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Commentary

Practical support for clinical courage

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Context

Clinical courage describes an integral part of rural clinical practice where doctors work at the limits of their scope of practice to provide place-based medical care not routinely available in their specific rural context[1], based on sound clinical reasoning.

Clinical courage requires the following from doctors:

- a strong sense of belonging and commitment to serve their community[2]
- patient-centredness and a deep respect for patients' place-based ties
- relationship capital with strong mutual trust between the clinician, patient and their community[1]
- clinical competence and ongoing preparation for clinical uncertainty[3]
- The humility to know their own clinical limits[1]
- knowledge of and capacity to marshal local human and physical resources to facilitate care locally[1]
- confidence to take the cognitive hurdle when deciding to act[1]
- resourcefulness to manage possible poor outcomes and judgement by external groups[3,4]
- collegial support to continue to commit to providing care at the edge of scope[2].

Clinical courage can be exercised in different contexts episodically or over time. Conducting an emergency tracheotomy in a small rural emergency department is a good example of a high-acuity, low-occurrence situation where a rural doctor is required to act to improve a patient's outcome, demonstrating clinical courage in emergency care. Clinical courage can also be exercised over time, where a rural doctor might undertake an unfamiliar management plan to enable a person to remain at home, for instance undertaking palliative care for a child on the family farm. On other occasions non-urgent surgery might be undertaken by a rural doctor in a circumstance negotiated over several weeks, such as excision of a skin cancer when a patient declines to travel to a distant location where this surgery is routine.

Importantly, not all examples of clinical courage involve care of a single patient. In our studies, several rural doctors described working deliberately to bring new much-needed clinical services to their communities such as cognitive behavioural therapy, chemotherapy, portable ultrasound or COVID treatment units[1,3,4].

A recently developed Clinical Courage Survey Tool demonstrated that clinical courage is a unique construct, with weak positive correlations to the existing concepts of professional fulfilment, empathy, self-efficacy and personal wellbeing[5]. Reassuringly, clinical courage demonstrates no significant correlation with psychological distress (burnout as measured by the Stanford Professional Fulfillment Index) and K10 (Kessler Psychological Distress Scale) anxiety and depression scores[5]. Importantly, clinical courage scores were positively associated with number of years in rural clinical practice and with self-reported likelihood of staying in rural practice[5]. These findings suggest that clinical courage is indeed part of the praxis of rural medicine. Our research to date has been confined to the medical profession. We recognise that our colleagues in multidisciplinary rural healthcare teams, including emergency care practitioners and remote area nurses, also demonstrate clinical courage[6,7], and are eager to support research across professions.

Issue

Medical professionals in urban areas often assume that patients have access to care. The contemporary discourse around quality and safety of medical practice therefore frequently considers risk as independent of access. Consequently, deviations from conventional best practice that result from rural doctors' adaptive expertise can potentially be considered poor practice by the city-based professional establishment. This geographical narcissism within medicine[8] puts rural generalists at risk of negative consequences, both professionally and legally. However, clinical courage is not 'cowboy' behaviour. It requires the judicious use of adaptive expertise[9] in a specific community context, to overcome contextual constraints to care, distance and patients' place-based ties.

Despite the risk of judgement from city-based peers, rural doctors consistently report high levels of community responsiveness based on their connections to community and mutual trust between community and clinician[5]. The risks of modifying conventional 'best practice' care to both patient and clinician are carefully weighed. The decision to take the road less travelled is patient-led and driven by the rural doctor's strong desire to be useful to their community[10].

Poor patient outcomes can occur even when clinical management is exemplary. For many rural generalists, their deep engagement in their community means that poor patient outcomes not only result in self-reflection and potential self-recrimination but are also accompanied by grief for the loss of a community member and potentially a colleague, friend or family member. This risk of distress through personal connection could be compounded by medico-legal sequelae and the addition of weighty judgements made by medical professionals with little or no insight into the context of care and the praxis of rural generalism. We need structures in place to minimise these risks. Illuminating the strategies of rural doctors in caring for patients in small communities, and highlighting the integral nature of courageous

decision-making that occurs routinely as part of sound clinical reasoning, can only benefit the profession. In addition, it articulates for learners and observers (eg trainees and registrars) that becoming a rural doctor is about developing tools to navigate in-context difficult decision-making and outcomes.

Lessons learned

Now that rural generalism has been recognised as a speciality within general practice in Australia[11], it is timely to make explicit the praxis of rural generalism including managing patients in small rural hospitals[12]. To make the practice of clinical courage more explicit, we propose an addition to the SOAPE (Subjective, Objective, Assessment, Plan, Education) format for documenting a clinical encounter. The COURAgE mnemonic (Box 1) can act as a tool for discussing modifications to conventional care with rural patients, their families and members of the local rural healthcare team as well as with city-based specialist support services. It provides a structured approach to documenting the decision-making process when clinical courage is enacted.

Box 1: the COURAgE mnemonic

The COURAgE mnemonic
C – Conventional management
O – Obstacles to care (patient place-based ties)
U – Unable to accommodate conventional management in this context
R – Review of options including:
- R – risks
- C – critical preparation
- T – local team involved in plan
- S – distant supports and safety net

Ag – Together, … agree to …
E – Exit strategy: If … then …

Clinical courage cannot be defended without knowledge of established protocols in the context in which one works. It is important to ensure the patient is clear about conventional management and that the treating doctor has respectfully documented the patient's place-based ties that prevent this conventional management from being possible in this circumstance. These steps enable the first consensus to be reached: that together the patient and the therapeutic team are unable to accommodate conventional management in the current context.

When using adaptive expertise to consider alternative care arrangements that will require clinical courage, risks are discussed openly with patients and other members of the team. Innovative plans for care may require critical preparation such as calling in other team members, checking or adapting equipment and just-in-time revision of procedures or treatment protocols. The local multidisciplinary healthcare team should be empowered to explore options, describing their own skills and risk appetite. Doctors consider the distant supports they might be able to draw on to improve patient care, such as engaging additional help by videoconference or phoning a specialist colleague to talk about options. They actively consider who can offer a safety net for them and their team if the clinical outcome is poor.

After all of these things have been thought through and put in place as much as possible, a decision needs to be made about whether to progress with the alternate care arrangements. Clinical courage is a shared endeavour rather than a solitary action. The decision to act with clinical courage is determined by the patient's need and usually shared by the immediate members of the patient's multidisciplinary team. Investment in relationships over time enables a rural doctor to earn the trust of patients, their families, the local community and the local healthcare team. Enacting clinically courageous management is facilitated by this 'relationship capital'. As part of the decision to act, doctors discuss how a decision might be made to change course if the situation deteriorates, being clear with the patient, their inner circle and the team about an exit strategy where this exists.

Part of the exit strategy needs to be to debrief with the team and have an opportunity to reflect, learn and recommit to clinical courage. Collegial support is essential to facilitate humble reflection without self-recrimination. Clinical outcomes are not always good, even when the care provided is exemplary. There are also times when care can be improved despite a good patient outcome. Importantly, clinical courage is not an individual episode; it is part of a longitudinal relationship with a community, and with the profession. Each episode contributes to the whole – a spectrum between a rewarding career and burnout. The exit strategy may thus be part of self-care to facilitate longevity of service and professional fulfillment.

Since developing this mnemonic, the authors have been considering examples from our own practice. One example is an obstetric patient in a town 50 km away from the regional obstetric hospital with early pre-eclampsia who did not want to be admitted (Box 2).

Box 2: Vignette using the COURAgE mnemonic adapted from a composite of actual patient encounters

A female patient seen for routine antenatal visit. G3P2, 36+1 weeks (pregnancy with new partner). Uncomplicated pregnancy to date. Asymptomatic.
On examination: Good growth, normal FM (fetal movement). BP 145/90 (routinely 130/75) Urine protein to creatinine ratio 0.31 mg/mg. Other bloods normal. Portable US normal AFI (amniotic fluid index). CTG (cardiotography) normal.
Assessment: early preeclampsia
C – Conventional treatment: offered for the patient to have pre-eclampsia observed overnight in regional hospital 50 km away from her home
O – Obstacle to care: patient is single mum with two children and a number of pets; feels she must go home
U – The regional hospital RGO (rural generalist obstetrician) and primary care GP are unable to accommodate this request as routine care
R – Review of options to manage her at home:
- Risks – her condition may exacerbate quickly, leading to risk to her (eclampsia) and her baby (abruption, fetal distress, precipitate birth); patient information sheet provided outlining risks of pre-eclampsia
- Critical preparation – friend to stay with her overnight, phone number to call if situation changes; has ambulance cover
- Team – community midwife can see her tomorrow, appointment come to GP practice any day
- Supports – discussed this with local obstetric team on call; RGO aware and would like her reviewed for CTG and bloods alternate days, for IOL (induction of labour) in 1 week

Ag – Agreement: Together, the patient, the community midwife, the RGO and GP agreed to manage her at home.
E – Exit strategy: If she gets a headache or if there are changes to bloods, or CTG, she will be admitted for hospital care.

The way that doctors undertake and document in medical records the conversations and decision-making processes that underly clinical courage have not yet been formalised. A traditional SOAPE model of recording does not adequately describe the important process of assessing care options, exploring with a patient what options might lie outside of usual scope in one's context, how risk is understood, what mitigation strategies may be used and who supports the decision to act. This work needs to be done by professional bodies or academic institutions, including specialty colleges, such as the Australian College of Rural and Remote Medicine (ACRRM), so that rural doctors can be secure in the knowledge that they are following best practice in the process of clinical courage and the documentation of this process.

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Conflicts of interest

The authors declare no conflict of interest.

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AI was not used for any activity in this commentary or in the research undertaken to inform this commentary.

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