Addressing Rural Nurse Burnout in the Face of Systemic Challenges

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A patient is wandering a sparse room in the ER, devoid of any equipment or supplies. "I want some lunch!" As a nurse who has worked in a few ERs, I had witnessed this scene before. I walked up to the small, forming crowd of a few calm nurses and the nursing supervisor. I recognized him; he has been here often since his mother died, for the same reason. "Man acting erratically in public, brought in as a baker act by police." The story is always the same for him. This is a small, rural hospital that services the westernmost communities of Palm Beach County, Florida. When he received his lunch and was taken by the ground transport team to the nearby Baker Act receiving facility, everyone expressed some form of exasperation, stating that we would likely see him again in a few weeks.

Working at a rural hospital, I have found myself at a junction between healthcare and the broad social issues affecting the health of our patients. In nursing school, we learn about the social determinants of health as an abstract concept, a faraway theory that can be summed up as "grandma can't get to the doctor's office because she has no one to drive her." In rural areas, the mixture of poverty, decreased health literacy, unmanaged mental health issues, and lack of access to quality housing, transportation, food, and clean water creates a population that is more chronically ill than the average. These patients have higher incidences of obesity, diabetes, heart disease, and higher infant and child mortality. Over time, rural nurses and healthcare teams develop moral injury due to hopelessness and the inability to truly help.

Coming from the ICU and trauma bays in large, level I hospitals, I had seen my fair share of patients who could not afford their medications or alcoholic patients who were given the option between jail and sobering up at the hospital. However, in a rural community, the social determinants of health appear to me to be a bigger, much more systemic problem. The population in any given sprawling metropolis in south Florida has multiple options for healthcare. In this area, there is one safety net hospital with extremely limited services and a smattering of primary healthcare clinics. There are few grocery stores and pharmacies, and every year, the nearby factory pumps burning smoke into the atmosphere that chokes the lungs of countless adults and children. In the westernmost counties of Florida, numbers of people with a bachelor's degree are in the single digits. This contributes to the complications of low health literacy, which include the inability to manage chronic conditions like asthma and vaccine hesitancy. Compound this with a shortage of healthcare professionals in the country without considering that doctors and nurses may not want to work in a rural area due to a perception of limited education opportunities and professional isolation. All these factors create fertile ground for the consequences of nurse burnout that include negative physical and emotional health outcomes as well as high organizational turnover.

Unfortunately, individual measures for combating nurse burnout, such as self-care and getting adequate sleep, are temporary and cannot work against systemic issues. Institutional changes such as having nurse leaders in administration, prioritizing healthcare worker mental health, prioritizing nursing professional development with robust nurse residency and preceptor programs, and giving point of care nurses and their direct supervisors more power to make changes in their workflow will help nurses feel more valued and supported. Communities such

as this are doing what they can to create programs to increase health literacy and dispel the stigma of mental health, but it is not enough; the problem is multi-faceted. One thing that I have noticed in my time here is how resilient this community is. I am surrounded by friendly people and doctors who know their patients from outside this ER. As a healthcare system, we cannot let our rural nurses and healthcare workers fall through the cracks. ■

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JUSTICE, EQUITY, DIVERSITY AND INCLUSION SPECIAL INTEREST GROUP

Equity, Equality, and Health Care

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The terms "equity" and "equality" both stem from the constitutional provision of "equal protection under the law", as well as laws and regulations prohibiting discrimination on the basis of race and/or gender.[1] Contemporary distinctions between the two terms describe equity as attempting to undo persistent disparities based on gender, sexual orientation, ethnicity, and other inherent characteristics which are not consistent with dominant norms.[1]

Sexual and gender diverse (SGD) persons, commonly referred to as LGBTQ+, are one such marginalized group that suffer from health care disparities. Sexual orientation and gender identity are two separate concepts, both related to identity.[2] Dimensions of sexual orientation refer to sexual and/or romantic attraction and behavior. Gender identity dimensions include a personal, deeply held sense of gender identification, sex assigned at birth, gender presentation or expression, current or former anatomy, and gender as perceived by others.[2] It is important to note that these concepts are extremely fluid, and can vary. Limiting terms such as heterosexual, homosexual and bisexual do not adequately describe variations in sexual orientation just as the binary terms male and female do not reflect the spectrum of gender identities.

Although the Affordable Care Act (ACA) was a great step forward in health care equity for marginalized groups, protections for sexual and gender diverse persons were removed in 2020 and efforts to reinstate them have failed to date.[3] Since then, several states, including Florida have enacted discriminatory laws specifically targeting SGD people, deepening already existing health care disparities.[4] As a result, SGD people do not enjoy the same presumption of care as do cis-gender (gender identity consistent with sex assigned at birth), heterosexual people. In other words, people identifying as "straight" have no reason to believe they will be denied health care based on their sexual orientation or gender identity. Sexual and gender diverse people do not share this confidence in getting health care and in fact fear and frequently experience discrimination.[5] Increased personal experiences of discrimination and legalized discrimination add to already-existing stress related to being a member of a sexual minority, resulting in reduced access to and use of health care and increased burden of disease and disparities.[6,7]

Health equity is a fundamental principle in health care that aims to ensure everyone has equal access to achieve optimal health outcomes, regardless of their social position or circumstances.[8] Equitable care has a significant impact on health outcomes. Health outcomes improve when existing barriers are overcome, giving all individuals equal access to high-quality healthcare. Barriers include social determinants of health such as socioeconomic status, education, social norms, economic policies and systems, racism, sexism, and all forms of discrimination. Equitable care promotes patient trust and satisfaction and can lead to better prevention, early detection, and earlier treatment of diseases, ultimately reducing disparities in morbidity and mortality rates.8 This trust and satisfaction can increase patient compliance with treatment plans, improve patient-provider communication, and improve overall health outcomes.9 Distrust of providers and experiences of discrimination are barriers to care not only for SGD persons, but also for patients belonging to minority racial and ethnic groups. By offering more equitable care, nurses and healthcare organizations can help reduce health disparities and improve the overall health of communities.[9]

Below are some recommendations for nurses and healthcare organizations to promote equitable health care, trust in