

Rural health care leadership in complex systems: a focused review



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Rural health systems face persistent workforce shortages, geographic barriers, weaker infrastructure, and poorer population health outcomes than urban counterparts. In rural settings, leadership is a critical determinant of service access, safety, and continuity, yet evidence on rural health care leadership remains fragmented. This review synthesizes peer-reviewed literature on this subject across six themes: challenges and leadership styles, crisis leadership, leadership development, workforce and leader well-being, community participation, and competencies and traits. Across studies, rural leaders commonly held overlapping clinical, managerial, and governance responsibilities, often with limited administrative support. This role-stacking increased reliance on reactive problem-solving, although staff frequently valued leaders who were adaptable and change-oriented. Sustained effectiveness depended on balancing flexibility with clear task systems and strong relational practices. During the COVID-19 pandemic, rural organizations demonstrated both fragility and agility: limited redundancy created vulnerability, while short decision chains and cohesive teams enabled rapid adaptation. Effective crisis leadership was associated with transparent communication, flexible governance, staff protection, and community engagement. Leadership development programs were most effective when they were longitudinal, team-based, and embedded in local contexts rather than limited to

short courses. Evidence also showed high levels of burnout and turnover intention among rural leaders, mitigated by greater decision latitude, organizational trust, and value alignment. Community participation was widely endorsed but rarely progressed beyond consultation to genuine, shared authority. Evidence suggests that rural leadership is not an optional administrative function but a core system capability. Health care systems should invest in structured leadership development, decision authority for local leaders, leader well-being, crisis-ready governance routines, and formalized community participation. Strengthening rural leadership offers a practical strategy to improve equity, resilience, and continuity of care in underserved communities.

KEY WORDS: rural leadership; health systems; service delivery

Giuseppe Guaiana, MD, PhD, Biya Wadhawan. Rural health care leadership in complex systems: a focused review. *Can J Physician Leadersh* 12(3): 137-149. <https://doi.org/10.37964/cr24812>.

Rural–urban health care inequities have been documented extensively across high-, middle-, and low-income settings, with rural populations experiencing a greater burden of chronic disease, lower life expectancy, and systematically weaker access to specialist services and enabling infrastructure.¹ The definition of “rural” and “remote” may be challenging. Eckersley defines remoteness as: “a measure of potential disadvantage in receiving timely and equitable care that is related to the geographic location of individual or family residence or of a community.”² In this article, we use the word “rural” to encompass the definition of remote and rural areas.

People living in rural and remote areas experience higher levels of morbidity and mortality,^{3,4} often due to misdistribution of health manpower.^{5,6}

Thin capital bases reinforce rural–urban disparities: aging facilities, travel barriers, lower economies of scale, and enduring challenges in recruiting and retaining clinicians and managers.¹ The gaps may also be widened by urban-centric research systems, in which funding, infrastructure, and evidence generation are concentrated in metropolitan centres; conversely, stronger rural research capacity may help narrow inequities by producing locally relevant evidence for policy, workforce planning, and service redesign.⁷



Leadership is not incidental in this context; it is a core production function of rural health systems. Compared with metropolitan organizations that can distribute managerial functions across dedicated departments, rural services often rely on a small number of individuals who combine clinical duties with administrative management and formal or quasi-formal governance responsibilities.⁸⁻¹⁰

The literature agrees on several contextual constraints that shape how leadership is expressed and perceived in rural organizations. First, resource scarcity and small team sizes amplify the effects, positive and negative, of leadership decisions; there is less buffering of poor choices and often no redundancy in critical roles.⁸ Second, in rural contexts, leadership is exercised in close-knit communities where professional and personal relationships often overlap. Although physicians broadly endorse professional self-regulation, reporting of impaired or incompetent colleagues can be reduced,¹¹ especially in smaller rural systems characterized by close professional relationships and limited formal governance structures. This embeddedness makes trust, fairness, and follow-through particularly salient.^{12,13} Third, the absence of formal managerial scaffolding and leadership pipelines means that many rural leaders learn by doing, with limited access to tailored development and mentorship.^{9,14} These factors help explain why staff in rural clinics frequently perceive a “change-oriented” leadership emphasis; leaders are compelled to adapt, innovate, and improvise under constraints, even as relational and task routines struggle to keep pace.¹⁵ Survey work in low-resource rural primary care settings similarly finds leaders oscillating between transformational practices, which blend vision with relational and task engagement, and control-oriented practices, focused on administrative compliance, with style strongly influenced by experience and the immediacy of operational pressures.¹⁶

The COVID-19 pandemic illuminated these dynamics with clarity. Rapid role shifts, evolving guidance, and precarious supply chains¹⁷ were coupled with emphasis on a unifying mission, rapid upskilling, adaptive decision structures, attention to safety, and community engagement as core leadership work during the emergency.¹⁸ These accounts suggest that the “smallness” of rural units is double-edged: limited redundancy makes them fragile, but short decision chains and cohesive teams make them agile.^{17,18} The implications extend beyond crises. If rural organizations can translate those adaptive routines into non-crisis governance, clear sense-making, flexible resource reallocation, protection of staff well-being, and



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after-action learning, they can offset structural disadvantages in day-to-day operations.^{17,19}

In this review, we synthesize evidence on rural health care leadership across six themes: challenges and leadership styles; crisis leadership; leadership development; workforce and leader well-being; community participation; and competencies and traits. It prioritizes peer-reviewed studies with demonstrated relevance to rural contexts in Scandinavia, Australia, North America, and sub-Saharan Africa, while drawing on authoritative institutional sources for system-level inequities and workforce distribution patterns.

The objective is to identify important themes about rural leadership, and translate those findings into implementable implications for policy, training, and organizational design.

Methods

This study was conducted as a focused narrative review. A narrative approach was selected because the literature on rural health care leadership is methodologically heterogeneous, spanning qualitative studies, surveys, mixed-methods research, and policy analyses across diverse international settings, which limits formal quantitative synthesis. The objective was to integrate recurring themes and practical implications rather than estimate pooled effect sizes.

Sources were identified through searches of PubMed, Scopus, and Google Scholar, supplemented by hand-searching reference lists of relevant articles. Search terms included combinations of rural, remote, health care leadership, physician leadership, nurse leadership, management, burnout, and community participation. Priority was given to peer-reviewed empirical studies with clear relevance to rural health care settings. Authoritative institutional reports were included selectively to contextualize workforce maldistribution and rural health inequities. We considered English-language sources indexed up to January 2026. Priority was given to peer-reviewed empirical studies published from 2000 onward to reflect contemporary rural health systems and leadership practice; however, earlier seminal publications were included selectively where conceptually important.

Challenges and leadership styles

Empirical studies repeatedly show that rural leaders operate with wide role



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spans, thin managerial scaffolding, and persistent resource constraints that shape both what they do and how their styles are perceived.^{8,9} In northern Norway, municipal lead physicians described a “wide leadership span” that merged clinical service oversight with public health responsibilities, under conditions of human-resource scarcity and time pressure; leaders aspired to coaching/coordination but defaulted to a less effective “management by exception” (lower the level of formalized leadership and opt more for problem-solving) when workload spiked.⁸ In the same national context, clinic staff subsequently rated rural physician leaders as predominantly change-oriented, valuing adaptability and improvement, while also signaling that relational and task routines must not be neglected in small, interdependent teams.¹⁵

Evidence from Malawi’s rural primary care centres similarly identified a composite “transformational” style (vision + relation + task + change) contrasted with a “control” style focused on administrative compliance; nearly half of those in charge of centres reported no formal management training, indicating that leadership repertoires are often assembled informally from lived practice.¹⁶ Across these settings, a common pattern emerges: the rural context pushes leaders toward adaptation and improvisation, but sustained performance depends on balancing change orientation with reliable task systems and intentional relational work.^{8,15,16}

Rural nursing leadership shows parallel pressures. Nurse managers in Australian rural services describe “expanded,” multifunctional roles (“jack-of-all-trades”) that regularly blend clinical duties with administration and staff coordination.¹⁰ Quantitative work on structural empowerment among rural nurse leaders in Victoria, Australia, found empowerment at a moderate level and highlighted that access to information, resources, and support correlated with stronger leadership climate and safer care culture.²⁰

In primary care physician leadership, Norwegian general practitioners reported tension between clinical work and leadership responsibilities, citing limited training and structural barriers, evidence that the clinician-to-leader transition is not scaffolded in rural systems.⁸

These findings align with conceptual expectations from leadership theory. Rural leaders often enact a situational mix: transformational behaviours to mobilize change, transactional behaviours to assure compliance and throughput, and distributed/relational behaviours to maintain cohesion in



small teams.^{15,16} Yet the absence of dedicated managerial infrastructure means the “system” frequently lives in the leader’s head and calendar, increasing variance in practice and exposure to burnout.^{8,19}

Structural misdistribution of clinicians compounds these style pressures. In Canada, a persistent gap remains between the rural population share (~18–19%) and the physician share (~8%), placing disproportionate leadership and coordination burdens on rural teams.⁵ In such conditions, “doing leadership” often means making repeated trade-offs, what service to sustain, which outreach to pause, which staff to cross-train, under information asymmetry and minimal slack.^{8,20}

The literature’s practical message is blunt: change-orientation is necessary in rural organizations, but insufficient unless leaders deliberately institutionalize task discipline (e.g., huddles, checklists, escalation criteria) and relational routines (e.g., structured debriefs, feedback norms) that prevent a permanent drift into ad hoc problem-solving.¹⁵⁻¹⁷

Crisis leadership

Public-health emergencies expose weaknesses in leadership routines. During COVID-19, leaders of small rural nursing homes and home-care services in western Norway described continual role renegotiation, policy churn, and precarious supply lines.¹⁷ Three cross-cutting themes characterized effective practice:

- Sense-making and communication: leaders reduced ambiguity for staff and families despite evolving guidance
- Flexible governance and resource improvisation: leaders adjusted rosters, repurposed spaces, and created ad hoc decision cadences
- Protection of staff well-being: leaders buffered psychological load and maintained team cohesion

These findings crystallize a form of resilient leadership: individual resilience supported by adaptive micro-structures that enable continuity in unstable conditions.¹⁷

Australian data from two rural health services reinforce and broaden this pattern. Through in-depth interviews with executives and clinical leaders, Watkins and colleagues¹⁸ identified six themes of pandemic leadership:

1. A unifying mission (“working toward a common goal”)
2. Delivery redesign to maintain care under constraints
3. Rapid upskilling and information flow



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4. Governance adaptation, clear decision rights, and incident command suited to local realities
5. Attention to psychological impacts, support for leaders and frontline staff
6. Community engagement, leveraging trust and local networks for behaviours critical to public health

The authors argue that rural preparedness requires codified emergency plans, exercised in advance, that reflect geographic dispersion, limited redundancy, and interdependence with local governments and civil society.¹⁸

A qualitative article²¹ for physicians on lessons learned during the COVID-19 pandemic in the Canadian rural setting showed that the four main factors that supported physician leadership in terms of rural resilience were:

1. Continuity of care (having a consistent physician who is familiar with the community)
2. Team-based care models (working in a team toward a common goal)
3. Physician well-being (the COVID-19 pandemic took a toll on physicians)
4. Openness to innovative care models (such as virtual care and new communication procedures to care for the most vulnerable patients)

Importantly, the three studies above^{17,18,21} highlight the double-edged nature of smallness in crises. Rural services are fragile because they lack redundancy; single points of failure (e.g., one respiratory therapist, one pharmacist) are common. Yet smallness also enables speed and cohesion in emergencies: short decision chains, strong social ties, innovative practices and visible leadership presence.^{17,18,21,22} Leaders who framed uncertainty transparently, flattened communication barriers, and translated policy to practice rapidly were more likely to sustain services and trust.^{17,18} The implication for non-crisis operations is straightforward: embed crisis-tested routines into everyday governance — hold brief sense-making huddles, set explicit escalation thresholds, conduct after-action reviews — to convert agility from an emergency reflex into an organizational habit.¹⁶⁻¹⁸

Beyond the pandemic, these crisis capabilities generalize to wildfires, floods, and prolonged workforce shocks. Strategic foresight work suggests that rural leaders will increasingly face compound events, disease outbreaks coinciding with heat waves, supply-chain disruptions, or digital infrastructure failures, where success depends on anticipatory planning and distributed leadership practised before the sirens start.²⁰ In short, crisis leadership in rural health is not a separate skillset; it is an amplification of

everyday rural leadership done with greater tempo, clarity, and protection of people.^{17,18}

Leadership development

Rural health care systems repeatedly report that formal leadership preparation is scarce, with most leaders learning on the job under conditions of high role complexity.^{8,9,22} This has motivated a series of interventions designed to build context-sensitive leadership capacity. In Arctic Norway, Hartviksen and colleagues¹⁴ used participatory action research to co-create a continuous leadership development program with 23 municipal health care leaders across levels. Two key shifts were identified, moving from “striving solo players” to “team players” and learning to navigate conflicting and complex contexts. The program was deliberately collective and relational rather than a skills course, and it embedded competence development, structured interaction, interpersonal safety, and shared values as core elements. The emphasis on interaction and trusted reflection highlights that in small, interdependent teams, leadership growth is best achieved collectively.

Parallel insights come from nursing. Bish and colleagues²⁰ found that rural nurse managers’ sense of structural empowerment, defined as access to information, resources, support, and opportunity, was moderate, but strongly correlated with improved safety climate and organizational responsiveness. In practice, this means leadership development in rural settings cannot be divorced from system design: leaders need actual levers and resources, not just training, to exercise influence. Elsewhere, nurse leadership initiatives stressed coaching, relational competence, and role modeling, recognizing that in rural hospitals and clinics, nurses often act as the de facto coordinators of interprofessional teams.

In low- and middle-income countries, where leadership training is often absent, nearly half of rural primary care managers reported no management preparation; leadership style correlated more with personal experience and improvisation than with training.¹⁶ This reinforces the need to provide structured training early in careers, ideally integrated into clinical education pathways, so that future rural leaders do not face leadership responsibilities unprepared.⁹ The converging message is clear: rural leadership development must be continuous, co-created with local stakeholders, and supported by system-level empowerment. Short-term courses may raise awareness, but they are not enough. Sustained practice change requires structural reinforcement and collective processes.



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Workforce and leader well-being

In rural health care, leadership is carried out under conditions of systemic workforce scarcity. This makes leader well-being a strategic issue: If rural leaders burn out or leave, the capacity gap widens.^{1,6} Recent data from a survey of 288 rural health care leaders across the United States revealed that, although 81% reported being satisfied in their job, 40% met burnout thresholds and nearly half (49.8%) intended to leave their leadership position within two years.¹⁹ The authors show that greater work control and organizational trust reduced burnout and turnover intentions, while higher stress strongly increased them. Leaders who perceived alignment between personal and organizational values also reported higher satisfaction.¹⁹ Qualitative responses emphasized daily operational pressures, interpersonal conflicts, and systemic industry challenges.

These findings converge with qualitative evidence from Norway and Australia during COVID-19, where leaders described being stretched across competing demands, struggling with personal stress, yet feeling bound by responsibility to sustain care.^{17,18} They illustrate that even when satisfaction is high, leaders may still burn out under chronic overload. Protecting leader well-being, therefore, requires structural interventions: redistributing responsibilities, increasing decision latitude, providing peer support, and ensuring access to psychological safety and reflective spaces.¹⁹

Looking ahead, Reimers-Hild²³ argues that rural health care leaders will need to adopt strategic foresight to anticipate disruptive workforce shifts: exponential technologies, demographic transitions, and evolving consumer expectations. The combination of chronic shortages and emerging disruptions means that workforce strategy cannot be reactive. Leaders must cultivate innovation, stakeholder engagement, and scenario planning as routine competencies. The evidence suggests that without protecting and equipping leaders, the rural workforce crisis deepens; with empowered and supported leaders, rural systems can build resilience.

Community participation

The participation of citizens and local organizations is widely promoted as a lever to align services with local needs in rural systems, but the empirical record shows that genuine



power-sharing remains uncommon. In an international scoping review, Kenny and colleagues¹² identified only a small number of cases that reached high-level “citizen power,” noting that, although strong partnerships and social ties were consistently cited as success factors, most reports lacked detail on representation, authority, and outcome measurement. A more recent synthesis of rural health leadership literature¹³ emphasized adaptive leadership and health promotion approaches that embed communities in decision-making and highlighted the value of international collaboration for knowledge exchange.

Together, these reviews^{12,13} reinforce the belief that participation must be structured. It is important to clarify who sits at the table, what decisions are delegated, how conflicts are resolved, and how results are measured; otherwise, participation may remain consultative rather than co-governed. In small rural settings, where leaders and community members share social networks, trust and transparency are especially salient: clear communication about constraints and trade-offs builds legitimacy even when resources are scarce. The leadership implication is that rural managers should institutionalize community authority (e.g., community health boards with defined decision rights and evaluation plans) rather than rely on ad hoc engagement.

Competencies and traits

Across heterogeneous contexts, studies converge on a competency profile that differentiates effective rural leaders. Qualitative work from Australian rural and remote services highlights adaptability, conscientiousness, role modeling, staff and community involvement, and resilience, with “rural-specific” emphases, such as generational awareness and deep community attachment.²⁴ As mentioned above, staff in Norwegian rural clinics most often perceive physician leaders as change-oriented, valuing direction setting and improvement behaviours under constraint, but they simultaneously expect relational and task discipline to sustain cohesion and reliability in small teams.¹⁵ Physician leaders consistently report role conflict and limited formal preparation, underscoring the need to scaffold transitions from clinician to leader with training in governance, finance, human resources, and community partnership.^{8,9} Synthesizing these findings with crisis evidence, the practical rural leadership profile includes adaptability, emotional intelligence (for difficult conversations in close-knit teams), cultural humility (especially in Indigenous and minority communities), clinical courage (decisive action under uncertainty), and change orientation anchored by task and relational routines.

Limitations

This review has several limitations that should be acknowledged. First, it is a focused narrative rather than a systematic review; although sources were selected deliberately and grounded in peer-reviewed empirical work, the synthesis is susceptible to selection bias and does not provide quantitative estimates of effect sizes or causal relationships. Second, the evidence base on rural health care leadership remains uneven: much of the literature relies on qualitative studies, small samples, self-reported perceptions, and cross-sectional designs, which limits generalizability and precludes strong causal inference. Third, the review draws predominantly on studies from Scandinavia, Australia, North America, and selected low- and middle-income settings; findings may not fully translate to rural systems operating under different political, cultural or financing arrangements. Fourth, leadership concepts and measures vary widely across studies, making direct comparison difficult and increasing conceptual heterogeneity. Finally, publication bias is likely, with successful programs and positive leadership practices more frequently reported than failed or neutral initiatives. These limitations underscore the need for more longitudinal, mixed-method, and comparative research to test mechanisms, outcomes, and transferability of rural leadership interventions across contexts.

Summary and conclusion

The rural leadership evidence base is smaller than the urban hospital literature but remarkably consistent across countries and methods. First, role stacking is the norm: rural leaders often combine clinical, administrative, and governance work; without structural support, this drives reliance on ad hoc problem-solving that erodes planning. Second, staff perceive effective leaders as change-oriented, but sustained performance depends on balancing change with relational and task routines. Third, crisis research shows that rural services are fragile yet agile: leaders who communicate transparently, adapt governance quickly, protect staff, and engage communities preserve continuity despite scarcity. Fourth, development and empowerment matter: co-created, work-embedded leadership programs and structural empowerment for nurse leaders strengthen capability and safety culture. Fifth, leader well-being is a system variable: high burnout and intent-to-leave among rural leaders threaten stability and are mitigated by decision latitude, organizational trust, and alignment of values. Finally, community participation must move

from rhetoric to real authority, defined membership, decision rights, and outcome evaluation, if rural governance is to be locally responsive.

Policy and practice implications are direct. Health systems should:

- Fund longitudinal, cohort-based leadership development for rural clinicians transitioning to leadership
- Codify structural empowerment levers (information, resources, decision rights) for nurse and physician leaders
- Institutionalize crisis routines into everyday governance
- Formalize community authority with measurement
- Protect leader well-being via workload design, decision latitude, and peer support

Rural leadership is not a soft add-on; it is the mechanism by which scarce resources are converted into access, trust, safety, and continuity. Investing in rural leadership capability is, therefore, a first-order strategy for health equity and system resilience.

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This article has been peer reviewed.