responsibility span by adding new groups of health workers that they had to be responsible for. Additional frequent vacancies at the superior level caused permanent instability:

> *… my superior is a teacher, the previous an economist, then a bureaucrat, a doctor, a social worker, a public health nurse…. (Gr1p11)*

Models and strategies for implementing health legislation and regulations were found to be too much coined by large and urban communities. This imposed much unnecessary administrative work and strained already exhausted resources. Examples were quality development and planning requirements:

> *… is about to kill small communities … national level dictates … these systems are to solve urban problems not ours…. (Gr2p5)*

> *… in this small community, I have 7–8 under me, about the size of a purseseiner boat [fishing boat], they [on the boat] do not go for training, they do not need frequent meetings with their superiors. Too many stupid things that take my time…. (Gr2p24)*

Personal qualifications

Motivation. The reasons for accepting the role varied; either it happened by accident, or there was an implicit demand. The motivation was generally low:

> *I became doctor in charge, and like most of us, in fact against my will. (Gr3p4)*

Those few who were positive from the beginning found it exciting to have the power and authority to make decisions and to motivate others to do a good job:

> *… the lead position was vacant 6 months before I took it on, a lot of work to get things going but very exciting, and then I have great support from those in municipality X. (G1p1)*

> *… to me it was great fun to have decisional authority. (G1p2)*

Leadership training. Participants felt they were not prepared for leadership. One had received training at college level and others had had short courses arranged by their municipalities in addition to courses required in their specialization. The latter were claimed to be too much hospital-based, too general, and not relevant for their context:

> *… had municipal training but … I am missing leadership tools, how to think, how to perform leadership in my kind of setting … the training I have had has not been applicable to my reality…. (G4p35)*

Building self-confidence. The interviewed doctors felt that, in addition to building their professional identity, medical training and experience also grounded their leadership competence:

> *… clinical work is fundamental to all I do as a leader. (Gr1p12)*

> *… we have a competence for leadership in health care nobody else in the municipality*

has … we must be conscious of it and proud of it. (Gr1p28)

The administrative and political leadership and other cooperating departments strengthened the physicians' self-confidence as leaders by profiting extensively from their professional knowledge:

… my position in the health care system gives me over time a lot of experience and I become a focal point of information in the system. (Gr2p11)

Exercising the leadership

The participants described their leadership practices mostly in general terms and through visions and the ideal situation. Their practical examples of implementation were dominated by administrative procedures.

Visions. The lead physicians often described their visions and ideas about their leadership by expressing themselves through "I want to…", "I wish I could…", and "I think that…". They rejected an autocratic style and supported a coordinating and coaching style:

… for me leadership is for the team to row the boat in the same direction, coordinate different options of directions and interests. (Gr3p3)

Practising leadership. Participants did not refer to leadership theories, but rather their own personality and professional training:

I am very sure that personality, good or bad, means a lot for how leadership roles are formed…. (Gr1p12)

… and as GPs we want progress and results, something that is appreciated in the municipal organization. (Gr4p16)

When choosing examples of practical leadership certain areas of clinical interests such as geriatrics, emergency medicine etc. were often mentioned:

… [leadership wise] … I have done things I have found [professionally] interesting…. (Gr1p5)

Proficiency in professional communication was claimed to be transferable to conflict handling and other management situations:

… hence our profession has many elements of leadership. (Gr3p9)

Extensive experience in decision-making and influencing others through clinical work became visible in their role as leaders:

… they [cooperating partners] have experienced us [as leaders] as result-oriented, decision-oriented … because of many years as clinicians and public health physicians. (Gr4p25)

A wide range of administrative procedures were mentioned as practising leadership, such as budgeting and other aspects of personnel administration, and delegated in different directions:

I have survived because I have delegated administration upwards and downwards. (Gr2p11)

Meetings were described in terms of details, frequency, content (much administration), participants etc., but were not explored specifically from a leadership perspective:

… quality development workshop some time ago. After that we changed our meeting-structure completely. More regular…. (Gr4p22)

Facilitating the rural context. The wide range of responsibilities also represented an interesting, professional diversity. The community size provided a good overview, geographically and organizationally. The interpersonal distances were short:

… if the municipality had been bigger and the public health nurse not just down the corridor, staff living in another place, psychiatric unit 20 staff members and not 4; then things would not be that easy. (Gr4p19)

They felt more visible in small communities and were utilized and appreciated in different ways.

Working inadequacy

Together, the categories form a mix of structural conditions, felt demands of being effective, experienced assets and deficiencies of the personal qualification profile, leadership ideals, and the factual execution of the leadership. The material contained examples of experienced successes, but the picture as a whole showed incongruence between demands and qualifications, and between how things were wished to be done, and a scarcity of descriptions of how they actually were done. The tasks were undertaken, but in a more reactive than reflective fashion. The leadership worked in an immediate sense but appeared, at the same time, to be partially inadequate. The lead physicians were coping as individuals but the organization appeared to be on thin ice.

Quotes within the three main categories (I–III) from one of the participants may illustrate the certain combination of experienced capability and inadequacy:

I.

… there are three parts in the leadership; we are employers, clinicians and public health officers.

The problem is not the complexity but we have no time to do it. It is just not possible….

… in a consultation; somebody asks about the nursing home, phone ringing, leave application, a prescription … all hats on. That is the challenge so difficult to cope with.…

II.

… a part of our authority comes from our clinical work….

… to move the community effectively from A to B, there is nobody to tell me how to do it. I have no tools, no mandate. We live on our authority and try to use it….

… I think I have had 2 weeks of local leadership courses, useless…. I need tools in leadership, how to think, how to practise leadership in my situation. These courses did not fit my reality….

III.

… the line lead role; there is a lot of administration, budget/personnel … kind of indirect leadership….

… now we use meetings [after training], it is OK after all, my personality likes doing things informally via indirect channels….

Discussion

The results

Demands and challenges, personal qualifications, and the ideas and practice of exercising leadership were described. Generally the interviewed lead physicians seemed to cope with their task as individuals, but the organization appeared to be on thin ice. There was incongruence in their descriptions between demands and qualifications, and a lack of descriptions of deliberate actions of leadership that matched the ideals. Shortcomings were also described explicitly. Although some of the findings should be no surprise to those involved in rural primary care leadership, an overall and systematic picture is necessary to understand its characteristics.

Medical training and practice were held to be important assets, but from a leadership perspective the doctor–patient and the leader–subordinate relationships differ.

To be a good lead physician and find ways of developing health care, so much more than medical competency is needed [18].

The authority from clinical experience as a GP reinforces the leadership role. A substitute function through professional competence has been described [19], but it might also hinder efforts to acquire specific leadership training.

Work experience has advantages but as the only substitute for leadership it is not sufficient. However, clinical experience seems to be essential to create motivation for leadership. This challenges many rural communities, which have no other choice than convincing young, inexperienced doctors with little motivation to embark on leadership [10].

Clinicians are action-focused problem-solvers. The more strained the situation the more probable it is that "clinical reflexes" also dominate leadership behaviour. This minimizes overview and the taking of long-term structural measures.

The participants advocated a supportive leadership style but gave few examples of implementation. In contrast, administration was described in detail, and they tried to avoid it, but in smaller communities it is often impossible to delegate. Overburdening clinical work forced them to take on ad hoc solutions and leadership became "left-hand work". This situation made lead physicians lower the level of formalized leadership and opt more for problem-solving. This shift towards *leadership by exception* has been found by others, where rural lead nurses advocated the supportive style but practised it only conditionally [20].

The Full Range of Leadership Model [21] incorporates all aspects of leadership behaviours, ranging from charismatic/relation/change-oriented style (transformational), through task oriented/active–passive management by *exception* (transactional), to laissez faire (no leadership). Research shows that the correlation of an *exception*-focused style with subordinates' satisfaction and performance ranges from slightly positive to significant negative [21]. The working but still inadequate leadership that stands out as a main feature in our material seems to correspond with an *exception*-focused style. Over time this style has been proved to place considerable strain on both the leader and the organization. We do not claim that major structural problems can be solved only by practising other styles within the model, but they could better contribute to what it is possible to do even under difficult circumstances.

Comments on the method

Recruiting lead physicians was challenging, which others have also experienced [22]. The most common causes for rejecting participation were tight schedules and long travel distances. Participants were probably a selection of motivated physicians. They constituted

a homogeneous group within a shared profession, which inevitably both represents and invites conformity. Despite this, the data were deep and varied, containing both positive and negative accounts.

The facilitator, also a GP clinician, seemed to give legitimacy to and make conditions favourable for creating an apparently trusting climate within the groups. These advantages of peer interviewing have also been described by others [23–25]. We believe them to outweigh the risks which have been pointed out by other researchers, that is, that a peer discussion leader, by increasing tendencies to loyalty and conformity, makes the participants hold back important information [26]. The study refers to conditions in rural general practice in North Norway. Different aspects of the results have found support in other studies, adding to its transferability [27–30].

Conclusion

Lacking the proper preparation for their task, rural lead physicians seemingly respond to their challenges through a less effective leadership style, leading by exception. Lead physicians manage the best they can, and cope with the situation as individuals, but the organization is on thin ice. The chosen strategies have the potential for improvement, and the expressed needs and recommendations of the lead physicians for tailored training rooted in their clinical practice should be listened to.

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Ethical approval

The required approval has been granted by "The Norwegian Social Science Data Services" (Ref 20050118455/RH).

Conflict of interest

None declared.

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