Rural general practitioners' experience of the provision of out-of-hours care: a qualitative study

N J Cuddy, A M Keane, A W Murphy

SUMMARY

Background: *Published research into the provision and utilisation of out-of-hours services shows long-term trends towards decreasing personal commitment among general practitioners (GPs). However, the on-call commitments of rural GPs remain especially onerous. There has been little research relating to either rural out-of-hours services or the implications of such services for the families of the providers.*

Aim: *To explore and describe how rural GPs in Ireland perceive and experience out-of-hours care provision.*

Design of study: *A qualitative study was conducted with 10 rural GPs and their spouses in their homes or practices using one-to-one in-depth interviews.*

Setting: *Ten general practices in rural Ireland.*

Method: *The interviews were guided by an interview schedule that was based on pertinent themes that had emerged from previous relevant literature. The interviews were audiotaped, transcribed, and analysed for themes and issues.*

Results. *Results indicated that rural GPs experience a wide variety of satisfactions from work related to the provision of out-of-hours care. However, the large proportion of time committed to out-of-hours care greatly infringes on their social and family life. The key stressors identified related to organisational system difficulties, especially with regard to locum cover, and unrealistic patient expectations. The stressors were mainly expressed as lack of time off, restrictions on family life, and interruptions.*

Conclusion. *System difficulties, such as difficulty with obtaining locums and rota extension, need to be addressed at an organisational level. Patient expectations of the role of the rural GP have significant implications for practitioners and their families.*

Keywords: *rural general practitioners; out-of-hours care.*

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Introduction

TIME spent on call is a shrinking component of general practitioners' (GPs) workload but is often perceived as an increasingly undesirable aspect.[1] The on-call commitments of rural GPs are still especially onerous.[2] A comprehensive 1996 census of general practice in Ireland suggested that the average on-call commitments of rural GPs was 66 hours per week, in comparison with 41 hours for their city colleagues.[3]

Much quantitative research assessing the presence of certain stressors has shown that the stress generated by the provision of out-of-hours care is considerable.[4-10] A qualitative approach, that provides a deeper understanding of the perceptions and experiences of practitioners, is also appropriate. Rout[11] performed a qualitative study of stress among GPs and their spouses in the United Kingdom (UK) that highlighted out-of-hours work as contributing significantly to their levels of stress.

The objective of this study was to explore and describe how rural GPs perceive and experience the provision of out-of-hours care.

Method

Eleven rural GPs (nine of whom were males) were approached and 10 agreed to participate in the study. The practitioner who declined to participate cited lack of time as the reason. 'Rural' was defined as at least 15 miles from the local hospital. Distances between GPs' practices and their local hospital ranged from 15 to 50 miles. Characteristics of the sample were similar to those of a national census of rural GPs in Ireland[3] with respect to age and sex. Six of the GPs were under 45 years of age, while the remaining four ranged between 46 years and 58 years. Six were single-handed, two had one partner, and the remaining two had shared assistants. The length of time in practice ranged from seven to 28 years (mean = 15.7 years).

Purposive sampling[12,13] was used to select GPs working in rural general practice in the western sea board area of Ireland. A maximum variation sampling strategy was also employed to ensure a reasonably diverse representation of GPs in terms of age, sex, and geographical location.[14] One-to-one in-depth interviews with the GPs were conducted by one of the authors (a qualified nurse and psychologist) either in their own home or at their practice. The sample size was not fixed in advance but by the end of the tenth interview it was deemed by the authors that data saturation had been reached. Spouses of each GP were also interviewed. Analysis of spouse data was used to corroborate the findings of the present study. The interviews were guided by an

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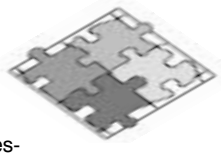

What do we know?
The on-call commitments of rural GPs are still especially onerous. Much quantitative research assessing the presence of certain stressors has shown that the stress generated by the provision of out-of-hours care is considerable. However, rural GPs' perceptions and experiences of the provision of such care have not been previously qualitatively explored.

What does this paper add?
The large proportion of time committed to out-of-hours care greatly infringes on the GPs' social and family life. Two principal new findings were also noted. First, although 'finding a locum' has emerged as a job stressor in some of the large studies carried out in the UK, it was not deemed, in comparison with this study, to be among the major stressors experienced by GPs. Secondly, rural GPs in this study derived significant emotional and practical support from their spouses. This is in contrast to the findings of Rout. Such support may have been provided at a cost to spouses in terms of social life and career. This appeared to reflect a sex difference.

interview schedule that was open-ended and exploratory in nature and was based on pertinent themes that have emerged from previous relevant literature.[5-8,11] Themes included night calls, dealing with problem patients, arranging admission, demands of the job on family and social life, 24 hour responsibility for patients lives, coping with interruptions on family life by telephone, time pressure, and unrealistically high expectations by patients of the GPs' role.

The schedule was piloted on two GPs before the study commenced. All interviews were tape recorded and transcribed. The transcripts were analysed (manually) line by line and category codes were applied and indexed appropriately to each meaningful section of text.[12] The categories, that were entirely generated from the data, were recorded on the horizontal axis of a large grid matrix with the transcript's index on the vertical axis so that the recurrent themes from the whole sample could be identified easily. Through this cross-sectional indexing and retrieval system, a final matrix was generated that provided an overall picture of the themes that had emerged across responders. Validation of the data extraction and interpretation process was performed by one of the authors (a psychologist) and an independent researcher.

Confirmation of the trustworthiness of the results was established. First, member checking was performed by sending each participant a written summary of the results followed by a telephone conversation to ascertain whether or not they were in agreement with the broad thrust of the findings and their interpretations. Secondly, spouse data was reviewed to check concordance with the findings.

Description of Irish healthcare system

Free primary care and medications are available to approximately 31% of the population of the Republic of Ireland; they are described as general medical services (GMS) eligible. The other two thirds, whose income is above a certain level (for example, in 1999: IR£88 per week for a single person aged up to 66 who is living alone), are responsible for their own primary health care costs. Ireland has a significant rural population with 38% of GPs describing themselves as rural, of whom more than 50% are single-handed.[15] This may have an impact on the intensity of the rural doctor–patient relationship.

Results

Satisfying aspects

The GPs expressed a wide variety of satisfactions about their work. The strongest themes were the satisfaction they experienced from helping to make people better and providing comfort for the terminally ill, that was viewed as both demanding and rewarding.

> *'I get great satisfaction from treating the terminally ill, you build up a great relationship with the patient and the family show great appreciation.'* (Doctor 5.)

There was a strong expression of satisfaction relating to continuity of care that GPs felt was unique to rural practice.

> *'The doctor–patient relationship is very treasured and special in a rural area. You get to know your patient very well.'* (Doctor 7.)

> *'Because you are actually around a lot for out-of-hours you are very often present in times of crisis and even though it can be a snag being on call a lot, it actually brings you closer to your patients and you can supply a very personal service to them.'* (Doctor 3.)

Drawbacks

Restrictions. The majority of GPs accept that out-of-hours care is part of the service they provide. However, it is the aspect of their job they found most demanding and some felt they did far too much of it. The strongest theme that emerged was the restrictions that they felt were imposed on them and their families by having to be available most of the time.

> *'If friends call unexpectedly I can't say with certainty that I will meet them for the night … besides you have to stay within a few miles of your place in case you get called.'* (Doctor 5.)

> *'I used to play an awful lot of golf. I hardly play any at all now. I don't make arrangements … I don't try to get to things at all because I know I won't get to them.'* (Doctor 3.)

> *'Often what becomes stressful is not what you have to do but what you have to be available to do …'* (Doctor 1.)

Data from spouses supported this.

> *'My husband works four nights out of five in the week and alternative weekends … therefore our social life is very restricted.'* (Spouse 3.)

Interruptions and patient expectations

Closely linked with restrictions was the irritation GPs experienced by what some described as constant interruptions.

> *'We are just sitting down to dinner and somebody he has just seen three hours earlier would ring up and say that the antibiotic hasn't worked yet.'* (Spouse 4.)

'My wife can't relax and she has no time at all for herself when she is on duty … the surgery is at the house during the weekend … people are constantly calling during meal times.' (Spouse 10.)

The type of interruption GPs found most frustrating was patients calling to their door. Most resented such intrusion in their lives particularly if they perceived the interruption as an inappropriate out-of-hours call.

'It wouldn't be unusual for somebody to call here at 11 o'clock at night just to get a form filled out for their glasses …' (Doctor 2).

Sleep interruptions were viewed by all GPs as stressful; older GPs found it particularly trying.

'I don't sleep anymore when I'm called … you get to a stage with night calls that you are not able to sleep … On my nights off, very often I take a sleeping tablet … I am not a good sleeper my job has made me that way.' (Doctor 4.)

Interruptions in the early hours of the morning were particularly stressful. General practitioners alluded to the detrimental effects that sleep interruptions had on their performance the next day and the severe consequences of mistakes. A persistent theme in relation to patients' expectations of their doctor concerned the selfishness and over-familiarity of patients.

'They know I'm off, but people think I am just there at home and it's only me … they don't realise there is another thousand people who think it is only me' (Doctor 5.)

General practitioners felt tourists were more demanding than their regular patients and often had unrealistic expectations.

Family

Spouses provided significant emotional and practical support for the GPs. Each GP highlighted the importance of a close relationship with their spouse and acknowledged that the demands of the job could place a strain on their relationship.

'There is no doubt but doing so much on call places a great strain on your relationship.' (Doctor 3.)

Many expressed concern for having to leave so many household and family responsibilities to their spouses.

'My wife does everything with the kids … homework and all that, I am always out on calls.' (Doctor 6.)

Some greatly regretted being unable to give sufficient time to their families and felt they were missing out on their children growing up.

'I am afraid I am grossly negligent to my family … I am so busy.' (Doctor 2.)

Being on call not only restricted them in their own lives but also greatly restricted their spouses as they could not pursue any social activity outside the home in the evenings.

'My husband couldn't mind the children if I wanted to go to a night class when he is on call … he couldn't even mind them while I go to mass.' (Spouse 6.)

In addition, GPs reported that their spouses were unable to pursue their careers owing to the demands of their work. Spouses often had to deal with awkward situations at the door or on the phone when the GP was off duty.

'If he is here and off duty … he is hiding in the sitting room … his car is around the back … I am sort of doing guard at the door … that is what I call doing the GP wife act.' (Spouse 8.)

Some participants expressed concerns regarding their spouses' and children's personal safety.

Current responses to out-of-hours care provision

The strength of GPs' dissatisfaction relating to out-of-hours care provision varied greatly. In all cases but one, it seemed to be reflected in their rota system arrangements. General practitioners working a one-in-two weekend rota were highly dissatisfied with this commitment and felt it interfered greatly with their family, social life, and work performance.

Locums. Most GPs had difficulty in getting locums. They felt that locums were not interested in coming to rural areas because of the isolation, the work intensity, the larger catchment areas, and the smaller volume of private patients' fees compared with urban practices.

'It's very difficult to get locums, increasingly more so because the locums just don't want to come to the rural areas, they want the soft pickings of the cities and the towns.' (Doctor 2.)

'Getting locums is awful hassle, there is not enough private income in this area to make it worth their while, so to lure them here we have to offer them the house.' (Spouse 1.)

They commented on the difficulty of getting locums during holiday periods and the virtual impossibility of getting a locum at short notice.

'He is running around like a lunatic trying to get a locum that takes some of the benefit out of the holidays.' (Spouse 8.)

'Getting a locum in an emergency situation is a huge problem. When my son was born, I couldn't get anybody to cover.' (Doctor 5.)

All reported that locums were expensive, particularly if they were accessed through an agency.

'Locums want as much for a week as I might expect to earn in three weeks.' (Doctor 9.)

Providing accommodation for them outside of their own homes proved very difficult and expensive in some rural areas. They strongly resented leaving their homes to accommodate locums and viewed it as an enormous infringement on their privacy and family life.

'Locums move in to your house and you have to go … we came back early one year and found a whole family had moved in … that isn't acceptable.' (Doctor 10.)

Coping strategies

In response to probes surrounding their coping strategies in relation to the restrictions and interruptions they experienced, some alluded to specific active coping strategies,

such as being 'firm' with patients, putting a notice on the door and a message on the machine.

'We have a notice on the door and a message on the machine … We got professional notices made out and it made a big difference.' (Spouse 6.)

Most GPs never answered the door themselves when off duty.

'If you answer the door yourself you are stuck …' (Doctor 2.)

Some found it necessary to resort to hiding their cars, not answering the phone, having special glass fitted to the windows of their home so patients could not see them, and going away from their area when they were off duty.

'We had special glass fitted to the windows so that the patients could not see me inside but I can see them coming to the door.' (Doctor 10.)

Most had developed strategies to try and cope with night calls, such as changing their attitude to night calls, trying not to get too annoyed, and working off their frustration before they arrived at the patient's house or their surgery.

'Sometimes when I am going out on a night visit I would physically have to shout in the car because I would be so frustrated and annoyed.' (Doctor 1.)

In terms of coping with out-of-hours care provision, all GPs felt that patient education was of paramount importance.

'None of my patients ever call to my home now they have learned over the years that I don't accept it.' (Doctor 4.)

'His patients are very well trained and they don't really call him unless they need to call but we find when we are covering for the other GPs it's a different story … they will ring us up before giving a spoon of Calpol.' (Spouse 6.)

However, there was certain ambivalence among some GPs about this issue when it actually came to putting it into practice.

'It's so much hassle sometimes trying to educate them. It is often easier to say give me the form and I'll sign it.' (Doctor 2.)

Trustworthiness of the results

Member checking confirmed the results to be valid, except that the two female GPs felt that the summary did not fully reflect their perspective. They believed that their situation differed particularly from their male counterparts in two domains. First, male GPs tended to involve spouses in their work lives (almost like a family business) whereas female practitioners were constantly engaging in multiple roles, juggling family life with out-of-hours work. Secondly, female GPs felt that they had to be particularly diligent with regard to personal safety, especially during out-of-hours visits.

Analysis of spouse data confirmed that the provision of out-of-hours care greatly infringed on their personal, social, and family life.

'It reacts on you and the children … everything is Shhh … the children are going around the house saying gosh Daddy is having a bad time.' (Spouse 4.)

'When he has a lot of on call he wouldn't have the energy for family life … he wouldn't have the space in his head for any other body's needs.' (Spouse 1.)

Many felt that the restrictions they experienced as a consequence seriously curtailed their social life and career. Spouses viewed interruptions as a chronic stressor, that caused great disruption to family life. Most expressed concern for their husbands'/wives' future physical and mental health as he/she gets older. Many spoke about the fatigue and sometimes negative mood the GPs experienced particularly before, during, and after working weekends on call.

'He would be narky with me and the children … but he wouldn't mean it … He is just tired.' (Spouse 5.)

Discussion

This study has highlighted the primary concerns of rural GPs with regard to the provision of out-of-hours care. A qualitative approach was used to provide insight into GPs' thoughts and feelings about this issue. The main limitation is that it is based on a relatively small sample of GPs working in a confined region. However, data saturation was reached and specific methods were used to confirm the trustworthiness of the results.

Karasek[16] proposed a job strain model that classified general practice as a high demand, high decision latitude profession. This meant that the high demands of the job would not be experienced as especially stressful so long as there is also freedom of action and autonomy in decision-making. This study has found that the provision of out-of-hours care has far-reaching stressful effects on the social and family life of GPs. It is possible that the issues relating to patient expectations and out-of-hours arrangements described in this study could impinge on freedom of action and autonomy and consequently affect levels of stress. Two principal new findings were also noted. First, although 'finding a locum' has emerged as a job stressor in some of the large studies carried out in the UK[6,7] it was not deemed, in comparison to this study, to be among the major stressors experienced by GPs. Secondly, rural GPs in this study derived significant emotional and practical support from their spouses. This is in contrast to the findings of Rout.[11] Such support may have been provided at a cost to spouses in terms of social life and career. This appeared to reflect a sex difference.

Lazarus and Folkman[17] indicated that the cognitive appraisal that an individual makes and/or the degree of control one experiences in the face of perceived stress will moderate the stress experience. As the majority of stressors relating to out-of-hours are unpredictable in nature, it is not surprising that GPs experience high levels of psychological distress. Responses to the findings of this and other similar studies suggest the need for both individual orientated and organisational responses (e.g. central provision of regular locum coverage to rural practitioners). Regarding the former, Winefield[18] demonstrated how a stress management programme conducted on 20 Australian women GPs significantly reduced their psychological distress and emotional exhaustion. Fundamental organisational changes in the delivery of out-of-hours care have recently occurred in the UK,[19] Denmark,[20] and Finland.[21] A recent study in the UK[22]

demonstrated that use of out-of-hours general practice co-operatives is associated with an improvement in the health of GPs. The role of co-operatives has increased markedly[23] and is feasible in rural areas.[24] The first co-operative in Ireland was established in 1999 and includes rural areas.[25] However, a significant number of rural practitioners may be unable to participate, owing to scattered patient populations or insufficient numbers of practitioners, and will therefore require additional support.

Local responses by Irish health boards and government to the difficulties outlined in this paper include provision of a central fund for locum payments and rotating locums. These have met with mixed success, partly owing to the general difficulties in rural practitioner manpower. To overcome these difficulties, a coherent and integrated strategy for the recruitment and retention of all rural primary care practitioners needs to be developed.

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