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Addressing Rural Health Issues through Policy Storytelling

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Police officers, teachers, and social (vocational) workers (SLBs) interact the most with citizens and can implement policy. The citizens being mentioned end up being our patients in these rural areas. We need to learn about who the patients and citizens are through a medical front-line lens the same way SLBs do. Interviews, focus groups, observations and other qualitative methods will help surgical administrative professionals who want to address the access to care issue in underserved and rural areas. In return, this can help retain staff and prevent staff burnout by addressing the problems of potential patients before they occur.

Approximately 66 million people live in rural areas in both the United States and Canada. More than sixty million people live in rural areas throughout the United States. A rural county is defined as a population under 50,000.[1] In 2019, 60% of people living in rural communities were without surgical care.[2] In fact, Dr. Timmerman, Chair of Surgery at the University of South Dakota stated that it could take anywhere between two to six hours to find a doctor, rather than 20 minutes in urban areas.[2]

A major component of the lack of surgical care in rural areas is the aging population of surgeons in rural areas versus urban areas. Surgeons who live in rural areas are mostly over 50 years old (55% to 60%) compared to surgeons who live in urban areas where that number is less than 50%.[3] McCartney provided several approaches on how to ease the shortage of rural surgeons which included 1) tapping a homegrown resource, and 2) rural track training programs emphasizing rural immersions. A few surgeons that McCartney interviewed were born in rural areas. In addition, Dr. Nykamp, a general surgeon in Orange City, Iowa stated that we should be attracting students to rural healthcare before they even begin the process of medical school. In addition, Dr. Timmerman believed that surgical residency programs should offer rural surgical rotation opportunities, for example, a one to three-month rotation in a rural community.

In March 2023, ABC News wrote an article titled "Less staff, longer delays and fewer options: Rural America confronts a health care crisis", where they interviewed patients in rural areas about the decreased numbers of Primary Care Physicians (PCPs).[4] For example, Owen Foster lived in rural Vermont where he stated it could take up to six months to book an appointment with a PCP. In rural New Hampshire, some women have to drive two hours to deliver their baby due to the few available beds in emergency rooms. This has also caused a delay for elective surgery procedures. Another major concern for the rural areas is the ability to not only find but also retain staff and prevent staff burnout.

The issue is two-fold, the lack of surgical care and the lack of medical staff in rural areas. Medical staffing issues can be addressed more immediately. A theoretical solution to retaining staff and preventing staff burnout would be for healthcare professionals and public administration professionals to collaborate with one another, specifically by introducing Street-Level Bureaucrats (SLBs).

SLBs were first introduced by Lipsky (1980) which were defined as public service employees on the front line such as police officers, teachers, and social (vocational) workers.[5] Citizens around the country encountered these front-line workers every day. Since SLBs were a direct representation of government entities, they worked with some of the most socioeconomically disadvantaged populations. Lipsky's research found that SLBs were faced with inadequate resources, large caseloads, and ambiguous agency goals.[5]

Further, Maynard-Moody and Musheno (2003) expanded on Lipsky's work through storytelling. They spent three years in the field with 19 police officers, 19 social workers, and 10 teachers.[6] The fieldwork consisted of collecting stories and agency documents, observations, entry, and exit interviews. They found that there were three poles that SLBs experience: 1) routine versus moments of chaos, 2) benevolence versus revulsion, and 3) hopelessness versus accomplishment. They found that storytelling was less obtrusive and allowed the storyteller to reveal their judgments and discretions.

Maynard-Moody and Musheno also found that there were five ways SLBs cope with discretion. First, they would cope with discretion through 1) a sense of belonging, 2) applying a fix, 3) developing relationships, 4) through ego, and 5) worthiness. Specifically, the SLB asked themselves the following questions: is the client like me? Does the client have a reasonable goal? Does the client respect me or do they cause me problems? Is the client considered a good or bad person? Will helping this client end up helping the community and society? They also found that SLBs focused on specific individuals that they worked with and

circumstances that they encountered rather than focusing on the laws, norms, and rules they have from their organization. They viewed themselves as empowered citizen agents, charged with making decisions to ration resources and maintain societal order.[7]

One of the stories from their 2003 book was from a Midwestern Vocational Rehabilitation Counselor which they titled "Harder than Brain Surgery". The Vocational Rehabilitation Counselor's client required brain surgery to remove a tumor. The client also had a learning disability. Due to the recommended surgery, the client was going to lose their home during the recovery due to the lack of support from the welfare agency. The counselor wrote an exception to the policy to the agency since "he did not meet the income guidelines because he was drawing unemployment. He was over the $375 guideline, so I wrote an "exception to the policy"'[6] The process took several weeks and included over 40 additional questions. After continuous discussions, the welfare agency decided to pay for three months of the mortgage which was only $420 a month living in a rural midwestern town, however, wouldn't pay for his rearrangements since they already occurred. After several disputes, the counselor went to her supervisor's supervisor and stated that they were not going to help the client halfway in which they agreed to pay for the client's rearrangements. The counselor stated that it was easier to pay for the brain surgery which would have cost thousands of dollars rather than asking for several hundred dollars in housing support. The welfare agent was acting as a state-agent following the stringent rules of the agency while the counselor was acting as a citizen-agent for their client.

Since the client was unable to read or write and required extensive physical and speech therapy post-surgery, they were unable to resume work. The counselor kept the case open for years to check up on the client.[6]

This story was only one of many instances where SLBs interact with citizens, especially in rural and underserved areas.

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REFERENCES

1. Ellison EC, Bhagwan S, Way DP, Oslock WM, Santry H, Williams TE. The continued urbanization of American surgery: A threat to rural hospitals. *Surgery*. 2021;169(3):543-549. doi:10.1016/j.surg.2020.06.027

2. The Need to Prepare More Surgeons for Rural Practice Is Urgent. 2024. https://www.facs.org/for-medical-professionals/news-publications/news-and-articles/bulletin/2024/march-2024-volume-109-issue-3/the-need-to-prepare-more-surgeons-for-rural-practice-is-urgent/

3. WWAMI Rural Health Research Center. The Distribution of the General Surgery Workforce in Rural and Urban America in 2019. 2021. Accessed February 22, 2024. https://familymedicine.uw.edu/rhrc/wp-content/uploads/sites/4/2021/03/RHRC_PBMAR2021_LARSON.pdf

4. Less staff, longer delays and fewer options: Rural America confronts a health care crisis. 2023. https://abcnews.go.com/Health/staff-longer-delays-fewer-options-rural-america-confronts/story?id=97911613

5. Lipsky M. *Street Level Bureaucracy: The Dilemmas of the Individual in Public Service*. Russell Sage Foundation; 1980.

6. Maynard-Moody S, Musheno MC. *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service*. University of Michigan Press; 2003. doi:10.3998/mpub.11924

7. Maynard-Moody S, Musheno M. State Agent or Citizen Agent: Two Narratives of Discretion. *Journal of Public Administration Research and Theory: J-PART*. 2000;10(2):329-358. doi:10.1093/oxfordjournals.jpart.a024272