The Structure and Enactment of Agency in the Context of Rural Nursing Practice

by

Barbara Jean Buckley
R.N., SIAST- Kelsey Institute, 1987,
R.N., Recertification, Malaspina College, 2003,
B.S.N., Thompson Rivers University, 2005,
M.S.N., The University of British Columbia, 2007,

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY
in
The Faculty of Graduate and Postdoctoral Studies
(Nursing)

The University of British Columbia
(Vancouver)

April 2015

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Abstract

There is a growing awareness of inequities in rural healthcare in Canada and internationally. Rural nurses are embedded within complex healthcare structures, yet little attention has been paid to their experiences. These complex structures can function to both constrain and enable nurses to provide equitable, safe, and quality healthcare services to rural populations. This ethnographic study was conducted with rural nurses to explore the relationship between healthcare structures and rural nurses’ enactment of their agency. Informed by Structuration Theory (Giddens, 1984), Sewell’s (1992) notion of reciprocity, and a relational ethics lens, this research illuminates the relationship between the structures and rural nurses’ enactment of their agency in providing healthcare to rural based populations. Carspecken’s Critical Qualitative Research method (1996) was used to guide data collection during 528 hours of fieldwork and participant observations with primary nurse and allied healthcare provider participants (n=14). Additional data collected included: in-depth interviews (n=18); participant demographics; documents; and cultural commodities.

Findings showed that the rural structure-nurse agent relationship was strained by urban-based policy-making. In particular, the rural practice context lacked sufficient physical and human resources to enact urban-policy directives (e.g. being unable to provide consistent primary and palliative care services). Nursing’s lack of active participation in policy decision-making has further impacted lack of policy directives toward fostering development of rural practice expertise. Key themes of: “we’re it”; “unseen complexity”; “pulling the nurse’s card”; “how many
hands do you see?” and “beg forgiveness Monday morning” exemplified the disjuncture between rural and urban healthcare policy and practice. Inequities in access to healthcare services ultimately expanded rural nurses’ perceived moral obligations to include providing ad hoc care to the community outside of the formal system.

Findings underscore that it is vital that rural nurses have an active voice in rural healthcare policy and decision-making in order to strengthen reciprocal relations and to provide equitable, safe, and ethical healthcare services for rural communities. Recommendations also include support for a nursing role in policy-making, increasing education opportunities, and expanding the scope of rural nursing practice to meet the demands of the rural practice context.
Preface

Ethical approval for this study was received from The University of British Columbia Behavioral Research Ethics Board (Approval Number H12-02523) on February 8th, 2013. Annual review and renewal received in January 2014 - January 2015 (Approval Number H12-02523).

Interior Health Authority Research Ethics Board Approval granted April 29th, 2013 for one year (Approval Number 2012-13-048-E). Renewal of Interior Health Authority Research Ethics Board Approval granted March 26th, 2014 for one year (Approval Number 2012-13-048-E).

This dissertation is an original, unpublished, independent intellectual product of the author, Barbara Jean Buckley.
Table of Contents

Abstract ........................................................................................................................................... ii
Preface ................................................................................................................................................ iv
Table of Contents ................................................................................................................................ v
List of Tables ..................................................................................................................................... x
Acknowledgments .......................................................................................................................... xi
Dedication .......................................................................................................................................... xiii

Chapter One: Situating the Study ....................................................................................................... 1
1.1. Rural Health and Health Care .................................................................................................... 1
1.2. The Challenges for Equity in Rural Health and Health Care ..................................................... 3
  1.2.1. The Broader Social Structures’ Impact on Health and Health Care .................................... 3
  1.2.2. The Problem of Geography and Rural Health ...................................................................... 6
1.3. The Problem of Rural Inequities ............................................................................................... 8
  1.3.1. Access Barriers in Rural Health Care and Barriers for Nursing Practice .................. 11
  1.3.2. Inequities in Rural Health Care and Inequities in the Rural Workforce .................... 13
  1.3.3. A Working Definition of Rural Nursing ............................................................................ 14
    1.3.3.1. Moral Climates and Rural Nursing ............................................................................. 15
1.4. Purpose and Aims of the Study .................................................................................................. 17
  1.4.1. Research Questions ........................................................................................................... 17
1.5. Articulating Relevance ............................................................................................................. 18
1.6. Chapter Summary ..................................................................................................................... 20
1.7. Organization of the Dissertation .............................................................................................. 20

Chapter Two: Literature Related to Rural Structures and Rural Nursing ........................................... 22
2.1. Introduction ............................................................................................................................... 22
  2.1.1. The Meaning of the Terms Rural, Remote and Northern ................................................... 23
    2.1.1.1. What Does Rurality Mean? ............................................................................................ 26
  2.2. Recent Canadian Rural Research ........................................................................................... 27
    2.2.1. Impacts of Moral Climate Change to Health Care Environments ................................ 30
  2.3. Known Structural Barriers for Access to Rural Health Care .................................................. 32
    2.3.1. Impact of Shortages of Health Care Providers ............................................................... 34
    2.3.2. Impact of Lack of Rural Health Care Services in Rural Communities .................. 35
    2.3.3. Impact of the Costs of Lack of Access .......................................................................... 39
    2.3.3.1. Further Impacts of Ongoing Rural Disparities .............................................................. 40
  2.3.4. Recent Rural Initiatives ...................................................................................................... 41
  2.4. Historical and Recent Tensions: Marginalization and Othering .......................................... 44
    2.4.1. Othering of Aboriginal First Nations People ................................................................. 47
  2.5. Shaping the Focus With the Literature ................................................................................. 51
    2.5.1. International Rural Research .......................................................................................... 51
    2.5.2. Implications ..................................................................................................................... 56
  2.6. Chapter Summary .................................................................................................................... 57

Chapter Three: Laying Out the Theoretical Framework of the Study ............................................... 58
3.1. Crafting the Study Design .......................................................................................................... 58
Chapter Four. Implementation of the Study .................................................. 76

4.1. Introducing the Methodology .................................................................... 76
4.2. Critical Ethnography .................................................................................. 76
  4.2.1. Methodological Approaches ................................................................. 78
  4.2.2. Qualitative Data Collection .................................................................. 78
  4.2.3. Site Selection for Fieldwork ................................................................. 79
    4.2.3.1. The Hospital and Community Setting .............................................. 81
  4.2.4. Negotiating Entry .................................................................................. 85
    4.2.4.1. The Fluidity of the Insider–Outsider Role ........................................ 88
  4.2.5. Participant Recruitment ....................................................................... 89
4.3. The Participant Sample .............................................................................. 90
  4.3.1. Registered Nurse Participants ............................................................... 92
  4.3.2. Allied Health Care Provider (AHCP) Participants ............................... 93
  4.3.3. Study Participant Demographics ......................................................... 93
  4.3.4. Tertiary Participant Voices ................................................................... 94
4.4. Constructing the Data: Methods and Process .......................................... 96
  4.4.1. Fieldwork: Participant Observation ..................................................... 96
  4.4.2. Fieldnotes and Journaling .................................................................... 97
  4.4.3. Conducting In-Depth Participant Interviews ....................................... 99
  4.4.4. Broadening the Reach of the Fieldwork .............................................. 101
  4.4.5. Collection of Participant Demographic Data and Analysis .................. 102
  4.4.6. Document-Based Data Collection ....................................................... 103
  4.4.7. Supplemental Sources of Data: Cultural Commodities ..................... 105
4.5. Managing and Analyzing the Data ............................................................. 106
4.6. Fostering Rigor and Credibility ................................................................. 108
  4.6.1. Coding .................................................................................................. 109
  4.6.2. Giddens’ Criteria for Credibility ......................................................... 109
  4.6.3. Theoretical Sensitivity ......................................................................... 110
  4.6.4. Reflexivity ............................................................................................. 112
4.7 Ethical Considerations ................................................................................ 114
  4.7.1. Research Ethics ..................................................................................... 114
    4.7.1.1. Informed Consent ........................................................................... 115
    4.7.1.2. Participant Voluntariness ............................................................... 117
  4.7.2. Data Protection and Security Measures .............................................. 117
  4.7.3. Protection of Participants and Confidentiality ..................................... 118
  4.7.4. Dissemination of Results to the Participants and Agencies ................. 118
4.8. Chapter Summary ...................................................................................... 120
Chapter Five. The Contextuality of Rural Nursing Practice

5.1. Introduction to the Context of Rural Nursing Practice
5.2. The Reality of Rurality
5.3. “We’re It”
5.3.1. Even on Your First Day You’re It
5.3.2. The Buck Stops Here
5.3.3. Isolation and Solo Rural Practice
5.3.4. Never Get Caught With Your Pants Down
5.4. The Unseen Complexity in Rural Nursing Practice
5.4.1. The Tensions in Rural Practice Add Complexity
5.4.2. Every Day is Something Different
5.4.3. Navigating Unpredictability in Practice Resources
5.4.3.1. The Challenges in Providing Care “In-Between”
5.5. There’s Relative Rural and Rural Relatives
5.5.1. Knowing the Community and Being Known in the Community
5.5.2. Living and Working Under the Scrutiny of the Community Gaze
5.5.3. Boundary Violations and Nurse Shaming
5.6. Chapter Summary

Chapter Six. Navigating Uncertainty in Rural Practice

6.1. Rural Structures that Shape Rural Nursing Practice
6.1.1. Locating The Rural Nurse as a Knowledgeable Agent Within the Structures
6.2. Locating the Complexity of Rural Health Care Structures
6.2.1. Rural Policy Gaps
6.2.1.1. Rural Nurses and Patient Safety
6.3. Supply and Demand Imbalances Impacting Access to Rural Health Care
6.3.1. Accessibility: About More Than the Doors Being Open
6.3.2. Access Inequities and Complexity in Rural Ambulance Service
6.3.3. Affordability: The Financial, Physical and Emotional Cost
6.3.3.1. Aging in a Rural Place
6.3.4. Availability: The Structural Recruitment and Retention Cycle
6.3.4.1. The Revolving Doctor Door
6.3.5. The Reciprocity Between Physicians and Nurses
6.4. Impact of Structural Inequities on Rural Health Care Sustainability
6.4.1. Rural Nurse Education
6.4.2. “We Are ‘Flying by the Seat of Our Pants’ Some Days”
6.5. Crossing the Lines
6.6. Power Relations in Structure and Agency
6.6.1. “Beg Forgiveness Monday Morning”
6.6.2. Political Structures
6.8. Chapter Summary

Chapter Seven. Moral Agents Grappling With Structural Borders

7.1. Agency Enactment: Inside and Outside of the Structures’
7.2. Breaking or Bending the Rules
7.2.1. Acts of Positive Defiance
Appendices:

A. Table 1: Conducting Critical Qualitative Research Using Carspecken’s Five-stage Approach and Giddens’ Structuration Theory ........................................ 302
B. Study Information Poster ................................................................................. 306
C. Study Information Letter for Registered Nurses and Other Health Care Personnel ................................................................................................................. 307
D. Study Field Work Calendar .............................................................................. 312
E. Table 2: Study Participant Demographics ......................................................... 313
F. Participant Demographic Data Collection Tool ................................................. 314
G. Registered Nurses Study Consent to be Observed and Consent to be Interviewed ................................................................................................................. 315
H. Study Information and Consent to be Observed and Consent to be Interviewed Form for Non-Registered Nurse Health Care Providers .......................................................... 321
I. Study Information and Verbal Consent to be Observed Letter for Patients and Families .................................................................................................................. 328
J. Observation Guide .............................................................................................. 331
K. Fieldnote Example ............................................................................................ 332
L. Institutional Document Collection Form ............................................................ 333
M. Transcription Services Confidentiality Form .................................................... 334

References .............................................................................................................. 266
N. Rural Registered Nurse Participant Interview Guide and Non-Nursing Participant Interview Guide........................................................................................................... 335
O. Map of Specialty Cardiac Service Units and Cardiac Catheterization Labs in British Columbia and Travel Time from Randomly Selected Centres.337
List of Tables

Table 1  Conducting Critical Qualitative Research Using Carspecken's Five-stage Approach and Giddens' Structuration Theory ........................................302

Table 2  Study Participant Demographics.................................................................313
Acknowledgements

I would first like to extend my deepest gratitude and respect to the study participants, all of whom cannot be named here for reasons of confidentiality. Please know that this study would not have been possible without your willingness to share your knowledge, your stories, your lives, and your expert rural practices with me; you inspired me each day want to be a better nurse. I would also like to acknowledge the facility staff, patients, community members, and health authority leadership for their support of this study.

I am truly humbled and I feel privileged to have stood on the shoulders of such scholarly giants as my Dissertation Supervisory Committee. I have been richly supported, thoughtfully mentored, and pushed to grow as a scholar by three of the finest minds the nursing profession has to offer. Thank you, Dr. Rodney, Dr. Varcoe, and Dr. Pesut. In particular, I would like to express my sincerest thanks to Dr. Rodney for being willing to supervise me through two graduate degrees over the past 8 years. Thank you Paddy; your mentoring has been exceptional and I have been truly blessed to be your student.

Finally, I would like to acknowledge my family and dear friends who have provided their support along my long, and at times seemingly endless, educational journey. Thank you to my family—Shawn, Alex, Elycia, and Zach, my parents Leslie and Lynn, my sister Cathy, and Auntie Beryl for your support, patience, love, and acceptance of my need to complete this journey. My heartfelt thanks, as well, for the love and support of my dear friends Pam and Blaine, Mona, Genevieve, Julia, Karen, and my mentor Dr. Penny Powers.
I have learned that no one travels this road alone. To the many wonderful UBC cohort friends and peers that have travelled with me along this road – thank you. Special thanks and heartfelt appreciation to my “UBC sisters”—Kim, Nancy, Sandra, and Sherry—for your love, friendship, and endless encouragement which have helped me to complete this journey.

Lastly, special thanks to Peggy Faulkner, former SON Graduate Records Secretary for everything you have done over the years to help make the process of navigating graduate school less confusing and more humane.
Dedication

For my children:

Alexander
Elycia
Zachary
Chapter One: Situating the Study

1.1. Rural Health and Health Care

There is an increasing global awareness of the importance of, and need for, sustaining viable rural health care delivery (Hunsberger, Baumann, Blythe, & Crea, 2009). Central to the concerns regarding health inequities and health disparities for rural populations are the many related economic, political, policy¹, and procedural structures related to regional and national systems in rural health care. In addition, specific health-care policies, procedures and processes, also have an impact on health care access and service provision for rural populations. To date, little inquiry has been focused on examining the experiences and challenges rural Canadian nurses face in providing quality care (Jackman, Myrick, & Yonge, 2010). Moreover, this lack of inquiry means that we also lack a full understanding of the strengths and capacities that exist in rural health care delivery.

Structures in rural health care, (such as the physical health care facilities), the policies and processes that govern services, and human resources are thought to impact population health both by determining access to resources for health and health care services, and by determining how health services are provided (Canadian Institute for Health Information (CIHI), 2006; see also Ministerial Advisory Council on Rural Health, 2002). These structures, in turn, influence nursing practice in rural contexts. For example, structural barriers such as reduced hospital infrastructure and service closures across all health care contexts are known to

¹ Within this study, I am using Pal’s definition of policy as that which “guides a range of related actions in a given field” and that policies are taken up as a “broad framework that structures the actions of a host of different organization” (Pal, 2006, p. 2).
influence the capacity for nurses to provide equitable access to appropriate services and supports (Peter, Macfarlane, & O’Brien-Pallas, 2004; Rodney & Varcoe, 2012). This reduction in services has occurred as a result of health care reform and economic restructuring. It has a particular impact on rural communities, which “has made it more difficult for people who live in rural areas to access services” (Hanvey, 2005, p. 4). In addition, the lack of available access to health care is a structural consequence that shapes health inequities and health disparities for non-urban populations by decreasing timely access to quality care (Tarlier & Browne, 2011). Further, the lack of access burdens patients and families with extensive travel and/or re-location for access to specialized services (CIHI, 2006; Romanow, 2002).

The lack of available health services is also apparent in urban environments. However, rural and urban populations are impacted differently. For example, in the rural context the lack of available local services creates serious geographical as well as service-based barriers to timely access (Laurent, 2002; Wong & Regan, 2009). The structures that frame rural health care provision ultimately function as key determinants of the nature, scope, and quality of nursing practice possible within local rural health care environments. For example, health care structures determine staffing positions and funding for nursing positions such as rural mental health nursing, rural nurse educators, and specialty practice areas such as wound care or diabetes educators.

In urban settings the lack of access to health care has been linked to several systemic and structural arrangements that foster health inequities, such as homelessness, poverty, and violence (Pauly, 2008a; 2008b). “Inequities in health
and lack of access to health care are morally concerning”, according to Pauly “as they are rooted in unjust social conditions” (2008b, p. 195). At the same time, current research indicates “most rural areas tend to have the worst health status” (Pong, DesMeules, & Lagacé, 2008, p. 63). However, not all rural populations suffer substantially lower health status than urban-based populations. Pong et al. attribute differences in health status to the rural area’s geographical distance from a Metropolitan Influenced Zone (MIZ). Implications from this finding should alert researchers to the fact that rural health provision and rural health are not homogenous across Canada. Just as “one-size-fits-all disease prevention, health promotion and treatment strategies for rural populations might not be appropriate” (Pong, et al., 2008, p. 63), assuming that all rural health care provision is problematic or inadequate is also not appropriate. Local strengths and capacities exist; the wide diversity across and between rural, remote and northern communities adds additional layers of complexity to the examination of rural health care. There is a pressing need for further exploration of rural community strengths and community capacities in order to build on resources already present.

1.2. The Challenges for Equity in Rural Health and Health Care

The challenges for equity in both rural health and rural health care are linked to “broader neo-liberal-informed political and economic influences” (Choiniere, 2011, p. 341). In other words, “the provision of health care in any country is influenced by economic, political, social, and cultural forces” (Pauly & Storch, 2013, p. 236). These forces contribute to unfair and preventable systemic inequity across all health care contexts. By definition, equity in health and health care implies that:
ideally everyone should have a fair opportunity to attain their full health potential and more pragmatically, that none should be disadvantaged from achieving this potential, if it can be avoided. Equity is therefore concerned with creating equal opportunities for health, with bringing health differentials down to the lowest level possible (Whitehead, 1991, p. 220).

Achieving equity in health and health care appears particularly challenging in the rural context.

Rural nurses are embedded within the structures of rural health care. According to Sewell (1992) a form of agreement or reciprocity is thought to exist between structures and agents within social contexts. The structures that produce inequities in health and health care in the rural context also function to facilitate or constrain enactment of moral agency. However, little attention has been paid to examining the relationship between these structures and the nurses’ ability to enact their agency towards more equitable care practices within the rural practice context. Understanding the enactment of agency within rural structures is important because known inequities in both health and health care in rural Canada are the unintended fruits of the broader social, political, and economic processes which directly influence rural health care services. An understanding of the relationship between rural health care structures and rural nurse agency—and the reciprocity between them—is an important area for inquiry if we are to gain a better understanding of how rural structures shape the conditions that support quality health care or (re)produce inequities. Knowledge about the way in which the broader structures shape the reciprocity between rural health care structures and

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2 By 'agency' I mean the way in which moral agents fulfill their accepted "moral responsibility and accountability and deal with ethical problems" (Varcoe & Rodney, 2009, p. 136).
rural nurses’ enactment of agency within the rural context is also useful to help identify systemic actions that may create more equitable care practices, decreasing inequities and disparities in the rural practice context. “Nursing sees its professional mandate as solidly grounded within a set of values and ethical principles such as social justice” (Thorne, 2009, p. 150). New understandings about what ethical actions are needed to address the harms associated with structurally produced health inequities in rural health care provision are required. Both the structural constraints on enactment of agency and the structure-agency link in relation to health and health care inequities require further study.

Although government reports have identified serious concerns in rural health and rural health care provision—including the *Future of Health Care in Canada*³ (Romanow, 2002) and *The Health of Canadians–The Federal Role* (Standing Senate Committee on Social Affairs, Science and Technology, 2002⁴)—rural health care issues have generally not been conceptualized as ethical problems. Rather, they have been conceptualized as economic and geographical issues that point to values-based conflicts, which are highly salient for ethical inquiry. For example, Laurent (2002) indicates that demographic shifts such as aging populations, economic differences related to income disparities, and high unemployment rates impact access to health care. McBain and Morgan (2005) argue that the geographies of jurisdictions compound issues of transportation and care provision in rural areas in

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³ The report titled, *Building on values: The future of health care in Canada* (Commission on the Future of Health care in Canada, 2002) has come to be known as the “Romanow Report”. For simplicity in this dissertation, I have adopted the common use of referring to this report by the lead author, Romanow.

⁴ This report is also referred to as the “Kirby Report” after the chair of the Standing Senate Committee on Social Affairs, Science and Technology The Honourable Michael J.L. Kirby.
addition to the barriers and disparities reported in Romanow (2002). The inequities and disparity issues demand ethical consideration because they set up conditions of social injustice for large populations. For example, rural-dwelling Aboriginal populations in Canada are known to suffer health disparities associated with broader “social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering” (Adelson, 2005, p. 45). An understanding of the ways in which structures reduce access to care is important because health inequities are both formed and maintained in rural health care through these broader structures. The influences these structures have on rural nursing work environments are of significant moral concern because of the impact they have on achieving equitable health and health care for rural populations.

1.2.1. The Broader Social Structures’ Impact on Health and Health Care

Broader social structural circumstances influence and shape health and contribute to fostering health inequities (Pauly, MacKinnon, & Varcoe, 2009). This is especially significant in rural settings where social conditions such as poverty, chronic health conditions, unemployment, and low literacy and education impact health outcomes by limiting the ability of rural residents to access medical care outside their community (Ministerial Advisory Council on Rural Health, 2002).

Urban-based research has produced a good understanding of how broader social conditions such as income, housing and education impact health (for example see Adelson, 2005; Vafaei, Rosenberg, & Pickett, 2010; Veenstra, 2007; Wong, Browne, Varcoe, Lavoie, Smye, Godwin, et al., 2011). Health care reform based on
competitive neo-liberal\textsuperscript{5} market based ideologies, which focus on individualism, system accountability and efficiency mandates, also impacts health by contributing to health inequities (Choiniere, 2011).

The demands of neo-liberal reforms and the subsequent impact on quality nursing care and patient outcomes have been examined in some areas of nursing practice, particularly urban acute care settings (Armstrong & Armstrong, 2002; Rankin & Campbell, 2006; Varcoe & Rodney, 2012). For example, Lynam et al. (2003) found that the consequence of mandated fiscal restraint has led to decreased resources that enable nurses to provide for patient care needs and that “changes in the work environment influence the quality of care” (p. 119). Their study also noted that patient and care provider safety was jeopardized by the increasing demands of the workplace. Leiter and Laschinger (2006) voiced concerns that hospital restructuring and the undermining of nursing work environments lead to a diminished ability of nurses to care for patients. More recently, Anderson, Rodney, Reimer-Kirkham, Browne, Khan, and Lynam (2009) broadened the analysis to include attention to the inequalities in healthcare and healthcare access resulting from restructuring initiatives. They write, “the lack of resources and the difficulty in accessing and utilizing healthcare services within the current politics of healthcare delivery systems are powerful constraints on health and illness management” (p.

\textsuperscript{5} Coburn (2000) states “neo-liberalism refers to the dominance of markets and the market model” (p. 139). According to Coburn, the assumptions underpinning this philosophy of ‘free-enterprise’ economic doctrine are:

1) that markets are the best and most efficient allocators of resources in production and distribution;
2) that societies are composed of autonomous individuals (producers and consumers) motivated chiefly or entirely by material or economic considerations;
3) that competition is the major market and vehicle for innovation (p. 139).
Given that neo-liberal ideologies have been found to be problematic for the provision of quality nursing care in the urban context, I considered that a clearer understanding was needed of how these ideologies also impact the rural health context and quality care practices. It may also be the case that strengths exist in rural health care delivery that serve to mitigate some of these neo-liberal effects.

The focus of this research therefore was to examine the relationship between the structures of rural health care and the agents who provided that care—particularity rural nurses—to provide evidence of the need to support the reciprocity between rural health care structures and rural nurses. It is the premise of this research that knowledge of this structure-agency relationship offers direction for future interventions aimed at amending the structures of rural health care to allow more equitable access for rural populations to the resources for health and health care and improved rural patient care practices. This research is also aimed at supporting nurses and other rural health care providers as moral agents.

1.2.2. The Problem of Geography and Rural Health

It is known that geographical location has implications for access to health care services, as well as the overall health of individuals (Wong & Regan, 2009). It is also known that, “the effect of place of residence...suggests that living in rural areas, particularly in small or remote communities, is associated with greater health risks” (Pong, 2008, p. 12). There is considerable evidence that geographical location and the general characteristics of the place where one lives have important implications for health and well-being (Solberg & Way, 2007; see also Canadian Institute for Health Information (CIHI), 2006; Crooks, Castleden, Hanlon, & Schuurman, 2011).
Geographic location is particularly important for the approximately 6 million Canadians living in a rural location or small town in Canada. This is because there are many known health risks, challenges, and health disparities associated with living and working in a rural setting (Pong, DesMeules, & Lagacé, 2008). For example, rural Canadians have a greater incidence of health concerns such as circulatory and respiratory diseases, cancer, and obesity. They also have higher infant, suicide, violence, and injury-related mortality rates than urban Canadians (CIHI, 2006; Pampalon, Martinez, & Hamel, 2006; Pong et al., 2008; see also Romanow, 2002). Additionally, working in rural-based industries such as logging, mining, fishing, energy and agricultural sectors carries health-related risks beyond physical injuries and disabilities. These risks include poisoning and exposure to environmental toxins and chemical hazards (Pong, Atkinson, Irvine, MacLeod, Minore, Pegoraro, et al., 1999). Life expectancy for both male and female Canadians is found to be lower in rural areas (CIHI, 2006; Kulig, 2010). Co-existing with lower life expectancy rates are higher teenage pregnancy and sexually transmitted infection rates in rural communities, nearly double those of urban counterparts (BC Centre for Disease Control, 2009; see also Shoveller, Johnson, Prkachin, & Patrick, 2007).

Rural Canadians are known to experience significant social, economic, environmental, and other inequity-related challenges in accessing health care services equivalent in outcome to their urban counterparts (see also Health Canada,

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6 The “Kirby Report” estimated in 2002 that 30% of Canada’s population (or 9 million people) lived in what is defined as “rural and remote” areas (see Kirby & LeBreton, 2002). Hanvey (2005) indicates a range of 21-30 percent (depending on how rural is defined) of the total Canadian population live in rural communities. I will expand on these definitions in chapter two.
Knowledge about inequity in access to resources for health is important, since access to, and distribution of, health care services in rural areas are foundational for creating health care structures that support health equity. In addition to the availability of health care services, a multitude of other factors also impact personal health status. These factors include smoking, substance misuse, poor eating habits, lack of exercise, stress, and other lifestyle factors. Poverty is also a complicating factor for rural based populations according to Hunsaker and Kantayya and “in some cases poverty serves as a surrogate indicator for the inability to access health care services” (2010, p. 701). This indicates that poverty is a factor that decreases rural populations’ ability to access the benefits of early health interventions. The accessibility challenge also delays possible interventions and increases the risk of complications and overall poorer health outcomes for impoverished rural populations.

In addition to overall poorer health, known social determinants in rural areas also include higher unemployment and lower education levels in comparison to more urban-based communities (CIHI, 2006). Confounding the fact that rural populations in Canada experience greater social inequities and health disparities (Health Canada, 2002; Kulig, 2010; Pampalon, et al., 2006) there are signs that the level of health care quality is poor for many rural Canadians (Romanow, 2002). According to the Canadian Institute for Health Information (2006), the levels of inequity and disparity in health care provision for rural areas in Canada were found to be particularly troublesome for mortality and morbidity rates due to work related injury, accidents, poisoning, and suicide in the context of socio-economic and
socio-cultural disparities. The manifestation of known health disparities for rural based populations compared to urban is “stark”, according to Ostry (2009).

The distinction drawn by authors Jiménez-Rubio, Smith, and Van Doorslaer (2008) between inequity in health, and inequity in health care is important, because structures in rural health care directly facilitate or challenge health inequities. These authors suggest inequities in health care often hinge on the distribution of health services as the key factor. This links to findings from the Canadian Institute for Health Information (CIHI, 2006), which reported that decreased access to prevention, early intervention, detection, treatment and supportive health services for rural residents is a factor in systematic differences in health status.

1.3. The Problem of Rural Inequities

Inequities in rural health and health care are structurally supported and are maintained through complex social, political and economic processes and structures. Rural nurses, and rural nursing practice, form part of the rural health care structures7 that organize and direct health care provision. Further, in this study the rural nursing practice context is explored to provide a broader understanding of what structures shape health and health care inequities and the implications structural inequities have for rural nursing practice. In this study I examine the constraining contexts and also explore the strengths and capacities that exist in rural nursing practice. The complexity of the rural practice setting has been examined in previous rural research work. For example, MacLeod et al. (2004a)

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7 Structures, according to Sewell (1992), are “constituted by mutually sustaining cultural schemas as sets of resources that empower and constrain social action and tend to be reproduced by that action” (p. 27).
found rural nursing practice is highly complex. They suggested that the level of complexity deserved acknowledgment; thereby supporting the need for better resources in order to address the specific educational needs the practice environment required. The reciprocity—that is, the interrelationship between structure and agency—has not been explicitly explored in rural nursing research. The concept of reciprocity implies an embedded mutuality within a relationship that is balanced between giving and receiving (Bergum, 2013).

An exploration of the reciprocity between rural nurses and the structures of rural health care is especially important in order to gain a better understanding of how the reciprocity supports nurses as moral agents in providing competent, ethical, safe, and improved rural patient care. The support of rural nurses as moral agents also recognizes the ethically grounded role of Registered Nurses to “enact their social justice mandate through recognition of the conditions that shape inequities” (Pauly, 2013, p. 440).

1.3.1. Access Barriers in Rural Health Care and Barriers for Nursing Practice

It is further known that multiple structural barriers exist and make accessing medical care in rural and remote places difficult. Known barriers and challenges to accessing care in rural Canada include: mobility, available transportation, geographical isolation, economic inequality and unequal distribution of health care resources, including the closure of rural care sites. The lack of access to health care services in rural areas can also be linked to professional health care provider shortages.
The lack of health care providers not only contributes to access barriers for the population, but also has a negative consequence for the nursing workforce as well (Stewart, D’Arcy, Pitblado, Morgan, Forbes, et al., 2005; See also Buykx, Humphreys, Wakerman, & Pashen, 2010). For example, staff shortages result in reduced staffing levels, which in turn contribute to increased workloads for nurses already dealing with higher patient acuity levels. Heavy workloads are a known contributor to stressful work conditions leading to fatigue, increased sick time utilization, injury, stress, burnout, and professional practice exodus across all sectors (Shaba & Rabenschlag, 2007; Spence Laschinger, Wong, & Greco, 2006; Sumner & Townsend-Rocchiccioli, 2003). However, offsetting the negative attributes of rural workplaces are the findings from a few studies on rural and remote nursing that provide some evidence that autonomy (Andrews, Stewart, Pitblado, Morgan, Forbes, & D’Arcy, 2005) satisfaction with professional status, professional interactions, collaboration in practice (Henderson-Betkus & MacLeod, 2004) community and job satisfaction (Roberge, 2009) and support for further education and skill development (Bennett, Barlow, Brown, & Jones, 2012) are contributing factors for job satisfaction and retention of rural nurses.

1.3.2. Inequities in Rural Health Care and Inequities in the Rural Workforce

A sustainable rural nursing workforce is a key factor in supporting health in rural communities (Kulig, Thomlinson, Curran, Nahachewsky, MacLeod, Stewart, & Pitblado, 2003; MacLeod, Kulig, Stewart, Pitblado, Banks, & D’Arcy, et al., 2004a). Current and projected shortages of qualified health care providers, including nurses, compound inequities for access to health care resources, and further the disparities
in rural health (Stewart, D’Arcy, Pitblado, Morgan, Forbes, Remus, et al., 2005). The lack of access for rural populations to obtain health care services due to care provider shortages is a significant structural barrier for equity. Hunsberger, Baumann, Blythe, and Crea (2009) emphasize that sustainability of the rural nursing workforce is a key concern, since “misdistribution of health care workers in Canada is a serious barrier to accessing services” (p. 17). Furthermore, Hunsberger et al. state that the issue of misdistribution is further compounded by the lack of other available human and health care technical resources, reduced or limited practice support, and lack of nursing decision-making in rural practice environments. Inequities in the rural workforce in general, and nursing shortages in particular, are structural factors that further rural health inequities by impacting access and availability of health care service provision to rural populations.

1.3.3. A Working Definition of Rural Nursing

Several broad definitions of rural nursing have been described in the nursing literature. Kulig (2005), described rural nursing as a “unique...multi-specialist, generalist practice”, in which nurses function in a “highly variable and challenging” context to support the broad range of health care needs of patients across the lifespan (p.1). MacLeod, Browne, and Leipert (1998) have described rural nursing practice as based on “the skills and expertise needed by practitioners who work in areas where distance, weather, limited resources and little back up shape the character of their lives and professional practice” (p. 72). Rural nursing practice, like all nursing practice, is embodied in a constellation of actions, functions, knowledge and skill application directed towards physical and relational aspects of health care
provision. Drawing on the literature, a working definition accepted for this study was that “rural nursing\textsuperscript{8} is influenced by unique geographical, social, political, historical and economic circumstances which shape the practice setting and structure how the practice is conducted, in order to meet the variable health care needs of the population across the lifespan in a non-metropolitan geographically situated context.”

\textbf{1.3.3.1. Moral Climates and Rural Nursing}

As I have indicated earlier in this chapter, alterations in the broader health care landscape, caused by restructuring practices in recent years, have given rise to serious concerns about their negative impacts on the moral climate of nurses’ workplaces and their ability to practice ethically (Rodney, Buckley, et al., 2013; Rodney, 1997; Storch, et al., 2002; Varcoe & Rodney, 2002). Further concerns have been raised, suggesting that these restructuring practices and policy mandates have “created a context for inequities in care delivery for those most vulnerable” (Lynam, Henderson, Brown, Smye, Semeniuk, Blue, Singh, & Anderson, 2003, p. 113; see also Anderson et al., 2009; Pederson & Raphael, 2006; Raphael, 2010; Rodney, Harrigan, Jiwani, Burgess, & Phillips, 2013).

Nurses require ethical work climates that both nurture and foster the ethical ideal, and also support a practice environment where professional values are upheld. This permits nurses to more easily provide safe, quality, and ethically based care to their patients, families and communities (Rodney, Kadyschuk, et al., 2013). Concern for safe, quality and ethical care also includes concern for equitable care

\textsuperscript{8} Rural nursing includes the practice of registered nurses, licensed practical nurses, and care aides.
practices and social justice. Rural nursing care provision is complex. It is highly influenced by local politics and economics, as well as policy decisions often made by an urban-based regionalized administration far removed from the rural practice context (Canadian Association for Rural & Remote Nursing, 2008; see also MacLeod, 1999). Increasingly, however, research into the social and structural inequities in rural contexts is being directed toward the fact that rural communities are not well served by simply modifying or adapting urban-based solutions or urban-centered health care policies (MacLeod, Kulig, Stewart, Pitblado, Banks, & D’Arcy, 2004a).

Rural nurses occupy a care provider role within the structures of the health care system. Within the context of their work, rural nurses have access to health care resources (albeit limited) within the rural health care structures. The lack of access for rural populations to health care resources, as well as the role of nurses within the health care system, raises ethical considerations similar to those raised by Pauly (2008b), who questioned how dominant “organizational values shape health care interactions and injustices in health care” and serve to support or constrain nurse agency in urban health care (p. 195). Health care inequities are the products of unfair social arrangements. Inequities in both rural health and rural health care are ethical concerns due to the harms they cause. Inequities also have implications for ethical nursing practice when structural constraints challenge nurses’ ability to enact agency and uphold professional ethical standards. There is a need for improved knowledge of the ethical challenges faced by rural nurses in the context of everyday rural nursing practice, in order to inform future policy development regarding rural nursing.
1.4. **Purpose and Aims of the Study**

Health care provider shortages and the misdistribution of the rural workforce are factors linked to inequities in health care. Shortages directly impact the ability of health care structures to sustain desired levels of patient access to the health resources in rural areas. Inequities and shortages of health care providers also challenge the long-term sustainability of rural health care provision. The role of the nurse in providing safe, ethical, and equitable care within the context of inequities in health, and access to health care services in rural practice settings has garnered little attention. The main purpose of this study was therefore to explore the relationship between health care structures and rural nurses’ enactment of agency, within the rural practice context, in order to gain a broader understanding of how structures shape practice in rural settings. A secondary purpose was also to learn how rural nurses enact their agency within the rural practice structures. This research has implications for knowledge development in the areas of nursing ethics, rural nursing practice development, patient safety, and health policy development. Aims of this research also providing additional knowledge about the needs of rural nurses in order to support competent, ethical, safe, and improved patient care practices. Knowledge thus generated can also further inform rural health care policy development, including policy around health care professional education and support.

1.4.1. **Research Questions**

In seeking to critically examine and analyze the reciprocity between structure and agency, and nurses’ enactment of agency in rural nursing practice
towards upholding professional ethical standards, my overall research question for this inquiry was: *What are the relationships between and within health care structures and nurses’ enactment of their agency in rural nursing practice?*

From this guiding question several other important focusing questions evolved, including:

1. What is the apparent impact of health care structures on rural nursing practice and the nurse’s ability to provide care?
2. What is the apparent impact of health care structures on how nurses enact their agency?
3. How do the rural context and the structures found in rural health care facilitate or constrain nurses’ enactment of agency in health care delivery?
4. What are the social, economic, and political processes that mediate the reciprocity between rural health care structures and the enactment of rural nurse agency?

1.5. **Articulating Relevance**

In this study I sought to examine the enactment of nurses’ agency in the context of rural health care structures, with a focus on inequities in health and health care in rural populations. This research is relevant in light of an emerging consensus that continued reform and economic restructuring within the Canadian healthcare system is creating increased moral complexity in nursing practice systems. “Increasingly reductionist demands for a cost-effective and efficient healthcare system have resulted in an exacerbation of conflicting professional and corporate values that make it progressively more difficult for healthcare providers
to balance the tensions” (Musto, Rodney, & Vanderheide, 2014, p.1). The research literature indicates that nurses are experiencing challenges in enacting moral agency in the current health care climate in urban-based settings. Yet, as I have shown in this chapter, little is known about how rural nurses are impacted in the rural practice context of decreasing access to quality care and increasing inequities in health and health care.

Since health care policy often has a distinct urban-based dimension, the perspectives of rural practice nurses and the patients and communities they serve should be considered. An understanding of the specific challenges nurses are facing in rural practice is necessary for policy makers to make better informed healthcare policy tailored to the rural practice context. For example, Skinner, Hanlon and Halseth (2012) draw attention to the disproportionate and growing demographic of aging rural populations compared to other places and the lack of public policy, programs and services available to meet this unique and growing demand. To understand the health needs of rural Canadians “we must be willing to believe that they might be different from the population at large” (Watanabe, 2012, p. xvi). Well-informed policy making offers the possibility of addressing and working towards reducing health and health care inequities within rural health care structures, thus

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9 For the purpose of this dissertation the terms agency and moral agency are at times used interchangeably. By enactment of moral agency, however, I am referring to the way in which moral agents fulfill their accepted “moral responsibility and accountability and deal with ethical problems” (Varcoe & Rodney, 2009, p. 136). For the purpose of this dissertation I adopt the conceptualization of agency to include, “the rational and self-expressive choice, embodiment, identity, social and historical relational influences and autonomous action within wider societal structures. That action requires recognition of and reflection on moral challenges, and is expressed at collective as well as individual levels” (Rodney, Kadyschuk, Liaschenko, Brown, Musto, & Snyder, 2013, p. 163). Beyond the definition of moral agency as a physical act directed toward fulfillment of a moral goal, a feminist perspective holds that moral agency is relational in nature, socially constructed, contextual, and that the choice to act is mediated by social practices and power (O’Keefe-McCarthy, 2009).
supporting improved moral climates inside health care and furthering nursing’s moral agenda of social justice.

### 1.6. Chapter Summary

Inequities that foster barriers to equitable access in rural health care need to be framed within the broader sociopolitical contexts. Structures found in rural health care serve to shape the nature and quality of nursing care and impact the moral climate. Structures also contribute to furthering unequal access to health care by perpetuating existing forms of injustice, with additional inequities created by the restructuring of rural nursing practice as a part of the current health care practice alignment with neo-liberal values, ideologies and discourses. An understanding of the reciprocal relationship between rural health care structures and rural nurse agency is an important area for inquiry if we are to gain a better understanding of how rural structures shape the conditions that support quality health care or (re)produce inequities.

### 1.7. Organization of the Dissertation

In this chapter I have introduced the research study, identified the problem, provided context and background, stated the purpose and the research question, and identified the relevance of the research. The next chapter is a comprehensive literature review, which summarizes current knowledge about the nature of rural nursing practice, its demands, and the concerns relevant to this study. The literature review also provides empirically-based direction for this study and support for the methodology chosen. In chapter three I articulate my theoretical perspective informed by Giddens’ theory of structuration (1984) as a means to examine the
reciprocity between structures and agency in rural health care. This perspective also draws upon relational ethics as a theoretical lens that informs and guides my understanding of the relationship between the structures and nurses’ enactment of their moral agency, as well as the implications in terms of social justice. The fourth chapter outlines how the study was implemented. In chapters five, six and seven I present the study findings and analysis. Chapter eight concludes the dissertation and presents some methodological reflections, study limitations, recommendations, and suggestions for policy, education, practice, and future research.
Chapter Two: Literature Related to Rural Structures and Rural Nursing

2.1. Introduction

An understanding of the ways in which structures mediate access to health care resources is important because inequities in rural health and health care are both formed and maintained through broader socio-economic and political structures. I have argued in chapter one that the influence these structures have on the capacity for rural nurses to provide quality nursing care to rural populations within a poorly resourced work environment is a significant moral concern. An examination of current rural health care structures is important because structures both influence and have consequences for individual and institutional actions that directly impact rural populations. The purpose of this chapter is therefore to provide a more in depth examination of what is currently known about the nature and complexities of the rural health care structures within which rural nurses practice and the structural impacts of health inequities.

I commence by exploring the meaning of the terms rural, remote, northern, and rurality. I elaborate on what the literature reveals about the problems of rural inequities. I then present an overview of the available Canadian and international rural nursing-related research in order to summarize the current state of knowledge about the structures relevant to this study. In this review I also identify the gaps in the current knowledge-base, which served as a rationale for this study. Relevant aspects of this literature review provided me with empirically-based direction and
support for this study, and assisted me in selecting the most appropriate methodology for addressing the research question.

As I illustrate in what follows, the provision of rural health care is mediated through complex social, discourse, and ideological structures. These structures must be taken into account since they impact health, health care and rural nursing practice. The literature, both Canadian and internationally, points to significant and pervasive structurally-produced inequities in access to resources for health and health care among marginalized and othered\textsuperscript{10} rural populations.

2.1.1. The Meaning of the Terms Rural, Remote, and Northern

In order to better appreciate how unique and complex the rural context is in relation to my methodology and methods, it is important to define what I mean by rural as well as remote and northern. Our understanding of rural structures is complicated because the term \textit{rural} is often left undefined in the research literature or is generically used to mean a place other than urban or “non-metropolitan” (Wong & Regan, 2009, p.3). The term \textit{rural} has also been used interchangeably, combined, or confused with the term \textit{remote} in the literature. There is a great deal of diversity among and between rural communities in Canada even within similar geographical areas. In acknowledging the complexity, I specifically draw attention to this diversity, which makes a firm definition of \textit{rural} challenging. “You know that you are rural if there is no Starbucks or Second Cup...you know that you are remote if there is no Tim Hortons” highlights the diversity and the need for social indices to

\textsuperscript{10} “\textit{Othering} is a process that identifies those that are thought to be different from oneself or the mainstream, and it can reinforce and reproduce positions of domination and subordination” (Johnson, Bottorff, Browne, Grewal, Hilton, & Clarke, 2004, p. 253).
be included in the definition of rural (Pitblado, 2005, p. 165). Given the complexity, it is important to establish a working definition of rural, remote, and northern because nursing practice is shaped by the social context, structures, culture, economics, and geography of the community (rural, remote, or northern) in which care occurs (Ross, 2008).

In acknowledging the complexity and debate that surrounds a clear definition of the term rural, I chose to modify the Du Plessis, Beshiri, Bollman, and Clemenson’s (2002) definitions of rural and small town. For the purpose of this dissertation I took as a working definition a geographically defined populated space as rural if:

1) The core population of the community is less than 10,000 people, and

2) The community is located outside of a one-hour commuting zone (by paved and maintained road) of a larger urban centre and is not influenced by the commuting flow of a metropolitan influenced zone (MIZ).

A larger urban centre is defined for the purpose of this dissertation as a community with a core population of more than 10,000 residents, which is consistent with the definitions used by other researchers (Kulig, 2010; Lockie, Bottorff, Robinson & Pesut, 2010; Montour, Baumann, Blythe, & Hunsberger, 2009; Pitblado, 2005; Soles, 2004).

In seeking a working definition of rural for this study, I considered that it was also important to try and differentiate a rural place from a place that is considered

11 See also Leipert, Matsui, Wagner, & Rieder, 2008; MacLeod et al., 2004a; Stewart et al., 2005.
to be a remote or northern community. The commonly used definition of *remote* is based upon the geographical location of one community relative to another larger community which provides health care services and the distance between them by road. For the purpose of this dissertation, in order to be *remote*, a community must be “3 or 4 hours from the next largest community or higher level of care” (Pitblado, 2005, p. 164; see also Soles, 2004). I understand the “3 to 4 hours” in Pitblado’s definition for *remote* to take into account the elapsed travel time by vehicle to the next largest community offering health care services or a higher level of care services; for example the distance includes elapsed travel time necessary to go from a community level facility to an urban based tertiary care hospital. Travel in many parts of rural Canada is by way of unpaved roads, grid roads, or in some cases logging or seasonal ice roads. Depending upon location, travel by water (lake, river, or in some cases ocean) may also be necessary to obtain medical care. Road and waterway travel are subject to unpredictable conditions and the use of these modalities of travel do not appear to be factored into travel time in available definitions.

The term *northern* in the research literature often goes assumed or undefined. At times it refers to the geographic parameters of the Northwest Territories, Yukon, and Nunavut in the Canadian north—commonly known as “above 60”, meaning above or directionally north of the 60th parallel in Canada (MacLeod et al., 2004a; Stewart et al., 2005). However, as with the term *rural*, the term *northern* suffers from conflicting definitions. For example, researchers Vukic and Keddy (2002) have adopted the 50th parallel as the dividing line in their
research for north and south in Canada without any explanation. This further illustrates the complexity of rural, remote and northern research. For the purpose of this dissertation I adopted the term *northern* to include what McBain and Morgan (2006) refer to as provincial north, i.e. communities above the 50\textsuperscript{th} parallel in the province of British Columbia. This is because within British Columbia the vast majority of the population resides in communities below the 50\textsuperscript{th} parallel. Many of the communities above the 50\textsuperscript{th} parallel have small populations, few services, and are in isolated locations. Thus these communities are considered as situated in the provincial north.

While the definitions I have established above are supported by related literature, clear definitions of *rural*, *remote* and *northern* remain inadequate in the Canadian nursing literature, and a full exploration of the advantages and disadvantages of one definition over another is beyond the scope of this dissertation. The difficulty in obtaining a consensus is indicative of the variety among rural communities and draws attention to the fact that location matters in rural research.

**2.1.1. What Does Rurality Mean?**

Describing the context and characteristics of rural communities is thought to provide for a more fulsome description of the individualities and the health needs of rural populations (Kulig, Andrews, Stewart, Pitblado, MacLeod, Bentham, et al., 2008; Pitblado, 2007; 2012). However, as with the terms *rural*, *remote*, and *northern*, little conceptual work is available to assist with a clear definition of *rurality*. Kulig et al.'s (2008) findings indicate that the use of rurality indexes (such
as the General Practice Rurality Index for Canada) has some utility, but also indicate that the indexes lack the social descriptors relevant to rural health care providers other than physicians. Kulig et al. found that rural nurses define rurality by “community characteristics, geographical location, health and human and technical resources, and nursing practice characteristics” (2008, p. 29).

2.2. Recent Canadian Rural Research

Recent Canadian nursing research into rural health has been broad in scope and has included studies examining health care system issues, professional practice concerns, workforce and working conditions, as well as specialty practice concerns and other related topics. In Canada, research into rural health has shown the difficulties that rural residents face in accessing services, as well as how nurses cope with limited resources (Montour, Baumann, Blythe, & Hunsberger, 2009; Tarlier, Johnson, & Whyte, 2003). The issue of viability and sustainability in the rural workforce (Hunsberger, Baumann, Blythe, & Crea, 2009) as well as issues of retention and recruitment for health care professionals (Canadian Nurses Association, 2002) are common concerns in the nursing literature. The issue of rural physician shortages is a well-known problem for underserviced regions across Canada, as well as internationally (see, for example, Bushy, 2002; Pampalon, Martinez, & Hamel, 2006; Romanow, 2002; Viscomi, Larkins, & Gupta, 2013). Attempts to rectify the health care disparities produced by physician shortages are reported in the literature as being focused on recruitment of internationally trained medical graduates by “passive recruitment to ‘fill-in’ the (rural) gap which is already shown to be ineffective in the long run” (Islam, 2014, p. 31). Both short and long-
term strategies are required to recruit and retain rural physicians, according to authors Viscomi, Larkins and Gupta (2013). Viscomi et al. state that rural physician recruitment strategies are urgently required to address the growing inequity gap in rural health care services resulting from an aging rural population with increasingly unmet health care needs.

The issue of geographical isolation and the difficulty small centres face in providing specialty services such as palliative care (Castleden, Crooks, Hanlon, & Schuurman, 2010; Kaasalainen, Brazil, Wilson, Willison, Marshall, Taniguchi, & Williams, 2011; Lockie, Bottorff, Robinson, & Pesut, 2010; Robinson, Pesut, & Bottorff, 2010; Pesut, Bottorff, & Robinson, 2011; Pesut, McLeod, Hole, & Dalhuisen, 2012; Pesut, Robinson, & Bottorff, 2014) and dementia care (Morgan, Semchuk, Stewart, & D'Arcy, 2002; Morgan, Crossley, Kirk, D’Arcy, Stewart, Biem, et al., 2009) are raised in the research literature to draw attention to the human impact of access inequities in health care services across communities. Further, a significant amount of research has focused on practice and problem-specific issues in rural health. Such issues include inequity concerns about rural public health nurse practice (Henderson-Betkus & MacLeod, 2004), rural maternity care services (Kornelsen & MacKie, 2013; Kornelsen, McCartney, McKeen, Frame, Fleming, Garton, Yang, & O'Sullivan, 2014; MacKinnon, 2010a; 2010b; 2011; 2012), and birth outcomes for rural First Nations women (Brown, Varcoe, & Calam, 2011; Luo, Wilkins, Heamen, Martens, Smylie, Hart, et al., 2010; O'Driscol, Kelly, Payne, Pierre-Hansen, Cromarty, Minty, et al., 2011; Varcoe, Brown, Calam, Harvey, & Tallio, 2013). Additional topics of study have included research into cancer (Rogers-Clark, 2003), as well as rural
stress (Brannen, Emberly, & McGrath, 2009), population health (Pampalon, Martinez, & Hamel, 2006); mental health (Brinkman, Hunks, Bruggencate, & Clelland, 2009; Drury, Francis, & Dulhunty, 2005) Human Immunodeficiency Virus (HIV) (Harris, Veinot, Bella, & Krajnak, 2012; Varcoe & Dick, 2008), and rural youth health challenges (Shoveller, Johnson, Prkachin, & Patrick, 2007). Generally, the themes of inequities in accessibility, availability, and appropriateness of rural health care delivery are pervasive throughout the research literature. All of these important concerns have implications for the overall health, health outcomes, and well-being of rural communities and rural nursing practice as they are linked to the larger socio-economic structures.

While much quality work has been done to address some of the unique health challenges for rural populations, structural barriers and the persistence of the rural health “deficit perspective has also contributed to the stereotyping of rural and remote health as problematic environments in which to work” (Bourke, Humphreys, Wakerman, & Taylor, 2010, p. 205). With this research, I sought to address this gap by examining the interconnectedness of the rural practice and nurse agency with broader system structures. As Buchan and Aiken (2008) highlight, “shortage is not just about numbers, but about how the health system functions to enable nurses to use their skills effectively” (p. 7). As I have argued in the first chapter, knowledge about the structure-agency relationship is needed to bring about system actions that will not only improve the moral climate of rural workplaces, but also reduce inequities between rural and urban-based populations and improve rural health and health care overall. I also sought a fuller
understanding of the strengths and capacities that already exist in rural health care delivery in order to discuss how they could be used more effectively. The following sections provide further context by examining what is known about the multilayered barriers for accessing and obtaining health care for individuals and rural communities. The consequences of these barriers have for rural nursing practice are discussed. Recent implementations of enhanced services for rural health service structure are also discussed to provide further context. I begin by examining the moral climate in the rural health care environment because healthy moral environments are thought to sustain nurses as they “respond to the demands that are placed upon them” (Pask, 2001) and positive climates have implications for supporting nurses’ enactment of their moral agency.

2.2.1. Impacts of Moral Climate Change on Health Care Environments

According to Austin (2007), health care’s ideological progression toward business-like principles reflects a growing corporate-based ethos within the Canadian health care system. This has led to a “paradigm shift in which health-care environments are viewed as marketplaces rather than moral communities” (Austin, 2011, p. 159). Within this altered environment, or changing moral climate, nurses are reported as experiencing direct challenges to enacting their moral agency and upholding their professional practice standards. Moral climate is defined in the literature as “the implicit and explicit values that drive health-care delivery and shape the workplaces in which care is delivered” (Rodney, Hartrick Doane, Storch, & Varcoe, 2006, p. 26). The values operating at “individual, organizational, and societal levels...affect the structural and interpersonal resources available” for professional
nursing practice and also serve to support or constrain enactment of nurses’ moral agency (Rodney, Buckley, Street, Serrano, & Martin, 2013, p. 196). The values operating in the rural health care context also shape the rural nursing practice context. An understanding of how the rural structures operate is important because “nurses are constrained by the structures in which they operate” (Rodney, Kadyschuk, Liaschenko, Brown, Musto, & Snyder, 2013, 167).

The ability of nurses to enact moral agency in practice has been linked in the nursing literature to the nurses’ understanding of ethics as well as the nurses’ ability to engage in “safe, compassionate, competent, and ethical care” practices (Canadian Nurses Association [CNA], 2008). The constraints on moral agency have been found to cause moral angst and moral distress¹² within the profession (Storch, Rodney, Pauly, Brown, & Starzomski, 2002). Constraints on the enactment of moral agency contribute to what Peter et al. posit are morally uninhabitable nursing practice environments (Peter, Macfarlane, & O’Brien-Pallas, 2004). The inability of nursing professionals to enact moral agency is an ethical concern and a troubling sign of a challenging moral landscape in healthcare—which I have conceptualized in previous work as a “moral winter” (Buckley, 2007, p. 45; Rodney, Buckley, Street, Serrano, & Martin, 2013, p. 190). This is relevant because of the implications the moral climate has for both contextual practice constraints on nurses’ agency.

Attention to the moral climate in rural health care is particularly relevant in light of the continued alterations to the rural health care landscape. Knowledge of ethical

¹² Morel distress is defined as the emotional state and accompanying negative feelings – often anger, frustration, or guilt - which occur when moral choices cannot be transferred into moral action (see Jameton, 1984; Rodney & Starzomski, 1993; Storch, 2004).
challenges these alterations foster in the rural health care climate remains an under-studied area of inquiry.

Despite perceptions of a shift in the implicit and explicit values that shape the moral landscape of nursing practice, nurses themselves are never without agency (Varcoe & Rodney, 2009). However, the complexity of nursing practice can often challenge the enactment of agency, and at times nurses are “complicit in reinforcing situational constraints” (Rodney, Buckley, et al., 2013, p. 197). For example, when moral agents are complicit within situational constraints of nursing practice, significant ethical concerns arise for patient safety including the practice of othering (Canales, 2010). This complex process changes how patients are perceived by the nurse, away from deserving of fair treatment that is respectful of the attributes and identity of the unique individual patient, towards that of unjust treatment based upon stereotypes and prejudice (Browne, 2007; Canales, 2010). The challenges rural nurses confront in providing care in the context of limited resources, staff shortages, multitasking, unpredictable patient care needs, and other contextual factors elevate the potential for othering of certain patient populations in the rural practice context.

2.3. **Known Structural Barriers For Access to Rural Health Care**

Health care access issues include the availability, affordability, timeliness and acceptability of health care services (Russell, Humphreys, Ward, Chisholm, Buykx, McGrail, & Wakerman, 2013). Access is clearly impacted by the physical availability of services and the geographical location and distance to be navigated between the population and the health care facility (transportation access by road, boat, or air).
But access is also related to the availability of human and other service resources. Access to the resources for health and health care includes the ease with which populations can meet the costs related to obtaining care services. For example, for some populations the related structural and systemic inequities such as poverty, unstable housing, lack of transportation or related co-morbid conditions (including mental health issues and addictions) can impact ability to access care much more than for other rural populations (see for example, Adelson, 2005; Ministerial Advisory Council on Rural Health, 2002; Tait, 2008). For some rural populations, financial support is made available to qualified applicants through complex jurisdictional and government related programs. For example, there is a financial arrangement between Ottawa (the federal government) and the provinces and territories in Canada in which the federal Canadian government provides some funding for insured health services (as defined under the Canada Health Act, 1985) for status Aboriginal First Nations people residing on reserve, and for members of the Royal Canadian Mounted Police (RCMP) (Waldram, Herring, & Young, 2006). This controversial funding arrangement sets up differential structures for access to treatment for some community members. Furthermore, research done by Aboriginal and other scholars shows that there are significant disparities between what is purportedly delivered as health care for Aboriginal peoples and the quality of what they actually receive (see, for example Browne & Fiske, 2001; Tait, 2008; Tarlier & Browne, 2011). The need to foster moral climates to promote equitable, safe, and ethical patient care is especially important in the rural practice setting.
because rural populations already face inequities in health and decreased access to health care.

**2.3.1. Impact of Shortages of Rural Health Care Providers**

One known barrier for rural-based populations in accessing health care services within their own communities is the shortage of available health care professionals, such as physicians and nurses (Bushy, 2002; see also Buchan & Aiken, 2008; Dotson, Dave, & Cazier, 2012). Professional shortages and difficulties in recruiting and retaining adequate numbers of health care professionals such as physicians, medical specialists, dentists, and nurses in rural areas are a global phenomenon (Pampalon, Martinez, & Hamel, 2006). Rural areas are also known to suffer from shortages of allied health professionals such as occupational therapists, who also provide necessary specialized patient care services (Fields, Van DeKeere, Hanlon, & Halseth, 2008). For many rural, remote and northern communities, registered nurses are often the only professional care providers of health services. In these communities nursing shortages are significant barriers to health for the community (MacLeod, Kulig, Stewart, Pitblado, Banks, & D’Arcy, 2004a). To illustrate, past research done by CIHI (2002) revealed that in 399 communities in Canada, nurses were the only available providers of health care services for the community. MacLeod and colleagues found 169 “sole RN communities” in Canada where one registered nurse lived and worked providing health care services for the entire community and surrounding area (2004a, p. 8). The situation has not improved since these studies were done. Further, the preference of Aboriginal communities to access Aboriginal nurses is identified in the literature as an ongoing
challenge and one that also impacts access to health care services (Stewart, Kulig, Penz, Andrews, Houshmand, Morgan et al., 2006).

2.3.2. Impact of Lack of Health Care Services in Rural Communities

Rural populations\(^\text{13}\) are burdened with the challenging and expensive task of travelling for the purpose of accessing medically necessary care outside of their home communities (CIHI, 2006; Kulig, 2010; Pampalon, et al., 2006; Stobbe, 2008). In addition to the inconvenience and delay for care services, rural residents face significant financial and social hardships (such as obtaining childcare) and encounter geographical and climate (weather) barriers when traveling to urban centres to access basic or specialized health care services, testing, or treatment (MacKinnon, 2010a; 2010b). Travel in many parts of rural Canada is by way of two-lane highways, unpaved roads, or grid roads. In some communities access is obtained by the use of logging roads. The variability of road conditions and the potential for travel delays does not appear to be factored into any definitions of travel time for rural populations to access medical care. Thus the complexity for rural populations to access health care is hidden by the reduction of travel for health care to simple units of time.

Reliable public transportation is not generally found in most rural areas. Travel outside of the community for health services can be problematic for those lacking the ability or resources to self-transport, and “greater for vulnerable populations” (Syed, Gerber, & Sharp, 2013, p. 990). Availability of reliable transportation is a basic requirement to overcoming transport barriers and “access

\(^{13}\) This burden would be the same or greater for remote and northern communities as well. However, my focus in this dissertation is on rural.
to a vehicle was consistently associated with increased access to health care” (Syed, et al., 2013, p. 990). McBain and Morgan (2005) claim there is an additional gendered burden shouldered by rural women because of the stress-inducing process of arranging, funding, and leaving their families so as to access care. Some medical care that would require necessary travel for medical care would include (but is not limited to) palliative care, obstetrical and reproductive health services, chemotherapy and cancer care treatments, mental health services\(^\text{\footnote{This would include pediatric, youth, adult, and geriatric mental health services including diagnosis, treatment, and support services for dementia and related diagnoses.}}\), substance misuse and addictions treatment\(^\text{\footnote{For example, programs such as methadone maintenance treatment.}}\), pharmacy services, special treatments for specific medical conditions including HIV/AIDS, dialysis, medical imaging (x-ray, ultrasound, echocardiogram), specialized radiological testing such as computerized axial tomography (CAT or CT scan), positron emission tomography (PET scan), or magnetic resonance imaging (MRI), as well as health-supporting treatments such as speech, occupational, and physical or physiotherapy (see, for example, Brown, Varcoe, & Calam, 2011; MacKinnon, 2011; Ministerial Advisory Council on Rural Health, 2002; Romanow, 2002, and Lockie, Bottorff, Robinson, & Pesut, 2010).

One example of travel as a structural barrier to accessing care occurs when provincial health authorities decide to close rural hospital emergency wards or health care centres due to lack of staff or availability of physician service coverage. Rural emergency department closures are a recurring problem for small centres (Fleet, Plant, Ness, & Moola, 2013). "Many rural communities across Canada are facing challenges to the sustainability of core emergency and acute care health
services, primarily due to problems with medical and nursing staffing” (Grzybowski & Kornelsen, 2013, p. 10). One specific example is Princeton, British Columbia, where the problem of physician shortages has resulted in sporadic closures of the Princeton Hospital to emergencies, which has been profiled in past media reports. Closures force residents to travel to the next available health care facility. In the case of Princeton when the hospital Emergency Department\textsuperscript{16} (ED) is closed patients are required to travel an additional 90 minutes to the next available facility. With increased travel time come increased risks for rural residents associated with motor vehicle accidents, unpredictable weather and road conditions, and travel delays due to construction or summer tourist traffic. Often such hospital emergency service closures coincide with public holidays. Although rural communities such as Princeton have been prioritized for recruitment of physicians, emergency room closures are reported as continuing to threaten the health and overall well-being of the Princeton community (Global News, 2012). It is becoming increasingly apparent that rural physician and nurse shortages are a significant challenge to the provision of rural health care.

Another example of lack of health care service availability necessitating medical travel is for childbearing women and their families. Many rural communities now have limited obstetrical service, or no longer offer obstetrical services at all (Sutherns & Bourgeault, 2008). Thus, women in rural Canada face significant barriers to reasonable access to pregnancy, childbirth, or reproductive services and are often sent from their home community to larger centres for

\textsuperscript{16} Both Emergency Department (ED) and Emergency Room (ER) are used in this dissertation to describe the area of health care facilities utilized for urgent and emergent health care.
obstetrical care, delivery, or related gynecological services (Klein, Christilaw, & Johnson, 2002; MacKinnon, 2010a; 2010b; 2012). A report prepared for the BC Ministry of Health and Perinatal Services found the lack of local maternity services was associated with worsened maternal and child outcomes as well as decreased continuity of care once the family returned to the home community (Kornelsen, McCartney, McKeen, Frame, Fleming, Garton, Yang, & O’Sullivan, 2014). Travel outside the home community for childbirth is identified as a particular burden for Aboriginal women for numerous reasons, including the lack of traditional birthing practices and meaningful birth experiences (Brown, Varcoe, & Calam, 2011; see also Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; O’Driscoll, Kelly, Payne, St Pierre-Hansen, Cromarty, Minty, & Linkewich, 2011; Van Wagner, Osepchook, Harney, Crosbie, & Tulugak, 2012). Further, the experience of childbirth outside their community has been reported as deeply affecting Aboriginal women who suffered with “loneliness, disconnection from community, isolation from family and culture and discrimination” (Varcoe, Brown, Calam, Harvey, & Tallio, 2013, p. 5).

Stoll and Kornelsen (2014) propose midwives as a logical and safe alternative to offer rural women a choice to remain in their local community to give birth. This also would address the social cost rural women experience, according to Kornelsen and MacKie (2013), because with the closures of rural maternity services they are left with little choice but to travel to larger centres to give birth. The potential solution to integrate the use of midwives into models of rural maternity care is, however, not without challenges (Munro, Kornelsen, & Grzybowski, 2013). The aforementioned authors cite “financial, legal, and regulatory barriers to inter-
professional collaboration [that] must be resolved if there is to be increased collaboration between rural midwives and physicians” (Munro, et al., 2013, p. 651).

A further illustration of the lack of health care services in rural areas necessitating travel is the need for other specialty services such as palliative care or hospice care. As with most services, provision of designated palliative care beds and related services varies between rural communities within the province. Designated hospice facilities are not available in all regions. Yet with an aging rural population the need for rural based palliative care services will only continue to grow in the future (Crooks, Castleden, Hanlon, & Schuurman, 2011; see also Castleden, Crooks, Schuurman, & Hanlon, 2010; Kaasalainen, Brazil, Wilson, Willison, Marshall, Taniguchi, & Williams, 2011; Lockie, Bottorff, Robinson, & Pesut, 2010; Pesut, McLeod, Hole, & Dalhuisen, 2012; Robinson, Pesut, & Bottorff, 2010). Until more rural communities are able to provide local palliative care services or freestanding hospice care centres, the commute for palliative care from rural areas is likely to continue, thus increasing the burden on patients and families dealing with life-limiting illnesses.

2.3.3. Impact of the Costs of Lack of Access

In addition to the cost of medical travel for rural residents, the need for rural health care centres to mobilize emergency ground or air transportation for a patient (for example in an obstetrical emergency) can be a hidden barrier to health care provision. Medical air or road ambulance transportation fees are often charged to the patient, even in cases where the transport is for medically necessary services that are unavailable in the local region. (MacKinnon, 2010a; 2010b; see also
Ministerial Advisory Council on Rural Health, 2002). Less obviously, if safe transportation also requires the attendance of a nurse or physician during the journey, there is another indirect barrier to access because the professionals are in short supply.

The net effect of a community’s lack of available qualified health care professionals becomes a circumstantial barrier to access, which is challenging for patients, their families, and nurses (MacKinnon, 2011; Montour, et al., 2009). In addition, for many communities the nearest ambulance service may be located an hour or more outside the community and additional travel time is required. The practical reality of driving distance, road conditions and climate complications can make the more expensive air transportation to urban centres necessary for critical and urgent cases (McBain & Morgan, 2006). The expenses incurred by transporting patients also means fewer resources are available for other care expenditures in rural health care budgets.

2.3.3.1. Further Impacts of Ongoing Rural Disparities

Despite acknowledgement by governments (both provincial and federal) of recommendations for targeted rural initiatives and strategies, contained in reports such as Romanow (2002), significant structural disparities remain for rural communities. Such disparities are often complicated by shortages of professional health care providers. Increasing disparities for rural health care raise concerns for the widening and worsening of the rural moral climate as “problems with the moral climate for nursing practice have become endemic in Western health care” (Rodney, Buckley, et al., 2013, p. 196). Further compounding this issue of disparities and
inequities related to the lack of care providers is the lack of agreement on what constitutes adequate access and necessary medical services. According to Romanow, the model of care provided needs to fit the rural community served since as, “unique rural conditions need to be taken into account” (p. 164). Romanow claimed attention should be paid to the unique needs of rural communities, as well as to the pressing issue of professional shortages. But greater attention, according to Romanow, is required to address the more fundamental and basic social determinants of rural health needs. These determinants include economics and living conditions. As Romanow states, “more emphasis needs to be placed on addressing the fundamental causes of the ‘rural health deficit’” (p.164). Addressing the larger socio-political structures and policy choices that influence inequities in rural health and health care must begin with targeting the multiple dimensions of access (Russell et al., 2013, p. 60). In this dissertation it is my premise that these structures and the related reform agendas and policy decisions they create can both support and constrain equitable access to the resources for health in rural populations and impact rural nursing practice. I return to this point in chapter eight.

2.3.4. Recent Rural Initiatives

Notwithstanding the challenges I have noted above, the British Columbia government has in recent years made efforts to address the problems of access and inequity in communities that suffer from physician shortages. As previously mentioned rural physician shortages are a global issue (Bushy, 2002; Pampalon, et al., 2006). One innovative solution has been to train and certify emergency department nurses in selected communities to work to their full scope of practice.
This encompasses management of minor uncomplicated health issues and injuries, using evidence-based protocols, in an alternative program of health care delivery known as “RN First Call” (Hanvey, 2005, p. 20). This alternative health care program, changing the structure of rural health care provision, was implemented with a dual purpose. Firstly, the program was presented as a means to address the issue of physician shortages in rural and remote areas and, secondly, as a means to address access to care. The program is designed to reduce rural physician ‘call back’ for specific health problems and injuries.

The certified RN First Call practice was first piloted in a small interior BC community and district general hospital in 1997 and was expanded in 1998 to include fifteen additional sites (MacDonald, Schreiber, & Davis, 2005; MacKinnon Williams17, 2000). The mandate of this expanded certified practice was to provide primary care18 by trained registered nurses using approved clinical practice protocols for diagnosing and treating adult and pediatric eye, ear, nose, and throat conditions, strains and sprains, allergic reactions, simple lacerations, and urinary tract infections in adult women. A single evaluation of the program was competed in 2000 by MacKinnon Williams. This evaluative report recommended that the program be expanded to include more clinical protocols, and that the program should also be expanded to other communities. “The RN First Call program offers patients access to an alternative health care provider with different training and a

17 MacKinnon Williams is a consulting firm.
18 The medically based concept of primary care refers to physician involvement in diagnosis, treatment, and follow up services for a medical issue or disease. Primary health care, according to the Canadian Nurses Association (2000), involves a team approach to provide a continuum of care including health promotion, disease prevention, curative health care services, rehabilitation and palliative care and support. The new initiatives included some of both.
different perspective” (MacKinnon Williams, 2000, p. 22). This program, according to MacKinnon Williams, has offered appropriate health services and reduced physician call back, and is one solution for rural communities to access health care. The program reportedly expanded to include 230 RNs practicing in the certified RN First Call role in the province in the year 2005 (Smith, 2010). In 2009 the program was amalgamated into the Rural Nursing certificate curriculum at the University of Northern British Columbia (Smith, 2010). Other initiatives in BC have also taken place. For example, in response to the previously discussed issue of sporadic emergency department closures in Princeton, the local health authority has made efforts to address the issue by employing a full-time nurse practitioner for the community, and has also fully funded five nurses to attend the RN First Call program (Halpenny, 2012).

The use of alternative methods of primary health care provision in rural British Columbia, such as RN First Call and nurse practitioners, has grown out of an awareness that rural practice nurses and the communities they serve are directly impacted by the level of accessibility, availability, and delivery method of health care services in their area. According to the nursing literature the impact on health, health care and nursing workplaces in Canada has also been influenced by political, economic and ideological structures present in the health care system (Choiniere, 2011; Rodney & Varcoe, 2012; see also: Austin, 2011; Cummings 2006; Daiski, 2004; Lynam, et al., 2004; Pauly, 2013; Peter, 2013; Shannon & French, 2005; Woodward, Shannon, Cunningham, McIntosh, Lendrum, Rosenberg, & Brown, 1999). Despite some promising new initiatives, the low level of resource allocation by policy and
related structures continue to create access challenges which further disadvantages and marginalizes vulnerable rural populations who already suffer higher rates of inequities in health (Dixon-Woods, Kirk, Agarwal, Annandale, Arthur, Harvey, et al., 2005).

2.4. **Historical and Recent Tensions: Marginalization and Othering**

Given the pervasive restructuring and reform initiatives undertaken in past years in the Canadian health care system, my concern with unequal access and inequity in rural health care is not simply a matter of distribution of limited health care services. Rather, in this inquiry I sought to better understand the broad structures that shape nursing practice and patient care practices and how these structures alter ethical care provision to rural communities. Some scholars have already begun to question the effects of health care reform measures on access, inequities, and social justice beyond the distributive justice paradigm (see, for example, Anderson, Rodney, Reimer-Kirkham, Browne, Khan, & Lynam, 2009; Brown, Varcoe, & Calam, 2011; Pauly, 2008a; 2008b; Peter, 2011). Recently, Chircop (2011) questioned the “inequity producing effects of public policy” (p.245). Shannon and French (2005) suggest the Canadian health care reform policy and restructuring initiatives are in response to the growing economic burden of health care provision for North American countries. On the surface this may appear to be so; however, this position fails to connect the policy and restructuring initiatives to the broader corporate and privatization agendas that are driving the changes in health care regulations, both nationally, and globally (Milton, 2011). The restructuring movement is said to have introduced the business-like management principles,
values, and ideologies of the marketplace into the Canadian healthcare system (Martinussen & Magnussen, 2011). More specifically the restructuring and reform movement is stated to be underpinned by neo-liberal based ideologies whereby the notion of accountability is clearly linked to efficiency (Choiniere, 2011). Dilts (2012) attributes increasing inequities “at a structural level of the global and local distribution of resources” to neo-liberalism (p. 193). Recently published nursing literature has revealed that the influence of some neo-liberal based ideologies within health care practice environments make it both more difficult for Canadians to access appropriate care, and more challenging for nurses to enact their moral agency (Rodney, Buckley, et al., 2013).

Corporate language also plays a leading role in capital allocation and distribution of services or resources in health care. The free-market force or distributive paradigm, known as the ‘invisible hand’, is operating wherever capital and resource allocation decisions are made. Those forces are largely unseen and unacknowledged however, hence the term invisible hand (Smith, 1776/1937, p.423; Browne, 2001; Crigger19, 2008). The values that underpin the free-market corporate discourse, such as efficiency and cost-containment, receive priority in the current health care discourse. These values also underpin capital allocation and distribution of health care services within the reform model. The priority given to corporate values within the discourse is linked to “broader neo-liberal-informed political and economic influences” which alter the workplace and nursing care practices (Choiniere, 2011, p. 341). Choiniere notes that one unexamined cost of the

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19 Crigger (2008) uses the term “hidden hand” in reference to Adam Smith’s (1776/1937) “invisible hand”. 
accountability mandate in health care reform is that it “fails to take patients’ and nurses’ contexts into account” (p. 341).

Further concerns have been raised in the research literature that these restructuring practices have “created a context for inequities in care delivery for those most vulnerable” (Lynam et al., 2003, p. 113; see also Anderson et al., 2009; Pederson & Raphael, 2006; Raphael, 2010; Rodney, Harrigan, Jiwani, Burgess, & Phillips, 2013). What is known is that “the impact of corporatized health care reform has not been uniform across all people” (Rodney & Varcoe, 2012, p. 98). A particular case in point is Aboriginal First Nation people in Canada. With a long history within the health care system of blindness to the needs of the marginalized (Anderson, 2000), “cost constraint measures have only made these dynamics worse, especially for those who are marginalized by other forms of oppression” (Varcoe & Rodney, 2009, p. 135). Anderson, Tang and Blue (2007) had assumed in their earlier work that, “health care restructuring would have positive ramifications for improving access to health services by diverse populations” (p. 292). However, they found that “when resources are limited, the assumed behaviours, practices, special needs, and expectations of the Other may be perceived as a barrier to biomedical treatment and the effective running of the health care system” (p. 294). This has particular significance for Aboriginal First Nations people living in rural areas because they represent such a relatively small population. Because of small numbers their needs for culturally sensitive and appropriate care to this population may be incorrectly perceived as special treatment and a barrier to the rural health care system (Castleden, Crooks, Hanlon, & Schuurman, 2010).
Jones, writing on the legacy of neoliberal politics, concludes, “neoliberal political success brought with it a number of consequences. There was a new-found acceptance of inequality as a necessary and unavoidable evil” (2012, p. 338). In this dissertation it is my premise that the inequities in rural health that are structurally produced in the context of neoliberal ethos are not necessary or unavoidable, and that rural health care structures can be altered towards supporting more socially just outcomes.

2.4.1. Othering of Aboriginal First Nations People

As I have noted earlier, the issue of access and barriers to obtaining health care services in rural Canada has garnered some national attention from policy-orientated commissions such as the Romanow (2002) and Kirby and LeBreton (2002) reports. In the 2002 Romanow report it was pointed out that rural Canadians needed better access to better care and recommended that a rural and remote access fund be developed to facilitate expansion of programs such as telehealth. Romanow found that there was a pressing need for more health care providers in rural and remote areas. Rural populations in general were found by Romanow to be disadvantaged, and specifically rural health care was found to be in dire need of technological upgrading, particularly in the area of diagnostic services and treatments.

While the rural population as a whole suffers disadvantages, not enough attention has been paid to how some groups within the rural population are more affected by rural health care structures than others. As a current example this attention has recently been drawn to the structural conditions of the Queen
Charlotte General Hospital. The Vancouver Sun reported in June 2011 that chemotherapy drugs are still being mixed in an old wooden smokehouse outbuilding and physiotherapy treatments continue to be provided in an old greenhouse (Vancouver Sun, 2011). Further, the hospital was reported as having only one wheelchair-accessible washroom in the entire building, located in the lobby. These kind of inadequate structural conditions are reported in Romanow (2002) as disadvantaging populations. The implication that some populations are more deserving of technological or structural upgrading in provision of health care services raises concerns for further marginalization of some groups of patients to be replicated in inadequate nursing care practices and in-patient care received—particularly by Aboriginal patients.

These structural conditions are particularly troubling because they bring to light the considerable health inequities that exist for Aboriginal peoples in Canada relative to the non-aboriginal population (Waldram, Herring, & Young, 2006). According to Raphael, “the health of Aboriginal peoples in Canada—the First Nations, Dene, Métis, and Inuit—and elsewhere is inextricably tied up with their

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20 This hospital provides health care services to a predominantly Aboriginal population in Haida Gwaii, located off the west coast of British Columbia.

21 Recently the lack of availability resulting in a response delay of over 60 minutes for ambulance service in Haida Gwaii resulted in what local physician stated was the preventable death of a Skidegate band councilor from a cardiac arrest. CBC News reported the physician wrote a letter to the health authority where the doctor claimed “the ambulance, which was suppose to be only 10 minutes away, wasn’t available and one had to be brought in from Sandspit, which is a 20 minute ferry ride and a 20 kilometer drive” (CBC News, 2014). The letter also detailed delays in ambulance wait times have been frequent over the past year in Haida Gwaii and are linked to rural ambulance staff shortages. The doctor is also quoted as stating, “neither the public, nor the hospital are advised of ambulance coverage gaps” (CBC News, 2014).

22 A number of terms are used to make reference to the indigenous inhabitants of Canada. In borrowing from Waldram, Herring, and Young (2006) I use the terms Aboriginal people(s) or Aboriginal (which also recognizes the Inuit, Métis, First Nations, and those who self-identify as descendants of the original peoples of this nation).
history of colonialization” (2010, p. 102). Any discussion of rural health and health care must be inclusive of the Aboriginal peoples of Canada, since they are a significant population in rural, remote and northern Canada. As a group, Canadian Aboriginal peoples have suffered from a long history of social exclusion. Since Aboriginal peoples are identified as being socially excluded (meaning that they often have less power in Canadian society), they cannot share in the full range of opportunities and advantages afforded other members of society, which include appropriate access to health care services (Raphael, 2010; see also Maddalena & Sherwin, 2004)\(^{23}\).

For rural dwelling Aboriginal persons, social exclusion frequently combines with other disadvantages such as low income, lack of appropriate housing, low food security, lack of meaningful employment, and poor social conditions (as a result of government policy making), all of which create profound differences in the health status of Aboriginal populations compared to the total Canadian population (Pederson & Raphael, 2006; Raphael, 2010). It is known that a connection exists between income inequity and poor health status especially for Aboriginal people who reside on reserves in rural Canada (Vafaei, Rosenberg, & Pickett, 2010). “Increasing evidence demonstrates that the Aboriginal population experience greater health disparities and receive a lower quality of health care services” (Bourque Bearskin, 2011, p. 548). Since approximately half of Canada’s Aboriginal peoples reside in rural and remote communities, the higher rates of injury, shorter

\(^{23}\) This is also true (to differing extents) for others who are socially excluded, including, for example, racialized minorities, immigrants and refugees, women, people with disabilities, people who are impoverished, homeless, elderly, socially disadvantaged, those with chronic mental health challenges, those who misuse substances, and lone-parent families.
life expectancy, high rates of diabetes, and higher rates of suicide among them can present additional challenges to providing health care in a rural-based system that already suffers from historical, legal and political barriers (Health Canada, 2011). It is also likely that members of Aboriginal communities and other marginalized and socially excluded group members may “find it more difficult to get access to necessary medical services” (Raphael, 2010, p. 100). For example, Aboriginal people in Canada are known to have higher rates of end-stage kidney disease. Aboriginal patients, however, despite having higher rates of end-stage kidney disease have significantly lower rates of transplants completed compared to other groups (Anderson, Yeates, Cunningham, Devitt, & Cass, 2009). Rural-dwelling Aboriginal people are less likely to be waitlisted for transplant because of their place of residence and systemic racism.

Discrimination and subtle or overt racism are “rooted in systemic structures that perpetuate differential and culturally unsafe treatment of Aboriginal people” (Vukic, Jesty, Mathews, & Etowa, 2012, p. 7). Structures manifest policy actions that can create barriers, affecting resource allocations, and other conditions that all contribute to social exclusion, racism, discrimination, and structurally produced marginalization of Aboriginal persons and other socially disadvantaged peoples as they attempt to obtain necessary medical care (Vukic, et al., 2012). Given the disproportionate burden of ill-health that marginalization produces, the strengths and capacity of aboriginal communities are not always visible in the rural health literature (Castleden, Crooks, Hanlon, & Schuurman, 2010). Another structural challenge for Aboriginal peoples in obtaining health care provision is the severe
shortage of nurses and the under-representation of Aboriginal nurses and other health care providers serving First Nation Communities (Vukic, et al., 2012). Health Canada reports vacancy rates of forty-five to sixty percent for federally funded nursing positions in First Nation communities. Nursing staff shortages in First Nation communities make the likelihood of accessing timely and appropriate care in these communities highly problematic (Health Canada, 2010).

2.5. **Shaping the Focus With the Literature**

The literature above informed this study and sensitized me to pay attention to the structures that shape practice in rural health and to examine how the structures impacted rural nurse practice. I sought to pay attention to the way in which certain groups within the rural practice setting may be treated differently. In linking the effects of neoliberal policy to marginalization of certain groups within society, Jones (2012) claims that the intended or unintended effects are “less important than the fact that neoliberal policies tended to affect the most vulnerable members of society in the harshest ways” (p. 338). This study's focus on the broader social structures and how these structures are replicated in the rural health care structure offers knowledge on how the reciprocity between rural health care structures and the rural nurse can be altered towards more equitable and socially just health care practices across all rural patient populations. Understanding such structures can be enhanced by also looking at other countries.

2.5.1. **International Rural Research**

The issue of human and resource shortages in rural areas is a global phenomenon (Bushy, 2002). Converging economic reforms, policy and trade
agreements between nations are generating health care systems that appear increasingly more analogous globally. In order to analyze this trend, I examined three similar nations with rural-based populations to inform this study. The following section summarizes publications from Australia, the United States (USA), and Canada.

I analyzed relevant rural nursing research literature from Australia and the United States in order to make a comparison with Canadian literature. My assumption was that both these countries shared similar rural demographic and geographical features in common with Canada and would be experiencing similar health care reform initiatives. A systematic literature review was conducted using the following databases: Academic Search Complete, MEDLINE, CINAHL, PsycINFO, ERIC, and Social Work Abstracts for all available peer-reviewed studies using the keyword search terms: rural, rural and remote, rural nursing, rural health, and rural health care. Articles that focused on any aspect of rural nursing practice and rural health care were reviewed.

Publications from Australian and American researchers, like their Canadian counterparts, revealed that clear, uncontested definitions of the terms rural and remote remain challenging (Baernholdt, Jennings, Merwin, & Thornlow, 2010; Hanvey, 2005; Kulig, Andrews, Stewart, Pitblado, MacLeod, Bentham, D'Arcy, Morgan, Forbes, Remus, & Smith, 2008; MacLeod et al., 2004a; Montour, Baumann, Blythe, & Hunsberger, 2009; Welch, 2000; Yates, 2010). Indeed, according to Australian researcher Yates (2010), the inability to work with a clear definition of
rural makes analyzing and comparing differences between rural areas and populations difficult.

Well-documented health differences, inequities, and overall poorer health outcomes (for example accidents, injuries, diabetes, infant mortality, asthma and suicide rates) were found to be common to rural areas in all three nations (Bushy, 2002; Kidd, Kenny, & Meehan-Andrews, 2011; Jackman, Myrick, & Yonge, 2010; Stewart, D'Arcy, Pitblado, Morgan, Forbes, Remus et al., 2005). According to Welch (2000), health outcomes in rural Australia are markedly worse than in other areas of the country and rates of illness, injury and accidental death increase in relation to ruralness and remoteness. Indigenous Australians also suffer lower health status, inequities, and higher mortality, which corresponds with findings for Canadian Aboriginal peoples (Welch, 2000). Reproductive outcomes were also found to be worse in rural and remote areas than in urban areas in both Canada and Australia, especially for the Indigenous and Aboriginal peoples in each country (Yates, 2010). Australian barriers to appropriate maternity care included, as previously detailed for Canada, access, distance to care facility issues, economic hardship, and lack of culturally appropriate and safe care practices (Yates). The inability of care providers to communicate with Indigenous peoples in their own languages was noted as being a significant barrier for quality care in rural and remote Australia (Yates). Kulig et al. (2004) found that practice complexities, provider and resource shortages, isolation, and language barriers impacted nursing and quality care provision in Australia.

In summary, access to care is a central issue for rural communities in all three nations (Hanvey, 2005; Jackman, Myrick, & Yonge, 2010; MacLeod, et al.,
Reduced access to services, transportation issues, isolation, and lack of care providers decrease optimal health care services in rural Australia (Welch). Kidd, Kenny, and Meehan-Andrews (2011) suggest that inequality and inequitable distribution of resources in Australian rural health care are linked to both sustainability of the rural workforce and to rural health outcomes (see also Russell et al., 2013).

The recurring themes of recruitment, retention, workforce shortages, sustainability and an aging workforce for nursing and other health care providers is a similar and significant concern for all three nations and is frequently referred to as a crisis (Bushy, 2002; Kidd, Kenny, & Meehan-Andrews, 2011; Kulig, Minore, & Stewart, 2004; MacKinnon, 2010a; 2010b; McLeod et al., 2004a; 2004b; Montour, Baumann, Blythe, & Hunsberger, 2009; Romanow, 2002; Stewart, D’Arcy, et al., 2011; Viscomi, Larkins, & Gupta, 2013). Tham et al. (2010) explain that the major problem in rural Australia, as in both the USA and Canada, is to “ensure adequate provision of appropriate health services where population densities are low and recruiting and retaining an appropriate health care workforce is difficult” (p. 166).

According to more recent research “severe shortages of primary health workers...are exacerbated in rural and remote communities” in both Canada and Australia (Visomi, et al., 2013, p. 13). Suggestions to address the growing problems of recruitment, retention and sustainability in rural areas include the need for research to draw attention to the forms of support nurses needed in their specific context of practice (Kidd, Kenny, & Meehan-Andrews, 2011). Hunsberger et al. (2009) suggest addressing the demands of practice by using resources that meet the
needs of both providers and patients, including educational resources in rural areas. Buykx, Humphreys, Wakerman, and Pashen (2010) suggest that addressing the issues of shortages, retention, and accessibility to care should be a priority for policy makers. They argue that the retention of nurses and other care providers in rural areas contributes to high quality health care because of the resources, skills, and experience of the staff. They maintain that the cost of poor care, through inability to retain a skilled workforce, is high for rural populations, and that retention programs and incentives for rural practice settings are urgently required. McLeod et al. (2004a) suggest that recruitment needs to begin with offering affordable education for future providers. Similarly, Stewart, D’Arcy, Kosteniuk, Andrews, Morgan, Forbes, MacLeod, Kulig, and Pitblado (2011) suggest that attention be paid to addressing the nursing concerns of stress and lack of autonomy in the nursing workplace as a means to stem the loss of the workforce.

Increasing concerns about the sustainability of rural health care have been linked to the provision of a sustainable nursing workforce in the rural context in Canada and abroad (Hunsberger et al., 2009; MacLeod et al., 2004a). Stress, heavy workloads, burnout, decreased job satisfaction, lack of autonomy, and insufficient policy and practice supports were commonly found across the international literature to constitute barriers to quality care provision and rural health care sustainability (Bourke, Humphreys, Wakerman, & Taylor, 2012; Brannen, Emberly, & McGrath, 2009; Lenthall, Wakerman, Opie, Dollard, Dunn, Knight, MacLeod, & Watson, 2009; MacLeod et al., 2004a; MacKinnon 2010a; 2010b; Montour, Baumann, Blythe, & Hunsberger, 2009). Tham et al. found that sustainability,
viability, and quality care practices in health care provision in rural and remote areas are underpinned by the combination of six key elements: workforce, infrastructure, funding, governance, management, and leadership (Tham, Humphreys, Kinsman, Buykx, Asaid, Tuohey, & Riley, 2010). Lenthall et al. found that the combination of geographical isolation, professional isolation, cross-cultural issues, and increasing job demands in the context of lacking human and service resources were significant stressors for rural practice nurses. Russell et al. call for “effective polices [that] must incorporate the multiple dimensions of access if they are to comprehensively and effectively address unacceptable inequities in health status and access to basic health services experienced by rural and remote Australians” (2013, p. 61).

2.5.2. Implications

The nature of rural nursing both in Canada and internationally is described in research and related literature as highly complex, multifaceted, ambiguous, and varied (Bushy, 2002; Jackman et al., 2010; MacLeod et al., 2004a; Stewart et al., 2005). “The nature and scope of rural nursing is distinctive” according to Scharff, “and now can be given a definition based on that distinctiveness” (Scharff, 2010, p. 249). Rural nursing concerns receive little attention globally from policy makers, and rural nursing issues should not be seen in isolation, without the context of the larger rural community (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004b). In order to support quality care in and for rural communities MacLeod et al. (2004b) found that rural nurses needed both policy and practice changes. American researchers Baernholdt, Jennings, Merwin and Thornlow (2010) found that rural
nurses believe that in order to provide quality care, they need to maintain both their clinical skills and knowledge through continuing education and practice supports24. Lenthall et al. (2009) suggest that the demands and challenges in rural and remote practice need to be supported through better resources, infrastructure, and management in order to supply nurses the conditions they need for providing quality care. Common to all the aforementioned literature themes was the often unwritten understanding that, “at the end of the day, structures should facilitate, not impede, the provision of patient care” for rural populations (Duffield, Kearin, Johnston, & Leonard, 2007, p. 44). I will address some of these implications in chapter eight.

2.6. Chapter Summary

All of the above reflect significant structural challenges for rural nursing practice in Canada and beyond, and, in turn, for quality, equitable patient care. These challenges figure prominently in rural health discourse. The impact for rural communities—particularly Aboriginal, but also all who are socially and economically marginalized—is persistent and enduring health service and health status disparity. Because of the importance to human health and social justice, it behooves us to examine how the local and broader structures of rural health care facilitate, or impede nurses’ ability to provide quality, equitable, and ethical care to rural Canadians.

24 This American study defined a *rural* hospital as being located in a non-metropolitan centre of less than 50,000 people. This is substantially larger population base than that used in the definition of *rural* in Canada, and this may account for the findings appearing to not be rural-specific. This may also be an example of what Laurence, Williamson, Sumner and Fleming (2010) call *latte rural* meaning that the lifestyle of rural living still has the amenities of urban living.
Chapter Three: Laying Out the Theoretical Framework of the Study

3.1. Crafting the Study Design

In this chapter I describe the theoretical framework and methodology I selected as being best able to address the research questions posed in chapter one. I begin by introducing Giddens’ theory (1984) of structuration and his articulation of the duality of structure. I then articulate the concepts of social structures, contextuality, and knowledgeability that underpin structuration theory. Giddens’ theoretical perspective of power is then introduced. I further expand on Giddens’ theory by introducing Sewell’s (1992) notion of reciprocity as a conceptual lens by which the relationship between structure and agency are examined. I will then describe the critical ethnographic approach used in this study, which was informed by Carspecken’s critical qualitative research (CQR) methodology (1996) and Giddens’ structuration theory. These approaches were combined and used as an analytic framework that informs and guides the entire study (see Table 1 in Appendix A).

Finally, I discuss how I drew upon relational ethics as a theoretical lens to inform and guide my understanding of the relationship between structure and agency. This use of relational ethics in viewing the moral terrain of the rural practice environment was undertaken so as to assist with exploring the values involved in the relational connections between and within the health care structures and nurses’ enactment of moral agency within the rural practice context. It was important to examine the values within and between rural structures because the structural values had the potential to be very different from the values operating
within and between rural nurse agents. As I will explain at the close of this chapter, exploring the potential for value differences helped me to evaluate how the reciprocity between and within structures and agency was mediated by similar or differing value orientations.

3.2. Giddens’ Structuration Theory: Duality of Structure and Agency

Giddens’ work, The Constitution of Society was first published in 1984, and outlines the principles of structuration theory. Giddens posits that structure and agency are entangled in a duality, as opposed to a dualism. That is, the deterministic features of society, (structures), and the deterministic features of the individual, (agency), are in a relationship with one another, hence the notion of a duality of structure. The mutual exchange between human agency and social structures is said by Giddens to be recursive and the repeated act of exchange between structure and agency reproduces social structures, social systems, and social order. Agency, according to Giddens, involves both the capacity and the intention of the agent to act. Agents therefore are not puppets who love their strings; rather they have the ability to be reflexive and to act with intent.

I drew on Giddens’ structuration theory (1984) while forming the conceptual framework that guides the examination of how rural nurses’ experience, envision, and understand the world they inhabit. The combination of Giddens’ structuration and Carspecken’s critical ethnographic approach was used because of the potential it offered to uncover the perceptions, experiences, and actions of rural nurses within the structures of their workplaces, and to further illuminate the impact these structures may have had on providing ethical and quality care in rural communities.
Further, this combined approach was adopted in order to fully explore the phenomenon of rural nurses’ enactment of agency within the context of rural structures.

More specifically, Giddens’ theory was used as a tool to identify the local and broader structures that supported, or at times constrained, enactment of agency in rural practice contexts. Giddens’ approach is consistent with the underlying critical orientation of this research, which is directed towards fostering social change. Additionally, the adoption of a critical lens committed this research to the development of strategies to decrease health inequities (Bungay, 2008; see also Austin, 2001; Pauly, MacKinnon, & Varcoe, 2009). Finally, the use of a critical lens committed this research to discovering ways to draw attention to the issues of equity and how inequities should to be addressed in the provision of health care to rural communities. Giddens’ theory was also utilized because it is compatible with both a critical epistemology, and an ethnographic methodology. Further, it allowed for structure and agency to be examined separately and as a duality. Finally, it offered a viable means to explore social and cultural practices and to illuminate the structural mechanisms that impact the context within which rural nurses seek to provide quality care. As I will further explain in chapter four, the use of a critical ethnographic approach in this study led me to conduct extensive fieldwork and participant observation, in-depth interviews, the taking of fieldnotes and self-reflective journaling, a document review, and the collecting of cultural commodities in order to produce the data necessary for thorough examination and analysis.
3.2.1. **Social Structures, Contextuality, and Knowledgeability**

Social structures according to Giddens (1984), are the shared systems in which actors engage in everyday activities and routines (for example nurses daily in practice). Giddens' understanding of social structures is that they are composed of both “rules implicated in the production and reproduction of social systems but also...resources” (p. 23). These structures are created, recreated, refined, and reinforced through social interaction across time and space. Within the duality of structure, structures can enable or constrain the agent in three ways. The first is by the structures of *signification*, which are the rules of language that are vital for communication, and which give meaning to the rules. Next are the structures of *legitimation*, which are the normative rules that are drawn upon to support and justify action. Finally, the structures of *domination* are those that allocate resources and are the means by which actors exercise power. These modalities of structure allow agents to draw upon interpretive schemes for the communication of meaning, for norms that can become moral rules, and for the use of resources of power (p. 29). Structures of signification provide rules of acceptable social conduct that enable or constrain communication. Language provides meaning to the rules that agents used in social life. In this research, the modalities of structure, signification, legitimation and domination were used as tools to examine the everyday routines, habitual practices, and actions of the rural nurse. The same modalities were also used to illuminate and analyze how the rules and resources found in rural social structures were used in the act of providing care to patients.
Contextuality incorporates several notions, such as time-space, locale, encounters and routines. *Time* and *space* are prominent in structuration theory since they relate closely to social interactions. The intersection of time and space situates and positions the actor in recursive patterns. Contextuality is the “situated character of interaction in time-space, involving the setting of interaction, actors [co-presence] and [the] communication between them” (Giddens, 1984, p. 373). For example, nursing routines and practices, such as the change of shift report, position nurse-to-nurse encounters in a room (space) at the beginning of the shift (time) and are connected. Further, the notion of context, which is central to structuration theory, is embedded in the stability of time-space in the predictable routine and social reproduction that begins each shift in acute care nursing practice. *Social integration* in structuration theory highlights the reciprocity of practices (of autonomy or dependence) between the individual actor and a collective of actors, in what Giddens refers to as co-presence. *System integration* highlights the reciprocity between actors across space and time. In this study, the use of Giddens’ notion of social and system integration brought to the foreground the way in which actors (rural nurses) engage and relate to one another as a collective, in specific social contexts (for example the change of shift report) and across time.

Giddens’ (1984) structuration theory posits that actors know voluminous amounts about their everyday circumstances and environment and their actions and the actions of others as they use rules and resources. This knowing of self and others is termed *knowledgeability*. The more knowledge agents have of their social context the more capacity they are assumed to have to enact agency. Within this
theory knowledgeability is viewed as consisting of layers of consciousness ranging from unconscious to discursive. Giddens’ focus is on the recursive nature of knowledge, stating that:

The routine (whatever is done habitually) is a basic element of day-to-day social activity... The term ‘day-to-day’ encapsulates exactly the routinized character which social life has as it stretches across time-space. The repetitiveness of activities which are undertaken in like manner day after day is the material grounding of what I call the recursive nature of social life. (By its recursive nature I mean that the structured properties of social activity—via the duality of structure—are constantly recreated out of the very resources which constitute them) (Giddens, 1984, p. xxiii).

It is assumed in Giddens’ theory that actors have some level of control over this practical level of consciousness and knowledgeability can therefore be used to enact agency. However, Giddens warns that actors are not always aware of the conditions and structures that influence the outcomes and consequences of their actions. However, since “human knowledgeability is always bounded” by embedded routines and habitual actions (p. 27), the agent’s knowledgeability of social structures and context (contextuality) “can enable and constrain the dialectic of control, privileging one person over another, depending on how structures are used during interaction” according to Hardcastle, Usher and Holmes (2005, p. 227). All agents have the capacity, or agency, to choose to act outside of the habitual and the taken-for-granted social structures—to transform social structures. But they may also be constrained in that agency by the same social structures, knowledge and context. The knowledgeability rural nurses have was explored in this research with the purpose of gaining a broader understanding of what structures shape the rural practice context and how agency is enabled or constrained within those structures.
3.2.2. Power

Carspecken (1996) is a key methodological theorist informing this research, and he relies heavily on Giddens (1984) to explain the relationship between power and knowledge. Carspecken puts forward the claim that “all acts are acts of power” and the relationship between power and knowledge is such that “who has what kind of power and why” is mediated by cultural and social conditions. (1996, p. 128). This view is consistent with a commitment to critical social theory. Giddens (1984) views power as present in all human actions. Power is accessed and then applied through social structures (the rules and resources) to accomplish a goal or intent. From this view of power, Giddens suggests that some individuals (or groups or structures—for example, the management structure of an institution) have influence or control over the behaviours or actions of others. Control, according to Giddens (1984), is “the capacity that some actors, groups, and types of actors have of influencing the circumstances of action of others” (p. 283). This is referred to as the dialectic of control by Giddens. Through this dialectic of control the ability of the actor to access and use the rules and resources can be both constrained and permitted. The dialectic makes reference to the alternating or fluctuating of power, such as the reciprocity between structure and agency. The dialectic of control relates directly to the enactment of agency, as Giddens (1984) posits, “constraints can also enable” (p. 174). This notion is an important consideration particularly because the dialectic of control will influence the agent’s understanding of what power can be accessed and applied within the social structures. The concept of dialectic of control relates directly to my rationale for this study.
The notion of power is also foundational to any consensus-based theory of truth, such as Carspecken's (1996) critical methodology. Critical research methodologies, “usually attempt to realize power sharing and collaboration between researcher and participants/co-researchers” (Grant & Giddings, 2002, p. 20). “Criticalists examine not whether a statement is true or false but, rather, whether it meets certain validity conditions to win consensus” (Cook, 2005, p. 134). Because the issue of power is central in any theory of truth, Carspecken's methodology, like other critical ethnographies, holds a critical epistemology in the relationship of power to communications as “unequal power distorts truth claims” (Carspecken, 1996, p. 21). As Cook explains,

Carspecken's analysis techniques are based on pragmatic philosophy, which defines truth in terms of consensus. Thus, although all truth claims are fallible, critical epistemology focuses more on validity than on truth...[t]herefore all ontological categories are open to examination, including objective, subjective, and normative/evaluative realms. Each of these can be regarded as valid if they ‘make sense’ according to the structures of human communication that enable people to reach agreed meaning (p. 134).

Carspecken suggests that all efforts should be made by the researcher to be alert for subtle and more obvious forms of power that might be displayed or enacted during consensus building in the research process. An unequal power imbalance in the researcher-researched relationship can distort validity claims, and should be guarded against. To protect against distortions in this research I invited participants to share in a dialogue about the analysis and descriptions and to share in the production of the research. I also invited participants to provide feedback once sufficient observational and interview data had been analyzed, producing some meaningful findings to participants to gain their perspectives. In this study I strove
to incorporate the perspectives of primary\textsuperscript{25}, secondary\textsuperscript{26}, and tertiary\textsuperscript{27} participants since each brought valuable contributions to the construction of knowledge about rural health care structures through observational and interview data.

### 3.3. Reciprocity of Structure and Agency

The concepts of structure and agency are typically contrasted with each other in the sociological literature, rendering the interconnectedness between the concepts lost or unseen, according to Hays (1994). In this research I took up Sewell’s (1992) notion that a distinct relationship, or reciprocity, exists between structure and agency. Sewell’s notion of structure-agency rests on the reciprocity and tensions held between and within both structure and agency. That is, human agency and social structures share a symbiotic-like exchange that is both antagonistic and mutually dependent. “The term structure empowers what it designates” (p.2) and “agents are empowered by structures” according to Sewell (p.27). The concept of structure-agency reciprocity, that is a shared exchange and a tension between structure and agency that can be both antagonistic and mutually beneficial, informed my approach to the power dynamics across all the structural layers I analyzed in this study. The notion of an action being reciprocal refers to the "give and take" flexibility that serves to support and sustain relationships.

\footnotesize
\textsuperscript{25} Key, or primary participants were registered nurses who were identified as likely to relate experiences and perspectives that would best inform my aim to gain a deeper understanding of the rural health care structures and rural nursing practice within those structures.

\textsuperscript{26} Secondary participants were those who were identified as non-nursing allied health care providers with experiences and perspectives that would also supplement my understanding.

\textsuperscript{27} Tertiary participants were other health care providers, facility staff, patients, family, or community members who were not formal primary or secondary study participants, but whom I came into contact with over the course of the study as I followed and observed the primary nurse and AHCP study participants.
The concept of structure is assumed to be a human-made creation. Social structures exist with the consent (willing or unwilling) and participation of human actors (see Giddens). Social systems, rules, and resources are known metaphors of structure according to Sewell (1992). These patterns and principles that guide action are said to be “mutually sustaining cultural schemas and sets of resources that empower and constrain social action and tend to be reproduced by that action” (Sewell, 1992, p. 27). In the absence of structure there can be no rules, and without rules there cannot be purposeful action (Hays, 1994). These structures are understood as both enabling and constraining according to Sewell. His reciprocity approach allows for differing levels of structures; some hidden, and others more visible, varying in resiliency, flexibility, and ability to guide the action of the human actor. In this study I sought to understand how the differing levels of structural rules and resources allow, or constrain, the enactment of nurse agency in rural health care. The notion of reciprocity is a lens I used to make sense of the rural context and the ways in which nurses engaged in ethical practice within and between the local and broad structures of rural health care.

In summary, agency is enabled by social structures through access to and use of available power resources. But agency is also simultaneously bound by structural limitations. The choices available for action are structurally produced. Agents create and recreate structure in day-to-day activities. Social structures persist through the mutual exchange and reciprocity of agency and structure. Giddens explains that “the structural properties of social systems exist only in so far as forms of social conduct are reproduced chronically across time and space” (1984, p. xxi).
The notion of reciprocity between structure and agency is a useful frame for understanding the enactment of agency within the rural context. The same structures in the health care system that empower action and provide benefits can become barriers to enactment of agency by constraining the resources necessary for the actors to facilitate action.

3.4 Critical Theory as a Theoretical Perspective

Theoretical perspectives lead to the ontological and epistemological foundations on which researchers support their quest for understanding phenomenon, human behavior, and the complexity of the world (Crotty, 1998). Theoretical perspectives serve as a lens which influences the way in which researchers view reality and participate in the search for knowledge. In a similar manner the theoretical perspective drawn upon is also influenced by the researcher’s personal system of beliefs, what is understood as reality, and what constitutes knowledge (Crotty). According to Crotty, theoretical perspectives are not value-free.

Critically orientated theorists hold that there is a “virtual reality” that is accessible, and knowledge is “shaped by social, political, cultural, economic, ethnic and gender values” (Guba & Lincoln, 2005, p. 193). It can be argued, therefore, that a critical epistemology and ontology is socially constructed. Epistemology is, according to Crotty a “theory of how knowledge comes to be embedded in the theoretical perspective and thereby in the methodology” and “a way of understanding and explaining how we know what we know” (p. 3). Similarly, the epistemology that underlies critical theory is what “gives us principles for
conducting valid inquiries into any area of human experience” (Carspecken, 1996, p. 8). Holding a critical epistemology implies a certain value orientation and acceptance by the researcher that meaning is subjective and it is created within a specific social context. In this research, the specific social context is rural nursing practice.

Carspecken (1996), Crotty (1998) and authors Kincheloe and McLaren (2005) each offer a similar representation of the assumptions, guiding principles and epistemology that underpin critical theory. The assumptions according to Kincheloe and McLaren are that:

All thought is fundamentally mediated by power relations that are socially and historically constructed; facts can never be isolated from the domain of values or removed from some form of ideological inscription; the relationship between concept and object and that of the signifier and signified is never stable or fixed and often is mediated by the social relations of capitalist production and consumption; language is central to the formation of subjectivity (conscious and unconscious awareness); certain groups are privileged over others within the same societal structures; the oppression characteristic of today’s society is, forcefully reproduced when subordinates accept their social status as natural, necessary, or inevitable; oppression has many faces and, while looking at one form of oppression we also need to consider the inter-connectedness of the parts to the whole, and mainstream research practices are generally, although most often unwittingly, implicated in the reproduction of systems of class, race and gender oppression (2005, p. 304).

This critically orientated study used the assumptions and value orientations given above as the basis for an in-depth examination of the rural social conditions, context, and structures that create the setting for health inequity and disparities. These assumptions and value orientations were adopted in order to make the relationships between and within structure and agency more explicit. They clearly articulate the goal of applying a critical lens to all societal activity in order to
identify privilege and oppression, with the overriding goal of emancipation for the betterment of society. Embedded in critical theory is the assumption that “all thought is mediated by power relations” (Crotty, 1998, p. 157).

Since privilege and oppression can take many forms within structures, knowledge in the rural context is assumed to be subject to the influence of these same power structures. Carspecken (1996) posits that there exists a constructed relationship between power influences and methods by which knowledge is acquired and developed. Sewell’s (1992) premise of reciprocity and Giddens’ (1984) duality of structure are both congruent with Carspecken, and all three highlight the power relationship between structures and agency. Giddens’ duality of structure clearly indicates power to be a structural resource. Taken together, these theories were applied to this research in order to examine the structures of rural health care and the relationship between the agent and the structures. My aim has been to expose the hidden, question the taken-for-granted, examine the political and address the impact of health and health care inequities in rural practice settings as well as nurses’ enactment of their agency within those structures.

3.5. Carspecken’s Critical Qualitative Research Methodology

In order to best address the research question and the purpose of this research within the context of my chosen critical theoretical framework, I required a method of inquiry that had the flexibility to expose the dialectical processes; the reciprocity between structure and agency; and the dialectic of power and control exerted through structures and between and within the enactment of agency. In other words, in order to interrogate the power dynamics within the structures, I
needed a critical lens. Carspecken’s (1996) critical methodology offered such a lens and a flexible methodology to inform the whole study.

Carspecken’s framework is sensitive to power relations. In a similar fashion to Giddens (1984), who argues that power is present in all actions and agents are capable of rational reflection, Carspecken posits a critical epistemology as a means to understand the relationship between power and action. Critical research is based on a critical realist epistemology, and the conceptual understanding that all knowledge is co-constructed and power is inherent in all relationships. This framework is of particular relevance to my study since rural nurses are embedded within the structures, yet Carspecken’s methodology supports the understanding that, “agents are not forced to act; instead, [they] are influenced by cultural conditions (norms and social conduct), or resource/constraints (law and economics) to act in broadly predictable ways” (p. 37), and agents always retain the “potential to act otherwise” (p. 128). This understanding suggests that structures can operate at an unconscious level and recursive actions—such as nursing routines and practice—can unknowingly reinforce power relations. This also suggests a form of agreement, or as Sewell (1992) advises, a form of reciprocity exists between structures, including power relations and the agent within the social context.

Carspecken’s methodology is not without critique or concerns, and he freely admits that his methodology continues to advance (Carspecken, 2001, p. 1). Although this methodology originated in the field of educational research, it has been applied successfully in the field of nursing (see Hardcastle, 2004; Smyth, 2008). This approach allowed me to account for the experiences of nurses and the
enactment of nurses’ agency within the complex structures of rural health care. The methodology was particularly appropriate for this research study because of the critical theoretical commitment to “problematising what is usually taken for granted, and generate a variety of alternative understandings” (Holmes & Smyth, p. 152). His methods are similar to conventional ethnography, and his collection and analysis procedure is laid out in a flexible and clear manner. The context-specific orientation and the focus on participant perspectives, plus the use of multiple methods of data collection, fitted the goal of this research. Carspecken’s methodology was flexible enough to include the contextual factors of rural practice, and the historical, social, economic, and political aspects that intersect rural nursing practice (Bourke, Humphreys, Wakeman, & Taylor, 2012; see also Hardcastle, 2004).

3.6 Relational Ethics Lens

In chapter one I established that there is an ethical dimension to the enactment of agency, and therefore this study includes an analysis of the moral terrain of the rural practice environment using relational ethics theory. Structures are thought to provide boundaries for normative commitments and the capacity for agents to make practical and normative judgments (Sewell, 1992). Current feminist informed theory posits that agency is enacted through a defined and contextually bound relationship, as for example the nurse-patient relationship (Sherwin, 1998; 2011). “Relational ethics exposes the relational space between the client, nurse and health care environments, and within the broader society” (Bourque Bearskin, 2011, p. 553). This feminist-based conceptual understanding supports the notion that agency, or, more specifically, moral agency in nursing, is complex and highly
contextual and embedded in relationships. Agency in nursing is embodied by ethical action within the relational space where “shared standards and normative expectations exist within relationships” (Keyko, 2014, 882). Agency is focused on meaning, human connections, and is attentive to the dynamics of power operating within the relationship at all levels, from micro level interactions through to organizations, communities and broader regions (see Bergum, 2013; Carnevale, 2013; Hartrick Doane & Varcoe, 2013; Peter, 2011; Rodney, 1997; Rodney, Buckley, et al., 2013). When reciprocity and trust are challenged by unequal power relations or broken in the structure-agent relationship by actions that devalue nursing expertise and interfere with providing safe, ethical, and quality patient care in favor of efficiency mandates, the enactment of moral agency may be constrained. Constraint of enactment of moral agency in the nurse-patient relationship is thought to foster the development of moral distress in nursing (Peter & Liaschenko, 2013).

Agency can be individualistic as well as collective in nature (Sewell). For example, because rural nurses act within rural health care structures, according to structuration theory they therefore play a role in the production and reproduction of the structures that support health inequities. However, the rural nurse can enact agency on micro and macro levels to address rural health inequities through existing structures in the workplace (such as policy, ethics, practice, and finance committees) and at the local community or regional level (through rural health policy development). I have used relational ethics as a lens in this study to view the moral terrain of the rural practice environment. In this study relational ethics was employed as an overarching viewpoint from which to explore the relational
connection between the health care structures and nurses’ enactment of moral agency within the context of health inequities, social disparities and the challenges to social justice that exist in the rural health care practice setting.

Overall, the relational view of agency from which I operated illuminates the vast complexity, interconnectedness, and social and historical contexts encountered by nurses. It also suggested that the human actors found within health care structures may not be equally positioned within relationships, and that the context in which the relationship occurs is not static or uninfluenced by the structures that border the nurse-patient relationship.

3.7. Chapter Summary

The theoretical framework for this ethnographic-based inquiry was designed to provide an understanding of how structures operate in the everyday practice of rural nurses, and the relationship of those structures to the enactment of agency. I drew on Giddens’ structuration theory (1984) and Carspecken’s critical qualitative research (CQR) methodology to form the theoretical framework, which guided the research in examining how rural nurses experience, envision, and understand the world they inhabit. Rural nursing practice is already socially and culturally constituted. Rural nurses have expert knowledge regarding the strengths, capacities, and deficits in rural health care work environments. The application of structuration theory and critical qualitative research (CQR) methodology provided a framework from which to understand and view the way in which power is manifested in rural nursing practice. The critical orientation of this study allows for the generation of theoretical-based nursing knowledge that is informed by analysis of power and
equity. This orientation enables me to move my analysis in chapters five through seven from pointing out “the ‘is’ to the ‘ought’ and thereby provides normative direction for change” (Starzomski & Rodney, 1997, p. 225). I now turn to outlining the research methodology and the methods used to generate data in light of the theoretical framing in this chapter.
Chapter Four: Implementation of the Study

4.1 Introducing the Methodology

In this chapter I explain my methodology and the processes I used in deploying critical ethnographic methods to create an account of nurses’ enactment of agency within the rural context. I provide an explanation of critical ethnography, and show how Carspecken’s critical qualitative research (CQR) methodology and Giddens’ structuration theory (1984) were used to guide study design, data collection and analysis. Combining these theoretical and methodological approaches enabled me to analyze the role of power relations between nursing practices, and the structures that shape nursing practice and patient care. This provided a better understanding of rural health and rural health care strengths and the way in which inequities are furthered within the broader health-related structures. As I continue in this chapter I will then describe the study sample, data construction and collection methods, research process, data management and analysis. I conclude with a discussion of ethical considerations and the steps taken to ensure scientific rigor and ethical integrity.

4.2 Critical Ethnography

Ethnography is the qualitative inquiry that is concerned with researching cultural behaviors and phenomenon of interest in a naturalistic setting in order to obtain rich, thick, descriptions of the culture under study (Hardcastle, 2004; Hardcastle et al., 2006). The critical theoretical perspective of critical inquiry I described in chapter three can inform a range of research approaches, including ethnography, as it is moored by epistemological ties to constructionism (Staller,
The basic assumptions of critical theory are adopted as guiding principles for the critical ethnographic approach to research, which is to “link social phenomena to wider socio-historical events to expose prevailing systems of domination, hidden assumptions, ideologies, and discourses, so that social situations such as nursing can be redefined” (Hardcastle, Usher, & Holmes, 2006, p.151). The assumptions underlying critical theory are mirrored in the research strategy of critical ethnography, since critical ethnography is the blending of critical theory and ethnography.

Classical critical theory and critical ethnography share a similar heritage; both are focused on empowerment and transforming systems of oppression. Both support the development of consciousness and self-reflection (Barton, 2001; Manias & Street, 2001). Critical ethnography, like classical ethnography, also has the goal of studying people within their own unique social contexts (Hardcastle, 2004). Because of the broad epistemological basis, “ethnographies can be conducted from an objectivist, constructivist or subjectivist epistemological framework” (Staller, 2012, p. 408). A critical lens is not meant to replicate patterns of dominance and power through the research process (Foley & Valenzuela, 2005). Thus, a central concern for critically orientated researchers is the need to avoid replicating oppression within the research process, along with an ethical obligation to minimize harm. A central tenet of critical ethnography is of a moral responsibility to be critically reflexive of one’s own social position, the research process, relationships with study participants, and the nature of knowledge constructed (see Reimer-Kirkham, & Anderson, 2002).
Critical ethnography employs critique as a means to expose oppression, reveal power relationships, and expose ideologies, with the express desire to evoke change (Hardcastle et al., 2006). This fits with my research aims of uncovering the structural processes that affected nursing enactment of agency in the context of rural nursing practice. One central aspect of critical ethnographic fieldwork is to develop a broad understanding of how power is operating. The use of a critical perspective therefore lent itself to the examination of power and oppression as well as strengths within the rural nursing culture by positioning myself within the structures to examine the structural processes. It was also a way to examine the personal, cultural, and political aspects of rural nursing practice to reveal how and why certain decisions are made and what potential effect they may have on the moral climate of rural nursing.

4.2.1. Methodological Approaches

The research methodologies employed in this study—critical ethnography informed by Carspecken’s critical qualitative research (CQR) methodology—guided the study design and provided direction on the selection of methods for data generation and analysis. This framework proved useful to make meaning out of the data, illuminate power, understanding the complexity in rural practice, and engaging rural nurses in the research process.

4.2.2. Qualitative Data Collection

In keeping with this framework and methodology, I employed critical methods in order to account for the understandings, experiences, and actions of nurses. I selected three data collection methods: participant and site observation, in-
depth interviews, and document collection. All of these data collection strategies are consistent with a critically informed ethnographic research approach, thus they are methodologically coherent (Carspecken, 1999).

The ethnographic method of collecting field and participant observational data was done over a prolonged period of time, which is consistent with ethnographic traditions. “Field work is the process by which the ethnographer inevitably comes to understand a culture, and the ethnographic text is how that culture is communicated and portrayed” (Polit & Beck, 2004, p. 251). In order to address my research question, I first needed to observe and learn about the rural nursing culture. This enabled me to gain an understanding of the embedded relationships between and within rural health care structures and the rural nurse. This prolonged engagement in the field illuminated the rural culture and the relationships between structure and agency in rural nursing practice.

4.2.3. Site Selection for Fieldwork

A fundamental criterion for choosing a research site was that it had to be located in a rural area by definition, and the community selected also had to have at least one health care facility that employed registered nurses (RNs) and offered basic health care services. According to the rural definition criteria adopted in chapter one, the site had to have a core population of less than 10,000 people, and the community must be located outside of a one-hour commuting zone (by paved and maintained road) of a larger urban centre.

A small community-level hospital and combined long-term care facility that was accessible by paved road and located in the rural interior of British Columbia
satisfied the fundamental criterion for this study. As I elaborate on later in this chapter, the facility employed registered nurses, licensed practical nurses and care aides, and provided both acute care and long-term care (LTC) services. Further, the facility offered some laboratory and diagnostic imaging services. I purposefully selected this small rural facility from a number of similar facilities in the region because it appeared to embody many of the typical rural structures. The community met all the criteria from the rural definition. The facility also employed an adequate number of RNs who could provide a range of experiences and perspectives. The highways to the community were well maintained and frequently travelled. This community-level hospital served a diverse patient population from both the local and surrounding towns and villages. As well, it provided health care services to seasonal non-local residents from the many surrounding lakes and resort areas.

The size and scope of services provided in this community hospital designate it as a common rural health care facility in between urban and remote structural contexts. The characteristics of this rural community were not unique. It resembled a number of similarly situated rural communities in British Columbia, and western Canada and therefore it was well suited for the focus of this study. In population size, resource-based community composition and distance from an urban centre it was similar to other small rural hospitals in British Columbia used in previous nursing research studies (see for example MacLeod & Zimmer, 2005). Health care provider shortages and other access issues impacted this community, not unlike many other rural communities reported in the news in British Columbia.

As I explain more below, some details have been deliberately obscured to protect participants and to aid in making the research site less identifiable.
and across Canada. In other words, the attributes of the rural community I studied are shared by many similar rural communities in British Columbia, which enhanced the relevance of the data generated and helped me to preserve confidentiality of the site.

One hallmark of ethnographic research is the detailed and thick descriptions of the culture studied (Higginbottom, Pillay, & Boadu, 2013; Polit & Beck, 2004). The otherwise expected detailed descriptions of the research location in this study have been deliberately altered to provide anonymity and to better protect the confidentiality of both the study participants and the community location. As the literature points out “rural communities have been likened to ‘fishbowls’ and the chances of confidentiality breaches with significant consequences for personal, family, and professional relationships are intensified” (Weiss Roberts, Battaglia, & Epstein, 1999, p. 500). Further, “concerns such as confidentiality and anonymity pose exceptional challenges in small communities, where strangers are few and personal information seems to belong to everyone” (Wilson-Forsberg & Easley, 2012, p. 281). With these ethical concerns in mind, I have provided enough contextual descriptions here, and in my presentation and analysis of data in chapters five, six and seven, to give rich details of the unique setting. However, I have limited and, at times deliberately altered, details and descriptions so that the community is not easily identifiable.

4.2.3.1. The Hospital and Community Setting

The facility in which the study was conducted was in a small industrial and farming community, with a population (including surrounding communities) of
fewer than 5,000 in the interior region of British Columbia. All government-provided health care services, including residential long-term care were located in the single rural facility. The nearest tertiary level hospital was located less than two hours away, travelling by paved road. Unpredictable and varied road conditions, weather, and geographical-related barriers (mud and rock slides, forest fires, avalanches, winter road and animal hazards, etc) were all known to impact travel times, particularly in winter, making travel hazardous and at times ill-advised. Minimal administrative office support and clerical staff were available during the week. On-site management presence was limited to approximately four days a month. The research site facility was predominantly managed from another rural town’s community-level hospital, which was approximately and hour and a half driving time away and served a population of approximately 5,000 under the same regional health authority structure. At the time of the study approximately twenty registered nurses were employed in the research site facility in the areas of emergency (ER)\textsuperscript{29}, home and community care, public health and mental health and addiction services. A similar number of licensed practical nurses (LPN) and residential care aides (CA) provided nursing care to clients in the long-term care unit (also known as residential care). The long-term care unit also employed an activity worker who provided therapeutic structured physical and recreational programs to meet resident’s social and physical needs.

\textsuperscript{29} The emergency department (ER) operated on a limited weekly daytime schedule with 24-hour access only available on weekends. This facility did not provide overnight acute care medical, obstetrical, or surgical health care services. Patients requiring admission to an acute care hospital bed were transferred to a tertiary hospital in the region.
At the time this study was conducted, the facility had two RNs per shift in the emergency department with routine nightly closures during the week and some weekend coverage according to physician availability. At times only one RN might be on shift while the facility was open to ER patients, due to nurse staffing shortages or unfilled sick or vacation leave. Staff illness and vacation leave would often not be covered so the facility was then closed to ER admissions. Although the facility was moving toward removing RN coverage during routine nightly closures, at the time of the study at least one RN was required to be in the facility at all times.

The facility provided other nursing care services on a regular weekly basis, including public health, home and community care, as well as mental health and addictions counseling. Some home and community care nursing service was available on weekends depending on staffing levels. ER nurses had the additional responsibility of overseeing the entire facility in the absence of management staff. ER nurses were also expected to assist LPN and CA as required in providing care or guidance on urgent health care issues arising for the long-term care residents in the facility. Patients accessing this facility for emergency services ranged from minor non-urgent medical concerns, such as sore throats, cough or headache (CTAS\textsuperscript{30} level

\textsuperscript{30} Canadian Triage and Acuity Scale (CTAS) levels are national guidelines designed to categorize patient needs into acuity categories so that the sickest patients are treated with priority. CTAS level 1 patients require resuscitation from cardiac, respiratory or other major trauma or shock states that threaten life or limb. CTAS level 2 are emergent conditions that require rapid intervention such as overdose, altered mental status, MI, CVA, head trauma, neonatal resuscitation, or other threats to life or function. CTAS level 3 are urgent medical conditions that left untreated could progress such as GI or vaginal bleeding, acute pain, asthma, or acute mental health conditions. Level 4 are less urgent conditions and may include headaches or back pain but depending on potential for increased complications these patients are seen within several hours. CTAS level 5 are non-urgent or chronic conditions that are easily deferred to physician office visits or delayed in priority in favor of more urgent cases. They may include such conditions as sore throats or diarrhea. (Elkum, Barrett, & Al-Omran, 2011; see also Beveridge, Clarke, Janes, Savage, Thompson, Dodd et al., 1999).
4 or 5), and medical issues requiring urgent attention such as asthma (CTAS level 3), and to major life-threatening injuries and major medical crisis such as myocardial infarctions (also known as STEMI\(^{31}\)), crush injuries and other critical injuries requiring advanced medical support and treatment (CTAS level 1 or 2).

Other nursing departments in the facility, such as home and community care or mental health and addictions care, provided a range of treatment services to patients. For example, in a single shift, the mental health nurse might see patients with chronic mental health challenges, patients needing medication reviews, families needing grief counseling, and patients in an acute mental health crisis in the ER department. In addition to treating patients in the community, home and community care nurses provided in-facility clinics for various care including medication administration (such as cancer drug therapy), wound care, and assessments for residential care and palliative care program entry.

It is important to note that additional supplementary data about other rural practice contexts (beyond the one I conducted my fieldwork in) were collected from interviews with study participants who had previously or were currently working at the research site hospital and also at other health care facilities. Several of these other facilities were also located one hour or more from the same urban tertiary referral hospital. They also offered varying degrees of health care services, ranging from basic treatment and diagnostic services on a limited basis, to a full 24-hour a day ER, some surgical services, obstetrical services, and acute care bed admissions.

\(^{31}\) STEMI is the acronym for ST segment elevation myocardial infarction, which is a severe type of health attack where the coronary artery is at least partially blocked and this decrease in blood flow to the tissue results in the heart muscle infracting (dying) (Tu, Donovan, Lee, Wang, Austin, Alter, & Ko, 2009).
Additional data from participants with rural or remote nursing experience in neighboring western provinces was also collected through interviews with participants who had previously or were currently working at the research site hospital and also at other health care facilities.

4.2.4. Negotiating Entry

Gaining entry in any ethnographic research “is an integral but sometimes difficult part of the research process” (Kawulich, 2011, p. 57). “There are sometimes several possible routes by which access might be achieved” (Hammersley & Atkinson, 2007, p. 50). Therefore entry to my research site required both formal and informal routes. I began by making informal inquiries of knowledgeable peers who had an understanding of the demographics of health care facilities in the region of the province, which I had predetermined, would be a logical geographical area, to use. This geographical area needed to be located between one and three hours travel from my residence. Once I had a list of potential sites, I again sought out the assistance of knowledgeable insiders to assist me in connecting with potential rural sites by helping me identify the relevant gatekeepers I needed to approach, since “identifying the relevant gatekeepers is not always straightforward” (Hammersley & Atkinson, 2007, p. 49). Once I had determined a potential health care facility within the geographical zone that satisfied the study criteria, I began the formal process of personally contacting the hospital manager to request a face-to-face meeting to introduce myself, and explain the proposed research. In the same timeframe I also received formal approval from, the University of British Columbia Behavioral
Research Board. I also was issued formal ethical approval and consent by the regional health authority to conduct the research.

At the time of my initial application I requested permission to add additional research sites at a later date, if my analysis led me to conclude that it would be beneficial. Although the addition of another site would have been preferable, I was only able to obtain approval from the health authority to conduct the study in a single site. However, despite this limitation, as I have indicated above, participants in the study also provided data on the basis of their broad range of work experiences in multiple rural and remote workplaces sites in BC and across Western Canada.

After obtaining ethical approval, I once again sought the local manager’s permission to enter the clinical areas in order to speak to nursing staff to introduce the research study, and extend them an invitation to staff to participate. I also asked the facility administrator for assistance in publicizing the study by hanging up posters and handing out study materials (see Appendix B; Appendix C). The manager of the research site hospital supported my entry by doing this, and also took the time to introduce me to some staff members.

Facility staff expressed significant interest in and support of my presence and stated that they were receptive to the conduct of the research study in their workplace. As the hospital manager had already previously supplied the nursing staff with study introduction letters, individual nurses and other allied health care
providers (AHCPs\textsuperscript{32}) increasingly came forward to participate in both participant observation and in-depth interviews.

Fieldwork commenced promptly after the facility introductions and continued on a regular weekly basis, starting with 2-5 site visits per week for 6 calendar months and then decreasing to 1-3 site visits per month for further 4 months. In-depth participant interviews and follow-up interviews were conducted over a total period of 14 months (see Appendix D). Being physically present in the facility for an extended period of time helped me to build relationships and trust with facility staff. Over time, as I became more known to them, I began to notice I was often referred to as “our PhD student” (Fieldnotes). I also noticed participants expressing a sense of ownership of the study when talking to peers about participating. Participants also expressed a deep interest in my learning, and an interest in me personally, with questions about my family and how I was doing. I engaged in acts of reciprocity with participants such as helping to clean and make beds or taking samples to the lab\textsuperscript{33}. These were deliberate acts that provided the nurses time for other more important tasks. It was my judgment that doing routine and mundane nursing tasks such as cleaning and making the patient care beds demonstrated my willingness to help and my gratitude to the staff for their support.

\textsuperscript{32} Allied health care providers (AHCPs) are defined in this study as regulated health care professionals who provide a range of health related patient care services including: direct patient care services such as licensed practical nurses (LPNs) and care aides (CAs); rehabilitation or occupational care services such as physiotherapy or recreational therapy; and other professionals that provide technical services such as diagnostic imaging (x-ray, ultrasound), or laboratory services such as phlebotomy.

\textsuperscript{33} These acts were sanctioned under a pre-negotiated agreement with the responsible health authority representative and covered by ethical approval. However, an agreement was made that I not provide or witness any personal care practices in order to protect patient dignity.
of the study. It also allowed me the opportunity to reflect on the small tasks of nursing practice and experience the practice setting in a different way.

Many participants have continued to contact me and inquire about my and my family’s welfare, and they ask if I will be making a site visit soon. They also report that community members have asked about me and sent their best wishes for finishing writing the dissertation. In a sense, I became the community’s student as well, through the sharing of their interactions with study participants.

Later reflection on my experiences of these expressions of welcome and support from the community helped me to understand some of the findings about the rural context and the social scrutiny experienced by rural nurses. Although my focus was on nurses, I also came to build valuable connections with other rural health care workers who shared their knowledge with me and gave me valuable insights through our many casual conversations, which helped me to see rural health care from another, previously hidden, viewpoint. I learned that non-professional rural health care workers, such as cleaning and food service staff, also share a deep sense of commitment to their community.

4.2.4.1. The Fluidity of the Insider–Outsider Role

Ethnographic research is well suited to inserting the researcher in a sensitive way into the culture studied. Bandypadhyay (2011) has written on this advantage and states “one of the most important contributions of ethnographic research lies in its unique contribution in understanding and unraveling the complexities, meanings and underlying raison d’être, embedded in people’s everyday lives and in their lived experiences, informing practice and policy” (p. 8).
Hammersley and Atkinson (2007) posit that navigation of the marginal position—that is, the complex role of both insider and outsider in the culture under study—is fraught with both challenges and positive benefits (2007). These authors warn that being too far outside of the culture may lead to the researcher assuming the “role of complete observer” which results in the risk of “failure to understand the orientations of participants” (2007, p. 87). On the other hand, they suggest that caution is required to avoid being too embedded, as the analysis risks being set aside “in favour of the joys of participation”, with an increased risk of biasing the data from “overrapport” (p. 87). Navigating the tensions between the strength of having intimate knowledge of the research participants and the rural culture as an insider, and risking impairing the ability to fully explore the culture by remaining an outsider was experienced as a challenge in the research. The fluidity of the insider-outsider role is highlighted by my awareness of the need for reflection on appropriate boundaries around my role as researcher, my social position, education and professional designation as a registered nurse.

4.2.5. Participant Recruitment

I initially used poster and information handouts at the research site to make potential participants aware of the study. I also asked the nurse manager to forward study information to the nursing staff by the internal email system. Since this facility encompassed acute and long-term care, home and community care, and public health all in one location, my sampling strategy was to recruit from all sectors within the facility, not just nurses from the acute care setting. This gave me access to diverse rural structures within one setting.
A purposeful recruitment strategy was used to maximize participation of all nursing staff from the available range of nursing services. This form of sampling technique is linked to the researcher’s judgment about which potential participants may have “specific knowledge or experience which is judged to be of interest to the investigation” (Higginbottom, Pillay, & Boadu, 2013, p. 4). This form of sampling was done as a means to draw on multiple perspectives (Creswell, 2007). That is, I made a judgment about which possible participants were more likely to be representative or be able to offer information relevant to the study. To improve the breadth of the sample, and to expand on the transferability of the findings, I invited nurse participants from all practice areas and allied health care providers (AHCPs) from a range of professional backgrounds to participate in the study. This was important to help uncover the health care structures that supported or constrained moral action from a breadth of health care provider perspectives.

4.3. The Participant Sample

Generally speaking, sample sizes in qualitative research are small enough to allow for a deep analysis and large enough to allow for rich and deeply textured understandings of participant experiences to evolve to “produce the knowledge we are seeking” (Thorne, 2008, p. 95). Sample size is also dependent upon both the purpose of the study and the nature of the data collected (Sandelowski, 1986; 1995). According to Polit and Beck, one factor influencing sample size is the breadth of the question posed (2004). According to Thorne, “the best way to justify a sample size is to generate a rationale that is consistent with the research question” (2008, p. 94). Similar ethnographic projects (e.g. Hardcastle, 2004; Sedgwick, 2008), and the
recommendations from Crosato, Ward-Griffin and Leipert (2007) suggested that 10-20 participants are recommended for a focused ethnography. Higginbottom, Pillay and Boadu (2013) state, “data saturation often dictates the sample size” (p. 5). One can never know ahead of time in qualitative work the exact number of the sample size. My review of the literature and knowledge of purposeful sampling strategy supported my selection of eleven key participants and three secondary participants whom I judged to have provided sufficient data to inform the research aims.

To be included in the sample, all key, or primary\textsuperscript{34} participants in this study had to be a registered nurse and have been employed at the facility for more than six months in a full-time or part-time position, or a long-standing casual position with regular hours\textsuperscript{35}. In addition, secondary or supplemental study participants (AHCPs) were considered for inclusion if they had been employed at the facility for more than six months in a full-time or part-time position, or a long-standing casual position with regular hours. The inclusion of study participants was made on the basis of my determination of how their in-depth knowledge and experience, might

\textsuperscript{34} Key, or primary participants were registered nurses as defined under the \textit{Health Professions Act} (1996) and with the scope of practice that is defined and regulated by the College of Registered Nurses of British Columbia (CRNBC, 2014a; 2014b). Registered nurses who were identified as likely to relate experiences and perspectives that would best inform my aim to gain a deeper understanding of the rural health care structures and rural nursing practice within those structures were included as key participants. I do acknowledge that other health care providers such as licensed practical nurses and certified care aids provide a significant amount of nursing care to patients and residential clients in rural health care settings. I also acknowledge that power relations exist between regulatory licensing bodies for all health related workers and these power relations divide the practice of nursing into categories of providers. Therefore in this study the term registered nurse as defined under the \textit{Health Professions Act} (1996) and regulated by the CRNBC was used to define primary registered nurse participants in a separate category from other study participants who also provided nursing care such as licensed practical nurses and care aides. Thus secondary participants were those who were identified as non-registered nurses and were categorized as allied health care providers.

\textsuperscript{35} Because of the significant travel distance involved in commuting to the research site, only participants with prior scheduled shifts were included as key participants in this study.
contribute to the examination of structure and agency in rural health care. Additionally, secondary participants were recruited when it was seen that they might contribute to a more fulsome understanding of the rural health care structures. As for example, in general, licensed practical nurses make up a large majority of rural health care providers (Pitblado, Koren, MacLeod, Place, Kulig, & Stewart, 2013). Thus, they are well positioned to provide their perspective on the rural health care structures.

Overall, participants were selected to reflect the complexity of rural health care provision and rural nursing practice and included RNs from multiple areas of nursing practice. I also sought to include participants with a range of nursing practice experience, ages, and educational histories. The total sample size for this research study was fourteen participants (see Appendix E).

4.3.1. Registered Nurse Participants

The study sample was comprised of eleven RNs identified as primary key participants, that is, they were believed to have knowledge relevant to the study. According to Thorne, “the rationale for key informants is that some members of a community will be better equipped than others to provide you with access to what is happening and why it is happening” and key participants also have a “willingness to engage” (2008, p. 91). Nurses in this study had a range of practice experiences, nursing practice backgrounds (including rural, remote and urban), nursing practice specialties, and years of service (see Appendix E). Demographic information was collected with each participant’s consent by way of a short questionnaire at the time of the initial interview (see both Appendix F and Appendix G).
4.3.2. Allied Health Care Provider (AHCP) Participants

As I have indicated earlier in this chapter, in addition to the registered nurse participants, the allied health care providers\(^{36}\) were also included in the study. These secondary participants were included in the sample because of their close affiliation and professional collaboration with rural nurses. I determined that these AHCPs could provide a uniquely informed perspective that would enrich my understanding of the structures that shaped rural health care. I also determined that their unique contributions would maximize the richness of the data. In considering Thorne’s (2008) advice to thoughtfully consider the scope and the nature of the research question for this study, it was reasonable to believe that fourteen participants (consisting of eleven RNs and three AHCPs) from rural health care setting would be able to provide the thick, rich, in-depth accounts necessary. My interviews with these AHCP participants were supplemented by the extensive observations I made during my fieldwork.

4.3.3. Study Participant Demographics

All participants in the study meet the inclusion criteria. RN and AHCP participants in this study were all female\(^{37}\) and ranged in age from their late 20s to late 60s. Two participants were previously retired and had returned to work. Education levels ranged from licensing certification through to professional degree

\(^{36}\) Allied health care providers (AHCPs) in this study may have included (but were not limited to) physicians, occupational therapists, physiotherapists, speech therapists, licensed practical nurses (LPNs), care aides (CAs), laboratory technicians, diagnostic technicians, physical rehabilitation assistants, recreational assistants and social workers. Due to the small number of AHCP employed at the research site the specific occupations of participants have been deliberately obscured to protect privacy and confidentiality of study participants and the community in which the research took place.

\(^{37}\) It is noted that a specific gender was not an inclusion criteria for participation in this study. However, the gender composition of this study is reflective of the predominantly female workforce in rural health care settings.
designations. The mean years of rural nursing practice experience for RN participants was 15.45 years, and 15 years for AHCP participants. Study participants had a mix of rural, urban, and remote placement work experience. Nine out of the fourteen participants had urban-based health care work experience, including large metropolitan, tertiary level, or special focused urban care facilities.

In this study eight participants had work experience at one or more similar rural health care facilities in British Columbia or another western province. A total of four participants had remote location work experience. Of the study participants, five were planning to leave their current place of employment in less than five years, and two participants had either recently retired or left for employment elsewhere by the close of the study. A total of eight participants lived locally in or near the community, and six participants commuted from other rural communities or nearby urban centres, with travel times ranging from approximately one to three hours. Four participants commuted for employment and took advantage of housing provided in the community. In summary, the broad range of rural health care provider practice experience and variation of practice backgrounds added a significant range of perspectives to the study of the relationships between rural health care structures and rural health care providers.

4.3.4. Tertiary Participant Voices

Over the course of the study I observed numerous tertiary participants—that is, other health care providers, facility staff, patients, family, or community members who were not formal primary or secondary study participants, but whom I came into contact with as I followed and observed the primary RN and AHCP study
participants. In order to fully explore the relationships between rural health care structures and rural nurse agency, the perspectives of those (potential) tertiary participants impacted by the structures and nursing practice needed to be accounted for in this study. Patients and family members were informed of my presence in the facility and the purpose of the research. They were told of my intention to observe the study participants while they went about conducting care. Verbal consent was obtained from patients, which allowed me to be present with my nurse participant during care interactions. No patients or family members objected to my presence and most expressed that they were interested in the research study and would actively engage in conversation with me about the research. They appeared happy to support my learning about rural health and health care. I did, however, excuse myself when my nurse participants conducted personal or intimate care practices for patients. The act of excusing myself was in compliance with the request of the health authority responsible for the operation of the rural health care facility.

Study introduction letters were available for patients and families but I quickly learned that they preferred to hear the details about the study from me rather than read the introduction letter (see 4.7.2. Informed Consent; and Appendix I). Many stated that they already knew who I was, and that they already understood what my study was about, because other community members had informed them of my presence in the health care facility.

Several times during the course of the study community members remarked that they knew I was in the facility because they had seen my truck in the parking
lot\textsuperscript{38}. One patient asked if I thought their trip to the hospital and medical condition would be interesting enough to be included in my study (Fieldnotes). Although I did not collect their tertiary participant voices directly, I did include their voices through selective contexts and with deliberately vague or masked details of my observations of their interactions with study participants.

4.4. **Constructing the Data: Methods and Process**

4.4.1. **Fieldwork: Participant Observation**

Using ethnographic data collection techniques of participant observation, I conducted 528\textsuperscript{39} hours of fieldwork in the hospital facility and the surrounding communities. I collected observational data in the form of fieldnotes and reflective journaling. The participant observation conducted for this study was consistent with ethnographic approaches that engage in prolonged immersion to gain an in-depth perspective, and with how fieldwork observations are structured. Through engaging in being a “buddy” to the key participants, I was able to observe them in their daily work with peers, other health care workers, patients, families, and the work environment. My observations of study participants were conducted during their regularly scheduled shifts, and in consultation with the participants’ work schedules. All observations were conducted with prior signed informed consent of all participants (see Appendix G; Appendix H; Appendix J).

\textsuperscript{38}I will discuss this “goldfish bowl” level of visibility in chapter five.

\textsuperscript{39}Approximate field time included 2 or more observational 12-hour shifts with each primary and secondary participant and additional hours of on-site observations within the facility. See Study Field Work calendar Appendix D.
Many of those fieldwork hours were spent buddying\textsuperscript{40} with the primary nurse participants. Buddy observation shifts ranged from 2-15 sessions with an average of 4 sessions per primary participant. At times during the research process buddy shifts were overlapped and shared between participants. During this fieldwork I observed and accompanied each nurse when appropriate as they undertook their activities during their working shift. Further, I conducted one formal interview with each primary participant, and based on my on-going analysis of previous interviews, observations, and assessments, I invited a number of them to complete additional follow-up interviews.

My observations included making fieldnotes on issues such as the physical layout and functioning of the workplace, my feelings about the environment, my interactions with people in the workplace, and the social and contextual aspects of the workplace. These detailed observations formed a written record of my experiences and observations of the rural nursing practice cultural context (see Appendix K). This helped me discern the normal patterns of interaction and the routines and operating practices of the facility and staff. It also helped me to notice the social practices and relationships between study participants and other actors or structures in rural health care that, according to Giddens (1984), are responsible for producing and reproducing social systems.

4.4.2. Fieldnotes and Journaling

Fieldnotes are the observations and experiences of the researcher turned into text. Emerson, Fretz and Shaw (1995) explain that:

\footnotesize
\textsuperscript{40} “Buddying” is the act of shadowing participants in the conduct of their duties while conducting participant observation.
Fieldnotes are distinctively a method for capturing and preserving insights and understanding stimulated by these close and long-term experiences. Thus fieldnotes inscribe the sometimes inchoate understandings and insights the fieldworker acquires by intimately immersing herself in another world, by observing in the midst of mundane activities (p. 10).

Fieldnotes became a source of data, providing an understanding of the complexity of rural nursing practice. I took the opportunity during each observational session to document my observations, experiences, feelings and encounters in the field. These notes were later referenced to enrich my understanding of the reciprocity I found between the participants, structures, and the rural nursing context. The process of writing fieldnotes also provided opportunities for reflection and exploration of my values as the inquirer. Further, fieldnotes were used in discussions with my supervisor about my experiences, which helped me clarify ideas. In this way my fieldnotes were a written form of my reflexivity, that is the back and forth of critical self reflection, during the research process.

The following is an example of my journaling I did in order to gain clarity about gaining trust and being transparent in my role as a researcher in response to some fieldnotes I had made earlier.

Interesting thing about taking fieldnotes is that it made some participants very uncomfortable and several times I was asked to explain exactly what I was writing. There were instances where participants asked for “in-camera” discussions to occur and I dutifully put my journal away as I determined they were in essence withdrawing consent and I respected their request. The longer I am onsite the less [some nurses] appear to be concerned about my note taking and at times someone would say “write that down.” Reflecting on it—I expected some difficulty in gaining a level of trust and understanding and I need to keep being transparent about what and why I am doing things and always need to
respect their direction—when in doubt I will ask if it is okay for me to continue [taking notes] (Journal Entry).

The fieldnote sample above is an example of the possible tension ethnographic researchers can experience being in field. Had I not been transparent about my role, and respectful of the participants when they requested I not document my observations of a particular encounter, I would have damaged the reciprocity and trust I had established. Being reflexive in that moment, as well as having an ethical understanding of on-going consent, allowed me to “do the right thing” in the situation and forgo documented data collection for reciprocity and trust.

4.4.3. Conducting In-depth Participant Interviews

All interviews for this study were only conducted after informed consent was obtained. An in-depth interview is “time-consuming and demanding, but it has real value when more structured research methods fail to deliver the information required” (Bandyopadhyay, 2011, p. 6). Because some aspects of the culture and the context cannot be ascertained through participant observation, the collection of dialogic data is one way to gain the participant’s views. It is also a way to test my observations and my understandings of the participant’s views on a phenomenon of interest. Further, it was a means to examine any disjunctures between what participants said, and what they were observed to doing.

In this study I conducted eleven private 60-120 minute formal, semi-structured, taped, in-depth interviews with primary RN participants. I conducted four additional private, 30-60 minute follow-up interviews (at my request) of selected participants, to clarify and explore certain issues in more depth as I
conducted my data analysis. These additional interviews also produced data on the experiences and perspectives participants had of working at other rural or remote health care facilities.

Interviews were conducted in a location chosen by the participant. Participants were given the option to conduct the interview out of the rural community at a private office located in an urban centre frequently travelled to by rural residents for shopping.

I conducted three private, one-two hour, semi-structured, audio-taped, in-depth interviews with selected secondary participants whom I believed were uniquely able to provide additional information pertaining to the research. The choice to do these interviews was based on my emerging analysis of the need to further explore the structures through the perspectives, experiences, and actions of AHCPs in rural practice settings. Follow-up interviews were also at a time and place of convenience for all participants. The follow up interviews were digitally recorded and transcribed in the same manner.

The total number of formal in-depth participant interviews conducted (for primary and secondary participants) for this study was eighteen. I took notes during the interviews, detailing my observations and impressions. These notes served to remind me of the context of the interviews. For example, in one interview memo I noted that during the interview I had to pause the tape recording after the participant shared the details of a traumatic event until we both regained our composure. Noting such interview details later helped to support my analyses of the ways structures either support or constrain rural nursing agency enactment. Such
notes also drew my attention to the way in which critical reflection “is key and requires a rigorous assessment of both your emotions and experiences” and the resulting “impact on the research process” (Staller, 2012, p. 410).

4.4.4. Broadening the Reach of the Fieldwork

At a mid-point in the research my analysis of the data began to point me toward expanding the study to include data from an additional site. I had previously identified several possible similar rural health care facilities that met the rural criteria set out in chapter one. In consultation with my supervisor, I began the task of trying to gain entry into one of these similar health care facilities less than two hours from my place of residence. As I indicated earlier in this chapter, however, I was unable to obtain entry into a second site.

I then realized that many of the participants I had already interviewed had spoken of their previous rural or remote nursing workplace experience. The data I had already collected contained multiple examples from nurses with current, recent, or past experience of working in the very facilities I was unable to gain access to. As analysis progressed, the need for including participants with work experience in remote or other rural facilities diminished because of the repeated references in the interviews to similar workplace structural challenges. I noted that a study by MacLeod and Zimmer (2005) interviewed twenty-four nurses from three small rural hospitals located in northern BC and found similarities between the participants in terms of experiences and practice issues. I actively sought out participants with remote and multiple rural workplace experience to gain a broader understanding of rural health care structures. This form of theoretical sampling was analysis-driven
and based on the emerging findings. The inclusion of the knowledge and perspectives of nurses with multiple rural or remote work experiences helped me to locate the actions, understandings and perspectives of the study participants within a broader range of rural practice settings and similar rural health care structures. This also helped to address my research question by locating the impact on rural nursing practice of larger policy and resource allocation structures beyond the local level.

By the completion of the study, I had collected data that drew from eleven RN participants’ broad range of work experiences of twelve other rural or remote nursing practice environments in addition to the rural facility where I conducting my participant observation. The data collected from participants’ accounts of other rural and remote work sites lessened the limitation of being restricted to one research site. Although I do not provide any identifying data regarding the locations of the other sites in this thesis, the participants’ work experiences and perspectives of these other locations helped inform my understanding of the context of the research site. In total, this study included the perspectives, experiences and actions of study participants’ from a total of thirteen rural or remote practice environments across western Canada.

4.4.5. Collection of Participant Demographic Data and Analysis

I collected demographic data on all fourteen participants. This data was important to help me to contextualize the study sample and provide insights. The demographic data included the total number of years worked in health care and number of years worked at the current job; the highest level of education; type of
nursing work experience (including urban, rural, and remote practice); other education (for example rural practice certification, remote certification or RN First Call); current employment status and desired employment status; and intent to stay or leave. Data about the research sample that lent itself to descriptive statistics was collected to inform the analysis and provide a statistically framed snapshot of the research sample. All quantitative descriptive data was entered in to Microsoft Excel™ to produce an organized and meaningful display of the demographic data (see Table 2, in Appendix E).

The research literature indicates that the collecting of demographic characteristics allows for later analysis, such as comparing retention of health care professionals across rural communities (Williams & Kulig, 2012). In this study participant demographic data was collected to inform my analysis on rural issues such as nursing shortages, recruitment and retention, and how those issues have impacted patient care and access to rural health care provision. The collection of quantitative forms of demographic data in qualitative research can also be useful in exposing insights that otherwise might have been missed (Thomas & Magilvy, 2011). For example, I noted in the demographic profiles of two participants that they both had previously retired and had returned to work, which caused me to reflect further on the role community plays in my analysis.

4.4.6. Document-Based Data Collection

In keeping with critical ethnographic methods of collecting data from a variety of sources, a significant number of policy documents were collected to support a critical analysis of rural nurses’ expressed perceptions of the ethical
tensions between the structures of health care and their ability to enact their agency. I collected document-based data such as policy\textsuperscript{41} and procedure publications that had implications for health care delivery and nursing practice in the study site. I specifically collected policy directives that directly impacted nursing practice and that were of expressed concern to study participants, such as a new policy about hand washing. I examined these, and other publically available\textsuperscript{42} policy documents for the ways in which the policy impacted or had implications for the conduct of nursing work.

Challenges to equity in health and health care are a known result from restructuring initiatives, economic reform practices, and current health care policies. Because of this I also examined electronically available government documents, such as the \textit{Canada Health Act}, the \textit{Health Professions Act}, and local health authority documents. These additional data sources included hospital policies and procedures, written hospital media and public information literature, posted hospital closure notices, and other relevant printed materials, including website job postings and educational session poster advertisements. These documents were analyzed in order to situate the broader structures that exist in the facility and in the community as they relate to the provision of health care services.

In addition to formal government and regional administration policy documents, I collected other relevant documents such as letters, emails, meeting

\textsuperscript{41}Policy, for the purpose of this dissertation is taken up as a framework that guides "a range of related actions in a given field"; or "frameworks that structure the actions of a host of different organizations", and policies can be "reconfigured to yield different results" (Pal, 2006, p. 2).

\textsuperscript{42}Of note, many policy changes were only available to authorized employees via the facility intranet computer system—which, I was not allowed to access as a non-employee.
minutes, job postings, posters, cards, and assorted documents and notes given to me by participants with their permission to include in the research. All documents were organized and catalogued with memo notations to link them to fieldnotes or participant interviews (see Appendix L). These additional documents alerted me to how information was communicated, and informed me of events or upcoming changes to the rural nursing practice context. For example, reading the job vacancy postings gave me insights into how well the practice description and requirements listed in the document appeared to match or contradict the observed context.

4.4.7. Supplemental Sources of Data: Cultural Commodities

Additionally, I collected supplemental data sources known as cultural commodities. According to Carspecken (1996), cultural commodities can include community newspapers, public notices, signs, and other cultural artifacts related to the day-to-day events and social practices within the society being studied. For this study I collected newspapers, advertisement flyers for community events, photographs of signs, maps, and electronic information from community web pages. These items are products of the rural culture and they have an impact on the daily lives of the participants. These items were useful to facilitate comparisons within systems of relationships. For example, I noticed a disjuncture between certain high-risk community events such as fall fairs and rodeos, road cycling, car racing and the availability of emergency care services. That is the planning for physician coverage of the ER did not appear to consider that participants in high-risk events hosted in the community, such as rodeos or car racing, often result in injuries that require
immediate medical care. Rural emergency department closures add an additional layer of risk to these events.

4.5. **Managing and Analyzing the Data**

All interviews were conducted by myself and were transcribed verbatim into text by a qualified transcriptionist under a confidentiality contract (see Appendix, N). I also read the transcripts multiple times to gain a clear sense of the content and the relationships. Transcription tapes were checked for accuracy. All data containing sensitive or identifiable materials was made anonymous. Initial and evolving sub-themes were developed through my analysis of the written texts, and were coded using the qualitative data management software program QRS N-Vivo 10™ as an organizational device. Broad codes (or nodes in QRS N-Vivo 10) were utilized to organize the data into easily identified and retrievable groups that could be then compared and linked to other code structures. Data were further analyzed using an inductive coding process derived from the data—which captured key themes as expressed by the participants’ perspectives, actions, and experiences. The coding process was iterative in nature. I employed conceptual mapping techniques to help me visualize and group related themes together into what evolved as three dominant themes.

All field and observational notes and reflective handwritten journals were also transcribed into electronic text format and uploaded into the QRS N-Vivo 10™ software program. Although I was using a data management program to organize the data, the programming features of the software did not drive the analysis of the data. Rather, the strength of such software is the function it can perform in assisting
the researcher to categorize and store large volumes of data (Thorne, 2008). Data management software “provides the analyst with the tool to query and audit the coding processes” (Bergin, 2011, p. 12). The program was specifically used as a tool to store, code, and categorize the study data in order to begin the analytic process. Throughout the coding process I employed the use of coding notes and memos in the program to keep track of decision-making processes. I also used the notes to stimulate analytical thinking and for coding reliability, and to provide an audit trail. A daily computer log was also kept within the program to track decision points made during the coding process.

Overall, the use of coding notes and the keeping of an electronic and daily log were done to ensure a dependable accounting of the research process (as suggested by Sandelowski, 1986). These documents chronicled the rationale for my decision-making, and made explicit the outcomes of those decisions throughout the entire research process. All notes taken using tablet-based technology were already in text format and were uploaded into the same software program.

Qualitative analysis for themes was conducted concurrently with data collection using an integrated approach combining Carspecken’s (1996) five-stages for CQR and Giddens’ (1984) structuration theory.

[The] first three stages employ critical analytic models to reconstruct cultural structures and themes...[the] last two stages are designed to discover how routine social actions form and reproduce system relations that coordinate activities across various reaches of time and space. Stage 4 involves the discovery of system relations, and Stage 5 involves the explanation of micro findings through...theory (Georgiou & Carspecken, p. 690).
In summary, data was collected, managed, coded and analyzed concurrently utilizing Carspecken’s (1996) five-stages for CQR and with Giddens’ (1984) structuration theory as a framework. A detailed description of the data collection and analysis processes employed in this study is found in Appendix A.

4.6. **Fostering Rigor and Credibility**

In order to establish credibility in qualitative research studies, a number of strategies can enhance the plausibility of study findings. Strategies include: plausibility, and the integrity of the study; trustworthiness, or the extent to which the study can be trusted for the truthfulness or adequacy, and rigor (Stringer & Genat, 2004). “Rigour and robustness in qualitative research are to some extent established via a self-conscious and reflective approach, but they are also accompanied by an explicit methodological framework (Higginbottom, et al., 2013, 6). Rigor, or the pursuit of disciplined adherence to soundness of methods of representing the data (Long & Johnson, 2000), was addressed throughout the study by utilizing strategies found within the methodology and methods embedded in the study design. For example, prolonged observation, detailed fieldnotes, thick descriptions of the data, and self-reflection through journaling were all undertaken to address the issue of bias and to draw attention to power differentials. Efforts to protect the integrity of the study included using fieldnotes and reflective journaling and regular consultation with my supervisor and the committee. I also regularly consulted with key participants to clarify study findings and solicit feedback.

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43 Authors Higginbottom, Pillay and Boadu (2013) use the alternative spelling “rigour” for rigor.
The feedback was helpful to enrich my understanding of both the social and the system aspects of rural nursing practice. Simultaneous data collection and analysis, member checks and triangulation, and a log of all analytic decisions made were kept as an audit trail as described in Carspecken, (1996). Credibility of the data sources is reflective of reliability. “Needless to say, the quality of a study is quite dependent upon the key informant selection” (Thorne, 2008, p. 93). Credibility in this study was also fostered by a clear consistency between the research question, the chosen methodology, the methods of data collection and the underlying epistemological and theoretical assumptions.

4.6.1. Coding

Coding (node) and category decisions were reviewed with my supervisor and committee members. In this study I used detailed coding notes, a computer log, and “software to organize...[and for the] creation of a comprehensive audit trail” (White, Oelke, & Friesen, 2012, p. 244). This ensured an audit trail and fostered credibility and trustworthiness of the research process. The act of journaling and putting pen to paper provided me with opportunities to question my own assumptions, biases and perspectives throughout the research process in a self-reflexive manner. In the follow-up interviews I looked for confirmation that my interpretations were credible, and recognizable to the participants.

4.6.2. Giddens’ Criteria for Credibility

Giddens describes the credibility criteria as “used to indicate how the grasping of actors’ reasons illuminates what exactly they are doing in light of those reasons...in what circumstances, in what discursive style...and with what
motives” (p. 339). This is accomplished in practice by reflecting about the selected participants to ascertain whether they are credible and dependable in both word and action, and if not why not? For example, Thorne (2008) warns researchers to be alert for potential participants who appear to have strong perspectives or “an axe to grind” mentality that might “jeopardize the integrity” of a study (p. 93). In attending to this warning, potential participants were ‘vetted’ by my perception of their ability to contribute knowledge that would further enhance the investigation and still maintain the integrity of the inquiry. My own reflexivity about vetting participants acknowledged the risk of including participants with strong perspectives and I determined that the risks must be balanced against what a certain participant would add to the research if included.

4.6.3. Theoretical Sensitivity

The ideological and theoretical commitments in Carspecken’s (1996) methodology place emphasis on meaning as being formed within action. “When humans interact, meanings are recognized through the play of many factors structured paradigmatically and temporally” (Carspecken, 1996, p. 121). Power is held as central in all social relationships. Expressions of truth can only be obtained via common agreement of the group studied. However, the researcher must be cautious of reconstructions by consensus to avoid reinforcement of dominant power relations. The main source of researcher understanding is observation paired with critical self-reflection.

According to Giddens (1984), the very nature of structuration theory indicates that patterns and actions of actors have the capacity to change. Therefore
the recognition of these changes is important, in order to ascertain whether the change is researcher—or participant—induced, or naturally occurring evolution. Acknowledgement of observed change therefore is vital to inform credibility and is not necessarily a problematic inconsistency of reliability between method and data source.

Throughout the research process I was alert for moments of validation or challenges to my findings when observing participants’ actions. To explore the possibility of alternative interpretations I regularly sought feedback from participants, had regular de-briefing sessions with my thesis supervisor, and conducted follow-up interviews to clarify or investigate perceived discrepancies. To ensure I was understanding their experiences correctly and not misinterpreting, this process of seeking feedback from participants occurred multiple times throughout the research process in formal interviews or informally by asking participants for their opinions about my analysis. Often I would frame the conversation by saying, “I think I understand what is meant by (for example, what nurses mean when they say ‘we’re it’) but I don’t want to make assumptions so could you elaborate on that to help my learning and to increase my understanding of this issue?” In this way I attempted to accurately reflect their voices and experiences and not my own interpretations. Obtaining feedback enhanced the credibility of this study because the findings were reviewed with several primary participants on multiple occasions to ensure that the descriptions and interpretations were representative of their experiences, perceptions and actions.
4.6.4. Reflexivity

Reflexivity draws attention to how social, historical, educational and personal positions may bias or influence the data. Reflexivity is also used to address the potential for researcher bias too, as well as a means to avoid reinforcing dominant oppressive power relations in qualitative research (Vandenberg & Hall, 2011). Reflexivity, according to Robinson Wolf (2007), highlights the tension between being the researcher in a culture, and how as an outsider the research will affect the context and the evolving data. Reflexivity allows the researcher to recognize “the need to incorporate the subjective value of the researcher’s feelings and attitudes into the considerations of the findings” (Long & Johnson, 2000, p. 32). Reflexivity also entails a critique of the impact of the researcher’s language, questions, and presentation of those questions. Thus, being reflexive serves to sensitize the researcher to the complex interplay of his or her role as researcher embedded within the research process. Reflexivity lends a sense of rigor to the process, as Creswell (2007) reminds us that research is value-laden, because the very act of collecting and interpreting data is filtered by the researcher’s personal view of reality.

As I have indicated earlier in this chapter, the concept of reflexivity was taken up in this research as a means to acknowledge my position and to address the power tension between rural nurse participants and myself. The ongoing process of reflexivity is the back and forth critical reflection between the researcher as self and the researcher’s role in the construction of knowledge as a whole (Guillemin & Gillan, 2004). Reflexivity is required to address the threat of reinforcing dominant
power relations and to increase rigor by acknowledging and monitoring researcher bias (see, for example, Carspecken, 1996; Giddens, 1984; Manias & Street, 2001; and Vandenberg & Hall, 2011). “Building on reflexivity enables critical ethnographers to acknowledge biases and give participants the opportunity to critique researcher views” (Vandenberg & Hall, 2011, p. 29). Reflexivity is one strategy used to increase “the plausibility or rigor of ethnographic research” (Pellatt, 2003, p. 29). The stance of being a reflexive researcher fits with the assumptions of critical theory in that it respects participant autonomy and acknowledges that emancipation is in the domain of the participant, not the researcher.

As Creswell (2007) notes, qualitative researchers are not separate from their research topic or from the participants of the study. As the researcher in this study I was already deeply invested in the research process, and my personal and professional values, beliefs, and experiences could not be completely distanced from it. In acknowledging my position and accounting for the fluidity of the insider-outsider dialectic, I adopted a reflective stance to help facilitate rigor within my analysis. At times it became necessary to step back from my prolonged engagement and cease field observation for short periods of time to guard against analytic challenges that might arise from over-identification with participants (Hammersley & Atkinson, 2007). It also gave me time to more clearly be able to “see” the data from a less emotionally clouded and more critical lens. I also sought out regular discussions with my supervisor about my evolving analysis and periodically sought seeking feedback and guidance from my other committee members.
4.7. Ethical Considerations

This research was subject to formal ethical review and ethical approval and certification was therefore obtained from the University of British Columbia (UBC). Formal ethical approval was also sought and obtained from the health authority responsible for the research site, prior to commencement of the research. Details for each certificate are provided in the preface (page iv).

4.7.1. Research Ethics

Maintaining and upholding ethical standards in critical ethnography is fundamental, according to Madison (2005) because:

we are involved in entering into the domains of Others [emphasis added] and in the interpretive practice of both representing them and the multiple ways they construct their experiences and their worlds. And, because ethnographers are in the business of both crossing borders and representation, the power and the politics of their enterprise demands ethical responsibility (p. 90).

Ethical considerations in this study included ensuring informed consent of all participants (primary, secondary, and tertiary) for both interviews and observation. Participants were informed of their right to withdraw consent at anytime without need to give a reason. Numerous steps were taken to ensure confidentiality, privacy, protection of confidential data, and attentiveness to emotional safety. These included providing participants with information about available institutional and community counseling services if required. Other ethical considerations included maintaining ethical research relationships (including acknowledgement of power, bias, and privilege in the study relationship) as well as emancipatory implications. There is a moral obligation in critical research to produce work that may improve care and that is consistent with a social justice agenda (Connelly, 2014; Hardicre,
2014: Manton et al., 2014; Polit & Beck, 2004), which I am attending to in the writing and dissemination of this thesis.

Other ethical considerations for this research included the vigilance necessary to protect the identity of the research site and participants. As I have indicated earlier in this chapter, because rural communities may have many distinguishing features, I have deliberately masked the exquisite detail normally expected in an ethnographic study in order to protect confidentiality without overly distorting the data. Clark (2006) warns that “research about particular problems in particular locales has the potential to perpetuate stigmatizing discourses about place” (p. 4). I have made multiple efforts to ensure that the research site is not easily identified so as not to contribute to stigmatization of location and participants. Including data from participants’ recounted experiences of working in other rural, or remote sites removes the focus from one particular site and draws attention to experiences common to many rural and remote health care sites. The privacy and confidentiality of all participants’ was further protected by not identifying the specific professional affiliations of the AHCPs.

4.7.1.1. Informed Consent

Research ethics requires three elements for valid informed consent: adequate information, voluntariness, and competence (Beauchamp & Childress, 2001). Prospective research participants should receive full and complete information as to the nature of the research, the potential risks and benefits of their participation, and an explanation of their participant rights. Consent also implies that the potential participant must have all their questions answered to their
satisfaction, and are able to competently comprehend the information provided. This enables them to give voluntary (meaning without coercion) agreement to participate.

In this study all potential participants (primary, secondary and tertiary) received a study information sheet that clearly stated the purpose of the study, the known risks and benefits of participating, the steps that would be taken to maintain confidentiality, and contact information should they have any questions or concerns prior to or during their participation. Participants had an opportunity to read and ask questions and were also provided with the phone number for the UBC Office of Research Services Subject Information Line, a dedicated information phone service line that research participants (also called subjects) can directly contact in the event they have any concerns about their rights as a research subject in this study. A signed written consent was only collected after the potential participant had an opportunity to read the information, had any concerns addressed, and had received satisfactory answers to their questions.

A study information sheet was also available for patients and other tertiary participants, which introduced and explained the purpose of the study (see Appendix, G). In the information sheet I asked for the patient’s permission to observe them and take notes while my participant provided their care. Voluntary verbal consent was sought from all tertiary participants for the inclusion of any information or direct observations of them. Individuals who were unable to give voluntary consent were not included in study observations. The letter made it clear that participation was completely voluntary, all information was confidential, no
names would be used, there was no obligation to participate, and if they declined to participate it would not impact the care they received nor would there be any negative consequences to them or their family. Almost without exception tertiary participants expressed a preference for receiving a verbal explanation, after which verbal consent was received. In reflecting upon this I considered the values that underlie the act of providing printed information and the rural values of relational connectedness and community. I also questioned what role literacy may have in the rejection of the printed materials and what implications that might also have for future knowledge translation. I revisit these assumptions in chapter eight.

4.7.1.2. Participant Voluntariness

Voluntariness is the “understanding that they are under no obligation to agree to take part and if they do decide to take part they are free to withdraw at any time” (Hardicre, 2014). Participants were fully informed through the consent process and reminded periodically as the research progressed that their participation was voluntary and that they could withdraw from the study, stop the recording of the interview, observations, note taking, or request to have data deleted at any time without the need to give a reason.

4.7.2. Data Protection and Security Measures

All digital forms of data are securely stored, and will remain locked in a cabinet in my office for a period of 5 years after which they will be appropriately and securely destroyed. All paper notes, paper signed consent forms, journals, and transcripts are also stored in a locked cabinet and will be destroyed after a period of 10 years. All computerized electronic data management systems are password
protected, and all electronic devices were transported to and from the research site in a locked case, and continue to be stored in a locked cabinet. The qualitative data management software program QRS N-Vivo 10™ used in this research is kept on a separate PC laptop computer designated solely for operating the N-Vivo program. This laptop is also password protected and stored in a locked cabinet. Finally, all data generated from this research was not shared with any individuals beyond my supervisory committee members, and myself as a means to ensure data protection and confidentiality.

4.7.3. Protection of Participants and Confidentiality

In order to decrease the risk of identification, all participants were assigned a random computer generated identifier and all data was stripped of identifying information prior to finalization of the dissertation. Participants had the choice of where they wished to be interviewed. Requests for interviews at locations outside of the community were accommodated. All reports, presentations, and publications generated from this research use randomly generated pseudonyms and are presented so that no one participant or event can be easily identified. Site descriptions and some patient and participant information have been slightly fictionalized so as not to be identifiable to anyone familiar with the research site or research participants.

4.7.4. Dissemination of Results to the Participants and Agencies

Participants in this study were instructed they had the right to be informed about the final study results and would receive a summary of the study findings via hard copies of the thesis and/or a verbal presentation according to their choice. My
plan for disseminating the research findings to the participants and agencies after the defense is in keeping with critical ethnographic approaches and the social responsibility of the critical ethnographic researcher to direct attention to the structural inequities and the impact those inequities have for access to health care for rural communities. The planning stages for knowledge dissemination of the research findings is also a time to connect again with participants and invite their participation in the decision-making concerning how the knowledge will be disseminated. I continue to maintain appropriate and respectful research relationships with study participants because:

[an] ethics of critical ethnography does not use human beings as a means to an end. We do not gain rapport and trust to simply get the data and then run in order to accomplish our own goals while leaving subjects vulnerable or feeling exploited. An ethics of ethnography considers the direct well-being of the Other as the first priority (Madison, 2005, p. 84).

Another responsibility of critical ethnographic approaches is to transform knowledge with the aim of decreasing inequities and of furthering a social justice agenda (Kincheloe & McLaren, 2005; Madison, 2005). With these responsibilities in mind, my strategies to disseminate the study findings are as follows:

• I will coordinate with study participants to host a final research report presentation in the rural community hospital or local hall for participants and interested stakeholders to participate in a presentation of the study findings in conjunction with a social celebration to thank them for their contributions;

• I will provide each participant a ‘thank you’ package which will include a personalized note expressing my appreciation and gratitude and a summary of the major study findings;
• I will offer to provide a research summary to the Health Authority and the research hospital site for publication on facility websites;

• I will offer to provide a research summary to the Association of Registered Nurses of British Columbia (ARNBC) to inform the association of the potential policy implications for rural practice that may be of interest;

• In conjunction with committee members I will create several manuscripts for publication and submit these to appropriate peer-reviewed journals; and,

• I will seek out opportunities to present findings from this research at appropriate clinical, academic, and administrative venues. I have already presented the preliminary findings of this research at the 25th Annual Canadian Bioethics Society Conference (in Vancouver, BC in 2014), and I plan on presenting this research in the near future at rural health and other appropriate conferences and venues.

4.8. Chapter Summary

Giddens’ (1984) structuration theory and Sewell’s (1992) notion of reciprocity provided the framework for this exploratory study. In this chapter I discussed how I employed a critical ethnographic approach informed by Carspecken’s critical qualitative research methodology (1986) to implement the study, generate data, analyze study findings, and attend to scientific rigor and ethics. In the following chapter I present a detailed description and analysis of the contextuality of rural nursing practice.
Chapter Five: The Contextuality of Rural Nursing Practice

5.1. Introduction to the Context of Rural Nursing Practice

Nurses in this study had a broad range of rural and remote practice experience in multiple worksites across Western Canada. In total, eleven RNs described their practice experiences in the research site facility and also in twelve other rural or remote nursing practice environments. I begin my interpretation and analysis of the participants’ reports of rural nursing practice with a detailed exploration of the rural context. Although findings were expected to be similar or comparable to those of previous rural nursing studies, this study adds a unique articulation of the complexity of rural nursing by showing how the relationship between health care structures and rural nurses is impacted by broader social structures — structures that have implications for both nursing practice and the quality and safety of patient care.

In this chapter, the perspectives, experiences, and actions of rural nurses as knowledgeable agents are explored to provide an understanding of the rural practice context and how social-contextual factors support or constrain rural nurse enactment of agency in the co-constituted relationship between health care structures and rural nurse agents. I begin by describing the “contextuality” (Giddens, 1984, p. 71) of rural nursing practice with the broad context-based theme the “reality of rurality.” This theme describes both the beneficial and the burdensome characteristics of the rural cultural context, from the nurses’ own perspectives. Following this grounding in the rural cultural context, I will draw from the voices of rural nurses as I explain their experiences of the core contextually-
based theme of this study "we’re it". Expressed by every nurse participant, this core theme is developed to reveal the complexity of rural nursing practice within the larger context of rural health care structures, and the inequities found in rural health care.

Other themes and sub-themes related to “we’re it” are discussed in this chapter, which also illustrate the complexity of the rural nursing experience. They include: “the unseen complexity in rural nursing practice” which describes the interrelationships between rural context, the rural nurse, and rural nursing practice in the broader experience of living and working in the rural setting; and “there’s relative rural and rural relatives” which describes rural social interactions, the complications of boundary violations and the ethical challenges of the social dynamics of rural practice. These dynamics often position the rural nurse in overlapping social and professional spheres where nurses frequently find themselves the first, and at times the only, health care provider available. The lack of both human and physical resources and the consequences of minimal infrastructure in rural places is part of the nature of rural nursing practice and forms the “reality of rurality” where rural nurses often find themselves in the multifaceted role of being “it”.

The analysis presented in this chapter reflects the multilayered social and professional context of the nurses’ experiences of the reality of rural nursing practice. The following chapter (chapter six) builds on this analysis and reflects a further analysis of the nurses’ experiences of the larger health care structures that impact their practices. I follow these chapters with an analysis of how the nurses’
experiences of enacting their moral agency in rural nursing practice is linked to both
the immediate social context of practice and to the broader organizational and
sociopolitical structures that frame rural health care provision (chapter seven).

5.2. The Reality of Rurality

The reality of rurality—that is, the notion that rurality is not just simply
determined by a geographical location on a map—has been previously discussed in
the rural nursing literature by Kulig et al. (2008), as well as Pitblado (2007; 2012).
Pesut, Bottorff and Robinson (2011) utilized the term rurality when making
reference to the social, environmental, and geographical characteristics that frame
rural living conditions. Informed by the above authors’ works, in this study I have
taken rurality to mean a constellation of deeply held values and meanings that are
tied to the land, to the rural lifestyle. The notion of rurality reflects a personal
connection to a geographical place and social space. There is distinctiveness to the
rural practice context, that is, a reality of rurality, which sets rural nursing apart
from other nursing practice contexts.

The social context of the world in which nurses and other rural health care
providers live, work and play, also has a distinctive and complex role in the
provision of rural health care. It is the complexity of multiple roles that fosters
reciprocity between the rural nurse (agent), patients and the local and broader
health care structures. Rural nurses are a vital part of the rural health care system
and form an important part of rural health care structures. Many rural nurses are
also active members of their local community social system and have expert and

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44 It is noted that social contexts plays a significant role in urban centres as well, but the social
contexts are particularly more visible in rural.
intimate working knowledge of that system (MacKinnon, 2010b; MacLeod, 1999).

Study participants described common and varied experiences of working in rural health care. Rural communities were not described as being homogeneous in nature. Rather, participants described rural health care settings as having distinctive local attributes. Participants discussed their understanding of the reality of rurality — that is, the notion that living and working in a rural place is somewhat different from other nursing workplace contexts because of the complexity in the overlap of social and professional roles. This overlap was described as both a privilege and a burden. Participants experienced context of rural practice as providing rural nurses with positive benefits such as “you get to be more intimate with the people that you work with and the people that you are caring for” (Participant, Vv045). At the same time, the more intense level of personal knowing also presented challenges for these nurses in navigating the social issues that come with higher social visibility and the ensuing lack of anonymity:

You get to sometimes know people on a personal level as well as professional level, which sometimes crosses [boundaries]. You can be out at the grocery store or whatever and see people and, ‘oh, hey, what about this’ or, you know, ‘I ripped this, what should I do’? (Participant, s50).

Participants perceived the unique cultural context of each rural practice setting as providing both a privileged status for the nurses within the communities

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45 All participants in this study were given a random three digit/letter computer generated code as an identifier and the use of this identifier preceded by the term Participant indicates the exchange took place in a primary in-depth interview. In selected exchanges the researcher is denoted by the letter “R” and participant denoted by the letter “P”. The term follow-up denotes the exchange occurred during an informal exchange between researcher and participant or participants. The term second interview indicates exchange occurred in a secondary or subsequent interview. To maintain confidentiality and anonymity highly identifiable participant or community characteristics, events, locations, demographics, and certain facility information will be disguised and details fogged.
they served, and also carrying a heavy social burden of increased responsibility and accountability, as they lived and practiced ‘under a microscope’. The knowledge of personal or intimate details of patients’ lives gleaned from repeated social and professional interactions was described as:

one of the biggest dilemmas I’ve had...about living and working in a rural setting...living and working in the area that you're working in is a privilege and it's a burden at the same time (Participant, cJ2).

Although the development of deep personal connections with patient populations is, of course, not unique to rural nursing, the participants in this study attributed their connections to rurality. In the rural cultural context having knowledge of personal details of coworkers and community members was also experienced by participants as having positive benefits for developing deeper family-like social connections within the workplace. The family-like workplace experience was perceived as being of unique benefit in rural practice settings:

I also think too with the rural staff, you kind of get more like a family with your co-workers and with, yeah, with all the co-workers. You know, your x-ray department, your docs, your lab, everything in the smaller communities you get to know a bit more about, oh, ‘so and so had a grandchild’ and ‘so and so had this’ or ‘so and so’s kids are starting school’ and different stuff like that (Participant, s50).

The mutually caring relationships nurses had with other health care providers, described above as being reciprocal and family-like are part of the reality of rurality. This attention to the relationship between nurses and other individuals encountered in the context of practice links “what happens at the bedside...to the broader issues” (Bergum, 2013, p. 128). Thus the relational practice of rural nurses and what happens at the bedside, or in the everyday interactions between health care providers, are linked to the wider influences that shape relationships between
actors or collectives. In other words, the interpersonal relationships nurses have with others are impacted by the broader structures, such as rural emergency department closures and physician shortages, and the availability of health care providers in general.

5.3. “We’re It”

As I have indicated above, an understanding of the reality of rurality and the characteristics of the unique cultural context of rural nursing practice is needed to understand the rural nurse practice context and the nature of rural practice and the role of the rural nurse in health care provision. Further analysis of the complex interplay between the rural practice context and the rural nurse is explored in the key theme, “we’re it”.

All the nurse participants in this study described their practice context using the words, “we’re it”, but the burden of being “it” was not limited to registered nurse participants. The notion of being “it” was also expressed by other allied health care providers, including LPNs and care aids, in describing their practice context. For example, one LPN said “we do not have a unit clerk here, we’re it”. The concerns expressed by this participant were in relation to taking on additional roles that support staff in larger health care facilities usually perform. The addition of non-nursing related administrative functions both increased the level of responsibility and decreased the time available to provide direct nursing care to residential clients and their families. In this study, the theme “we’re it” embodied a description of practice unpredictability, professional isolation, increased responsibility, and the practice challenges to provide nursing care with limited and, at times, unpredictable
resources. The theme “we’re it” resonated with the previous research findings from MacLeod (1999) where “we’re it” was also used to describe the nature and realities of rural practice. MacLeod and Zimmer’s research found rural nurses used the phrase “we’re it” to describe the central pattern of nursing practice in small rural hospitals (2005, p. 74).

5.3.1. Even on Your First Day You’re It

On my first day of “buddying” with a key participant, an ER nurse, I asked her what it was like to work in a rural facility. The reply was straightforward yet very complicated. She replied, “we’re it” and then immediately diverted her attention to a patient approaching the desk area (Fieldnotes). As I have indicated above, this simple yet profound declaration emerged as a core theme in this study and it best encapsulates the totality of the rural nursing practice context. It also locates the nurse in an interesting and complex space. MacLeod’s (1999) interpretive phenomenological study of very small rural and remote hospitals in northern British Columbia found participants commonly used the words “we’re it” to describe the nature of their practice and to suggest the level of responsibility and accountability borne by nurses in rural and remote practices (p. 169). The theme “we’re it” encompasses the totality of the rural nurse day-to-day experience both from within and outside of the rural health care structures.

When asked what it meant to be “it” a participant recounted her first day of work in a rural emergency department as a newly graduated nurse. Her story describes the embodiment of suddenly finding herself in the position of being “it”:

It’s my first day on the job and I get to work and we have a patient, a critical patient that needs to be transported to [the city]. We have no
H.A.R.T. (High Acuity Response Team) available. We have no higher level of care to transport so we have to send a nurse with this patient. The nurse I’m working with says, ‘Well I’m not going—ambulance trips make me sick.’ Literally my first day as a real RN I’m in the back of an ambulance with this critically ill patient. I mean looking back on it now I had no idea what was wrong with him! But I get to work and I’m told I’m going in the back of the ambulance and I think that I have no choice (Participant, 2GV).

This nurse spoke about how scared she was to be unexpectedly “it” on her first day. Nurses used the mantra “we’re it” to depict the burden of responsibility borne by rural nurses in often difficult and complex situations. For example, in this story the new graduate nurse felt she had no choice but to be “it”; in other words she was the only trained medical professional available to provide treatment for a critically ill patient during transport. What might not be apparent in this vignette is that the ER nurse who stayed behind also became “it” to manage the department alone. A participant explained that being the only trained medical professional available is often situational in nature, as in the previous example, and is related to unpredictable practice situations over which the nurse has no control. Often there is no physician available to physically attend the emergency department to assess, diagnose and treat a patient. This lack of physical availability of physicians is a common contextual reality for the rural nurse. The nursing staff, or at times an individual nurse, might be the only available health care resource in a rural community.

Another participant explains her experience of being a rural nurse in the following:

We are it. We’re the ones that they come to. We’re the ones that they see when they come through the door and that doctor could be on the other side of the railway tracks and we’re it (Participant, QSM).
Most participants expressed concerns and angst over the increased responsibility and risk to both patient and nurses safety that is borne in practice when they are “it” without physician support:

We have to know what we’re doing and we have to remain calm. We don’t have a choice. Am I shaking inside? Yeah! But I can’t let them see that. But yeah, we could be all the difference between them living and dying. And that’s a little scary. It’s also thought-invoking when you sit and you think about it, especially late at night! (Participant, QSM).

The knowledge that the ER nurses are physically present in the facility was also described as comforting for the communities they served. According to participants, the level of the surrounding communities’ knowledge about the presence of nurses in the facility also contributed to the nurses’ experiences of being “it”. This was said to be especially true when there was no physician coverage available:

When emerg[ency] is closed they just drive around the sign and they come to the door because they feel safe, they know that there’s a nurse there, they know that somebody will help them (Participant, p5q).

The nature of rural practice is such that ‘anything can happen’ and nurses have to be prepared to assume the role of being “it”. The reality of rurality portrayed by my study participants is that rural nursing practice is structured so that rural nurses do not ever stop being “it”, even when the facility is closed. The lack of both human and physical resources and the consequences of minimal infrastructure in rural places are part of the nature and reality of rural nursing practice.

5.3.2. The Buck Stops Here

Being “it” in rural practice was seen as having the benefits of expanding practice boundaries, developing skills, and building confidence. The advantage of
being “it” in rural practice was explained as the process of becoming known as the problem solver to whom people would often come for help:

...so you find you really grow. It’s not for everybody. Some people have a hard time with it. But the ones that make it, I find, they really mature...your decision-making skills, like they become a lot stronger when you work rural because you’re kind of the end of the line. You’re the last person. The buck stops here kind of thing (Participant, mi3).

The development of problem-solving and decision-making skills through being “it” and bearing the weight of the responsibility was constructed as practice strengths. Participants’ ability to engage in being “it” and to respond as “the end of the line” and embody the responsibility of a “the buck stops here” mindset for safeguarding the community is part of the complex reciprocity between the rural nurse and the rural health care structures.

Being the only nurse available at night in the ER, the "last person" when critical decisions need to be made is anxiety-producing because of limited options for immediate assistance, and insufficient authority and education to support decision-making done in a state of crisis. As I learned from my study participants, during the day, other nurses can be called upon from other departments to assist in medical traumas and life-threatening situations. The quiet of the night may at any time be broken by the wailing of an ambulance siren or pierced by headlights entering the hospital driveway. The night shift was said to provide nurses with moments to reflect on the complexities and challenges in their practices.

More experienced nurses tended to worry, ruminate, and reflect after crisis situations have resolved, whereas newer nurses reported worrying in advance. “When you’re young you worry beforehand” reported one nurse, but the more
experienced nurses reported staying awake after being “it”, rehearsing “it” in their heads. “I replay it to reflect on it so what I learned that day is burned into my head” (Fieldnotes, cJ2 Informal discussion). This nightly mental repetition of events appears to be the nurses’ way of coping with the many ‘what-if’s’ in rural practice and with the increased burden of responsibility nurses bear when the "buck stops" during the time the nurse was in the role of being “it”.

5.3.3. Isolation and Solo Rural Practice

The experience of being “it” was also claimed by participants to be a heavy burden—especially for those nurses working solo in the emergency department, in isolated solo practitioner positions, or in departments with minimal or very low staffing ratios, resources or available practice supports. According to one participant in a solo practice setting, the consequences of a single nurse bearing the burden of a heavy workload, with little in the way of practice support in the workplace, was that “people were getting depressed and anxious and burning out” from bearing the burden of solely being “it” (Participant, uaT). The reality of being the only staff member in a practice area was seen as contributing to feelings of isolation and disconnection from other departments.

Minimal resources and lack of physical practice support for some solo practitioners resulted in feelings of being disconnected. Unlike in the ER, I observed that nurses in solo practice areas, such as mental health and addictions counseling, did not appear to have the ability to easily call in another staff member to physically back them up. The seclusion and being a lone “silos” was expressed as, “it plays into like isolation. Hello! Like I feel like—I feel like I’m in...[a dark] dungeon! Hello! Is
anybody here?” (Participant, uaT). For some participants the isolation and physical distance from other team members made rural practice a lonely and isolating experience. “The ‘isolation is just [a] huge...component and it’s eroding the ones of us that do stay” (uaT). For another participant being the “one-nurse show” was experienced as becoming less of a challenge for her because:

I’m used to it now because I’ve actually worked in a community where I was the only healthcare provider in the actual entire community. So I’m used to it and it doesn’t...scare me anymore (Participant u64, Second Interview).

5.3.4. Never Get Caught With Your Pants Down

In rural nursing, my participants claimed, you never want to “get caught with your pants down” because the practice context is so unpredictable you always need “to be prepared to hold the line” (Participant, cJ2, follow-up). Getting “caught with your pants down” might entail working with another staff member who has little, untested, or exaggerated experience and is therefore unreliable, thus the full burden of care in an emergency (“holding the line”) falls to one nurse.

When asked why it is so important in rural practice that everyone collaborate and adopt the position of being a team player, one participant replied, because “if they’re [meaning the other nurse] not holding the line then you’re more ‘it’ during time of crisis” (Participant, cJ2, Follow-up Interview). The ability to depend on team members for professional conduct was seen to be essential for providing safe working conditions in the rural nursing context so no one is ever “caught with their pants down.”
5.4. The Unseen Complexity in Rural Nursing Practice

Nurses expressed that the complexity of practice was often misperceived by nursing educators, government policy makers, urban-based health care management, health care union leadership, and, to some extent, urban-based health care providers. They believed that the responsibility shouldered by rural nurses is not easily understood by those unfamiliar with the complexities of the rural nursing practice context, as this study participant explains:

Oftentimes I go to these union meetings and they always have these periods where [people] talk about...the problems they are having in their workplace. And often they are bigger sites and I think, ‘oh I wish that’s all we had to worry about’. You know, we don’t...[and we] feel like people have no idea what it is like to be ‘it’. They can’t fathom the fact that we don’t even have a doctor in the building. They just, you know, they can’t fathom. ‘What do you mean’? You know, or that we don’t have a lab or that we don’t have a respiratory therapist. You know, they don’t get that we have to do all of that even as a new grad, we still have to do that (Participant, 2GV).

Study participants were especially distressed by the increasing health care inequities created by the closure of all acute care beds in the facility. Nurses believed that the decrease of acute care beds in general, and the closure of acute care beds in rural hospitals in particular, was the single most important structurally-produced barrier to equitable access to health care for rural populations. The shortage of acute care beds in urban hospitals is increasingly problematic and has been linked to problems such as ER overcrowding and “patients being ‘warehoused’ on stretchers and treated in corridors” (Eggertson, 2004, p. 1653). The lack of acute care beds in rural hospitals also adds to the complexity of practice and challenges the nurses’ ability to provide quality, culturally appropriate, local care:
It is very frustrating to me that we don’t have the resources that a larger facility has. It is very frustrating to me that we don’t have medical beds because patients who need more care. And they say ‘I don’t want to go to [the city]. I don’t want to go! I won’t get good treatment there. I won’t be seen. I will be left in a hallway. I don’t want to go there. It’s far away from my home. Nobody can pick me up. My wife can’t drive at night’…Whatever their reasons, they don’t want to go to a bigger facility. But yet I don’t feel safe in sending them home. What do I do? I have these moral dilemmas…And if we had medical beds that I could help these people recover and help them get better to a point where they can go home in their own [community], that would be wonderful. But my fear is…that we’re [never] going to get our medical beds because what tends to happen is that once they take something away, you never get it back and it’s gone forever (Participant, KS3).

Without patient care beds, nurses told me that they had to transfer all rural patients to an urban centre by ambulance or private vehicle in order for them to receive in-patient overnight acute care services. Nurses expressed the desire to have acute care beds returned to the facility to better and more appropriately serve the health care needs of the population:

Well losing our acute care beds was huge. And not being able to provide care [sigh]…You’ve got to transfer and you’ve got to make arrangements. And then you’re getting the song and dance routine from [the city hospital] that they’re too busy. ‘We’re swamped, we’ve got no beds’…So the patient gets stuck in the middle and then they and their family can get quite frustrated. And you try to tell them it’s not me. It’s the way it is…I’d like to have [our beds] back (Participant, m13).

From my observations, interviews and conversations with participants, it appears that the closure of rural acute care beds and the resulting need to transfer patients to urban facilities is not preferable for many rural patients and families. At the same time, research I reviewed in chapter two indicated that tertiary hospitals are increasingly functioning at overcapacity and are struggling with high patient acuity and staffing shortages. The lack of rural acute care bed capacity may also be
compounding urban ER overcrowding and bed shortages (Fleet, Plant, Ness, & Moola, 2013).

5.4.1. The Tensions in Rural Practice Add Complexity

Rural nurses in this study related numerous instances when they felt their rural nursing practice and professionalism had been misunderstood and disrespected by urban-based health care providers. One experienced rural nurse recounted instances when she has encountered the lack of professional practice respect during patient transfers to larger health care facilities:

I’ve done numerous ambulance transfers from a smaller centre to the bigger centre and it really ticks off when you walk into that centre and they go, ‘Where are you from?’ And you say [where you’re from] and they give you this look, like, ‘oh great you don’t know nothing’. And they won’t listen to your report or what you’ve done or that. I think that is such a disrespectful thing. I’ve probably done more for this patient than what [they - the urban ER nurse] will [do] (Participant, s50).

The perceived lack of common professional courtesy by urban nurses towards rural nurses and the apparent lack of understanding of the complexity of providing care to rural patients (despite limited resources) is reflected in the participants’ words. There is a perception of an underlying tension between rural and urban nurses in the above quotation. This tension may be fostered in practice work environments where there is a lack of communication between nursing staff during the transfer of patient care. This tension creates an additional layer of complexity, which has the potential to negatively impact the patients’ health and well-being; in this example by the apparent refusal of the receiving nurse to obtain a complete patient report during the patient transfer process.
Study participants’ perception that there is a lack of understanding of the complexity of rural nursing by urban health care providers is consistent with other studies, such as Rosenthal’s (2005), which examined rural generalist nurses. Rosenthal’s study highlighted the need for rural nurses to tell their stories of the “complexities and challenges of rural nursing” in an effort to reduce “urban nursing prejudices and misconceptions regarding rural nursing” (p. 44). Another researcher explains that when “…realities of rural practice settings are not acknowledged by those outside the settings, rural practitioners can feel undervalued and unsupported” (MacLeod, 1999, p. 168).

The reduction in the number or the total elimination of acute care beds in rural hospitals is occurring across the province (Fleet et al., 2013). One new finding this research adds was that some participants expressed the belief that the reduction or elimination of rural-based acute care beds and the resulting increase in rural patient transfers to tertiary facilities might be responsible in part for urban nurses’ perceptions that rural nurses lack the necessary skills to give complex care. The pervasive linking of the consequences of limited rural health care resources (such as bed closures and resulting patient transfers) as a mischaracterization of rural nurses being somehow incapable of providing a higher level of care, obscures the underlying issue of inequities in rural health care resourcing. The risk to rural patient safety is exacerbated by concomitant inequities in urban resources. For example, a rural health care facility’s ER may be closed to admissions because of lack of physician availability. However, this participant explains that:

if someone shows up we deal with them—well we have protocol for that [referred to as the ‘No Doc protocol’]…people choose to come because
there’s a hospital here, they don’t understand that we’re closed...they just want to know if we can help them. And the answer to that is yes, we can, it just might not look like what they’re expecting (Participant, dLk).

In this study I learned that the closure of acute care beds in many rural health care facilities in the province is compounded by restricted hours of ER operation. This participant shares a common practice problem experienced by rural nurses because of restrictions to ER department hours and the lack of acute care beds in rural areas.

Maybe ethically too sometimes you maybe exaggerate a patient’s symptoms because you know it will get them out [to...] faster...I think I’ve heard doctors sort of...change [patient] status...Yeah, [sometimes the patient] needs to be gone out of here pretty quickly and it could be because it’s almost 5:00 [the facility cannot keep patients after hours]...You know, if you’re sitting in a rural area and you don’t have the resources and something does happen bad with that patient, you know, you’re better to get them out sooner or later, right? (Participant u64, Follow-up Interview).

In many rural facilities, when physician coverage is unavailable the facility mandate is to either discharge patients home or transfer them to the next level of care facility. Nurses without similar experiences, such as those who are urban-based do not easily understand the fact there is often no physician available in the building, or the entire rural community. For participants in this study the lack of physician services is one of the main reasons they must take on the role of being “it”. The lack of respect and understanding of the complexity and demands of providing health care services in rural locations was articulated by participants as creating an invisible barrier to collaborative care practice between rural and urban sites within the broader health care system. The perceived lack of acknowledgement and respect for
bearing the burden of being "it" adds to the feelings of further isolation in rural practice.

The perceived lack of recognition of the complexity of providing rural nursing care by urban-based health care decision makers is summed up by one nurse who states “I think it’s a whole different spectrum of its own that’s not really recognized” (Participant, s50). Similar to findings in this study, MacKinnon’s (2011) exploration of the nature and social organization of rural nurses’ work found that “rural nurses have consistently reported that the complexity of their work is vastly underestimated” and that rural nursing is “different from nursing in urban and suburban settings because of geographic and social isolation, increased visibility within and social connections to their community, limited access to resources including continuing education, and varied and extended professional responsibilities and scope of practice” (p. 120).

Overall, participants perceived a gap in an understanding by urban-based health care leaders of the level of inequities between rural and urban practice settings. Nurses in this study felt that there was very little awareness by urban-based care providers that resources were so limited that acutely ill patients had no other option but be transferred to the urban centers. My description of such perceived differences is not intended to create a dichotomy between rural and urban practice. Rather, the descriptions offer an understanding and explanation of how physical and social geographies influence nursing narratives. The nurses’ accounts may actually be reflecting the “differences between social groups and differing levels of underlying social advantage or disadvantage” (Lowe, 2015). How
rural nurses refer to this described tension is not fixed, but appears to be used as a heuristic device to frame the borders of their nursing practices. That is, in order to make sense of the complexity of the rural practice context, nurses have, consciously or unconsciously, categorized their practice to make a general differentiation of experiences. In doing so, they have created a pattern of thinking which serves to frame the structural and resource differences of rural nursing within the broader health care system. Participants hold the tension between rural and urban workplaces as an expression of this categorization; a mental shortcut used to decipher and identify rural practice deficits as well as strengths. Future exploration of this tension is required to shed more light on the possible environmental influences and structural inequities that foster categorization of all nursing practice areas within health care systems.

I will now turn to further exploring the relationship between “we’re it” and the structures of rural health care by examining how rural nurses describe their practice context and how they cope in situations of being “it”– often with minimal support, infrequent educational experience, underdeveloped skills, and at times inadequate or unavailable health care resources.

5.4.2. Every Day is Something Different

In seeking to examine the interrelationships between structure and agency, I was often confronted with participant descriptions of how rural practice was “different”. “How so?” I would ask. The replies ranged from, “it’s just different the way and we do things” (Participant, Vv0), to “it’s a different kind of responsibility here... you feel like you’re kind of running the entire hospital” (Participant, mi3).
Rural nursing practice has been recognized in the nursing literature as “separate and unique” from remote nursing practice and also different from urban-based nursing (Lea & Cruickshank, 2005, p. 22; see also Zibrik, MacLeod, & Zimmer, 2010). Unlike urban settings, which are more specialty practice focused, rural nursing practice is generalist in nature (Rosenthal, 2010). Nurses working in rural (or remote) areas are “expected to function at higher levels than nurses employed in urban areas” (Drury, Francis, & Dulhunty, 2005, p. 19). Rural practice is “more focused because it is just you and the doctor” (Participant, u64). This nurse shares how the scope and nature of her current rural practice is characterized by non-nursing work:

Now a typical day of mine probably is 40% administrative duties. It didn’t use to be, I used to do a lot of patient care because I had acute care patients, I had emerg patients, I did some work in long-term care but that’s changed. I have no acute care beds, I have 5 beds in emerg, that’s variable depending on who comes in. Some of it’s pre-booked but not enough to be a full-time job. But we’ve also taken on jobs that other people no longer do. We do not have an on-site scheduler, the scheduler we have is 4 hours a day, 4 days a week. The rest of it is an RN job, we do ordering, we make sure we have enough supplies...a lot of... [non-nursing work] is maintenance of the building and the emerg[ency department] to make sure it’ll run (Participant, dLk).

The increase of administrative duties adds an additional layer of complexity to rural nursing practice and further increases the scope of practice responsibility well beyond providing direct patient care.

**5.4.3. Navigating Unpredictability in Practice Resources**

Rural nursing practice is unpredictable in that nurses are never really sure what resources will be available to help them navigate patient care needs or any health care crisis. Certain injuries or illnesses are expected in the normal course of
providing emergency health care services (in both rural and urban ER departments), such as heart attacks, broken bones cuts and fevers. Relatively rare and unexpected health crises, often requiring immediate access to emergency medical care, also occur in both urban and rural populations. Rare and unpredictable events can be problematic in rural settings due to the infrequency of such events, and because of the lack of practice resources and support. Staff may lack the experience, training, or the proficiency needed to perform necessary skills or care tasks to a required or expert level. In essence the infrequency and low numbers of certain health care crises jeopardize the nurses’ abilities to be up to date on all the diverse practice skills required.

One unpredictable, infrequent and problematic event that concerned several participants was when obstetrical patients in labor still attended the rural ER department even though, as the participant cited below explains, the lack of maternity experience by nursing and medical staff makes every infant delivery a potential crisis for everyone involved. The loss of rural maternity care in this facility was not unique, as many rural health care facilities across British Columbia are no longer able to provide maternity services for rural women and their families (see MacKinnon, 2010a; 2010b; 2011). However, the rural ER nurses in this study were quick to remind me that although the responsible health care authorities across the province no longer support maternity services babies are still being born in rural communities:

It’s a skill that you have to keep up to be safe. So what happens now is nobody does any deliveries except for the ones that walk in off the street and they’re usually the ones in trouble. So you have a crisis situation and when you have some of the new grads um it could be a bad outcome and
it scares the pants off of them. It scares the pants off of the senior staff that’s working with the new grad, too. But fortunately I’ve not heard of any deaths, we’ve been very lucky and the docs that have had to deal with it fortunately have had experience...So it’s an emergency delivery for everybody. In fact I had one last year and I haven’t been in on a delivery for probably 8 years. And it worked out okay (Participant, p5q).

Since the frequency of such events is low, staff may not be prepared, experienced or have the necessary skills or abilities with some procedures, which would compound the burden of being “it”. Indeed, Kidd et al. (2011) found “skills rusting” led to a lack of confidence in rural nurses’ ability to respond to emergency situations, and was one element that made rural nursing challenging (p. 4). The nurses expressed the challenge as follows: “one day you are delivering a baby and the next day you’re helping with a heart attack” (Participant, s50). Skill rusting, lack of previous experience, inadequate resources and other practice challenges have the potential to impact nurses’ ability to provide safe and competent care across such a diverse range of health care challenges.

5.4.3.1. The Challenges to Providing Care “In Between”

As is indicated in my analysis above, the lack of available support and health care resources in rural locations is a contextual factor that impacts the accessibility and availability of health services for rural populations. It is also a structural factor that has shaped rural nursing practice by making nurses “it” when resources were lacking. The challenge for providing safe patient care in the context of unpredictable resources is described as trying to find a space “in-between” patient care responsibilities where none exists:
Shortly after I started...our lab tech [was]...not being able to take [after hours] calls. So we got this unknown crazy thing called the I-STAT\textsuperscript{46} and we had no idea what it was. We just knew all of a sudden we were responsible for doing our patient’s blood work. Well we all hit the ceiling and said, “What are you talking about? We don’t have time for this”! And our manager at that time who was not a nurse was, like, “it’s not a big deal, you just do it in between”...“oh okay” so while we’re in between, while we’re getting our patients set up in the bed and while we’re putting on their oxygen and doing their ECG, doing their vitals, getting their histories, getting meds ready, getting IV meds ready, doing all of these we’re supposed to say, ‘Oh yeah, right, we also have to do your blood work’ and you’re supposed to be trying to chart and so now it’s kind of a joke: ‘we’re it’. We don’t have anybody to do our ECG’s for us...sometimes when we have nobody [available] to replace in the kitchen we’re down there making toast because we’re it. Or, you know, we don’t have housekeepers...we’re cleaning Emerg. That’s when we say, ‘we’re it.’ Or before we had this ‘after hours registration’, we had to register our own patients and that’s when we said, ‘we’re it.’ (Participant, 2GV).

The participant above raised serious questions about the quality of care provided to the patient in the lack of space “in between” being the lab technician and being the nurse. Such questions include the safety of the patient when the nurse was compelled to take on the additional role of collecting patient blood; a function usually done by a trained laboratory technician. The rural nurses in my study were also concerned for the impact that changing roles and responsibilities might have on the working relationships they shared with other health care workers, especially the laboratory personnel (Fieldnotes). Nurses were required to draw and process the blood sample correctly despite having minimal training and infrequent experience with the technology. This lack of training and experience concerned the entire

\textsuperscript{46} An I-STAT system ®™ (Abbott Group of Companies) is a handheld electronic patient blood diagnostic testing device which is capable of providing a range of clinical blood screening tests at the bedside.
nursing staff. They questioned how such factors might impact the accurateness and reliability of the test results.

Participants in this study also cited concerns with the device limitations such as the lack of full range of testing capacity. “It runs cartridges, however the ones I have don’t give me a white count [white blood cell count] which is problematic” (Participant, dLk). The nurse went on to explain that a “white blood cell count...it’s an issue when you have an overdose” (dLk). As “treatment is based on your overdose” (dLk), without a white blood cell count treatment is delayed until the patient is transferred to another hospital with a laboratory. The device limitations impact rural patient care because of the distance to the next level of care facility.

Nurses were also concerned about the readability of the device. The numbers on the machine are small, and many middle-aged and older RNs reported having difficulty reading them. Because of readability issues, I was informed, errors have been made in the interpretation of blood results (Fieldnotes). The infrequent use of the device means that it was difficult to obtain a level of proficiency with it; many nurses had concerns about their ability to perform diagnostic blood-testing test with proficiency (Fieldnotes). Overall, the extra responsibility of performing diagnostic testing in addition to regular nursing functions illustrates challenges to providing care to fill “in between” while being “it”.

A further example of how inequities in health care resources impact rural patient care is the uncertainty in access to rural diagnostic imaging (x-ray) services.

We had no x-ray. We had no x-ray! Nobody was available. Not [oh don’t worry] ‘X-ray is coming from [the city]’. No x-ray available. And somebody phoned from [a popular lake area 45 minutes from the facility] and she said to me, ‘I’m pretty sure my friend has a broken leg
are you open?’ I said, ‘Oh yeah we are but we have no x-ray’ (Participant, Vv0).

This nurse directly attributed the inability to provide triage care to this patient with a suspected bone fracture to allied health care provider shortages and insufficient structural resources for rural health care provision. In the interview the nurse was near tears as she stated, “of course we’re lacking” (Vvo) in reference to rural health care provision. Although the facility was open and had physician coverage, the nursing staff was unable to meet the health needs of this individual. The inability to meet this patient’s needs was a source of ethical concern for this nurse. Recognition of the health needs of the community and knowledge of the limitations of available resources — as in the example given above where there was no diagnostic imaging (x-ray) technician available — was motivation for this nurse to act because she understood that “we lack those services so we try to advocate harder for people to get to those services and get what they need” (Participant, Vvo). In summary, navigation of the unpredictable nature of the resources to support safe rural nursing practice was fraught with challenges. Nursing practice in rural communities where nurses live and work provides an additional challenge for nurses to navigate the ethical complexity of providing care to friends and family members. The challenge to provide ethical nursing care to friends and family members and maintain appropriate boundaries is discussed in the following section.

5.5. There’s Relative Rural and Rural Relatives

Rural RNs, LPNs and CAs often have to provide nursing care for community members who are known to them. This can be ethically challenging for nurses to navigate and maintain appropriate boundaries and confidentiality. Yet caring for
community members was also described by as being a positive and satisfying experience and one that created a small town “family” like feeling, as this care aide expresses:

I like the kind of family feel of being and working in a facility in a small town. Yeah sometimes it’s kind of weird [laughs] to be changing diapers on somebody...that was your grandparent's friend or something. But if you kind of put that aside, you know, I think it helps you, maybe in the long run you actually take care of them better (Participant, Yq5).

Being the only health care facility in the area, family members, relatives or friends of the rural nurses in that facility require nursing care. As another rural researcher has also noted, it is “not unusual for a rural nurse to care for friends, neighbors, and even relatives while in the professional role” (Crooks, 2012, p. 48). This can be awkward for both the patient and staff, and create complex ethical challenges. One such encounter I observed in the ER was a patient being told by the RN that they would have to wait until after shift change to be seen by another nurse (Fieldnotes). When I asked why, the RN replied because they were related, and ethically she did not feel she was the best person to provide care (Fieldnotes). At the same time, for some RNs the arrival of a close family member to the ER was not considered to be ethically problematic, depending on the circumstances. As this nurse explains:

You know, like because you already know everything about them as well. Yeah, you just don’t have to establish anything. It’s already there and it’s worked really well. I mean I’ve had to treat my sister here. Never anything traumatic or anything but, you know, you still have to do nursing care and it’s been fine. It’s been totally fine (Participant, 2GV).

The social and personal connections within the community also impact nurses when difficult medical situations arise for a patient personally known to the
nurse. These connections can cause additional psychological burden to the nurse, especially when they are “it”, as in the following example:

there have been some instances where my children’s friends have come in dire straits, that’s difficult. You do the best you can as a nurse (Participant, dLk).

At other times social connections and bad patient outcomes collide in rural ER departments, and the RN is caught between the professional role and the pleas of friends to help a loved one in the face of the medical futility of further intervention:

When someone comes in and if you get a call and they say, ‘We’re coming in with a code’ or ‘We’re coming in code three with somebody who’s blood pressure is in their boots’ or that you see them coming in and you think, ‘oh my god, I know him’. Number one, you’re worried because you know them because you know either him or his wife or their children. How do I deal with the patient and deal with the family because I’ve been in that situation before where the family is going, ‘Do something’. You need to do something’ and you know it’s futile (Participant, QSM).

Participants in this study were quick to acknowledge that family relationships are the most difficult for them to navigate in their practice and cause a great deal of angst:

I think one of my biggest fears is if it’s his [referring to their partner’s] brother or sister that comes in the door… I’ve had to deal with his dad. I’ve had to deal with his mom and that’s a tough thing to deal with. When it’s friends who comes in you’re hurting for the person who is watching their loved one (Participant, QSM).

Because of the frequent need to provide care to people with whom they had close relationships rural nurses reported finding it especially difficult to maintain their professional role when faced with medically futile situations, poor outcomes, or when loss of life occurred. Often nurses were also grieving in these tragic circumstances, but they felt they had to maintain their professional role in order to give nursing care to family, friends, and neighbours.
5.5.1. Knowing the Community and Being Known in the Community

As can be seen from the examples above, the close-knit nature of rural communities and the interconnectedness of nurses with their communities can produce a dynamic that violates appropriate boundaries. For example, a simple trip to the grocery store can result in neighborliness and polite conversation turning into a medical consultation or expectation to receive more personalized care at a later time:

They want to sit there in the grocery store and tell me all about their wound there or is it, ‘Oh I’m doing fine’ and away you go, that kind of thing. Or people saying, ‘Well I know where you live so no problem if something happens, I’ll come to your house’ (Participant, s50).

The close connection of rural communities and the familiarity of the nurses and other health care providers with local citizens can foster an unspoken expectation of an elevated level of engagement and trust between patients and care providers. Knowing and being known through community engagement in multiple roles such as a parent, sports team player, volunteer or spouse brings to the foreground how rural nurses are deeply embedded in multiple, complex and interconnecting relationships at and beyond the local level (see also Rodney, 2013). This AHCP47 explains her experience working with local long-term care residents and their families:

I think working rural you know, even though there’s lots of new people in the area that you may not know as well but you still kind of see and

47 As I indicated in chapter four, due to the small number of allied health care providers in this study they have been categorized as a single group to ensure confidentiality and better protect the identity of participants. The field of work or professional affiliation the participant belongs to will, at times, not be identified beyond ‘allied health care provider’. This category may include but not limited to: physicians, occupational therapists, physiotherapists, speech therapists, licensed practical nurses (LPN), care aides (CA), laboratory technicians, diagnostic technicians, physical rehabilitation assistants, recreational assistants and social workers.
recognize faces. Whereas in the city, like, there’s so many people you don’t know. Like, you know, when you are working in a small town like you may not have known them for a long time but you know them from around town. So then, you know, you get to know them. You, maybe they’re in, you know, the city, there’s more of a changeover. So you don’t get to know them and their families, what they were like before—their past and their history (Participant, Yq9).

Because of the multiple social connections and high visibility of health care personnel within small communities, nurses felt that they needed to self-monitor their actions and behaviours in the community and reflect on and adjust their practices frequently in order to maintain an appropriate level of professionalism: “I know the people here—they know me” (Participant, uaT). Knowing each other could be viewed as a positive and beneficial aspect of practice. However, at times these connections produced difficult social tensions; “like, it’s damned if you do, damned if you don’t, living there” (Participant, cJ2). Living and working in a small rural place also requires an additional level of monitoring the nurses’ professionalism:

You try not to be abrupt and rude to people even if you’re having a [bad] day because you might see those people next week or they see you at the grocery store. So what happens here, it’s a small town and people talk. So you always try to be professional in your manner (Participant, mi3).

I learned from the research participants that the friendliness and small size of a rural health care facility could also cause concerns at the organizational level because interpersonal conflicts between employees had the potential to disrupt or have negative impacts on the moral climate of the workplace. At the same time, interpersonal conflict can also be used as an important opportunity for personal growth and may encourage re-focusing on accountability and ethical actions so as to improve the moral climate:
I feel that just being a smaller group, that you’re forced to either get over your personal differences and learn to work with this person whereas in a bigger site you can maybe just take the easy route and say, ‘I’m just going to avoid that person.’ Here you have to be the bigger person. So it actually works out in the long run because rather than being lazy in our relationships, you have to be the better person and you end up having better relationships in the long run (Participant, kS3).

At times, the crossing of personal and professional roles can create ethical challenges concerning confidentiality and the need to recognize ethically precarious moments. Strategies must be developed to help shift these complex encounters towards a more appropriate time and place, as for example:

the lady that...you did the pap test on would...see you in the grocery store and go ‘so did the results come back?’ And if the moment that you [recognize the ethical issue, and] just say, ‘well we’ll talk about it later.’ ‘What is something wrong? Is something wrong?’ You know, and then they’d follow you out to your vehicle...because they were paranoid at that point, because they were worried about an STD 48(Participant, cJ2).

Participants often described navigating these multiple social roles that rural nurses occupy as requiring a good understanding of their own boundaries in order to “keep the power structure in the personal and professional” separate (Participant, cJ2, Follow-up Interview). The ethical challenge to not break confidentiality was a common occurrence. Nurses reported times when they had been caught in social situations where information was being sought about other patients:

I quickly learned how...smart the community is in getting the information out of you...that they want...they would say to you...’oh that was so wonderful how you know you looked after Mary’...if you said anything you’d just acknowledge that Mary was there and received treatment (Participant, cJ2).

48 The medical abbreviation STD stands for sexually transmitted disease (also called STI which stands for sexually transmitted infection).
This nurse also relates how it was necessary to understand how the boundaries on maintaining privacy for patients can be challenged within the small rural context. She and other nurses also claimed that knowing the community provided a practice benefit and challenge of understanding the needs of patients in relation to their unique contexts:

Yeah so...that's...kind of the hard part too is that...[people will] phone you at 2 o'clock in the morning: ‘what do I do about this? I can't get my wife off the floor.’ It’s like ‘phone an ambulance.’ But you know their issue is they can't afford it, they're looking for you to come over and [take a] look, they’re looking for you to drive them in [to the city], be their advocate because they're too afraid to talk, they don't know what to say (Participant, c2).

In linking the broader social structures to the local health and health care context, this nurse demonstrates a deep understanding of how poverty, culture and various forms of social exclusion and marginalization serve to create inequities in access to health care resources for some patients. Some rural individuals were described as more likely to use informal avenues and social connections in order to seek assistance from knowledgeable and trusted nurses as their way to obtain care.

5.5.2. Living and Working Under the Scrutiny of the Community Gaze

As can be seen in the accounts above, trying to protect confidentiality and privacy —both professionally and personally— while living and working in the “goldfish bowl” of a rural community was described as being fraught with challenges. The social-cultural context of rural living offers few places to hide, especially in communities with very small populations. Nurses described how the scrutiny of the community created social challenges and limited their actions and social engagement in community events.
P: You’ve got to be very careful how you act outside of the hospital too.
R: How so?
P: Well I don’t go to the bar anyway! I never did that anyway but, no, I’m very... A lot of my friends will tell you that even when I’m curling and that I very seldom let loose, let go. Because I’m afraid when I’m in my professional role and somebody says, ‘Oh I saw you the other night!’ I don’t want that. You know, that’s not worth it. It’s not worth it for me for my reputation, for my family, for my kids. It’s not worth it, you know (Participant, QSM).

The lack of anonymity is experienced as having no place to hide and of disallowing any “secrets on Main Street.” Personal and professional overlap is common, explains this participant, since:

more than half the people I play bridge with have been patients of mine...your private life comes into play and everything overlaps each other and yeah. But that’s a good thing about a small community and people caring other than it makes it difficult to keep privacy (Participant, kHA).

One nurse related that the closeness of the nursing staff and the gaze of the community was one positive benefit for raising her children in a small town. Coworkers and community members would always know where and what her children were up to, even when she was working the night shift (Participant dLk).

This participant relates that not being able to hide and “getting caught” is a frequent occurrence:

I would keep getting caught—again your small town, people would see me, they know I’m back...usually in the post office or down at the grocery store or they might arrive on my doorstep or on the phone. I get contacted on Facebook...I’ve had it in yoga class (kHA).

Frequently when “caught” they ended up providing care:

I’ll often do 2 or 3 consultations as I’m going through the [grocery store picking up] margarine and potato chips and the avocados, you know, ‘oh how’s your shoulder doing?’ and you know and...‘did your dad get his knee replacement done?’ (kHA).
Being visible and trusted in the community could also be seen as a hidden strength of rural nursing practice—the community is aware of who the nurses and other health care providers are, and they feel comfortable enough to approach them for help. These encounters are mutually beneficial and reciprocal in nature, since they provide opportunities for health care providers to obtain information they might not acquire otherwise, while giving patients a less formal way to access care.

The advent of social media has provided an additional avenue for access to health care for rural residents:

I’ve had phone calls and Facebook, ‘Oh hey, I hate to ask you but I did such and such, you know, what do I do?’ (Participant, s50).

Although social media has lessened some access barriers for some patients, it also appears to have created an additional layer of community surveillance and intrusion into the private lives of rural health care providers.

The lack of social distance between private and professional life impacts rural care providers in varying degrees. For example, according to one participant, the lack of social space impacted doctor retention in one rural site as, “One of our doctors left here because people were constantly arriving on [the] doorstep” (Participant, kHA). The struggle to keep private health care knowledge from becoming public knowledge is explained as:

You have to be careful not to gossip or I never discuss patients outside of work because chances are they’re related to somebody you’re talking to. So that’s a real issue. Yeah, you’ve got to keep everything quite close to your chest. It’s what you’re supposed to do anyways with confidentiality (Participant, mi3).

This participant further explained that secrets are hard to keep in small places. In a joking manner she told me: “where I live now, everybody knows everything and
they actually know things about me that I don’t even know about myself” (Participant, mi3).

The need to be constantly vigilant about maintaining professional practice standards and confidentiality was juxtaposed against the increased knowledge rural professionals retained from their multiple encounters with community members in both private and professional roles:

So here [in the ER], you see the same people or you see a family member [of] the [regular patients] and you get to know people. Not that you’re prying but just over the years you get to know people. So you have a good sense of who they are (Participant, mi3).

Participants thought that this additional and expanded personal knowledge about the social context was a benefit for nurses. Some participants in this study considered that the personal connections provided additional knowledge — beyond the chart details — about the patient. Often this additional knowledge allowed for the provision of more complete care:

I think that rural nursing is... a big bonus because I know the people—a lot of them—that are coming through. If I don’t know them, I know some of their family members, I think you give more rounded care, you know more about them. They’re not ‘oh I have a sore leg.’ They’re your neighbour and you know their family, you know their background, I think you can give them more complete care (Participant, dLk).

Notwithstanding overall challenges in rural nursing practice, this participant explained that a deep sense of trust is fostered by the relationship nurses develop with the community they serve:

People know who you are, and they trust you, and want your opinion. And they want your advice and they want your help (Participant, mi3).
Indeed, during my fieldwork I encountered a patient insistent on seeing a specific RN. The patient declared that they knew she was working, “because I saw her truck in the parking lot” (Fieldnotes). The lack of both anonymity and appropriate social distance in the rural workplaces can also lead to some socially uncomfortable situations. One participant shared a particularly challenging moment:

I was asked to orientate my [husband’s] ex-[wife] who came here to work...our manager asked me to orientate her. And I said, ‘Well, it’s going to be kind of awkward’ (Participant, 2GV).

Living and working in a rural place presents other interesting challenges when nursing staff themselves access health care services, since “you know, that challenge to your privacy and having your personal and your professional life kind of cross” (Participant, 2GV). To mediate the privacy challenge the nurse cited above would access services in another centre. Her strategy for maintaining privacy was to see co-workers only for limited care issues. She explains:

You know, I’ve seen them for minor things, which is okay if... Because even then the next day they’ll ask you, ‘Oh are you feeling better?’ And you just don’t want that. You know, it’s, you try to keep it separated (Participant, 2GV).

The attempt to separate and maintain professional and personal boundaries was portrayed as a constant struggle for rural nurses. Study participants who had also worked in remote communities reportedly experienced the spotlight even more in those smaller communities. One participant felt that the level of intrusiveness was greater in remote nursing situations, expressing that there were more staff in a rural area, and therefore the issue of heightened visibility in a rural nursing was more of a shared experience of living in the spotlight:
I know that a lot of people saw me as part of the community because I went to a lot of the dinners and the ceremonies and community events, you know. So I guess that’s maybe how remote and rural are different. You have, you’re more in the spotlight. You have to be careful what you say and what you do. Rural you do to some extent but you’re not the only one in the spotlight, you know (Participant, u64).

Overall, the overlapping of roles within the context of living and working “in the spotlight” of rural practice presents a constant challenge for rural nurses to keep their private lives private and to have a sense of separation and balance between work and family life. The intertwining of the social and the professional roles in the rural practice context creates complexity and serves to structure nursing practice for a role of being “it” in the spotlight.

5.5.3. Boundary Violations and Nurse Shaming

When high visibility, decreased privacy, risk to confidentiality, increased responsibility, and malleable social boundaries combine in the rural context, violations of appropriate social and professional boundaries can occur. For example, the complex rural dynamic can produce boundary violations and confidentiality breaches when community members choose to air their concerns about their medical care in an inappropriate and/or non-professional setting or situation. This inappropriate airing of concerns in rural (or remote) communities leads to the practice of what I have termed public nurse shaming. This occurs when patients, families, and community members use public information resources, (for example the local radio network or letters to the editor in community newspapers) to publicly complain about and intentionally shame nurses.

The use of the media to express displeasure with decisions made by health care administrators has previously been documented as part of the challenges of
working in rural health care (Pesut et al., 2014). These public displays of disapproval often appear to be crafted to exert social pressure on the nurse to provide restricted or limited health care resources. For example, public nurse shaming may be used as a method to obtain treatments previously denied because of dispensing policies in the health care centre. One participant who works both rural and remote postings explained that her experiences of nurse shaming were demoralizing:

It's one of the reasons I resigned...you become the enemy if you don't give the patient what they want. They go on the radio [public community radio station] and they blast you [public shaming], “This nurse, she’s this...” I think I’ve already been [complained about] on the radio a few times...it’s very demoralizing (Participant, u64, Second Interview).

The gaze of the community and the acts of shaming can reach a serious level of intrusion into the everyday lives of nurses. The impact on care providers is said by participants to range from altering their day-to-day behaviour to avoid scrutiny or shaming to resignation and practice abandonment. Shaming was not always confined to one specific nurse. Nurse shaming was also directed at the nursing staff in general, as a response to not getting the care and treatment the patient expected, or believed they deserved:

You know, one example... [a] woman came to the clinic seeing [another RN], [the patient] was deemed [to have] a virus. And she was so upset she didn’t get antibiotics that she went on the radio about it, like went on to the radio saying, you know, that we’re not doing our jobs and we’re not giving people antibiotics because we’re ‘sick’ (Participant, u64, Second Interview).

Overall, participants felt that the capacity for acting on behalf of patients in situations where nurse shaming occurred was constrained by the violation of confidentiality and trust in the nurse–patient relationship. The shaming of nurses
acts as a powerful sanction on agency within the social structures of rural and remote health care provision. This sanctioning changes the “dialectic of control” (Giddens, 1984, p. 16). Those who may have been perceived as subordinated within the health care structures by a policy that limits the actions of the nurse (for example antibiotics are not given to treat viral infections), apparently engaged in acts of public nurse shaming as a means to punish and influence the future actions of the nurse. Acts of nurse shaming could also be interpreted to be one method for patients to voice their disagreement with certain health care policy restrictions. What is unclear is whether or not the nurse shaming serves to enable, further constrain or remove the voluntariness of nurses from future acts of agency. Certainly, future research is required to further explore the way in which nurse shaming may impact patient care practices, nurse retention and moral agency in rural and remote communities.

5.6. **Chapter Summary**

My study findings indicate that the complexity of the role of the rural nurse is related to the broader experiences of living and working in a small rural place. The lack of role separation in the context of fragmentation of resources and minimal support for rural nursing practice frequently left rural nurses feeling they had no choice or control over being “it” and subsequently bearing the increased responsibility for patient care under difficult circumstances. Both RNs and AHCPs were personally impacted by the burden of being “it” while trying to serve the health care needs of rural communities in the context of health care inequities and health resource disparities. Rural nurses described feeling privileged to serve the
community and yet also burdened with personal and professional challenges extending beyond the practice context. At times their actions in everyday practice, intended to uphold the policy structures, were scrutinized by the community and perceived as barriers, and the community’s reactions against the perceived barriers resulted in the practice of nurse shaming. The following chapter contains an analysis of the impact of rural health care structures on the nursing practice context, and how unpredictability of health care resources can risk nurse and patient safety.
Chapter Six: Navigating Uncertainty in Rural Practice

6.1. Rural Structures That Shape Rural Nursing Practice

The rural context is used in this chapter as a lens to analyze the complex relationship between rural health care structures and rural nurses. This is done to better understand how “nurses as moral agents are influenced by—and influence—the complex social-political structures they inhabit” (Musto, Rodney, & Vanderheide, 2014, p. 3). In this chapter I explicate how rural nurses navigate the uncertain terrain of practice and the power inequities within the complex social-political structures that frame rural health care provision.

6.1.1. Locating the Rural Nurse as a Knowledgeable Agent Within the Structures

The knowledge that humans hold is always bound and embedded in the everyday actions and routines of human activities within social structures (Giddens, 1984). The nurses in this study were significantly well informed about the structural conditions, social practices, rules, resources and consequences of the day-to-day activities within the structures of rural health care. As I will show in this chapter they drew upon their knowledge as a critical practice resource needed to try to 'get things done'. Carspecken (1996) explains the relationship between power and knowledge as being mediated by both culture and social conditions. Thus the use of nursing knowledge to 'get things done' is an act of power.

Power has a transformative capacity since “all forms of dependence offer some resources whereby those who are subordinated can influence the activities of their superiors” (Giddens, 1984, p. 15). This is what Giddens calls the “dialectic of control in social systems” (p. 16). The capacity to act—or the choice to enact agency,
for self or on behalf of another, can be enabled or constrained. In this chapter I will show how nurses have important insights on navigating the complexity of the health care structures on behalf of patients, their families, and their communities.

6.2. Locating the Complexity of Rural Health Care Structures

The characteristics of rurality discussed in the previous chapter and the structural consequences of health care inequities have an impact on rural nurses and rural nursing practice. It is important to understand how the complexity within the health care structures impacts the rural nursing practice context. I found that many variations exist with respect to the level of care or service availability in rural places that directly impact nursing interactions. In recounting a former workplace in rural Alberta, one RN said that although the Alberta site was larger and had more services it still had many of the same challenges for providing care as her current workplace. She reported that:

when we worked there we screamed lots about being rural and that we didn't get the things that the City got. We had a general surgeon, we had obstetrics [patients] but, you know, staffing-wise we struggled sometimes with the staffing because, okay, you're supposed to be 17 beds but really you have 21 [patients]...we had to continually send people to the city but we had a 24-hour Emerg [emergency department and] 24-hour obstetrics (Participant, s50).

Such differences add additional complexity for both practice and policy development and implementation in Alberta and other provinces, including B.C. For example, currently in the B.C. regional health authority where this study took place a policy directs that health care facilities provide a separate seclusion room in the ER for the containment of violent patients. Most rural facilities, however, according
to study participants, are unable to provide a proper seclusion room because of the lack of appropriate physical space.

6.2.1. Rural Policy Gaps

The seclusion room policy for containment of violent patients is one example of a well intentioned, but ill-fitting “one size-fits-all” policy-making approach that does not account for the gap between policy and the structural inequities in rural health care provision. In discussing the lack of rurally-focused policy that attends to the unique needs in rural mental health, this participant stated:

I think it’s quite a tragedy that they see that there’s a problem and they choose not to do anything about it. It’s deeply troubling and unfair we need so much more (uaT, Follow up interview).

As many participants in this study explained, urban-based policy and educational programs and practice solutions do not always fit the rural practice context:

We're rural and then we're going to union meetings and stuff like that saying, you know, they would say, ‘Okay everybody is going to do this’ but we’d say, ‘well that doesn’t work rurally’ (Participant, s50).

This RN felt that her practice is now dictated by rules and regulations that are not always grounded in the everyday reality and knowledge of rural practice:

Our practice is based now not on what we learned in our experience and what we know or the protocols it’s more based on the rules and regulations and [it feels like the employer] is dictating our practice... which sometimes doesn’t make sense to us. It goes against...what we’ve learned, you know? (Participant, cj2).

Nurses in this study claimed that the rules, policies, and governance structures that directly impacted rural care provision and nursing practice often failed to take into account the everyday reality of rural practice and the rural context. As a further
example, nurses expressed significant concern about the fact that neither medical nor nursing staff were able to admit a particular patient into the only local palliative care bed located in the long-term care (LTC) facility:

Staff received many e-mails from Management regarding the use of the Palliative room over the time frame that this client was being routed around the area beds. One of note ... stated ‘we will ensure, we are doing what is best for the client’. Really, what I saw was a lack of compassion and humanity for the dying. There was a sense of unwillingness to consider any ideas from staff, wanting to accommodate this client in the [local] Palliative room, with many excuses as to why the room could not be made available. I, and many other staff, believe these obstacles could have been removed and the situation solved, so that the Palliative room could have been used for this client (p5q, Letter).

The distress caused by this practice change was significant for the nursing staff. According to the participants in my study, the new rules governing palliative care bed admissions and end-of-life care by LPNs in the LTC facility failed to take into account the already high ratio of LTC residents to LPNs and CAs and their availability to provide optimal end-of-life care. The policy change, which removed the provision of palliative care from RN practice responsibility, also failed to take into account the reciprocal relationship - that is the mutual dependence and trust — between RNs and patients as well as the nurses’ ongoing commitment to serve their patients across their lifespan, as this participant explained:

I have lost many nights’ sleep, distraught and disgusted at the situation around how our last palliative client had to spend the last 72 hours of his life. I feel personally ashamed of our health care system, which I have been a part of for [many] years (p5q, Letter).

This specific example of the gap between policy structures and the need to provide local end-of-life care that was valued by community members created distress and confusion for nurses. It is important to note that the distress and
confusion was likely not intended by administrative staff, but was articulated by nurses as a consequence of policy gaps. Another example of a poor policy fit in rural practice settings is that of treatment protocols, or care pathways, that were developed for urban-based practices settings, and are implemented without first taking into account the limited options available in rural patient care. According to my participants, for example, the use of cardiac care pathways (such as STEMI-ST elevation myocardial infarction care protocol\(^{49}\) developed (in urban settings) for use with patients experiencing a heart attack contains many clinical goals and treatment actions that are required to be initiated for the best outcome. Any variations to the treatment pathway must be documented as to why the treatment action was not followed. Many of these clinical options are not offered in rural health care settings (for example fibrinolytic therapy, cardiac catheterization, and angioplasty). This was a source of frustration in particular for one participant as she showed me that not one treatment protocol was developed with a rural focus and the pathway protocols were not designed to account for the variance in workplace resources (Fieldnotes).

The observations I made supported the participant’s assertion that the rural context (lack of both physical and human resources and geographic distance in

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\(^{49}\) STEMI, stands for ST elevation myocardial infarction, which in layman’s terms is commonly referred to as a ‘heart attack’. This critical life-threatening event is where the blood supply to the heart muscle is interrupted or blocked for a prolonged period of time. Best practices indicate that patients are more likely to survive this life threatening event if they receive initiation of fibrinolytic (blockage breaking) therapy in less than 30 minutes from onset of symptoms (door to needle time); and if cardiac catheterization and rapid revascularization of the heart occurs in less than 90 minutes (door to balloon time) (Tu, Donovan, Lee, Wang, Austin, Alter, & Ko, 2009). Depending on location, in some rural places travel to the nearest health care facility may exceed 90 minutes and in British Columbia only five facilities offer cardiac catheterization (see Appendix O). The Kelowna General Hospital is the nearest facility for most communities in the central and southern interior of the province of British Columbia.
particular) would be a challenge to the treatment goal of the STEMI pathway to initiate fibrinolytic therapy in under 30 minutes, and that the goal of “door to needle time” of 30 minutes was likely unobtainable for most, if not all, rural patients due to geographical factors such as substantial driving distances. The accessibility of a cardiac catheterization lab to meet the goal of “door to balloon time” of less than 90 minutes was likely unobtainable in most rural areas of the province except those nearest to the five urban based facilities with the specialized cardiac catheterization units.

The nurse who showed me the protocol explained that she believed it was necessary to develop rural-based care protocols and policies. She indicated that she understand the logic behind the regional health authority’s adoption of these protocols as best practice for cardiac care across the region. The STEMI pathway and other treatment protocols are useful tools in the urban health care context, they were not perceived by this nurse as being congruent with the rural practice context. Interestingly, in recent Australian research it was found that there was a similar lack of understanding by policy and decision makers of the contextual issues and challenges faced in rural practice, including implementing procedures and structural or system wide protocols that are not suited to the rural practice context (Paliadelis, Parmenter, Parker, Giles, & Higgins, 2012). Urban-based policy structures have a significant impact upon rural nursing practice and the delivery of rural health care. In chapter eight I further explore how policy “impact[s]... the

50 See Appendix O: Map of Specialty Cardiac Service Hospitals in British Columbia and Driving Distance from Randomly Selected Centres for examples of the driving times from rural locations to the nearest specialty cardiac unit.
equity of provision of rural health services and health outcomes for rural and remote populations” (Russell et al., 2013).

**6.2.1.1. Rural Nurses and Patient Safety**

Navigating the complexity of rural nursing practice also meant navigating safety challenges. Rural nurses in this study reported that a recent policy change toward decreased staffing levels was particularly problematic for rural nurse safety. Throughout the study I noted many nights when a sole RN would be alone on shift in the ER department (Fieldnotes). I have come to understand that the facility I observed is not unique, since other participants informed me that the tendency toward not replacing nursing staff in rural facilities, in order to save money, is common across multiple health regions and provinces (u64, Follow up Interview).

The current trajectory towards not replacing nursing staff on nights when the facility is closed to admissions may be related to another serious trend in rural health care—the constant struggle for health authorities to recruit and retain physicians in rural places (Kulig et al., 2006). The limited supply and high demand for available physicians to practice in rural communities across Canada has led to management strategies to “accommodate these problems” which include closing facilities to fit the available physician’s desired schedule (Urban, 2014, p. 69). To accommodate physician availability, rural ER departments are routinely closed to admissions at night, even though nursing staff is present in the building. When there is no physician coverage, participants indicated that the employer policy dictated that the facility must be closed to emergency admissions. Because many patients still enter the facility even when closed to emergency admissions, nurses are told to
consult the “no doctor manual” provided by their employer. This manual contains a limited number of approved nursing actions that can be implemented in the absence of a physician. These protocols appear to function as pre-approved standing physician orders to direct nursing work in the absence of an attending physician:

We actually have our binder called our ‘no doctor manual’. We have flow sheets on what we can do and what we can’t do. It’s crazy (Participant, 2GV).

This trend towards saving costs by not replacing medical staff, or use of a “no doctor manual”, was found to be particularly concerning by the participants I observed and with whom I spoke. Most participants in this study expressed concerns for patient and nurse safety and personal wellbeing. The following ER nurse expresses her concerns about personal safety—especially when working alone at night:

I feel...unsafe if I’m by myself not only just dealing with ER patients that would bypass the emergency sign but...you never know who’d coming to the door (Participant, p5q).

Another participant shared several safety concerns:

I feel...unsafe if I’m by myself not only just for dealing with ER patients that would bypass the emergency sign but just you never know who’s coming to the door. Even though we have to buzz them in people can be con artists and you can let in somebody that you think is an actual – in need of help and they’re not. We’ve had instances a few years ago with somebody who was – we had to call the police every time he came to the door because he had a knife at one point (Participant, p5q).

Another participant expressed her angst when asked about how she felt working alone on a night shift when her work partner was not replaced. Her reply was, “on a night shift! Oh crap! Don’t leave me here by myself” (Participant, QSM).
Yet another nurse spoke about safety concerns and how she expressed a sense of powerlessness while working alone:

Sometimes you get a sense of powerlessness because if somebody really truly wanted to, they could yell at me, scream at me—physically intimidate me. And if they really wanted to, they could physically strike me but...goodness [I] have never had that. I’ve had people come into my face and I have felt threatened. At nighttime at one point our front door wasn’t working properly and it wasn’t locking properly. And I’m here all by myself...and the front door wasn’t working properly. Yes, I was concerned for my safety (Participant, kS3).

In the facility where I conducted my research, the trend towards not replacing sick nursing staff on a night shift because the facility is closed to ER admissions was described by participants as a recent restructuring change. I observed many patients would still attend the facility and expect to receive care, even when it was closed:

So then you work on nights or even the daytime people are walking through [the doors] trying to find somebody to help [them, and] you help these people that are walking past the closed signs (Participant, sS0).

Often these individuals would be transported by ambulance to the next level of care facility at a significant cost to the health care system.

The unpredictability of the rural practice context and the burden of being “it”— especially when working alone — was experienced by participants as particularly problematic. The reported angst accompanying practice isolation and concerns for patient and nurse safety was also reported as a significant situational stressor in rural nursing practice:

But to get into the isolation, it’s just...it’s very – it’s very weighing into the point where you know I wonder if there was an opening [in another community], what I would do (Participant, uaT).
Recent research investigating interventions to support nurse retention in rural and remote places found professional isolation and poor working conditions were barriers for effective retention (Mbemba, Gagnon, Paré, & Côté, 2013).

Some study participants expressed concerns that management may believe that when the facility is closed (usually due to lack of physician availability) full nursing staff coverage is not required. It is unclear why the health authority management had moved toward a decreased model of staffing, given that rural ER department closures did not appear to be a deterrent for patients trying to obtain medical care:

You know, there’s two nurses [per shift] and there’s no saying of what can come through the door. Just because we’re rural doesn’t mean we don’t have sick patients (Participant, 2GV).

According to participants in this research, “because even on the nights that we’re closed, we’re never truly closed” (Participant, QSM). Another nurse added, “but being closed at night we sure get a lot of phone calls” (Participant, Vv0). Indeed I was present many times during my fieldwork when the ER was officially closed to admissions, yet people would enter the facility seeking medical attention (Fieldnotes). I frequently observed patients and families calling the facility to talk to the nurses and seeking information and guidance (Fieldnotes). I also learned from nurse participants that similar problems occurred in other rural health regions.

In summary, rural hospital ER closures due to physician and other health care provider shortages is a well-documented barrier to rural patients accessing health care. Gaps in rural specific policy structures created practice complexity and raised concerns for both provision of safe patient care and for nurse safety. The
multiple factors that impact the imbalance between the health care needs and the availability of health care services for rural populations is discussed in the following section.

6.3. Supply and Demand Imbalances Impacting Access to Rural Health Care

Health care provider shortages impact health care facility operations. Study participants had many concerns regarding how rural health care was being provided. These concerns were focused around the issues of accessibility, availability, and the affordability of health care services for patients, families and rural communities. Access can be complicated by many factors in rural communities, including economic, psychosocial, organizational, geographical, and temporal barriers (Moss, Racher, Jeffery, Hamilton, Burles, & Annis, 2012). Availability refers to the provision of existing services and resources, including human personnel and infrastructure, to provide health care services, programs, and facilities to meet health care needs (see Bushy, 1995; Moss, et al., 2012). Affordability relates to the ability of both the patient and the health care structures to pay for services (see Moss et al., 2012). All three relate to the most challenging issue for rural nurses in this study: that of the acceptability of the level of care provided and the extent to which the level of care provided is congruent with nursing values. Acceptability also refers to the fit between the nursing (and medical services) offered, and the actual services required by the patients, families, and communities served. Further, acceptability is about how well services offered fit with patient health beliefs and values (see Bushy, 1995).
6.3.1. **Accessibility: About More Than The Doors Being Open**

The lack of available physicians and the policy-driven need to have physicians physically present (to provide the doctors’ orders required for medical care) for the ER to be open directly impacts both accessibility and availability of rural health care services. In some cases the lack of access to medical care resulted in tragic outcomes. As one participant claimed, “We’ve had people die because emerg[ency] wasn’t open” (Participant, kHA).

The lack of physician coverage is a barrier to the timely provision of appropriate health care. The continued reliance on physician availability as the sole criteria to providing rural emergency services further marginalizes rural population access to timely care, and limits any exploration of other options such as using nurse practitioners (NPs) to provide better accessibility (Archibald & Fraser, 2013). One participant explained the frustration that results when physicians are not available and policy dictates that the facility must be closed to patient admissions:

> It’s kind of an oxymoron when you say you’re a hospital and they walk in and you have to call the ambulance to take them away. That’s not right. And then not even being to keep people – you know, we can keep you here until 6:00 and then I don’t have a doctor so now we have to either discharge you or get you a bed somewhere else into hospitals that are already full and overcrowded. And sometimes it’s just a matter of watching them and giving antibiotics, whatever, basic nursing stuff you can do. But can’t do it because nobody is there to back you up should something go wrong, because there’s no doctors on call (Participant, s5o).

ER closures were experienced as disruptive by the nursing staff. Rural ER physicians themselves have also questioned emergency department closures in rural health care, suggesting, “service cuts may contravene the accessibility clause of
the Canada Health Act, a key feature of our universal health care system” (Fleet, Plant, Ness, & Moola, 2013, p. 57). One participant, when asked about her experiences of ER closures as a rural nurse, responded that, for her:

[ER] closures are a moral dilemma - we are screwed both ways – if we turn someone away we feel sick about it - if we provide treatment without a doctor’s advice we’re in trouble (Participant, cJ2, follow-up).

Study participants had moral concerns about how the decreasing levels of access to rural health care produced increasing levels of inequities in access, particularly for those who could not self-transport to another care facility, such as children, those economically marginalized, and the frail elderly. Rural nurses also had moral concerns about how the closures impacted nursing practice and placed them in morally complicated positions.

I frequently witnessed staff trying to explain to patients why the hospital was closed, and why they were calling an ambulance to transport the patient to another facility. One participant explains the process undertaken when patients attend the ER while the facility is closed to admissions:

If I don’t have a doctor and a patient needs help then I contact 9-1-1. Same as if someone shows up and they say ‘I just drove by the closed sign but my husband had a stroke in [another town], I’ve just driven 40 minutes to get here, can you help me?’ Of course I can help you but it’s not with doctor care immediately, it’s me doing the assessment, I phone the physician in [the city], based on my assessment we decide if there’s something else I need to do before they go by ambulance to [the city] (Participant, dLK).

At times family members refused the suggestion that the patient should be transported by ambulance to another facility. I noted in my observations the reason given was often related to the costs (Fieldnotes). This refusal to travel to another
care facility can create further moral issues for rural nurses, as the following excerpt explains:

Whatever their reasons, they don’t want to go to a bigger facility. But yet I don’t feel safe in sending them home. What do I do? I have these moral dilemmas (Participant, kS3).

After witnessing a particularly threatening vocal outburst from a frustrated and apparently scared parent who was attending the ER department after hours seeking help for his/her child, the participant involved in the interaction remarked, “some days it’s like juggling dynamite—you never know when they [patients and families] are going to blow” (Fieldnotes). Despite the rural health care provider’s commitment and efforts to provide care and facilitate alternative care arrangements for patients, the lack of local access and availability of affordable health care services in rural home communities cultivates a feeling of substantial inequality.

The nurses perceived a lack of government acknowledgement of the need for better rural health care. This perception fueled their anger — particularly when rural patients and families were forced to travel for care:

I think what governments fail to see is that probably the majority of people that live rurally have 3rd class access to health (Participant, p5q).

Participants, who were often faced with the unpleasant task of redirecting patients and families to alternative facilities, also perceived what they interpreted as political rhetoric and platitudes:

They, [the politicians and health authority management] like to say that there’s this seamless continuity of health care, which is [false]. And that everyone living in B.C. or [within this health authority region] has the same access to the same care. Well that’s also [false] (Participant, kHA).
Participants perceived that the administrative decisions prioritizing and allocating health care resources did so at a level that resulted in a “3rd class” level of access to health care in rural communities.

6.3.2. Access Inequities and Complexity in Rural Ambulance Service

The availability of, and access to, ambulance services in rural health care is a critical resource for rural nursing practice and patient care. The relationship between rural nurses and the rural ambulance system is further complicated by administrative decision-making and policy directions beyond both the ambulance attendants’ and the rural nurses’ control.

The transfer of rural patients to urban centres was described as a result of past cost-containment strategies, which resulted in the removal of rural acute care beds. Because of the lack of acute care beds, rural nurses engaged in an often-complex process of obtaining timely access for patients to the ambulance transport service:

It used to be 15 phone calls and nobody knew which end was up. However there’s 3 different ways to phone an ambulance (Participant, dLK).

Although the process had undergone recent changes, according to participants, difficulties and delays continued. I observed many instances of both nursing and medical staff trying to navigate the ambulance labyrinth:

A few years ago provincially they came out with the patient transport office, which is government, which we call 8 in the morning till 8 at night for all transfers unless its LLTO [Life and Limb Threatened Organ], I just find that’s put another level of bureaucracy into getting an ambulance. And we’ve had more issues since they’ve come to be than we’ve ever had. If we could just talk to dispatch ourselves which was the other way - we
got ambulances much faster, sometimes you can sit on that line waiting for 15 minutes before anybody even answers you (Participant, p5q).

The long delays in accessing the patient transport office to arrange for service are not the only structural issue impacting nursing practice and patient care. There are often significant delays that neither the nurse nor the rural ELS [emergency life support] ambulance crew has any control over:

If I have people sitting in my emergency waiting for transfer I have no control over when the ambulance may or may not be able to come and get them because that service is a different stove pipe than health care. It has its own funding and it has its own rules and it has its own dispatch and they decide in order of priority who goes when and where the ambulance is coming from to get your patient (Participant, dLK).

The uncertainty around timely access to rural ambulance service is significant because it forms another layer of inequity in rural health and health care access. When the context of the rural facility is taken into account, reliable and timely access to ambulance service takes on a dimension of increased risk of harm to patients and risk to safety that urban-based ambulance dispatchers may not fully understand:

The wait times are incredible...you know, sometimes we will say...'we've got this patient' and they say 'well okay we’ll be there'. You know, we’ll phone them at five and they’ll say they’ll be there at eight. [And we say] ‘Well no, I don’t have a doctor. I close at 6:00’. ‘Oh well, you know we’ll try our best and get there when we can’. So you’re sitting on a patient when technically you’re closed. I mean our doctors are pretty good at that point. You know they’ll continue care until they come. But really closed means closed and they shouldn't have to do that. But on the other hand we shouldn't be closed (Participant, 2GV).

The relationship between rural nurses and the ambulance service is complex. The inability of emergency life support [ELS] crews to perform certain medically
supportive tasks can be a source of frustration for nurses who were used to working with more advanced trained ambulance personnel:

And the other problem that we have is we only have ELS [emergency life support] crews here. They’re not trained in advanced airway management or they’re not allowed to give much in the way of medication. They’re not ACLS [Advanced Cardiac Life Support] trained. So that’s a problem because all the paramedics live, all work within a few minutes from major centers. They don’t work rural, which to me is kind of crazy. They should be working rural because I mean when I worked in [major metropolitan centre], our patients would be intubated, a couple of IV’s and the first line drugs all given before they even got to our department (Participant, mi3).

The working relationship most nurses have with the ELS crews was described as mutually respectful and the nurses perceived the ambulance services as a structural resource that assists them in providing the best care possible to rural patients. The nurses were also appreciative of the specialized ambulance service known as HART. (High Acuity Response Team) that is often called in to transport critically ill patients safely to the next level of care. This urban-based service not only facilitates safe transport of patients with state of the art equipment, but because it has its own medical staff or nurse it also allows the rural staff to remain in the facility to care for other patients. As one nurse explained:

HART (High Acuity Response Team) started because 1 RN and 1 physician in a small community needed to get in the back of an ambulance and left no coverage. It’s been a huge boost to rural health care I think because the patients get the appropriate people taking them in and they’re waiting in a safe environment for that to happen because they’re going to be with a doctor and a nurse. And then my community’s not left with nothing (Participant, dLK).

Rural nurses and physicians are unable to access the local ambulance service directly and appear to have limited knowledge of what service levels are available in
the community at any given time. The inability of rural physicians and nurses to collaborate with the local ambulance resources, and the resulting lack of knowledge about the service level gaps have a direct impact on rural health care and rural population health.

One example of a structural gap is that ambulances in rural areas lack 4-wheel drive capability to navigate mountain roads. In my fieldwork observations I noted that when ambulance crews needed to travel certain roads they requested community members with appropriately equipped 4-wheel drive vehicles to assist them. I also noted the ambulances were not equipped with suitable studded winter tires which would provide better traction on winter roads. In my analysis, this lack of integration of related health services points towards the need for more coordination and collaboration between leaders and decision-makers behind the rural health care structures to ensure better harmonization of resources.

6.3.3. Affordability: The Financial, Physical and Emotional Cost

In addition to the issues of access and availability of health care services, participants in this study were concerned about the general affordability of travel cost to obtain health care services for rural populations. They perceived travel to obtain necessary health care services as part of an increasing financial burden for community members. Fleet et al. (2013) identify the affordability issue in rural health care as an “increased burden that travel consequently imposes on patients and their families, who often travel for time-sensitive emergency care” (p. 57). Similar to Fleet et al.’s study findings, participants in my study expressed concern that many community members might not be able to physically access health care
services in other locations because of the cost of travel and other social barriers. The additional cost for medical travel due to hospital closures can be a significant economic barrier for some rural residents. The lack of access to health care services is further complicated by geographical, environmental, and travel hazards as well as significant social barriers including poverty. This participant shares a common affordability issue she encounters in her everyday practice:

There are people that just can’t afford the gas. They don’t – they don’t drive themselves, they don’t have somebody else that will drive, or they can’t afford... not everybody can afford it or – or have somebody that can drive them in. And the time as well the – you know it’s an hour there and an hour back and ... I think there are definitely people that do without (Participant, kHA).

The loss of income to the rural working poor for having to take time off work to travel to another location to access health care services, the cost of childcare, or the lack of access to transportation for those who cannot self-transport (for example the elderly) were identified by many participants as a common barrier for many rural residents:

You know, we have quite a few elderly that, you know, can’t drive or no longer are able to drive or shouldn’t be driving (Participant, s50).

Many small rural centres have few structural resources (such as a public transportation system) to deal with the ever-increasing elderly population. According to participants in this study, the creation of seniors’ housing, assisted living, and long-term care facility beds for permanent placement for seniors requiring increasing levels of care has not kept pace with the needs of the community. As a result, study participants informed me that many rural seniors remain in their homes, at times in unsafe living situations, while waiting for a long-term care (LTC) placement (Fieldnotes, s50, Follow-up). According to participants, many rural patients requiring increased level of care remain in inadequate living
situations, often with an overburdened elderly care-giving spouse. They choose to--or feel they have no choice but to remain--in these inadequate conditions because the first available palliative bed often is located in another community, and the financial and other barriers associated with an outside placement are unacceptable to the patient or family:

The financial cost, not to mention the emotional and physical aspect of this outside placement, is tremendous on the family, wishing to be at their loved one’s side. Many seniors cannot drive, or choose not to drive the mountainous roads (Participant, p5q).

The struggle to provide local rural palliative care services under the current ‘first available bed’ policy\textsuperscript{51} in a region covering over 200 thousand square kilometers in size\textsuperscript{52} was challenging for care providers to navigate. This is because there is an increasing demand for LTC placements due to aging populations. The health authority policy, which directs that a patient must be admitted to the first available bed in the region, was described as unpalatable for many rural patients and many may go without palliative care or LTC placement because they do not want to leave their community.

Nursing staff believed that the transfer of patients to other communities for LTC care strained family relationships and interfered with supporting the rural values of community and family:

So if you have someone that’s in palliative [care program] that needs a long-term care bed we have no beds open here. Sometimes they can wait here ‘til the preferred bed comes open. Sometimes it’s a gamble because if [the patient] doesn’t end up palliative, they have to go first available bed, they will be moved to where the [LTC] bed is to open [to free] up your palliative bed And that’s a struggle that we’ve had because now you have, take this one person who is, was deemed palliative but isn’t dying

\textsuperscript{51} The first available bed policy directs that patients requiring a LTC placement, palliative, or end-of-life care are to be admitted to the first available bed in the region. The ‘first available bed’ may not be located in, or near, the community where the patient currently resides.

\textsuperscript{52} For perspective 200 thousand square kilometers is roughly half the size of the entire country of France.
right today and now you’re going to shift them to a different community and their family members now have to struggle trying to see them. Which, you know, because they are still palliative [they] could die tomorrow (Participant, s50).

The finding of inadequate palliative and LTC care services is similar to other rural research findings in B.C. (Robinson, Pesut, & Bottorff, 2010).

**6.3.3.1. Aging in a Rural Place**

Although participants in this study worked in various positions within the health care facility and had differing professional responsibilities, every participant expressed concerns for meeting the health and well-being needs of aging community members. According to Statistics Canada data, seniors (age 65 years and older) account for 15% of the population in rural areas, which is higher than the urban Canadian average of 12% (Dandy & Bollman, 2008). With the impending demographic shift created by the Baby Boomer generation, the elderly population will continue to increase in rural places. This demographic shift suggests many seniors will be aging in a rural place where their health outcomes will be highly impacted by access and availability of health care services (see Dandy, & Bollman, 2008; Robinson, Pesut, & Bottorff, 2010). The increasing numbers of seniors aging in a rural place will also impact the health and well-being of family members—particularly rural women who often assume care-giving roles (Crosato & Leipert, 2006).

The imbalance between an increasing need for health care and decreasing access due to frequent turnover of rural physicians was cited as a concern for the growing rural elderly population. It was cited as a challenge for nursing staff to try to manage large populations with chronic and age-related conditions with limited
resources. The turnover of medical staff also presented challenges to the patient-physician relationship, with an emotional toll to the patient when the continuity of care is disrupted, as noted in the following account:

Older people want to be able to have a doctor. They want to be able to go to the Emergency department. So I think we’re seeing a change in the way people live actually because of the way the healthcare system is being, has changed. The biggest concern there is that the doctors are changing here about every two or three years. And people want to be able to trust the doctor. They want to have continuity with their doctor. They don’t want to start all over again with a new doctor. And so they either follow their doctor to wherever he ends up going. We’ve had patients follow doctors to [other major cities], seriously (Participant, mi3).

Some rural patients had additional logistical and personal concerns beyond the affordability issues that often needed to be navigated by nursing staff prior to patient transport by ambulance to the next level of care:

Sometimes we send people to [the city] and they have no way of getting back home because their car is here in the parking lot or they don’t have family who can go pick them up (Participant, mi3).

The combination of shortages and frequent physician turnover was especially concerning for the frail elderly with chronic health conditions, who required more intensive physician support and services in order to safely continue “aging in place” (Dandy & Bollman, 2008, p. 1). The notion of trying to safely “age in place” in a rural community with limited access to limited resources for health care, is described as:

a catch 22 [when elderly rural residents] get to a certain age where they develop more health issues and they end up moving. They move to a bigger centre... overall we’re not really meeting the needs of the population by forcing them to give up their retirement homes to move into larger centre just to be closer to doctors and hospitals and what have you (Participant, mi3).
Thus, there appears to be a logistical vulnerability related to physical geography and the ability of some elderly populations to age safely in a rural place. Romanow’s (2002) claim that geography needs to be viewed as a determinant of health reflects this lack of attention to the personal challenges Canadians face in aging in small poorly serviced rural communities.

6.3.4. Availability: The Structural Recruitment and Retention Cycle

In further compounding the problems noted above the chronic tension of recruitment and retention of rural physicians was described as a “vicious cycle” by one participant as she explained how the recruitment and retention cycle also impacts rural nursing practice and service to patients:

So – and then we had problems getting physicians [a few] years ago and we had a small number of physicians so emergency room hours were cut because that’s all we could service. And it’s – it’s been difficult recruiting doctors and then recruiting staff to keep – it’s a vicious cycle: you don’t have the doctors, the nurses are bored if emerg is not open and they go on – especially the young girls – to more exciting things ... like I say it’s a vicious cycle, you lose nurses, you lose ER hours (Participant, p5q).

The cycle of shortages of nurses and physicians in rural Canada and internationally is well documented in the nursing literature (Viscomi, Larkins, & Gupta, 2013). However, participants in this study also identified shortages of other health care providers such as LPNs, physiotherapists, and other allied health care professionals including diagnostic technicians. To date, allied health care provider shortages have not been well documented in the literature. Because of staff shortages there was a limited availability of nurses to cover staff illness or a personal leave-of-absence to care for a sick family member. Nurses experienced emotional stress as a consequence of trying to make good personal choices about
their own health or their family's wellbeing. An example given was the emotional cost they paid when deciding to call in sick—or go to work while ill:

Doctor and nurse retention is the biggest thing I can think of. You know, it’s crazy that for us to not want to call in sick or not take all of our vacation dates because we have no coverage. We have nobody to cover for us and you know, like I said, you don’t want to [call in sick], I can’t stand the thought of this place closing because I called in sick. You know, and like but we deserve sick time. We should be allowed to take time off when we’re sick, you know [laughing] or take time off to go to education or take time for vacation or if you need time off for family emergencies (Participant, 2GV).

The level of personal responsibility taken on by this participant to keep the doors open can be explained in part by her personal experience with staffing issues and facility closures. She explains a more personal reason for her motivation—she is also a rural resident:

People have asked me, you know, why can’t we keep doctors here or nurses here? And well because not everybody loves the lifestyle we love. People want shopping [laughs]. Me living in [small rural place], I have to drive to [the city] to buy my groceries. That’s an hour and a half, you know, just to buy food. And some people can’t live like that and they don’t want to live like that. And it’s not worth it for them. But for me it is... but I also think that we deserve just as much adequate healthcare as a person living in [the city]. And we deserve to get x-rays too on our broken legs [laughs] the night that we go to Emerg [ency] (Participant, 2GV).

The participants in this study characterized the lack of physicians and other care providers in their rural communities as a chronic ongoing issue. The shortage of rural physicians, RNs, NPs, and other professionals in Canada has fostered a federal Canadian Government initiative that offers financial incentives in the form of student loan forgiveness to medical professionals who agree to practice in eligible
designated communities with populations under 50,000 (Employment and Social Development Canada, 2014).

According to one participant it should not surprise anyone that “in small communities you have trouble retaining doctors” (Participant, kHA). Many participants told me stories of efforts their communities had made over the years to attract and retain physicians—including offering furnished housing and feeding young doctors (Participant, p5q). Participants expressed concerns that the shortages of physicians in rural communities has even forced communities into competition with each other to entice both Canadian and foreign-trained physicians to practice in their communities. As an example of this increasing competition to attract physicians, during the course of my fieldwork I became aware of a rural community that had installed a highway billboard sign to entice physicians to relocate and practice in the community. One participant particularly disagreed with health authorities and rural communities offering financial incentives to entice physicians to take on a rural practice, because offering competing financial incentive packages, she claimed, often:

pits one community against another for doctor incentives... I know our doctors’ offices over the years, one of their employees; let’s say their office managers probably spent 40% of her time always in the recruitment mode like over the last 30 years (Participant, p5q).

This nurse also suggested that past recruitment and retention models based solely on financial incentives have not been entirely successful. Indeed, the Canadian Medical Association conducted a survey in 2008-2009 to examine the factors physicians considered when choosing to practice in a rural setting. Although
financial incentives were a strong factor in deciding to choose a rural practice, lifestyle and practice contextual features, such as workload and professional support, were more persuasive factors in attracting and retaining physicians in rural communities (Chauban, Jong, & Buske, 2010).

6.3.4.1. The Revolving Doctor Door

Nurses described the frequent turnover of medical staff and the increasing need to use locums to cover physician vacancies as the “revolving door of doctors” (Participant, 2GV). The constant turnover of medical staff was said to have implications for nursing practice:

I think it does become challenging when in the small place there’s the turnover of the doctors and you’re just not knowing what to expect (Participant, Vv0).

High physician turnover often resulted in staff needing to quickly evaluate new physician practice competencies in order to optimize patient safety:

I’ve never felt so panicked in my life, seriously, figuring out through a vehicle trauma that this doctor has no idea what he was doing” (Participant, Vv0).

Rural physician shortages and the resulting service cuts by health authorities are known to negatively impact rural patient safety and access to health care services (Fleet, Plant, Ness, & Moola, 2013). Many rural communities in the interior of British Columbia are experiencing difficulties in recruitment and retention of physicians. Participants in this study raised questions about the impact these difficulties may have had on past hiring practices, and how the current shortages

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53 *Locum*, also known as *locum tenens* (the Latin words meaning place holder) refers to temporary or substitute physicians employed on an interim basis to cover for regular physician vacancies.
may impact future hiring practices and what that could mean for long-term patient safety:

It is so challenging. It is getting a little bit easier for me now five years in but at the beginning when I’m a new grad and they’re a new doctor and they’re asking me what I should be giving and...[Or] how they should be doing [something] I had one particular instance when we had a doctor that the day I met him when he came here I said, ‘I don’t think this man is a doctor’ (Participant, 2GV).

6.3.5. The Reciprocity Between Physicians and Nurses

Notwithstanding the serious challenges I have noted above, nurse participants in this study expressed that they had mutually respectful collaborative working relationships with most rural physicians. Participants reported that they had made purposeful efforts to support and complement the practice of rural physicians in order to better provide care to patients:

You get to really know your doctors because you get to work with them very intimately and you get to know their strengths and weaknesses. You try to complement and you try to work, you know, to the best of your ability and you try to help them be the best they can be (Participant, mi3).

This apparent reciprocal — mutually dependent and respectful relationship — between physicians and nursing staff was experienced by participants as being mutually beneficial, although, at times, navigating it was perceived as challenging for both nursing and medical staff.

In discussing the issue of collaboration between physicians and nursing staff one nurse participant shared her perceptions of the reciprocal relationship between physicians and nursing staff and the rural workplace culture:

I think it’s more unspoken. It’s sort of a, it’s more of an understanding that I guess we know what our expectations are as nurses there in terms
of I think because the trust is given to us more in terms of our responsibility there. And because a lot of times you do socialize out of work, you are more friends I guess in a way. You know, my one doctor there, he's my own [family] doctor, we also socialize outside of work. So you've got that friendship going too. You can throw out ideas to each other and talk about it together. Yeah it's not a 'I'm the doctor and you're a nurse.' It's not that type of relationship (Participant u64, follow up interview).

This unspoken reciprocity is one of shared trust and understanding and extended, at times—especially during physician shortages—to protecting rural physicians from what the nurse participants perceived as overwork. Participants took on the role of being the physicians' keepers by helping to structure the physicians' workload through managing non-urgent patients in the ER. This would often entail the RN managing patients in the ER without interrupting the physician so the physician could complete his/her office cases before attending the ER. This arrangement might require the non-urgent patients to return later to be seen by the doctor, or might require the patient to make an appointment with the physician's office (located in the same facility) to be seen at a later date.

This informal reciprocal and mutually beneficial arrangement, according to study participants, required the physician to be willing to attend the ER department when called by staff to avoid creating a backlog of non-urgent patients waiting there to see the physician. The role of gatekeeper was described by participants as intended to protect rural physicians from burnout, and it was my observation that the act of gate-keeping by triaging out non-urgent patients was a practice strategy that functioned to ensure that the physician would respond quickly when nurses did call. Nurses further explained that if the patient was triaged by the RN and found to
be non-urgent (that is a CTAS level 4 or 5\textsuperscript{54}) then the RN might weigh the potential patient risks. In doing so, the nurse might make the decision to ask a non-urgent patient to return in the morning to see the physician, rather than wake the physician up (Participant, cj2, follow-up).

This form of gate-keeping has the potential risk for nurses practicing out of scope of professional practice guidelines. Although no participants described treating patients outside of their scope of practice, the act of gate-keeping in the rural context has the potential risk for non-compliance to scope of practice professional practice boundaries—especially during times when the nurse is “it”.

6.4. Impact of Structural Inequities on Rural Health Care Sustainability

The structural challenges discussed in the previous section impact the accessibility and availability of rural health care services and are linked to the sustainability of the rural health care system. For many participants, the ability to satisfy the health needs of the population is complicated by structural barriers outside of the nurses’ span of control. These outside influences are perceived by rural nurses to be barriers to providing quality care. This participant listed some of the barriers she encounters in her practice:

[Regional referral tertiary level] hospitals, waiting times, ambulances, lab on call, now with x-ray they are, you know, staying in [the city] when they’re on call. So the physician has to decide, is this worth getting them to drive here for an hour and a half or can this patient wait until tomorrow? Or do we send them to [the city] and that is so wrong to me. Like, you know, it’s so wrong. We don’t deserve worse treatment or worse healthcare because we love where we live. It’s not fair. It’s not fair (Participant, 2GV).

\textsuperscript{54} See page 83 for a full explanation of the CTAS triage system.
The need to refer patients with complex health challenges or needing addictions treatment to facilities in larger communities because of unavailable programming or limited service options was frustrating according to one participant. The need for these patients to travel for treatment was a barrier:

And it's really frustrating having to refer out all the time. You know and then my clients say 'I don't want to travel there' (Participant, uaT).

The challenges experienced by this study's participants also stem from historical decisions made to decrease the number of acute care beds in rural facilities as part of government downsizing and efficiency movements in previous decades. This participant reviews the historical changes to rural health care structures, which have present day consequences:

We were a 42 acute care bed [facility] initially and probably starting in the 90s the government started chipping away at acute care beds I think in most hospitals. And we'd lose a couple here and a couple there and I don't want to blame any one government because they've all done the same (Participant, p5q).

Reflecting on changes in rural health care structures over her career, this participant said:

A lot has changed but some things haven't changed at all. The bed crisis was a problem back in the early '80s. Staffing was an issue back in the '80s. I had one friend who quit her full-time job and went traveling for a year. She came back a year later into the same job she left. It never got filled the whole year she was gone. That was back in the mid '80s. So certain things haven't changed at all...They act like it's all a new problem but it just keeps rearing its head. It never gets dealt with and I don't know how to fix that. I really don't [laughs]. I've seen it for so long and I still haven't figured out how to fix it (Participant, mi3).

Another participant also relates that the structural changes are ongoing and workplace conditions continue to decline. She explains that rural nurses are
creating remediation strategies in order to mitigate the effects of the cost containment strategies of the health care structures:

And things have changed. You know, they say it’s not for the better but that’s to do with costs and, you know, budget. They’re always cutting back and I think because we’re nurses and we’re all caring, I think you do the best you can with what you have (Participant, Sh6).

In summary, the ability of the rural population to access timely health care services is strongly mediated by power structures, including policy and management processes, efficiency discourses, decreased structural supports and decreased resources for health and health care services. These include the lack of rural physicians and lack of twenty-four-hour and seven-day-a-week access to care providers. The inability of rural populations to access health resources was linked to broader structural and policy barriers that formed systemic health inequities. The impact was especially noticeable among the rural poor and the elderly who were unable to self-transport to an open health care facility in another location.

The challenges for access and resource gaps identified by study participants were not unique or localized to the facility where the research was conducted, but were said to be common in their practice experiences across B.C. and in other provinces. According to MacLeod (1999), issues impacting rural practice are not wholly dependent on local health care structures, but “also on systems and structures that lie beyond the small communities” (p. 167). With this in mind, the challenges in providing health care to rural populations should be viewed with a broader lens.
6.4.1. Rural Nurse Education

Further structural challenges that impact rural health care provision include a lack of targeted funding for rural nurse education. The lack of financial support for mandatory practice certifications and required rural practice specialty courses is thought to inadvertently create a threat to rural health care sustainability, patient safety, and workforce retention:

And they [management] would say, ‘Well there’s no money in the budget.’ What do you mean there’s no money in the budget? Nobody else has done anything all year? I’m the one person who is asking to go to a course and you’re saying no we don’t have the money? What do you mean? Like, it’s, what, $300. I don’t have an extra $300 to pay for a course that you say I need to work here. Yeah it doesn’t make sense to me (Participant, 2GV).

In this instance the rural nurse questioned the rationale behind the refusal to provide funding to complete a course understood to be a requirement of employment. This nurse was also disappointed with the lack of educational opportunities offered in rural settings and states “it is very frustrating to me that we don’t have the resources that a larger facility has” (Participant, kS3). Cuts to education and support resources have been noted across all arenas of practice (Rodney & Varcoe, 2012). The assumption that “urban receives more continuing education” may not be entirely correct in the current fiscal climate.

In general, nurses in this study came to the conclusion that they, unlike their urban counterparts whom they believe have unrestricted access to clinical education resources (which may actually be an incorrect assumption), are responsible for acquiring continuing education and maintaining clinical skill and practice competencies on their own:
I think one of the challenges for rural nursing is the education component is left to you. You know, like at [the tertiary city hospital] and I would imagine at other big hospitals they have educators in each department. And they set up education days. Up until last year we really didn't have anybody and now I've been doing that on top of my other work. You know, so and I'm not an educator by any chance but I try to find the people who can bring it in...But really you don't get taught things as much. Like, sometimes...the HART team will come out to pick somebody up and they'll say, 'Oh well this is the newest thing.' Well we haven't even been taught that. It's like we're expected just to learn without anybody coming out and making sure you know what you're even reading. I don't know what else. Kind of, yeah, education is a hard thing, very hard (Participant, QSM).

Participants constructed this discrepancy in fiscal prioritizing for educational needs of urban nurses as just another way in which rural health care is structurally under-resourced, to the point of not even providing the same level of educational opportunities afforded urban nurses. The need for supporting continuing education and improved access for rural nurses to educational resources was expressed as important for study participants in order to improve or maintain their clinical skills and knowledge base. The need to have appropriate support resources for rural nurses to adapt and meet the changing demands of rural nursing practice is discussed in the following section.

6.4.2. “We Are ‘Flying by the Seat of Our Pants’ Some Days”

Participants described "flying by the seat of our pants" as a necessary response to ongoing structural challenges in areas such as access to health care services, unpredictable patient care crisis, or the introduction of new routines or policies that impact the day-to-day operations. Both structural and unpredictable contextual challenges were cited by many participants as factors that forced nurses to draw on their knowledge, make decisions, and adapt their nursing practice
quickly in order to provide the best care possible in the circumstances that lacked appropriate structural resources and practice supports:

Sometimes you 'hit the ground running'. And that expression means, you know, as soon as you walk through those doors, you have to jump in (Participant, kS3).

The ability to adapt to changing workplace conditions, routines, or altering patient care needs was expressed as a skill nurses required for rural practice. I noticed that the nurses appeared to be proud of their ability to adapt. The adaptation response to unpredictable work environments was described in the following:

We’re not supposed to have patients come in [into the health care facility when the ER is closed]. We have our set of chores that we’re supposed to do at nighttime and we’re not supposed to see patients. But sometimes they come in. They know that there is a nurse here and if they need emergency help, sometimes they’re, like, we’re going to the closest place that we know that we can get help. So you adapt...People don’t plan heart attacks. People don’t plan to be short of breath. People don’t plan to be sick. It just happens when it happens. And so when it happens to be at shift change, well, you adapt (Participant, kS3).

Often the process of adapting requires the rural nurse to anticipate the immediate care needs of incoming patients and begin to marshal available resources to cope with emerging or imminent crisis situations. Participants shared their experiences of what it is like to be “it” in those situations and how they adapted as they were “flying by the seat of our pants” (Participant, mi3). One rural nurse shared what the moments are like after receiving a call from the ambulance notifying the rural facility that they are transporting a critical patient to the ER. “In that five minutes you have to prime lines, you have to get all your equipment set up and think, hmm, now who is in this building? Who can help me?”(Participant, kS3). This ER nurse explains other strategies used by rural nurses:
well we sometimes will grab staff from next door. We'll grab, like an LPN. Or I even grabbed... Actually in the past I've grabbed lab staff or the x-ray technician, whoever happens to be walking by and get them to... You know, you just use what you've got... depending on what comes in and the resources you have. And that doesn't just go to immediate staff. It goes to support staff too. Yeah, I've even grabbed the housekeeper if I have to. [laughs] It's [helping out in the ER during a time of crisis under the direction of the RN] not beyond their capability but some of them, they can manage. So I mean, yeah, it's like everyone pitches in. Which, you know, is something you wouldn't see in a larger centre (Participant, mi3).

I learned from the participants in this study that the unpredictability and inconsistency of access to health care resources and continuing education had a significant impact on nursing practice and the provision of safe patient care. Rural nurses in this study linked the inconsistency of resources and ongoing hospital ER closures to provider shortages—especially rural physicians that left nurses in situations where they were “flying by the seat of [their] pants.”

6.5. Crossing the Lines

“Crossing the lines” concerns the explicit and implicit social rules embedded in rural practice structures and the consequences of the overlapping social and contextual dynamics of practice. Professional and personal lines are often blurry and at times appropriate social lines may get crossed in rural practice. The multiplicity of roles taken on by rural nurses, the act of “wearing 100 hats”, was expressed by one participant as a contributing factor to professional and personal lines getting crossed (Fieldnotes). For most participants, personal lines were easily crossed because of the reality of small town rural living and relational interconnectedness of health care in this context. One study participant recounts:
it’s very hard to draw a line between hospital and community and therapist and patient or nurse and patient. It becomes quite blurry (Participant, kHA).

The lack of clarity regarding appropriate boundaries has been identified in the nursing literature as problematic and ethically challenging (see Bushy, 2002; MacLeod et al., 2004a; Stewart et al., 2005). In this study participants shared similar concerns for lack of visible clarity on the overlapping of roles, because in the rural context:

there’s such a greying in areas...[especially] in a rural site to try and keep confidences...I’ve been a patient here myself too you know...and [when] you come in [here] as a patient it’s... [really] ‘blurring of the lines’ (kHA).

The participants explained that they understood that the social aspects of living in a small place and the overlap of roles would at times cross over into the area of professional practice. Although they were mindful of the lines, they were also willing to cross professional lines when they perceived them as constraining or blocking access to what they regarded as appropriate, competent, ethical and necessary care for rural patients:

You know, I really advocated for it [transfer of a paediatric patient to next level of care facility] but it wasn’t going to happen [because the physician blocked all efforts to transfer the patient out to the next level of care facility] so, you know, you tell the parents, you know, ‘if anything happens, if anything changes take him directly [to the city] don’t come here, go straight to [the Emergency department in the city]’. You know, again maybe it’s an ethical thing when you know better [when you are aware the patient may suffer more harm because your facility lacks resources you try and share as much knowledge as you can for the patient and family to make informed choices]. You know, I think we’ve all done it especially in rural. Like, we’ve told patients to maybe get a second opinion or third opinion, you know. I think we’ve all done it. You know, there are ways of saying things to patients where I think they get it [the implied message to go to the next level of care facility] (Participant, u64).
This is a complex example of a rural nurse having significant concerns about the quality, competency, and appropriateness of the level of care and medical expertise offered to a rural patient. This participant felt constrained by the rules of professional practice in this context of the physician’s refusal to transfer the patient. This nurse struggled with an ethically significant practice moment and her reflection led her to act to try to balance the safety and well-being of the patient. She reported that she felt so strongly about this particular situation that she made the choice to enact agency to use carefully worded conversations with the patient’s family which implied the level of care in the rural facility was inadequate to meet the patient’s health care needs and that other health care options were available elsewhere. Her actions also illustrate her recognition of the limitations of rural health care resources and the need to act in ways that recognize the confines of rural practice. Her recognition of those limits enabled her to initiate a conversation with the patient’s family to suggest care alternatives. This conversation is an example of an intentional act of “positive deviance” (Gary, 2013, p. 26) in nursing practice towards the goal of providing quality, safe, and competent care to patients, families, and rural communities. The context of minimal health care resources also required her to step firmly over a line into enacting agency on behalf of this patient.

Another nurse spoke about the personal and professional challenge she encountered in the care of an elderly relative as “overstepping” the line in the context of being “it”:

Overstepping...[I] was overseeing [the patient care of an elderly relative that was in the ER]...and I was his nurse and there I am with my stethoscope listening to my [elderly relative’s] last...heartbeat...You know and part of me thought that this is so special. And part of me thought that
this is so...wrong...And I sat there afterwards...And I’m thinking...that to me is overstepping but that’s what I have to do because this is my place where I work (Participant, 2GV).

In this example the rural nurse found herself in the dual role of being both nurse and family member in the end-of-life nursing care of a close relative because of the contextual constraints and lack of available nursing staff. This participant felt a line was crossed when, as an unforeseen consequence of her work, she was the only nurse on duty when a family member passed away. The context of rural practice is one of unavoidable overlapping social and professional roles. At times the boundaries between the role of rural nurse and that of daughter, spouse, sister, cousin, or granddaughter are in conflict in rural practice, and the competing values this role overlap brings is a little-acknowledged ethical conflict commonly experienced by rural nurses.

Many everyday situations, such as going to the grocery store, challenged participants in this study to not cross lines by breaking normative rules of professional practice—yet at the same time they were expected to be engaged in socially expected behaviour. The context of rural nursing practice, including low availability of support, few diagnostic and other technical services for rural patients and the broader experience of rurality, was seen as contributing to study participants crossing professional lines. The lack of ethically preferable options in some care situations left some participants feeling that overstepping the lines was the only conscionable choice. There is a disjuncture between what many participants thought should occur (as in the preceding example where the nurse expected to transfer an injured child to the urban facility), and what they felt they
would have do in order to provide what they thought of as “good care” for the patient. In the preceding case, the nurse felt she ought to give the parents some carefully worded cryptic suggestions to take their child for a second opinion. Participants made it clear that difficult patient care situations often left the rural nurse to make difficult choices, which resulted in crossing the line.

6.6. Power Relations in Structure and Agency

The power relations in rural nursing practice are embedded in the broader cultural, historical, and structural context of the rural nursing practice. Participants in this study described their perceived position and their power in the structure-agency relationship through their use of the maxim “it is better to beg forgiveness”. The increased level of autonomy in practice decision-making that infrequent managerial oversight appeared to foster also appeared to facilitate a growing culture of nursing staff decision-making and self-empowerment. At times, this decision-making came into conflict with the various levels of health care management. There appeared to be a growing awareness by participants that they did possess a certain form of power, but at times structural policy barriers acted to constrain them from enacting it. The juxtaposition of the complexity of the unpredictable practice context and the perceived inflexibility of the health care structures created the perfect environment for nurses to challenge constraining structures. Later, if and when participants were rebuked for their actions, the rural dance between structure and agency taught them how to beg for forgiveness as a way to restore the balance and mutual exchange between structure and agency.
6.6.1. “Beg Forgiveness Monday Morning”

Bushy (2002) described rural nursing as having a rich history of resiliency, and that rural nurses are resourceful, adaptive, and creative in meeting the challenges posed by rural practice. Nurses explained that at times their need to adapt their practice to provide patient care meant they learned “it is better to beg forgiveness Monday morning than to try and find someone to make a decision Saturday night” (Fieldnotes). Nurses spoke of instances where they were "it" and had to adapt within patient care or hospital functioning situations without—or in contravention of—established rules or policies. One example of adapting and making decisions in the absence of administrative authority to do so is described below. In this example the impetus for action was said to be how the lack of appropriate resources and accommodation for out of town staff was compounding an already serious shortage of LPNs in the facility. The nurse claimed she took steps to adapt to the unfolding situation in an attempt to ensure the safety of a staff member against several layers of apparent structural resistance:

P: And there is a shortage, an extreme shortage of LPNs. It's terrible. And when we have...had several instances where a casual RN would come in and fill a shift. She was coming from [another community that was far away and had] nowhere to stay because [the residence] was full, yeah, I remember...it was after a day shift and she said, 'I'm just going to drive home. I'll come back in the morning.' She would commute here in the morning and leave her house at 4 [am] to drive here!

R: It's over two and a half hours.

P: And they knew that [the provided housing for out-of-town staff] was full. I said, 'You are more than welcome to go and sleep in my bed.' She said, 'No, no, it's okay. I'll go.' And then she was on the road and I remembered [local motel]. Because Management to solve the problem [of staff shortages] was funding the nurses to stay at [local motel] if this place was full. So I phoned the [local motel] and said, 'Have you got space?' I phoned her on the road,
got her turned around, ‘Come back and stay at the [local motel].’
And the [local motel] was saying, ‘Oh well, do you have approval?’
And I said, ‘I don’t care.’ I’ve got a casual nurse here who is driving
over two hours to get home? I said, ‘Yeah, they’re going to pay for
it’ [laughing]. Like, I don’t care because I will fight for this woman
to stay. Like, it’s not safe for her to drive. It’s ridiculous and I have
come in personal grief, fighting to get a proper [housing for out-
of-town staff] and been told there’s no money for it (Participant,
Vvo).

In adapting to the situation while “it” and taking a risk to ensure this staff
member was safe, this nurse encountered structural resistance and what she
referred to as “personal grief” over the decision. Even though there was supposed to
be provision in place to accommodate overcrowding in the housing provided for
out-of-town nursing staff, this nurse explained that she needed to beg forgiveness
Monday morning for her actions. Taking the risk and acting on behalf of the casual
nurse without prior permission was felt to be the right action for this study
participant even though it resulted in sanctions. The context of inadequate staffing
and knowledge of the risk to patient safety that results from longstanding
recruitment and retention issues may have also influenced this participant’s choice
to act without authorization.

The research literature indicates that nurses are aware of the risks
associated with working while fatigued and that “patients are in potentially unsafe
situations due to workload, inadequate staffing and nurses working while fatigued”
(CNA-RNAO, 2010, p. 5). In retrospect, this nurse related that her practice has
changed in relation to how she was treated in this situation and in other encounters
she has had with decision-making while in the context of being “it”. She told me that
her mantra, like many rural nurses, is, “don’t ask for permission—ask for
forgiveness or something, right. Yeah. But now forget it. We ask for forgiveness” (Participant, Vv0).

Another participant described her position as:

My rule is you do it and you ask for forgiveness instead of for permission. All... in the context of the well-being of the client. I really don’t I don’t have a lot of patience for bureaucracy ‘cause I’m used to kind of having free reign in a small hospital (Participant, p5q).

This lack of nurses’ acceptance of bureaucracy in rural health care settings may relate to the history of rural nursing practice and the increased responsibility most nurses have in decision-making in the everyday conduct of their work, in environments where their practice is respected and their decisions supported by physicians. For example:

So you call them for a consult but they really relied on your assessment skills. And they usually let you make the decision. In fact, we didn’t always have to call them. If we felt that a patient had to go out, we didn't, like we didn't need permission. We sent them. We could even book air ambulance if we had to and then we consulted with the doctors in [regional referral centre] saying ‘we’re sending so and so’ (Participant, u64).

This study participant related that the personal connections and friendships she had formed with the regional referral physicians resulted in them having some understanding and respect for her assessment and decision-making skills. This level of understanding made the act of asking their permission in certain contexts unnecessary, for example to transfer a patient. In a subsequent interview the aforementioned nurse was able to explain that although she was able to make many patient care decisions in her practice, she was mindful to function safely within the defined scope of practice under the direction of a physician:
The doctors trust us a lot. They allow us to [make patient care decisions] I mean within reason — because it is within our scope of practice to suture (Participant, u64, Follow up Interview).

Participants said that they would avoid calling the designated manager especially during the night to ask permission because they wanted “to avoid the wrath of the manager for being woken up at such a terrible time” (Fieldnotes). In not seeking the manager’s input during the night hours, study participants inadvertently excluded the potential for the manager on call to offer suggestions or solutions or the opportunity to make good leadership decisions. This action also limited managers’ awareness of the rural practice challenges. At other times patient care situations were so dire that the process of contacting designated authorities to seek permission was delayed until after a plan of action had already been formulated. In this study participants were in agreement that “taking the heat” always felt better if they first canvassed for support from peers and available resources (Fieldnotes). Weighing the consequences after troubleshooting and brainstorming together was said to be easier than trying to make a decision alone. (Participant, cJ2; Participant, mi3, Follow-up).

The context of rural health care creates a significant propensity for nurses becoming “the beg forgiveness type” (Participant cJ2). The "we're it" burden of responsibility expressed by participants in this study raises questions about the practice challenges of trying to provide quality health care in rural Canada. The Canadian health care system as a whole has many challenges; two specific ones that are associated with the rural context—accessibility and adequacy of health care
services—have significant impacts on health (Romanow, 2002). Designated authorities may not easily understand the level of responsibility taken on by rural nurses, since many decision makers are urban-based and far removed from the rural practice context. There is a need for those in positions of leadership and policy development (both nursing practice and non-nursing leaders) to better understand the complexity of rural practice. If leaders and health care policy makers could more closely examine the overlooked complexity of rural nursing practice then perhaps the perceived need for the rural nurse to cross the lines and break the rules and then later beg for forgiveness in order to provide patients with quality care, may quickly become unnecessary in the future:

And I really think the government is kind of walking away, moving away from rural totally; that their focus is all on the bigger centres and we’re seeing that. That’s my impression over the last ten-fifteen years. You know, continually cutting back and doing more with less. And, yeah, it’s making it difficult for people to retire to rural settings (Participant, mi3).

Health care structures shape rural nursing practice. When, where, and how nursing and medical services are provided, are, to some degree, dictated by rules, policies, and other health care structures. Nurses know the rules, but they also have the knowledge, the ability to marshal resources, and the capacity to bend those rules by way of the dialectic of control (Giddens, 1984), shifting the balance of power, with the stated intention of providing quality patient care.

6.6.2. Policy Structures

Rural structures help to shape the work environment of health care workers, and the ultimate sustainability of healthy rural communities. This is similar to the Hunsberger et al, (2009) study that also questioned the sustainability of rural health
care in light of the complexity of rural practice and the increasing responsibilities of rural nurses in the context of low control over practice decisions. In that study, variability of rural practice structures was thought to present challenges for rural policy and practice development.

As noted throughout this study, urban policy and practice structures do not always fit the rural practice context, and subsequently present practice challenges for providing patient care in the context of rural resource inequities. A better understanding by health care administrators and frontline managers of the complexity of rural health care provision in the context of resource inequities is needed to address the problematic lack of fit between governing institutional policy and processes in resource allocation and rural health care needs. A greater understanding by health care leaders and managers about how the structural constraints challenge quality nursing care practices is required in order to decrease the need for nurses to cross lines and later beg for forgiveness in order to provide care. In a similar fashion rural nurses could also benefit from gaining a better understanding of administrators’ points of view and their workplace challenges. Further, we do not know enough about the moral stresses that managers and administrators face in increasingly constrained health care contexts (Mitton, Peacock, Storch, Smith, & Cornelissen, 2011; Musto, Rodney, & Vanderheide, 2014).

In the rural practice context, a trusting reciprocal and mutually beneficial

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55 Another way to gain a better understanding of the complexity of rural health care provision and the apparent lack of fit between policy and rural nursing practice may be to examine the rules or texts. Bisailon (2012), drawing on Dorothy Smith’s notion of boss or governing texts, explains that these texts supply the “context for what we can see, hear, and know... boss texts are authorized through institutional procedures through which specific people are instructed to carry out specific practices” and these texts are many layered (p. 610).
relationship between the rural nurse and the administrators and leaders within the structures of rural health care is an overlooked resource that could be strengthened to support “organic rural capacity” (Pesut, Beswick et al., 2011, p. 54). This research points out the need to build trust in the relationship between administrators who manage and support rural health care structures and rural nurses, as a starting point towards fostering moral workplaces that support quality care practices and enactment of moral agency.

6.7. Chapter Summary

The relationship between the rural health care provider and the structures that allocate and authorize resources for service provision in rural settings can often conflict over practice decisions made when the rural health care provider is “it”. Participants expressed a level of practice uncertainty around certain rules or policy structures. Structural inflexibility and the lack of availability, affordability, acceptability, and timeliness in access to health care services were often cited as the factors that frequently led to situations where policies, rules, or practice routines were debated, questioned, challenged, reluctantly accepted, or in some instances lines were crossed by nurses, in order to provide an acceptable level of care. Many nurses chose to enact their agency against the policy structures in consideration of what they saw as the best interest of the patient. They also reported that they did so willingly and with the knowledge of possible sanctions. An analysis of the findings also indicated that the structure-agency relationship was both supportive and at times adversarial. Nurses stated that their concerns about health care provision were not unique to the research site facility, but that they faced similar challenges in
multiple provincial health care facilities and across provincial boundaries in Canada. Study findings indicate that accessibility, availability, and affordability challenges in this rural location are similar to those in other research studies published on rural health care (see also Ministerial Advisory Council on Rural Health, 2002; Nagarajan, 2004; Pong, DesMeules, Guernsey, Manuel, Kazanjian, & Wang, 2012). The knowledgeability\textsuperscript{56} (Giddens, 1984) of the rural nurse was used as a resource to change practice through acts of agency. Albeit limited, nurses in this study used what resources they had available to provide care. The enactment of agency was not without risk to the nurse and the consequences of nurse enactment of agency will be analyzed in the next chapter.

\textsuperscript{56} Giddens’ (1984) definition of knowledgeability holds that humans know a great deal about the conditions and consequences of their daily activities and that knowledge of self and others is bound and embedded in everyday actions and routines. These actions are thought to be habitual in nature and according to Giddens, it is through the repetitiveness of these actions that the duality of structures is produced and reproduced - yet knowledgeability also produces the ability to change social practices through the enactment of agency.
Chapter Seven: Moral Agents Grappling With Structural Borders

7.1. Agency Enactment: Inside and Outside of the Structures’

As I have shown in chapters five and six, the role of the rural nurse is highly relational, lacking firm boundaries. Nurses are required to be responsive to the day-to-day reality of rurality and the shifting rural health care context. Participants in this study spoke of times when they took steps and enacted agency to fill the rural health care gaps and inequities to provide safe, compassionate, competent, and ethical care. For example, nursing staff would travel to provide care to isolated patients on their way home from work, find foster care for a patient’s pet, or break organizational rules to provide end-of-life care. Acts of agency reveal the complex nature of the relationship between health care structures and the rural nurse, which was both harmful and beneficial to rural nursing practice. According to Sewell (1992) there exists a tension in the structure-agency relationship. The reciprocity between structure and agency is dynamic. In this study reciprocity was fragmented by rule breaking and sanctions, but it could also be supported and nurtured by actions that fostered collaborative, respectful, and supportive work environments.

The contextual and structural aspects of rural nursing practice described in the previous chapters influence nurse enactment of agency. Nurses explained that their daily witnessing of the harms created by inequities in access and health resources motivated them to enact agency toward more acceptable and just health care practices. At times, enactment of agency by the rural nurses in this study involved breaking rules in order to provide what the nurses believed was a more acceptable level of care.
7.2. Breaking or Bending the Rules

For many of the participants in this study some decisions made in less than ideal circumstances required bending or breaking the rules. The nurse’s inability to make resource decisions to best fit the health needs of the rural population without breaking or bending the rules is a consequence of structural constraints that interfere with nurses trying to provide care and enacting their full scope of practice. Nurses helped me to understand that there are times when rigid rules and policy structures do not work well or fit the rural context, especially when nurses find themselves being “it”. I learned that there are explicit and implicit rules embedded in rural nursing practice structures. These rules can range from an unwritten common understanding that nurses are not to create an atmosphere that is divisive or fosters splitting of staff (Fieldnotes), to written policies and procedures, dictated by the employer, or laws and regulations (such as the Health Professions Act or The CNA Code of Ethics) that guide or define professional nursing practice. Nurses were aware of the rules and boundaries of practice and understood them as necessary. However, in the conduct of their work, under the conditions that exist in rural facilities, they stated that they often found themselves bending or ignoring the rules to provide better care for patients:

You’re not allowed to [give vaccinations in the patient’s home] unless they’re prenatal and postnatal; you’re not supposed to go into the home to do immunizations. It’s a big rule they have. But...we pretty much ignored that rule (Participant, u64).

Nurses in this study were more likely to ignore or bend the rules if they had the support of peers or a likeminded manager, or if there was agreement that the
rule or restriction constrained the rural health care provider’s ability to meet the health care needs of patients, families, or communities. In this next account, the rural ER nurse participant explained that palliative care and end-of-life patient care should be provided to community members and their families in an appropriate space such as a palliative care room—not in an ER department area that lacks proper accommodations and privacy. Although the facility in question has a designated palliative care room, my understanding from study participants was that facility rules did not permit patients to be directly admitted to the bed. This participant talks about how staff sought alternative ways to provide end-of-life care to a dying individual and their family:

The [end-of-life] care was provided and of course when management came back [on Monday] they weren’t very happy about it. But I did phone her [the administrator] actually. I did phone administration on call that night [weekend] to let them know that this is what we were doing. And she said that was fine [and to] ’Keep him as an ER hold’ [this means the patient was kept in an ER bed without having direct physician coverage and not to transfer the patient to another facility]. But she forgot that we were closed that night. So, whatever [laughing], it worked! And you know what? I’d do it again and I wouldn’t phone because it’s not right. It’s not right to send somebody who is imminently dying to another community. It’s not right when we were perfectly capable of providing care for him (Participant, Vvo).

Several participants discussed the dying patient’s situation with the physician. As a group they identified multiple concerns they had for this patient and the family members. They discussed the facility rules and current policy that disallows direct patient admissions to the patient care bed designated for palliative and end-of-life care. As a group they debated the options available to them for this patient, which included the option of transferring the patient to another facility eight hours away. As a group they came to the consensus that the rules and current
policy were barriers to both the attending physician and the rural nurses’ desire to provide appropriate end-of-life care. They all concurred that the patient’s need for end-of-life care nursing services and the family’s need for support from the community was reason enough for the nurses to all to be willing to pay the price for breaking the rules by keeping the patient in their home community hospital:

And even when we’ve done things to bend the rules to accommodate them, to make their quality of care better, we somewhat got our hand slapped. And I understand that there are rules and they are there for a reason (Participant, kS3).

Falk-Rafael and Betker (2012) state that acts of agency are fundamentally actions that support human dignity and social justice. Falk-Rafael and Betker further concluded that the relentless restructuring of the health care system has eroded agency, resulting in practice dilemmas regarding what is in practice and what ought to be in practice. This was the cause of considerable moral distress. If rural nurses are expected to be “it” then they ought to have the resources, skills, and decision-making capacity required in order to provide an acceptable level of care that is safe, ethical, and equitable for rural populations.

The nurses in this study appeared to fully understand that rule breaking could carry negative implications and sanctions such as receiving a reprimand from the employer. Although the intention was to provide optimal patient care, study participants may not always have taken into account that rule breaking can, as outlined by Rodney and Varcoe, also result in inconsistent treatment for patients, increased rules, regulations and policies, escalated sanctions, and the unintended entrenchment of rule-breaking into rural nursing practice (see Rodney & Varcoe, 2012). Nurses who openly discussed instances where they felt they had crossed the
line because of the rural practice context also reported that they did so willingly, and would likely do it again. How far ought they to go in rule-breaking? Are there lines that should not have been crossed? These are complex ethical questions. In the broader sense; nurses acted in ways that challenged the social and contextual complexities of rural practice in order to use the reality of rurality to their advantage for better patient care.

Nurses reported having to bend rules in order to provide care. Later, the nurses had to "beg forgiveness" and accept disciplinary actions for acting outside of the formal health authority structures. These same structures were often cited as barriers to equitable care. Structural supports (not sanctions or disciplinary actions) were identified by nurses as being needed to reduce the number of practice decisions made while in states of crisis. The ill-fitting structures within the rural practice context often required nurses to make patient care decisions without adequate resources, clear direction, or support.

Rule bending or breaking and learning to beg forgiveness are power-infused themes that outline the complex reciprocity that occurs between leaders within the rural health care structures and rural nurse agents when policy and practice collide in the complexity of rural health care provision. Rule-bending or rule breaking were methods rural nurses used to provide what they believed was a more acceptable level of health care for rural communities. Rule-breaking was also related to the social and structural context demands of rural nursing practice. At times nurses felt compelled to break certain rules in order to decrease the personal risk of social sanctions and to decrease the risk of nurse shaming in the community. For example,
one participant, who also had remote nursing experience, related that the rule not to drive patients to or from the clinic was often ignored. The nurses did not want seriously ill patients walking miles to the clinic—because so few people had vehicles. The nurses also wanted to keep good working relationships with the community by being generous with resources. Nurses in this study were caught between the health needs of the community and the restrictions on resources. While subversive actions like bending the rules are explained as actions to support patient care, these actions also have potential risks including increasing sanctions if caught, fostering inconsistent care practices or leaving the problematic rules and structures unchallenged (Rodney & Varcoe, 2012).

7.2.1. Acts of Positive Defiance

In a sense the rule-breaking by the nurses in this study could be viewed as an act of positive defiance (see Gary, 2013) toward the moral goal of socially just and equitable care provision. The narrowing of choices in the rural structural context, created by managers and policy makers, and including ill-fitting protocol or policy options, was felt by some participants to result in nursing practice being dictated by rules and regulations, rather than by their years of nursing experience, good judgment, and nursing education. The loss of control over practice decision-making was reported as not necessarily what the nurses felt they, or their community wanted (Participant, cJ2, Follow-up). Nurses in this study reported they had at times crossed both professional and personal lines with the best of intentions for providing better patient care—which may not necessarily have been the outcome in every case. For instance, in a previous example, rules were bent when the nursing
staff made the decision to care for a palliative patient in the ER instead of transferring the patient to an available palliative care bed in another community eight hours away. The staff, in consultation with the family, held the patient in the ER where there was little privacy, whereas the designated palliative care bed at another facility might have offered more optimal end-of-life services.

At times such as this the burden of taking on the role of “we’re it”, and the reality of being the front line and the visible face of health care, blurred the boundaries between what nurses believed their professional practice required, and the facilities’ policy structures that limited their actions. As a consequence, the rule-breaking actions of nurses in this study suggest that there is a significant need for policy and protocol structures to become more flexible in the rural context, so as to meet cultural expectations.

In what follows I will illustrate more specifically how nurses grappled with structural borders as they attempted to enact their agency.

7.3. Pulling the Nurse’s Card

In order to support one another and to sustain an acceptable level of safe patient care, nurses in this study participated in a practice strategy they called “pulling the nurse’s card”. The act of “pulling the nurse’s card” was explained as an unspoken expectation, especially between senior staff nurses, that if they should ever call one another at home for help, the nurse receiving the call would “drop everything” —including, in one example I learned about, serving a family holiday meal —and come to help in the local health care facility. As one nurse explained:

Unconditionally, we ‘pull the nurses card’. It’s —you know when they say ‘get in here’, she knew I had company coming over and I had [a big meal]
in the oven and she said ‘I need you now.’ It’s like ‘okay...I got to go!’...‘because she pulled the nurses card’. And she knew that I had [lots] people coming over, [for dinner] she would never have crossed that line and I know she would never have asked me if she didn’t need me (Participant, cJ2).

As explained earlier, rural nurses often found themselves in situations where they were the only or highest qualified health care provider available. Rural nurses found themselves being “it” in situations where the level of medical or nursing intervention required additional skills or knowledge beyond their own. Due to persistent rural health care staff shortages nurses also found themselves without physician support or another staff nurse on shift. The lack of physician support resulted in the hospital ER being closed to emergency admissions. However, it was not uncommon for patients to appear at the hospital for care even when the facility was closed to admissions. Nurses told me that these unpredictable arrivals sometimes required the “pulling of the nurse’s card” to provide safe care.

Nurses in this study talked about the issue of physician shortages and the consequent decreased ER hours and reduction of nursing staff. The lack of physician availability frequently placed rural nurses in difficult care situations of being “it”. The unpredictability of the rural context created times when health care provision was necessary despite the ER closures or other structural challenges. As one participant remarked, “people don’t plan to have a heart attack—they happen when they happen” (Fieldnotes). Nurses in this study characterized the informal network of “pulling the nurse’s card” as a necessary practice response required to mediate staff shortages and support each other. This informal support network is one way rural nurses see themselves as fulfilling a moral obligation to provide patient care
and being accountable to fellow nurses and their communities. Although these actions were meant to create a safety net and provided at least some practice support in crisis situations, they were undertaken without formal sanction or acknowledgement by the management structures.

In covering the gaps in rural health care by “pulling the nurses card”, serious structural health care provider shortages and inadequate levels of practice supports are obscured and continue unaddressed by the management structures. These unaddressed structural gaps have the potential to create situations of risk. Rodney and Varcoe (2012) warn that such acts of subversion “often helped nurses to mediate the constraints inherent in the social structures of their work, [but they] also had the potential to jeopardize their role and their care of patients and families” (p. 108). Covering for the inadequacies in rural health care by “pulling the nurses card” also has implications for hiding the serious rural health care provider shortages and the furthering of rural health inequities that result from decreased access to health services. Nurses’ actions that cover structural inadequacies so that they can provide care to patients are often unacknowledged and thus are set up to remain invisible within the institutional processes (MacKinnon, 2012). The actions nurses take in order to support care in the complexity of rural nursing practice, such as “pulling the nurses card” are structured to remain hidden. Holmes and Gastaldo (2002) suggest that nurses may feel “compelled to be loyal to urgent patient needs and employers’ strategic plans, and keep the system running under almost any circumstance” (p. 558). The act of responding when the nurse’s card is pulled is a form of reciprocity — that is a mutual exchange between nurses and a hidden way
of shaping rural nursing practice in order to keep the rural health care system running.

7.3.1. Answering the Call

Related to “pulling the nurse’s card” is the unspoken expectation that another nurse will “answer the call” for assistance and will respond immediately. The ability to “pull the nurse’s card” and in doing so be confident that the person answering the call would “come no matter what” was described by nurses as providing them with a small sense of security, especially when relatively inexperienced staff were working alone on nights:

I know if I’m in trouble in the middle of the night and Brandi is in town, she’s going to come no matter what. Like, she answers the phone. She is there in ten minutes no matter what. And there’s definitely a huge comfort in that (Participant VvO).

“Answering the call” could also be a strategy to ensure the safety of the nurse and the best care possible for the rural patient:

We would call each other for support or stuff or [with questions such as] ‘how do I do this?’ (Participant, u64).

Calling for help did not always require the answering party to attend the facility to provide hands on care and support. At times it was a matter of a nurse seeking practice support and guidance from a more experienced co-worker. “Answering the call” was found to be a way in which rural nurses provided support to each other when health care structures and resources were insufficient to meet the demand of practice. For example, when recounting a situation where she was working alone and a critically ill patient came to the ER in a life threatening situation, this nurse

57 As with all names Brandi is a pseudonym.
explains how she needed to have intimate knowledge of whom and where to call.

She said:

when they [critical patients] come in it can be scary. You know, you've got an anaphylaxis [allergic reaction that causes airway obstruction] and I mean I dealt with that one night. A lady had an anaphylactic reaction to... She was allergic to penicillin and she was [exposed to an allergen]... And they [family members] drove her down from [neighboring town] in a car. Yeah, I wanted to [punish] the guy who drove her [instead of calling an ambulance] but she showed up and luckily I had a friend [fellow nurse] who I called. I knew where [she was and I called for help]. And she came up (Participant, QSM).

The act of answering the call creates practice support structures and capacity outside of the official rural health care structures. However, this practice is dependent upon the collaboration among nurses and the willingness to continue to answer the call. However, this practice of supporting rural health care by nurses voluntarily giving up private time to return to work in order to cover for crisis care situations is ultimately unsustainable, as nurses need to be both willing and able to “answer the call”. The act of calling each other for help also fails to address the underlying issues of inadequate staffing in rural health care. By covering up this inadequacy of the rural health care structures, the health authority is never confronted with the necessity of dealing with the staffing crisis. As a consequence, the health care structures appear to be 'off the hook' regarding dealing with the pressing issues of staff shortages. When the responsible structures are let off the hook practice problems remain unseen and unexamined (Rodney & Varcoe, 2012).

7.3.3. “How Many Hands Do You See?”

The following account demonstrates the complex relationship between the rural nurse, the rural health care structures, and the nurse's enactment of her
agency. I had just walked into the building and gone to find the nursing staff to let
them know I had arrived. I walked into the doorway of the trauma bay and stopped.
It was from this vantage point, unseen by both the nurse and the patient, that I
witnessed the exchange below. As the nurse later described:

I fling his curtain open. I put my two hands up in the air and I said, 'How
many?' And him and his wife look at me like, what are you talking about?
And I still have my hands in the air. And I say, 'How many hands do you
see?' And the wife is kind of smirking. But he's still not happy because his
butt is now getting sore because of our Emerg stretcher. And I say, 'I
have two hands!' And he still is looking at me with, 'what on earth are
you talking about? Don't you get it? My butt is sore!' And so I say to him,
'When you walked through these doors, you were the most critical
patient here. You got my undivided attention. Now I have three other
critical patients here and now they deserve my undivided attention. We
have taken care of your problem. We know that you're not critical. We're
still doing some further testing and you still get our care too. But these
guys now get my undivided attention' (Participant, 2GV).

At first I was shocked to see the nurse holding her hands in the air and demanding
to know “how many hands do you see?” I continued to observe the exchange and
was unable to comprehend exactly what was going on. I noticed that the other nurse
appeared unconcerned about what was happening. I had no previous history or
context with which to ground this event. It was only later that I learned the full
story, including how the patient was a close acquaintance of the nurse.

The choice to enact agency cannot be teased apart from the local community
context in which it occurs. In the situation above, two nurses were the only staff
available to care for and manage a large number of patients. By confronting this
unhappy patient, the nurse sought to limit his disruptive behaviors, which were
preventing her from providing necessary care to other more critically ill patients. In
a way, this nurse putting her hands in the air was a visual (albeit abrupt and
potentially rude) acknowledgement of the limitations of rural health care, and she was likely more overt about her frustrations because she knew the individual.

The nurse’s actions were also a powerful expression of the experience of being “it” while navigating the overlapping of professional and personal roles that epitomizes the simultaneous complexity of rural nursing practice. As explained to me by the nurse, her enactment of agency was not just in order to change the conditions that were interfering with her ability to care for the other patients in the room, but also to influence the patients waiting to be seen in the hall and waiting room area. Although her actions to navigate the constraints had the desired result of providing care for all the patients, there was the potential for them to be misinterpreted not only by myself, but also by the anxious patient and other patients and families in the department.

7.3.4. Hear Our Voice

Hear our voice...we care about our patients just as much as the next person and we want just as good healthcare as the next person. But we don’t have the resources and when we are speaking out for our patients and for our communities...it's not just community. It's communities. I wish that we–our voices were heard more. And the lack of resources—from equipment, to doctors, to staff...ordering supplies even and then you get questioned about everything. That’s really frustrating. You get questioned on your meal break. And you think, are you kidding me? There are only two bodies with two hands [in our unit]! I just wish we had a voice (Participant, 2GV).

As the above quotation indicates, complex social, cultural, political, and economic structures can act in ways that constrain enactment of nurses’ agency, including having their voices heard. What I have learned from my participants is that the contextual, structural, and agency based themes explicated in the findings chapters all relate to how the rural nurses are situated in their relationship with the
health care structures. As the above quotation also demonstrates, the interconnectedness of the rural context and rural practice structures shape nursing practice. Structures impact patient care through issues such as “the lack of resources, from equipment, to doctors, to staff” and other factors (Participant, 2GV).

The nurse’s ability to fulfill professional practice obligations to provide quality, safe, and ethical care practices to the rural communities is at times constrained in the rural practice context—as I have illustrated in chapters five and six, a context of significant resource inequities, service closures, and care provider shortages (particularity shortages or unavailability of rural physicians).

**7.4. The Shadow System**

In most practice contexts, nurses are constrained by the structures within which they practice, but nurses are never fully without agency (Rodney & Varcoe, 2012). Rural nurses were constrained within the formal rural health care structures. Gaps in access and availability of formal health services prompted agency enactment and the creation of a ‘shadow’ system of health care provision in the community. Rural nurses provided care and support both within and outside of their formal roles. Participants described the care provided in the shadow system as unseen and unacknowledged by the health care structures. This was because the nursing care provided, like the dressing change in the grocery store described in chapter five, occurs outside of the gaze of the formal health care structures. The willingness of rural nurses in this study to provide nursing care to community members outside of the hospital facility was embedded in the complex social
relationships between the rural nurse agent and the rural communities, which was visible in the day-to-day rural context of nursing practice. As one participant noted:

We advocate hard for the people in this community. We work hard to make sure that... [sigh] [people get care]. Because we feel that rural health care is lacking...[I have] colleagues that have worked here forever and lived here forever, you know, they know...[a great deal about people’s lives and circumstances]. There’s just things happen [care becomes more tailored to the unique circumstances of the person because of the nurse’s knowledge of the patient’s history and context] different types of actions and I’m not saying that its specialized care but they have somebody to advocate for them in a different way (Participant, Vvo).

Many nurses in this study reported that they often took on additional tasks or actions that might be perceived as giving certain patients more specialized care. However, participants explained these actions as a form of advocacy towards providing a more acceptable level of care. These acts of advocacy often took the form of chronic illness surveillance of the population. For example, the following nurse explains how rural nurses use their nursing knowledge and their high level of personal knowledge of patients with chronic health challenges to act on critical blood test results received after hours to provide more comprehensive care:

At night now without any lab we get a lot of nighttime lab follow-up. We get these results that come back at 9 o’clock at night. So we had one the other night and I looked at my watch I said it’s Friday night oh ‘Mary’ will be at the legion, so I phoned up the legion I said can you get – can you get ‘Mary’ on the phone for me? They didn’t even know it was the hospital calling. I said, ‘Mary I’m at the hospital, your INR [international normalized ratio that measures the clotting tendency of blood] is too high you need to come up right away and get some vitamin k’. ‘Oh, oh good thanks’. Done and over with (Participant, cJ2).

Rural nurses’ personal knowledge of the community and community members was a beneficial resource, which formed a surveillance network within the shadow system that built health care capacity within the formal rural health care structures.
Indeed, it appears that the rural nurses’ knowledge of the patient becomes a partial safety net for the rural population served. This is also an example of the structures implicitly supporting the nurse-led initiative to follow up on all critical laboratory values as a form of population health surveillance. Agency is actively pursued in this instance without the need for prior permission from management.

Intimate knowledge of community members is also used as a resource in the day-to-day activities of rural nurses to enable enactment of agency in positive ways within the scope of practice. In the following example the role of the rural nurse to conduct population surveillance is explained:

I think in remote and rural, like you have to follow up with people. You have to follow up with people otherwise you don’t know what's going on...There’s a different way of thinking. You have to think differently as a rural nurse, I think...You have to think, you have to see the bigger holistic picture, you know. You have to be their pharmacist, social worker, educator, [and] taxi driver. It’s, you’re everything, you know. Yeah, you liaison with everybody, you know (Participant, u64).

The nurse’s account above emphasizes that multifaceted follow up is required to better manage the health needs of the population served.

The context of rural nursing provides fertile ground for complex and interconnected relationships between rural nurses and the rural community to shape and foster the unseen secondary system of rural health care. According to participants these embedded surveillance practices have become normalized actions that support the health of the community. These unseen practices are also the means by which rural nurses appear to be mitigating some of the structural barriers to accessing health care services. These practices are in accordance with the tenets of primary health care, that is, health supporting care practices, health
promotion, and disease prevention (CNA, 2000). Such actions reflect enactment of agency by nurses in their attempts to move towards a more just system of rural health care.

As noted previously, the close-knit nature of rural communities provides the rural nurses with additional knowledge about patients and families. This expanded knowledge is used within the formal rural structures to extend the nurses’ gaze and acts of agency in order to provide more holistic care practices. For example, the nurses’ additional knowledge of the patterns and routines of community members extended their care beyond that of residential long-term care (LTC) resident, to also include monitoring the health and well-being of the resident’s family members:

> Usually we have regular people that come in that we know that are going to be there at mealtimes. Like, so and so’s family so like if they’re not there, ‘Oh where’s John tonight?’ – Sally’s husband. Usually he’s here by now? Unless of course he’s told us that he’s going away and we don’t expect him. Then they become, you know, part of our worry too because where is he? It’s 4:00 and he’s not here yet (Participant, Yq9).

I assumed that the length and depth of the relational connections with patients and their families would be deciding factors in whether or not nurses engaged in acts of agency. However, I did not observe a marked difference in the manner in which nurses approached providing care to patients on the basis of their community or familial connections. While I am not claiming that the treatment of all patients was universally equitable, I did observe nurses engage consistently in what I saw as their enactment of agency towards supporting outcomes they perceived as more equitable, desirable, and acceptable for patients. The following quotation further illustrates this point:
And last week, same thing, we had a palliative patient who needed pain management. They sorted it out with the physician on the phone. They lived in [a neighbouring town]. They were leaving for Vancouver the following day to go to hospice there because our bed was full. So I said, ‘There’s no way in hell you are leaving your last day in your house. [no way] you’re leaving your husband to drive to [this facility] to get your pain management. I will bring them to you after work.” So I drove them out to their house. They live actually north of [a neighbouring town some distance away]...I said I actually went to the pharmacy, picked up their prescription, signed for it [laughs], put it on my Visa and drove them out there. I spent two hours with them talking about palliative, you know, management, how to manage pain, how to make things easier. I gave her ideas and more options and just talked with them about death and how we just have to make it as comfortable as possible. And that’s our job is to make it a good death. And [the wife] was just blown away that that’s how we can look at it (Participant, 2GV).

Acts of agency that go beyond regular professional obligations were inherent in the complexity of the relationship between the rural nurse and the community served. Health care structures facilitated a range of health care inequity by failing to provide services nurses viewed as necessary. This was particularly evident in the context of the narrative account above where the palliative patient was unable to receive end-of-life care in his home community or the hospital due to the structural lack of care beds. Although the patient and family were traveling to a large metropolitan urban area the next day to access hospice services, the nurse felt compelled to act for community members requiring palliative care services and do what she could to support quality end-of-life care and “make it a good death.” I will comment more in chapter eight about the implications and sustainability of such actions.

Overall, the rural nurses’ ability to provide palliative and end-of-life care for community residents was often challenged or constrained by structural factors such as lack of availability of a care bed. In trying to uphold the values that underlie
nursing practice, for example, nurses often took what they felt were necessary actions to support the patient’s choice to remain at home\textsuperscript{58} rather than access palliative care services in a hospice or other facility. This frequently entailed providing end-of-life care for patients and their families in the rural emergency department instead of in a more specifically designated palliative care room. This use of a rural ER department for providing end-of-life care might be seen as receiving health care services that are unfair, inequitable, or of poor quality. However, in observing several instances of this type of end-of-life care provision, it appeared that the nurses were attempting to enact their agency to support community members’ choices regarding the values of family, community, home, and support a good death in their home community. The nurses may also have been acting to decrease the distressing likelihood of the patient dying while in transport by a family member to another facility for palliative care services.

It was my observation that the decreasing level of primary care services offered in rural communities in general fostered the continued need for the rural shadow health care system. The policy shift toward reducing acute care beds in rural communities in general and the resulting transporting of patients for care to larger urban centres, was found to have direct implications for the relationship between rural health care structures and rural nurse agents. Similar findings from Fleet, Plant, Ness, and Moola, (2013) led to a call for additional acute care beds to service rural health care needs in rural hospitals including the provision of high-

\textsuperscript{58} What I came to understand from both the nurses and several palliative care patients I spoke with was that the decision to let rural residents to die in their community hospital represented a valued act of ‘dying at home’ among family and friends.
acuity level beds. Fleet et al. also indicated that the current system of critical care transport is fraught with lengthy delays and patients are transferred in inadequate and improperly monitored conditions.

In summary, the nurses’ inability to provide care within the health care structures provided to meet the needs of the population and the fragmentation of trust in the structure-agency relationship resulted in rule-bending and policy-breaking behaviours by nurses. The fragmentation, loss of local primary health care services and unpredictability of access to rural health care services in general appeared to further reinforce the need for the provision of nursing care in the shadow health care system.

7.4.1. Trying to Fill the Gaps

As can be seen from the narratives above, nurses in this study reported that they often felt compelled to act for patients in less than ideal circumstances, and without clear direction, because of the lack of available services. In this example one nurse explains her experience of trying to provide care while navigating the gaps in the rural system:

There’s no Community Access Coordinator\textsuperscript{59} here. How am I supposed to send this patient home, you know, when their wife can’t drive? How can I get them home safe and how can I make sure that somebody is going to go check on them? What do I do? And am I overstepping my bounds if I make these calls or try and make arrangements? I can’t in good conscience let them go. So I do what I can to give them the best care and still fall within the lines (Participant, Ks3).

\textsuperscript{59} A Community Access Coordinator (CAC) also known as a Community Care Coordinator (CCC) is responsible for assessing, coordinating, implementing and integrating service delivery and care for patients or clients prior to discharge from a health care facility.
There was a tension between what actions nurses should take and what actions the nurse was able to take because the ability to act was mediated by gaps in service needs, and insufficient, unknown, or limited community resources. In this study, as well as other studies I have reviewed (MacLeod, 1999; Hunsberger, Baumann, Blythe, & Crea, 2009), rural nurses reported experiencing confusion and difficulty in attempting to make what they felt were the ideal ethical and patient-appropriate decisions when no appropriate resources or practice directions were available.

The specific context of the work setting is important, and, as Nelson et al. have pointed out, the “unique characteristics of the rural setting shape and influence the frequency and the nature of specific ethical issues and also influence how health care professionals respond” (Nelson, Pomerantz, Howard, & Bushy, 2007, p. 137). The lack of direction and clear articulation of appropriate avenues for accessing services for patients is confounded by the many service gaps in rural health care and scarce resources. For example, the limited availability of home care service for rural populations beyond a predetermined travel radius presented moral challenges for nurses managing patients in the larger community. As one participant explained:

Sometimes people are needing help through the night. We don’t have home support workers that work through the night. So they [families] may have to hire privately or use more respite—in hospital respite to give caregivers a break. [Management] keep talking about keeping [rural patients requiring long-term care placement] in-home longer—but I don’t know. [Management] kind of said to us [we need to keep them out of placement as long as possible]. How are we going to manage that and keep them [safely at home] that much longer? And you always have to weigh the risks of, are they at risk or not? Especially with the dementia clients, I find...it’s harder because if they live out of town in different spots, sometimes they may not even be qualified for service because they live too far out of town (Participant, s50).
The moral issues related to quality of care and equity of access by patients who live in more isolated places raised by the rural nurse in the above example are, as Nelson et al. (2007) suggest, shaped and influenced by the unique characteristics of the rural setting. As I have indicated in the previous section of this chapter, nurses frequently spoke of instances where they took actions towards trying to fill the gaps in rural health care services for the rural population served because, as one nurse put it, “they deserve it” (Participant, 2GV). Trying to fill the gaps in rural health care services under the mandate to keep residents in their homes as long as possible was expressed as an act of the nurse having to “weigh the risks.” The risk of keeping rural people in their homes longer was particularly concerning for clients with dementia or for those rural residents who lived beyond the service provision boundaries. This led to participants taking action to decrease the risks and foster more equitable care for rural residents, as I describe in the next section.

7.4.2. Nurse and Community Reciprocity

The nurses I observed were attempting to address the impacts of health care inequities and enact a collective moral responsibility beyond the structures by working in the shadow system and supporting with one another by answering the call or other acts of agency enactment. Rural health care provision was not confined to the policy, processes, and physical structures of any one health care facility. As was evident throughout the nurses’ accounts and my observations, health care was provided to community members through interpersonal connections that existed in the web of rural social structures as another form of reciprocity. From the nurses’ accounts and my observations, it appeared that the relationship between this
community-based shadow health care structure and the rural nurse was voluntary (albeit constrained at times by the rural context) and was an extension of the nurses’ web of personal-connections in the community. As one nurse explained:

I had a patient that [was personally known to me] and the mother phoned in and said, ‘I can’t bring him in for his IV antibiotics. I don’t have anybody to bring me to [town]. So I won’t be bringing him.’ And so I said, ‘That’s not acceptable. I will finish my shift and I will bring the IV antibiotics to you and I will give them to you’ (Participant, 2GV).

Rural residents who cannot transport themselves face additional barriers to accessing health care services (Syed, Gerber, & Sharp, 2013). In this above example the nurse, having made the decision that the inability to bring the patient for medical care to be “unacceptable”, chose to act in response to the broader structures (in this case limitations in public transportation and economic disparities that marginalize certain populations) that foster inequities in rural health. It appeared that the nurses’ awareness of the broader context and social conditions such as poverty may have also contributed to the shifting of rural nursing practice beyond the formal physical structures so that they could provide more personalized and direct care (e.g. taking the antibiotics to the patient). However, despite the multiple examples I witnessed of nursing actions to support more equitable care, it was not clear if these agency actions were common practice, or if they were primarily undertaken in situations where the nurse had an established relationship with the patient in the community.

**7.4.3. Storytelling as Reciprocity and as an Act of Building Resilience**

Participants were often observed talking about their experiences of being “it” with one another through the sharing of stories. The storytelling appeared to
function as a time of debriefing and therapeutic decompression after difficult and stressful events. It was also a time when the nurses shared strategies and actions; in a way, it became something of a dress rehearsal for the next crisis. I also perceived this telling of nursing stories as a special time when they came together and collectively supported one another and shared the burden of being “it”.

In discussing why rural nurses engage in storytelling, one nurse shared that her reasons for participating were two-fold:

We have a way of debriefing one another, we can’t be there at the time so we like to talk about it, get kudos, [and discuss] what we could do better next time. No one else understands that experience. Even the doctors don’t understand (Participant, cJ2, Follow-up Interview).

Engaging in storytelling apparently offered practice advice and emotional support, but it also appeared to serve a protective purpose by the nurses collectively building resilience by preparing for the next time they are “it”. This also means that nurses created an informal system of practice support and knowledge transfer network rather than relying on, or asking for, outside or employer-provided resources.

This practice of mediating practice stress by relying on one another for debriefing sessions also serves to support another form of reciprocity - the shared respect and mutual exchange of knowledge between nurses. However, it may also inadvertently hide practice challenges and educational barriers from decision makers and under-utilizes outside practice supports and educational resources that may be available (see also Rodney & Varcoe, 2012). In this study storytelling was found to be a powerful practice strategy used to share the emotional burdens of practice, build resilience, and foster an atmosphere of teaching, learning, and planning for future experiences of being “it”. Similarly, in a study of new graduate
nurses (Kelly, 1998), explored storytelling as a moral experience and an adaptation for coping with moral distress, vulnerability, and the preserving of moral integrity.

The act of storytelling was reciprocal— that is, mutual— and aided in creating positive moral climates, producing safe teachable moments and highlighting positive practice strengths, while they shared the everyday struggles, successes, and funny moments that weave through the fabric of practice. It was my observation that storytelling was a very positive rural practice strength forged by the challenges of being “it”. From my observations, storytelling appeared to create times of deep reflection and growth and fostered support for enacting agency. The nurses shared knowledge of what they had done in practice that worked or did not work, in order to also support practice development. Storytelling was also a time when nurses took the opportunity to compliment each other’s strengths, and offered help to coworkers who need more practice support in certain areas. The telling of stories developed collegial relationships, fostered reciprocity in the form of mutual exchange of knowledge and trust, helped to build on individual practice strengths and provided opportunities for skill strengthening and development.

In summary, the enactment of agency is both enabled and constrained by social and rural health care contexts. Nurses having witnessed the harms created by unjust social conditions and inequities in rural health and health care enacted their agency to try to mitigate the harms, and to provide more equitable care. In the next section I discuss how rural health care inequities have become normalized within the broader sociopolitical structures and how this legitimacy has fostered a form of
geographical privileging which positions some populations as more deserving of health care services and resources.

7.5. **Ideologies Normalizing Rural Structural Inequities**

Falk-Rafael and Betker (2012) posit that inequities are deliberately created through neoliberal ideologies that maintain socially oppressive deficit narratives serving to normalize the assumption that those with advantage in society are more deserving of reward—and therefore some members in society are deserving of disadvantage, inequities and social injustice. Thus, enactment of agency is one way nurses chose to push back against the normalizing of inequities and change the narrative to reflect actions that better support social justice.

Rural communities, like urban centres, have been increasingly subjected to the ideology of efficiency, health care restructuring initiatives, and the “ideology of scarcity” (Varcoe, 1997, p. 123; Varcoe, 2001, p. 109; see also Varcoe & Rodney, 2012). Ongoing reductions in rural health care resources through economic and political mechanisms create structural barriers that are added to the historical geographical barriers rural populations already navigate to access the resources necessary for health. These social and political arrangements foster what Farmer, Nizeye, Stulas, and Keshavjee (2006) describe as forms of *structural violence*\(^60\). In a similar fashion the term *cultural violence* is used to describe aspects of culture, such as ideologies, that “justify or legitimize direct or structural violence” (Galtung, 1990, p. 291). Galtung posits that structural violence is often legitimized and therefore it is rendered invisible within cultural structures. Forms of cultural violence renders

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“avoidable insults to basic human needs” invisible through structural barriers and sanctions designed to alienate subjected groups (p. 293). Aspects of alienation involve the subjected group being “desocialized away from [their] own culture to be resocialized into another culture” (Galtung, 1990, p. 293). Forcing rural populations to face difficult challenges in order to obtain access to health care services outside of their rural communities creates inequities in health and health care for rural residents. It is my contention that such inequities can be seen as forms of political and economic structural violence against geographically bound and economically vulnerable rural (and remote) populations. As decreasing health care access and increasing inequities become “normalized” in rural health care, structural violence becomes embedded in the everyday experience and begins to appear “ordinary in our ways of understanding the world, [and the violence and resulting inequities and vulnerabilities are rendered] invisible” (Farmer et al., 2006, p.1686).

Similarly, Reimer-Kirkham and Anderson (2011) claim that “vulnerability is not a static or preexisting category belonging only to certain individuals affiliated with particular ‘marginalized’ groups; rather vulnerability can be situational and dependent upon the negotiation of micro politics of power in any given situation” (p. 200). Drawing on Farmer et al. (2006) and Galtung (1990), it can be said that the policy trend toward providing fewer rural acute care hospital beds is a form of geographical privileging that is moving towards the redistribution of health care resources to centralized acute and specialty services in urban settings, which are viewed as more deserving of health care resources. Drawing on Reimer-Kirkham and Anderson, the privileging of health care resources can also be seen as a form of
structurally produced violence that creates situational and geographical vulnerability, and furthers inequities for large populations. The constrained ability of rural nurses to provide comprehensive care for rural patients in rural communities was found to be suffered as both as a practice loss for nurses and as a loss of access to culturally preferable care for the patient in the local community. Certainly some rural populations—such as the elderly, those unable to self-transport, the impoverished –or– Aboriginal, may experience a greater personal or cultural impact from the differential effects of the limits of local health care provision.

Study participants spoke of experiences that resonate with Farmer's notion of structural violence. They reported experiencing a blaming discourse that they felt positioned them as responsible for living and working in isolated conditions, and therefore they should not expect to have the same resources as facilities with geographical privilege. As other researchers I have cited above have also noted, the differences in service provision and the limiting of opportunities for equitable health outcomes for rural populations are the results of broader social, political, and economic structures that result in geographical privileging of some communities as more deserving than others.

7.6. Chapter Summary

The previous two findings chapters presented the contextual and structural challenges and strengths that served to shape rural nursing practice. This chapter explained how the enactment of agency is influenced by the nurses’ experiences of the contextual and interpersonal connections within and outside of the rural heath
care structures. Agency was found to be influenced by the nurse’s perceptions of the level of acceptability of what care the patient “ought” to be receiving. The enactment of agency both inside and outside the formal health care structures in the shadow system, the act of “pulling the nurse’s card”, “answering the call”, and “storytelling” are all actions that foster reciprocity - mutual trust and support between nurses. They are also the ways in which rural nurses enacted agency towards what they considered to be more acceptable and equitable health care. Inequitable access to health care resources creates increasing vulnerability for rural-based populations, and this insidious form of structural violence also inadvertently creates contexts of geographical privileging of certain populations over others for health resources.

In the final chapter of this dissertation I will discuss the conclusions drawn from my analysis of the structure and agency relationship, and I identify study strengths and limitations. I theorize on how access inequities in rural health care impacts population health and serves to further marginalize certain rural populations, and how inequities in rural health care also impact nursing work environments and alter the moral climate. I conclude by making recommendations for moving forward in order to strengthen reciprocal relations between rural nurses and the decision and policymakers within the rural health care structures. I will close by making some suggestions for future research.
Chapter Eight. Discussion and Recommendations for Policy and Action

8.1. Overview of the Study

In this critically informed ethnographic study I sought to examine the structure-agency relationship in rural nursing by exploring the reciprocity found between structure and agency in this unique context. This ethics-informed inquiry questioned the effects of the broader ideological and social-political structures that underlie resource allocation and impact rural health care delivery and nursing practice. I also sought to explore the enactment of agency by rural nurses directed toward addressing ethical challenges posed in rural populations by health inequities, resource disparities, and unequal access to health care.

The relationships that shape the contemporary rural health care context were explored to gain a broader understanding of how the larger socio-political and economic structures operate, and what the implications are for shaping the everyday clinical practices of nurses. As I indicated in chapter two, inequities in health care services are structurally produced and directly impact population health by controlling the access, availability and affordability of the resources necessary to maintain health. The same structures that frame access to health care also frame the nature, scope and quality of nursing practice. The previous three findings chapters detailed the study participants’ experiences of the complexity of their practices, and how the structures function to both facilitate and constrain enactment of moral agency in rural nursing. For example, nurses felt constrained by a revised policy that removed the care of palliative patients from the acute care setting, and transferring
care of these patients into a LTC setting where the nursing staff was struggling to care for an already-large number of residents with complex health challenges.

As I indicated in chapter two, the broader social, economic, and political structures that affect health care delivery have been previously implicated in the research literature as producing and maintaining multiple barriers to access resources for health for many marginalized populations (Canadian Association for Rural & Remote Nursing, 2008; Choiniere, 2011; Russell et al., 2013; Stewart, et al., 2005). I identified that these broader structures also had an impact on availability of structural resources and on the rural patients’ ability to timely access health care services. For example, in this study the closure of rural emergency departments necessitated costly travel or the deployment of ambulance service to transport patients to health care services elsewhere. The lack of access to health care resources impacts population health and the nurse’s ability to enact agency towards providing an acceptable level of care across all health care contexts (Pauly, 2008b; Peter, Macfarlane, & O’Brien-Pallas, 2004; Rodney & Varcoe, 2012). Findings from this study, as well as others focusing on rural health care that I have cited throughout this thesis, have raised concerns as to the way in which those larger structures impact the rural nurse’s ability to provide safe care, as well as the affordability of access to care for those populations that suffer from poverty and other forms of marginalization and stigma. This research also draws needed attention to how the resource inequities (which are taken for granted) affect the nursing task of providing safe health care delivery in rural communities. In bringing the impact of these inequities and challenges forward, I hope to add to the call for a
collaborative reshaping of the practice environment towards a more equitable and safe care context for rural populations.

I draw on study findings and reflect on the structure–agency relationship for possible actions and interventions for supporting reciprocity and fostering moral work environments. Further, I reflect on the strengths and limitations of this research study and I offer some methodological reflections about conducting rural nursing research. I discuss how findings from this study contribute to the growing body of knowledge about the way in which broader structures create access to health care resources inequities, and I theorize about the ways that access inequities impact rural nursing practice and agency enactment. I close the dissertation by making several recommendations for policy, education, rural nursing practice development and suggestions for future research.

8.2. Methodological Reflections

My choice of an ethnographic approach provided a broad range of sources from which to explore the rural nursing practice context and the structures that framed rural health care provision. The prolonged engagement of 528 hours of observation in the field and the conduct of fourteen in-depth interviews and four follow-up interviews offered opportunities for me to build trust and establish ongoing relationships with study participants. Prolonged engagement also had the benefit of granting me access to more “casual” conversations in the research setting, which enriched my understanding of the social complexity of rural nursing practice. Another benefit was that I had numerous opportunities during fieldwork to solicit further feedback from participants as the data collection and analysis progressed.
It is, however, important to note that my choice of methods also created unanticipated challenges. Maintaining confidentiality and trying to be an unobtrusive presence in such a small facility was a constant challenge. I was a novelty in the facility as I was the only non-employee. Because I was not a local my vehicle was highly recognizable in the parking lot. On many occasions community members who recognized my truck came into the facility to visit when I was onsite and often brought me packages of donuts and other food items. Indeed, the high visibility of my vehicle in such a small community was reinforced when I attended one participant’s home because we had arranged to conduct an interview. Following the interview I returned to the research site only to be asked by a staff member how my visit went with Sally. I agreed to conduct the interview at the participant’s home in order to accommodate their stated preference of location. In hindsight, I realized I would have been less visible had I simply left my vehicle at the health care facility and walked to the interview. This incident deepened my understanding of the nurses’ experiences of living and working in a small town—in the “fishbowl.”

Reflecting on the issue of high visibility of researchers in small communities led me to consider other ways to protect participant identity beyond simply walking to appointments or only meeting with participants at a location outside of the community. One possibility I have considered was the use of video based internet technologies. Programs such as Skype or FaceTime, are examples of these internet-based technologies known as voice over internet protocol software applications (VOIP). These new technologies in video streaming might be useful adjuncts to both

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61 “Sally”, like all names used in this dissertation, is a pseudonym.
further protect the identity of participants and to decrease the travel required for interviews. However, the loss of face-to-face contact and the researcher’s limited ability to see and experience the environment “beyond the screen” would need to be balanced against privacy concerns in the consideration of the use of these technologies in future research.

In reflecting on the use of multi-page study information letters, I noted that primary and secondary participants read the information letters and consents. However, tertiary individuals I encountered during my observations were not as receptive to reading a multi-page document. In reflecting further on the rural context and my knowledge of the potential for low literacy, I began to question future use of such letters when conducting research with rural community members. Their stated preference to me was to have information conveyed verbally to them in a conversation. This verbal form of study information sharing and verbal consent preference reinforced to me the value of face-to-face conversation and the need for incorporating culturally congruent methods. It also reminded me of the importance of supporting human dignity and being alert and sensitive to those who are more likely to experience challenges with literacy in English.

This also brings to light the need expressed by Andrews (2002) for “more place-sensitive nursing research” to enhance the understanding of the “dynamic relationship between people, health and place” (p. 221). For example, place-sensitive research practices would take into account the “complex social and cultural contexts of people’s lives” (Bandyopadhyay, 2011, p. 1). In taking the rural social and cultural contexts into account, in future I would consider having a video
presentation of the study information available for viewing, in addition to written and verbal information. The addition of visual media to present study information is one approach to fostering informed consent that would also support the dignity of those with low literacy challenges and allow them to be more comfortably as they engage in research initiatives.

8.3. **Study Strengths and Limitations**

This in-depth study was able to capture perspectives from eleven registered nurse participants with rural and remote nursing practice experiences at similarly situated health care facilities located in the same health authority region, across the province of British Columbia and in adjacent western Canadian provinces. The focused ethnographic nature of the study, with a small group of participants, was a significant strength of the study. The intimate nature of the setting allowed me to have a prolonged engagement in the field with my participants within their practice setting as well as outside the workplace for one-on-one interviews. This engagement meant that additional questions evolved as the study progressed, which resulted in the inclusion of perspectives from three additional AHCP participants. However, my prolonged field observations were limited to one geographic location within a single western Canadian province and health authority structure. I did not observe those who did not come to the health care facility and therefore I was limited to observing nurse interactions with only the populations that accessed the facility.

Applying my study findings directly to all rural locations and rural populations would be inappropriate, as the rural context is not homogenous.
Potentially, additional information may have evolved to inform the study from observational research conducted at additional rural research sites. Observational fieldwork in additional rural workplaces may have yielded contradictory or additional data, although participants in this study spoke of features common to all work sites from their experiences and perspectives drawn from twelve different rural and remote workplaces (in addition to the research site location of this study). Their accounts, while consistent and compelling, cannot be generalized to all rural contexts.

Additionally, this study may have been limited by the participant inclusion criteria. It is possible that different participants or another researcher may have produced other findings. My educational and nursing background and my history as a former rural resident frame my interpretations of the data. Further limitations may also include unique social, historical, and geographical aspects of the rural community where the research was conducted.

In this study I tried to incorporate as many perspectives as possible. While the full range of rural diversity could not be captured, this study does provide a thick, in-depth exploration of the participants’ experiences with multiple rural sites. Despite the focused nature of this study in one single location, the findings from it should be of interest to health care providers, administrators, and policy makers. The findings should be useful in informing future rural educational program development so as to improve rural recruitment and retention strategies. Overall, the findings have relevance for similarly situated rural communities with similar health care structures in other regions of Canada; pointing to the need for the
nurturing of moral agency and fostering of positive moral climates within rural health care structures toward safe, ethical, and more equitable health care provision.

Another potential limitation to this study may result from my inability to formally recruit manager or leaders participants. My observations led me to consider the need for future rural workplace research to include rural manager perspectives. I did observe that rural managers in general appeared to have large portfolios containing multiple rural sites, many with significant driving distances between sites. Udod and Care's (2013) study on the work stressors and coping experiences of nurse managers found the role of the nurse manager to be overwhelming due to the combination of limited resources, increasing span of control and workload challenges, as well as underinvestment in the building of leadership skills. I remain curious about rural manager\textsuperscript{62} perspectives, in particular the way in which travel demands, large spans of responsibility with high workload volumes, and limited support resources might impact their ability to provide practice support and leadership. From my limited observations, travel time between multiple sites of responsibility may be a factor that limits the ability of rural nurse managers to most effectively provide day-to-day leadership in rural practice settings. This is an area that requires further study. Finally, although I did not interview patient and community members directly, I highlighted their common contexts through the ethnographic fieldwork. Interviewing patients and community

\textsuperscript{62} It is noted that not all rural managers are nurses. In reviewing management job vacancies I noted that the postings I reviewed stated a nursing degree or ability to provide direct patient care as a requirement for the position.
members may have provided additional information on rural health and health care structures beyond the information obtained from my observations.

8.4. Knowledgeable Agents

Nurses are knowledgeable agents living and working in rural areas. Because of their depth of practice experience, they are uniquely positioned to offer valuable insights towards redressing the systemic health disparities, inequities and economic challenges posed for geographically disadvantaged and vulnerable populations. In this dissertation I documented numerous ways in which rural nurses enacted agency within the local health care context, in response to the impacts of broader health and health care inequities and resource disparities. Both RNs and AHCPs recounted that they undertook actions they hoped would help support the health and well-being of community members. For example, I observed RNs advocating for patients and families to acquire lower priced generic medication prescriptions from physicians instead of higher priced pharmaceutical drugs, as a means to decrease some of the economic burden.

The rural nurses’ knowledge of the rural context was often used as a resource to assist patients and families locate and access care services outside of the local community. When access to health care services was unavailable at the local facility (or inadequate in some way to meet the needs of some patients), rural nurses were recruited in an ad hoc manner to provide care in an informal “shadow” health care system. The shadow system functioned within the web of the interconnecting social relationships between nurses and the rural communities.
Enactment of agency was not just undertaken in times of acute distress but also in the everyday business of helping patients with simple challenges. For example, calling to make an appointment for a patient to see a specialist in the city may appear to be a simple task easily accomplished without nurse intervention. However, what I have come to understand is that the nurse’s intimate knowledge of the patient’s social background, culture and history is often taken into account in the day-to-day actions such as this. The nurse’s knowledge of the patient’s literacy and cultural challenges was the impetus to act on behalf of the patient. I observed many acts of agency by nurses on behalf of rural patients. From the expressions of gratitude they received from patients and families, and from comments such as “it’s rural and they deserve it” or “you try to kind of go that little extra step” (Participant, 2GV), the enactment of agency appeared to produce a sense of moral satisfaction for nurses. Judging from the gifts of food I often saw brought into the facility to thank the nurses, these acts also appeared to forge respectful and reciprocal relationships with patients, families and the community.

The ethical challenges in rural nursing practice are often linked to access issues and the resulting inequities in the health of rural populations. Ethical challenges in rural and remote locations are thought to be more acute “because usual practices to ensure ethical conduct are narrowed by scarcity of health care resources” (Weiss Roberts, Battaglia, & Epstein, 1999, p. 499). The day-to-day reality of managing high acuity patients under less than ideal working conditions with few resources was experienced as ethically challenging. In order to keep
patients safe in complex care situations, especially during the times when the rural nurse was “it”, often required more than just two hands.

Rural nurses found their ability to provide an acceptable level of care challenged by structural and resource constraints common to rural practice. Structural constraints fostered nursing actions such as “pulling the nurses card” or rule-breaking and later “begging forgiveness” as ways to mitigate the impact of these resource inequities and disparities. In the rural practice context nurses make everyday decisions in order to mitigate the impact and harms associated with rural health inequities, such as providing care in the shadow system or the arranging of transportation, medication, or food delivery for a patient in isolated living conditions. At times, these agency actions risked sanctions if they did not adhere to institutional values or policies. Which values are privileged by the structures often determined whether acts of agency are facilitated by the structures or constrained in the current rural practice environment. An example from my study was an institutional rule that directs the nurse to instruct any after-hours patients that arrive at the closed and locked ER door to call 911 to obtain health care services from the rural ambulance service. Nurses in this study reported that not helping patients who came to the door was morally distressing and that they preferred to suffer the sanctions of the employer by breaking the rules and providing care rather then suffer the moral pain of inaction, or risk public shaming in their community.

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63 Rule-breaking actions can put nurses in jeopardy for regulatory violations and discipline as well as other legal complications for both the nurse and the employer. Further discussion of regulatory discipline and potential risk for liability is found on page 250.
8.5. The Intertwining Complexity of Context, Structure and Agency

The reality of rurality, including the construction of deeply held values and cultural meanings, impacted nursing practice in multiple ways. The complexity of rural nursing practice in the rural context has been well documented in previous nursing research (MacLeod et al., 2004a; 2004b; Kulig et al., 2008). MacLeod found that this complexity is such that it deserves formal recognition and increased financial and educational support. In a study similar to MacLeod’s previous work, MacLeod and Zimmer (2005) found that the nurse’s personal and social roles were intertwined. In my study, like the MacLeod and Zimmer study, the mingling of social and professional roles were found to have perceived benefits, consequences, and risks for rural nurses. Every nurse participant in this study used the phrase “we’re it” to depict their experience of rural nursing within the complexity of intertwining relationships.

The intertwined relationships between rural health care structures and the rural nurse agent is not always formalized as being reciprocal. For example, in reviewing the Health Authority policy on “Standards of Conduct for Interior Health Employees” (IHA, 2004) I noted that the policy demands the “employees have a duty of loyalty to the Interior Health as their employer” but the duty of loyalty was not formalized in the document with nurses as reciprocal. Participants expressed feeling disrespected and unappreciated at times by the employer and this policy document revealed an interesting underlying tension. The lack of stated reciprocity of loyalty in this policy document made me curious as to how the employer-employee
tensions are textually-mediated\textsuperscript{64} and how these tensions may foster rule breaking. This tension in power relations deserves further analysis in future rural nursing research.

\textbf{8.5.1. Simultaneous Complexity}

The notion that rural nursing is simultaneously complex due to the intertwining of the professional and social contexts affects all of the study findings. Rural nursing concerns in this study pointed to common contextual issues and structurally-related health care deficits such as lack of specialized services, professional worker shortages, an aging population, and professional recruitment and retention issues, which is also reflected in other rural nursing research (Bushy, 2002; MacKinnon, 2010b; Montour et al., 2009). In this study, akin to previous findings in the literature, participants acknowledged that rural populations appear to suffer multiple health and health care inequities (Bushy, 2002; Kidd, et al., 2011; Stewart, et al., 2011). The experience of isolation and the intense scrutiny of living in a small community found in this study were likened to that of living in a fishbowl in the Weiss Roberts et al. study (1999). Participants in my study used the word “fishbowl” to describe life in a small town. In my study life in the fishbowl was a shared experience between nurses and had ethical implications for privacy and boundary violations.

Many of the findings in this study echo previous work. The challenges and barriers to rural health care provision found in this research are highlighted in other

\textsuperscript{64} See Dorothy Smith’s work on the ruling relations and the notion of boss texts for further explication of how “the intersection of the everyday local settings and the abstracted, extra-local ruling relations is mediated by the materiality of printed and electronic texts” (1999, p. 73).
studies as being common to rural locations provincially, nationally and internationally (Bushy, 2002; Bourke, Humphreys, Wakeman, & Taylor, 2012; Brannen, Emberly, & McGrath, 2009; Lenthall, Wakeman, Opie, Dollard, Dunn, Knight, MacLeod, & Watson, 2009; MacLeod, et al., 2004a; 2004b; MacKinnon 2010a; 2010b; Montour, Baumann, Blythe, & Hunsberger, 2009). However, this study does contribute new knowledge about the need to foster reciprocity between structure and agency as a means to build on rural practice strengths in order to support quality health care provision for rural populations. This study contributes a broader understanding of how health care structures impact the everyday work of rural nurses, and links resource inequities such as care provider shortages to furthering access inequities for rural populations.

An interesting finding in this study was that the rural practice context fosters a complex reciprocal relationship between the rural nurse and the communities they serve. This relationship carries with it expectations that appear to be grounded in perceived strengths of rural communities, such as the close personal and social nature of rural living and strong community commitments. But this relationship was also premised upon the complex intertwining of nursing and rural values. Rural core values are said to include a focus on family, sharing, and being a committed part of the community’s institutions such as schools, churches, and service clubs (Riebschleger, 2007).

The overlap of values and the high visibility of health care providers in small communities combine in the context of the access inequities and poor availability of resources for health to create a “parallel” health care system outside of the formal
structures. This “shadow” system that I described in chapter seven fills the gaps in access for some rural residents, for example, when nurses or AHCP are approached to provide wound care and a dressing change for a community member in the grocery store. The shadow system also created ethically challenging practice moments for rural nurses in my study, especially when they felt pressured to provide care for their own family members or when the act of caring for a community member was in a public space and had implications for maintaining privacy and confidentiality. However, it is important to note that the shadow system is, likely, ultimately unsustainable, prone to exclusion of certain segments of the population and linked in this study to physician and nurse turnover and burnout. Although nurses’ commitment to caring practice and their social responsibility within their communities is admirable, by trying to cover systemic gaps in rural health care access and participating in the shadow system, nurses risk their licensure and could face other potential legal complications. It also poses the issue that some rural residents (e.g. those who have nurses as acquaintances or family members) may have access to the shadow system and others may not. This creates another unintended layer of inequity.

65 Nursing is regulated under The Health Professions Act Nurses (Registered) and Nurse Practitioners Regulation, B.C. Reg. 213/2010 legislation. The College of Registered Nurses of British Columbia (CRNBC) has a legal obligation to protect the public through the regulation of registered nurses. Providing nursing care in emergency situations is permissible under The Good Samaritan Act, which “protects a person, including a nurse, who provides emergency medical services at the immediate scene of an accident or emergency. In these circumstances, the nurse will not be liable for damages caused by providing assistance, so long as he or she is not grossly negligent. This protection covers only those people who are not employed to provide the emergency medical services, or who do not provide the services with a view to gain” (CRNBC, 2014). The provision of nursing care (subsumed in the legislation under the term “medical services”) to the public in non-emergency situations has the potential risk for liability for not meeting the legal standard of what a reasonably prudent nurse would do if confronted in similar circumstances. This has implications for regulatory discipline and has the potential for removal of licensure.
In addition to participating in the shadow system as a strategy for providing care, nurses in this study were found to advocate on behalf of patients in multiple ways within the system structures. This advocacy was both a positive affirming part of rural practice and a practice that could take the form of subversive strategies and rule-bending. As I have noted in chapter six, rule-breaking or bending was a context-specific response to situations that occurred in practice where the nurse was trying to mediate perceived inequities, resource disparities, or unjust treatment through enactment of agency, as for example when the nurses kept a patient in the ER against policy to provide end-of-life nursing care. When nurses’ agency enactment was met with structural reprimand, the nurse agent often turned to the act of “begging forgiveness.” This was a strategy employed in an attempt to continue to shift the trajectory of the patient care situation towards the nursing notion of fostering acceptable levels of patient care with the intent to support nursing values of equity and social justice and “the well-being of the patient.”

8.6. Policy and Rural Nursing Practice Development

The findings in this study led me to understand that some aspects of rural and remote contexts are so significantly challenged by resource inequities that responsible governments and health authorities ought to consider meaningful policy actions (such as those recommended by Romanow (2002) and others noted in chapter two) to redress inequities. Action is needed to foster multilevel stakeholder collaboration that will bring forward knowledge gained from multiple fields of rural inquiry to focus on innovative solutions that can address inequities and the growing rural health care crisis. In addressing the larger structures that
influence the level of health care services in rural communities, the inequities in rural health can be targeted by addressing the fundamental causes or the “rural health deficit” and returning to supporting good primary health care\textsuperscript{66} (Romanow, 2002, p. 164). The reciprocity between structure and agency point out the need to foster moral climates that support quality, ethical and competent care practices in meaningful ways tailored to meet the health care needs of rural populations, and in more culturally acceptable ways that support equity and uphold the rural values of trusting relationships, community commitment, and mutual responsibility.

In this study I have found that a “complexity” viewpoint is more useful than a “rural deficit” viewpoint, in order to examine the strengths and challenges of rural health care provision within that environment. By viewing rural health care only through its deficits, the strengths of rural health care are overlooked and underutilized when framing solutions. The tendency to focus on the deficits is thought to keep the issues of rural health care on the political agenda, according to Bourke, et al. (2010). However these authors also found that it contributed to negative stereotyping of rural health care provision in general, and focused attention on problems, rather than focusing on more long-term solutions. The vulnerability of rural based populations is a structurally produced consequence of the inability to access appropriate and timely health care.

Nurses’ experience of the rural health care structures is shaped by the simultaneous complexity they experience in their practices and the social context

\textsuperscript{66} Romanow’s definition of primary health care is that which provides high-quality health care for the individual based on collaborative practice models which are tailored to the needs of the community with 24-hour a day, seven days a week access.
they inhabit. This study reinforces other rural nursing research in pointing toward current health system inequities and that inequities are structurally created as products of embedded neoliberal values and larger social structures. Gilson (1998) recommends a more critical examination of policies because, although they may be promoted as being value neutral, they are inherently based upon efficiency discourses that carry the explicit value assumptions of larger more powerful structures. In this study, I found the structure-agency relationship to be strained by the embedded values of both broader and more local policy structures that emphasized the efficiency discourse. These embedded discourses acted in ways that narrowed the practice actions available to rural nurses, who were attempting to provide more socially just and equitable care for rural patients. I highlight the nurses' concerns with the policy governing the provision of palliative and end-of-life care to draw attention to the overall need for a re-evaluation of rural health care policy towards a better balance between organizational goals and the need to be culturally sensitive to rural values in policy-making.

8.6.1. Policy and Palliative Care

The policy governing use of rural palliative provision was described by study participants as being misaligned with the needs and values of the community. The current policy restriction on excluding rural nurse participation in providing palliative nursing care was raised by nurse participants as denying them the opportunity to provide expert care. I listened to many accounts and observed many instances where participants made decisions to break or bend the rules in attempts to provide what they felt was expert and necessary end-of-life care for dying
community members—especially when a local palliative care bed was unavailable. As one nurse expressed,

The RNs have repeatedly stated their wish, to be involved in the care of palliative clients. We are there 24/7 and can provide the expertise needed to care for high acuity clients. The RN’s feel, we are being denied the opportunity to be involved in the care of these clients (p5q, Letter).

The policy which removed the care of dying patients away from rural nurses, and which required the transfer of those requiring end-of-life care to other communities due to local bed shortages or restrictions, in my analysis, did not appear to be consistent with either the values of the nurses, the rural community or the vision and mission statement of the organization. Palliative care was relocated from the acute care setting into the long-term residential care setting. The LTC setting in this study was observed as having a LPN staff-to-resident ratio of greater than 20:1.

The obvious impact of this ratio was less availability and flexibility of the LPN to adjust their workload to meet unexpected LTC or palliative patient care needs. This policy enacted in support of health care reform and the restructuring of rural health care service provision has the appearance of ‘fairness’ as all are subject to the ‘first available bed’ rule. However, my analysis indicates that the complexity and struggle to provide local rural palliative care services under the current policy structure can be challenging for care providers to navigate. The transfer of patients to other communities for end-of-life care puts the rural values of community and family at risk. The change in policy structures was the impetuous for nurses in this study to

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67 For a comprehensive discussion on staff-mix decision-making and nursing care delivery models see Staff Mix: Decision-Making Framework for Quality Nursing Care (Canadian Nurses Association, Canadian Practical Nurses Association, Canadian Council for Practical Nurse Regulators & Registered Psychiatric Nurses of Canada, 2012).
break or bend policy rules, particularly around how end-of-life care was provided. Gilson (1998) warns that reform practices that are inconsistent with societal or health care provider values can have unpredictable consequences. In this particular situation the conflicting values resulted in instances of rule-bending to support the patient values of family, and community and their desire to die among family and friends in the local hospital.

The values tension between the structures and the rural nurses regarding the care of dying community members was found in this study to challenge reciprocity as well as constrain nurse enactment of agency. Pesut, Bottorff and Robinson's (2011) research about the values that informed good rural palliative care from a rural perspective concluded that, “when initiatives violate deeply held values and hard won rural capacity to address the needs of their dying members is undermined, there are long lasting negative consequences. The social fabric of rural life is frayed” (p. 1). The rule-breaking behaviors I observed may be a sign of damaged trust between health care leaders who are responsible for the structural changes and policies of efficiency and neo-liberal based standardizations and the rural nurses. The rule-breaking may also be what Gilson (1998) referred to as an unpredictable consequence of differing value orientations and a sign of the fraying of the rural social fabric identified by Pesut et al.

The ethical conflicts raised in my study point to the need to reexamine palliative and end-of-life care in rural communities. Similar concerns have been documented in previous studies and support a recommendation for the re-evaluation of policies related to rural palliative and end-of-life care with special
emphasis on how the policy supports rural values. Robinson, Pesut and Bottorff (2010) have called for the development of tailored approaches for the provision of palliative care to be optimized in rural communities. My study suggests that rural health care in general requires approaches that are tailored to meet the diverse health care needs of rural populations in culturally appropriate ways. In addition, there is a significant need for palliative care to be tailored from policy inception through to a complete evaluation of how the policy impacts nursing practice and safe patient care at the bedside.

8.6.2. Rural Nurse Practice Regulation and Education

In my study, findings suggest the need to expand the regulatory scope of rural practice, including advanced practice certifications to have rural nursing practice stretch to meet the increasing health care needs of the community. Rural nurses “were it” and shouldered significant responsibility, yet lacked the authority or regulatory coverage and the education that is commensurable with their level of responsibility. In the social and unpredictable resource context of rural nursing practice the disjuncture between the high responsibility of practice and the lack of authority to make independent nursing practice decisions is untenable and often resulted in rule-breaking or risky actions by nurses.

Tarlier and Browne’s (2011) study explored the clinical implications of expanded models of care delivery in remote health care provision, including Remote Nursing Certified Practice (RNCP)\textsuperscript{68}, and RN First Call certified practice, to increase

\textsuperscript{68} For example, Remote Nursing Certified Practice (RNCP) is a newer category of regulated practice developed for Registered Nurses in remote practice settings. RN First Call is a certified practice developed for advance practice and primary care nursing. Certification grants the nurses the ability
the scope of nursing practice to better fit the practice context. Smith (2010) suggested that the use of RN First Call would aid in decreasing ER waits and improve access to health care services. Further, previous research by Hoodless and Bourke (2009) calls for the increased use of rural nursing research to inform future rural policy making and a push for changes to the scope of rural nursing practice.

In consideration of the potential regulatory and safety risks posed by rule-breaking for both the nurse and patient, there is a clear need for a re-evaluation of nursing practice regulatory structure to meet the increasing demands of the rural practice setting. Evidence in the literature, such as Tarlier and Browne’s study (2011), also supports increasing the scope of the rural nurse to meet the demands of rural populations for access to health care—one possibility could be the formation of a rural nurse policy focus group to collaborate in conjunction with practice support organizations such as the Association of Registered Nurses of BC (ARNBC) and other stakeholders. This collaboration could serve to ascertain specific rural practice regulatory policy challenges and provide leadership and direction for future policy-making to be more attentive to the rural practice context. As the scope of nursing practice is broadly controlled by a number of regulations, practice standards, employer policy and the individual nurses competence (CRNBC, 2014a; 2014b), it would seem that a collaborative re-evaluation of the regulatory scope of practice and of rural nursing competencies by the College of Registered Nurses of BC (CRNBC), with consultation from other stakeholders as required to realign the

to practice beyond the regular RN scope of practice using designated protocols to provide a range of care services to patients in small rural and remote health care settings. Protocols can be initiated without the presence of a physician, however access to a physician is required (Tarlier & Browne, 2011; see also Browne & Tarlier, 2008).
regulations and better address the increasing demands on rural practitioners. Re-evaluation is also required to protect nursing licensure by increasing regulatory coverage to match the reality of rural practice. The current regulations do recognize, in a limited way, the independent functions of professional nurses to make decisions in order to carry out particular nursing activities. However, with the increasing responsibility and demands within the health care system, further clarity on nursing actions that may be carried out independently without a doctor’s order or patient-specific order is needed in order to more accurately reflect the changing landscape of practice demands.

Along with the need to increase the scope of rural practice to meet the changing needs of the rural practice environment, the need for continuing education was also indentified as necessary to meet increasing practice demands. Nurses in this study reported that their educational needs were not being met for a number of reasons, including difficulty in accessing upgrading and specialty courses due to time and travel requirements, and the lack of financial support. Other rural researchers, such as Kulig (2005), have also linked the sustainability of the rural workforce to educational preparation. Given that education plays a particularity important role in the recruitment and retention of rural nurses and the sustainability of rural health care in general, it is timely to explore ways for improving rural nurse access to educational resources through the use of advancing technology to provide educational upgrading, educational resources and skills training, and on-going practice support. According to study participants, there is a need to make educational upgrading and practice specialty courses more accessible
by way of technology because the need to travel to access face-to-face learning options is cost and time prohibitive. The development of online and video-supported education sessions could assist in expanding the scope of practice education and aid in building rural nursing practice capacity in more financially and logistically accessible ways. Indeed, a recent study by Place et al. (2012), online learning was found to be one cost-effective way to provide improved access for rural nursing education.

Educational resources and skill development are required to address the rural practice knowledge gap and to meet the pressing educational and practice needs of rural nurses. Therefore partnerships between educational institutions, rural nurses, nursing practice regulators and associations, and provincial health care policy makers is suggested, with the aim of making education accessible to rural nurses and improving the regulatory and clinical practice guideline structures so they reflect the practice reality of rural nurses.

8.6.3. Building Supportive Structures to Enhance and Protect Agency

My study findings illustrated how structures in rural health care can operate to both enable and constrain the enactment of agency. Constrained agency within the rural health care structures left nurses bearing witness to the impacts of health and health care inequities without the resources to provide an acceptable level of care. Not having access to the structural resources necessary for providing an acceptable level of care left nurses feeling distressed. Failing to provide care due to structural inequities put nurses at risk for social shaming in their communities. Constrained agency also damaged trust and frayed the reciprocity between the
structures and the rural nurse. Since reciprocity is built on shared trust and mutual respect, it can be broken or frayed, and without trust being fostered the delicate web of relational connections can untangle (Rodney, 1997). Acts of resistance and rule-breaking were common actions used to mitigate structural inequities as nurses participated in a shadow system of care provision that operated outside of the formal structures.

Enactment of agency by study participants was found to center on actions that supported increased access for rural patients to necessary health care services. Nurses often reported struggling to provide care under less than ideal circumstances, and under policy structures that were insufficiently attentive to the practice contexts. Since the policies that fail to mitigate the inequities are system made, then it is probable that they can also be altered, removed or changed—to reflect more equity—by the system, as well as by individual agents.

Farmer, Philip, King, Farrington and MacLeod (2010), suggest that true equity would require ethically sound policy-making and structural mechanisms for the many voices of rural to be heard at the decision-making table. While acknowledging that sweeping policy recommendations are beyond the scope of this research, the recommendation for a more rural informed policy lens at policy tables is one possible route. Another recommendation for fostering reciprocal relationships within the rural health care structures is to redesign the structures, policies, and rural health care discourses with a goal of creating safer moral climates

69 I note that the British Columbia Ministry of Health has recently put forward a new policy discussion paper that offers one possible framework for improving rural health care services (see Ministry of Health Province of British Columbia (2015) Rural health services in BC: A policy framework to provide a system of quality care. Cross sector policy discussion paper).
where the many voices of rural health care might be heard. Fostering reciprocity within the structures is, according to Musto et al (2014), a way to “better support nurses as moral agents and the structures within which they practice so that they can deliver safe, compassionate, competent, and ethical care” (p. 4). Fostering reciprocity through actions such as collaborative policy meetings with rural nurses could draw attention to the needs and moral concerns of rural nurses and rural nursing practice.

Rural nurses influence, and are influenced by, their practice environments. Fostering reciprocity has the potential to reshape organizational values and rural health care policy towards shaping a moral climate within the rural practice environment that supports ethical nursing practice and challenges rural inequities. Reciprocity holds the promise of a means to acknowledge structure-agency strengths, recognize rural practice gaps and address the everyday ethical challenges in health care.

8.7. Future Research Recommendations

Despite a growing body of rural nursing practice research, gaps in understanding the complex nature of rural nursing practice and the challenges rural nurses face in providing health care in rural practice settings remain. Such gaps mean that a full understanding and appreciation of the practice challenges and strengths is not yet possible. Future research is recommended to support a broader, more complete understanding of the strengths and challenges in rural nursing practice and rural health care.
More specifically, findings from this study point to the dearth of research into the practice concerns and educational needs of LPNs and CAs in rural long-term care practice settings. As important members of the rural health care team, their perspectives, experiences and practice requirements remain largely unknown, according to Cruttenden (2006). In light of my study findings that the rural LPN practice was different from the role of the rural RN, and in considering recent changes to the LPN role and increasing responsibilities, the need for future research into the practice and learning needs of rural LPNs and CAs appears warranted. With aging rural populations and increased complexity in care needs—particularly for persons with dementias—targeted research into understanding the practice and educational needs of LPNs and CAs, so they can provide quality care in rural residential and long-term care facilities, is recommended.

This study also highlighted the challenges and complexities in the provision of end-of-life and palliative care services. Nurses in this study raised questions about the quality, acceptability, and cultural appropriateness of the palliative care services being provided. Nurses further questioned the limitations on access to designated palliative care beds for their community. In light of study findings, further research is recommended to explore the current health care policy for the provision of rural palliative care as well as respite programs in rural health care facilities. Recent research findings by Pesut, Robinson and Bottorff (2014) indicate that in order to support quality palliative and end-of-life care to rural communities, consideration of cultural appropriateness and rural cultural values is required. Further, Castleden, Crooks, Hanlon and Schuurman (2010) and others suggest
opening up a dialogue between professional groups to enhance culturally appropriate palliative care services in rural areas, particularly for Aboriginal peoples. In light of this study’s findings, and in consideration of the growing concern for culturally appropriate palliative care provision—additional research into this area is recommended.

Research into health inequities in urban centres points to the fact that the health care needs of certain groups in society are not well met (Pauly, 2008a; 2008b; 2013; Pauly, MacKinnon, & Varcoe, 2009). This study points to similar concerns for certain groups within rural populations who may suffer more disadvantage because of limited rural mental health and addictions services. This is particularly concerning especially in light of continued restructuring, decreasing access, resource inequities, and sustainability challenges in rural health care provision. My study findings indicated that the level of services and resources was inadequate to meet the needs of the population. While this is also of concern in urban health care provision, it is of particular concern in the rural practice settings. Rural mental health nursing practice in particular was described as isolating and inadequately resourced to meet rural mental health needs in general. Minimal research literature was located on the role isolation plays in the retention of qualified psychiatric nurses in solo rural practitioner positions. Drury, Francis and Dulhuntly (2005) examined the complexity of rural mental health practice and found there is a need for future research since concerns around practice complexity remain highly underexplored. In light of my study findings, I concur.
8.8. Conclusion

This study began with a broad question about what the relationship was between the structures that frame rural health and the nurses’ enactment of agency in rural nursing practice. My findings revealed that nurses were positioned as knowledgeable agents within the health care structures and rural nursing practice is nested in complex layers of social and organizational relationships. The uncertainty in health care resources and declining service levels had a direct impact on nursing practice and patient access to health care. Further, rural nursing practice was found to be fraught with ethical concerns. Service disruptions, such as ER department closures, posed risks for both community and nurse safety. The lack of structural responsiveness to meet the health care needs of rural communities often required nurses to provide care outside of the hospital in the shadow system, and inadequate support and resources required nurses to bend the rules and make difficult care decisions in a state of crisis.

Rural nurses have a tremendous amount of knowledge about rural cultural values and how unpredictability in service levels and resources impact rural population health and equitable access to health care services—particularly for marginalized populations. Consequently, it is vital for rural nurses to engage in collaboration with government policy-makers, local and regional health authority leaders and other health care providers, to work together on initiatives to address systemic structural inequities and inequalities in resources and service provision in rural communities. This study started to illuminate the reciprocity between structures and agency and may offer a way to build and move toward fostering
better collaboration between stakeholders with the ultimate goal to improve equity in rural health and health care delivery.
References


Connelly, L.M. (2014). Ethical considerations in research studies. MEDSURG Nursing, 23(1), 54-55


northern British Columbia. Community Development Institute: University of Northern British Columbia.


ethics for leadership ad practice, (2nd ed.). (pp.143-159). Toronto: Pearson Education Canada.


Health Professions Act, R.S.B.C., 1996, c. 183.

Health Professions Act, Nurses (Registered) and Nurse Practitioners Regulation, B.C. Reg. 213/2010.


Starzomski (Eds.). *Toward a moral horizon: Nursing ethics for leadership and practice* (2nd ed.). (pp. 188-214). Toronto: Pearson Canada Inc.


Appendix A

Table 1: Conducting Critical Qualitative Research Using Carspecken’s Five-stage Approach and Giddens’ Structuration Theory
<table>
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<tr>
<th>Stage</th>
<th>Description</th>
<th>Data Collection</th>
<th>Analysis</th>
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<tr>
<td>1</td>
<td>Construction/compiling stage of building the primary etic record is begun to gain insight by observing rural nursing practice to see what is happening. This includes on-site (passive) field observation to locate patterns, roles, rules, power relations, structures, behaviours, movements, and practices. Field observation is also done to gain information on the socio-political, socio-cultural, historical, and economic aspects of rural practice. Observations include attention to individual nurses, ward/site, and facility as a whole and continue until no new information is obtained.</td>
<td>Fieldwork: Observation of rural nursing practice from etic position; use of fieldnotes, reflective journaling, and reflections on the routines, rituals, practices, deviations and interactions to gain a thick description for use as a comparison for data collected in later stages 3 to 5. Conduct passive observation noting how behaviours may change. Previously collected data is used to in this preliminary reconstructive analysis stage.</td>
<td>Social Integration emphasis. Focused and dense records of routines, rituals, and interactions constructed in fieldnotes and electronic journal is uploaded into Nvivo program. Stage 2 begins the contrasting and comparing of how rural structures and nurse agency are seen and experienced in context that will later inform further analysis on the relationships and reciprocity.</td>
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<tr>
<td>2</td>
<td>Preliminary Reconstructive Analysis stage is undertaken to explore the researchers interpretations of subjective personal feelings and the agreed upon beliefs and normative structures that guide participant actions from an etic perspective.</td>
<td></td>
<td>Social Integration emphasis. Initial low level coding used for analysis at later stages. Descriptions of the cultural context, social interactions, rules, resources, power relations, and routines. Themes are teased out and that which requires further exploration were noted for stage 3. This stage is repeated again after stage 3.</td>
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Dialogical data is generated from participant interviews (emic perspective) with interview guides that are semi-structured, based on previous observation, and that are carefully constructed, and mindful of not reinforcing dominant power relations.

Fieldwork: Semi-structured interviews guided by previous observations to confirm, clarify and confirm the previous data and open dialogue between participants and myself.

Midway through the data collection with primary participants (5) and when some meaningful analysis had occurred, I sought out feedback from participants to ensure that participant voices and the rich emic perspective were accurately being represented in the analysis. This was also done to address the tension between Carspecken’s critical perspective based on a realist framework and the rural values and culture. Because what might have been seen with a critical lens, might also be a misinterpretation of rural values and cultural strengths. As an example rural health may be perceived as “less than”. For example rural patients choosing to remain at home in their community rather than access palliative care services in an urban centre might be constructed as poor care. It can also be seen as a choice that facilitates the value of family, community and home. Both possibilities may exist in rural health care and I am aware of the tension. There may be times where many lens are required to gain a broader deeper understanding.

Social Integration emphasis. Interview data is compared back to the primary record data to illuminate consensus and conflict in the enactment of agency and reciprocity. Data was critically examined for any inconsistencies between my observations and interviews. Linkages were explored between inconsistencies and the broader rural context. Triangulation of the data was explored to verify content validity. Giddens’ concept of contextuality within structuration Theory provides the conceptual and theoretical framework to examine the data for agency, structure and duality of structure-agency. Carspecken suggests peer debriefing (this would be with committee members) and member checks to challenge my (researcher) understandings—although he warns reconstructions may or may not be revised in event of discrepancy.
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<th>Stage</th>
<th>Description</th>
<th>Data Collection</th>
<th>Analysis</th>
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<td>4</td>
<td>Conduction of system analysis to describe system [structure] relations to broader context</td>
<td>Fieldwork: conducted more interviews and observations based upon previous analysis [for example I needed to return to key informants to explore experiences of other work sites]. I examined cultural commodities to compare and support observed system [structure] relationships.</td>
<td>System Integration emphasis in this stage was done by examining the reconstructions between the Research Site (common access point) and participants experiences of other rural/remote sites. Published literature was consulted to identify theories to help further analyze the findings.</td>
</tr>
<tr>
<td>5</td>
<td>Conduction of system analysis to explain system [structure] relations</td>
<td>All findings were re-examined for linkages of participant responses to existing macro-level theories; stages 1-3 were revisited again in order to gain any further ideas and to clarify and recheck any outstanding issues and to protect against making “cognitive leaps” (Morse, et al., 2002 p. 13).</td>
<td>System Integration: Carspecken suggests that stage 5 is the creative stage where research findings are supported by theory and the dissertation includes both reconstructions referenced by participant interviews and observational materials from fieldnotes. Change noted with participants and researchers including personal growth, practice changes, attitudes, etc are also documented.</td>
</tr>
</tbody>
</table>

Rural Health Care and Nursing Practice Research

Care to Share?

If you are:
• a Registered Nurse;
• allied health care provider, physician, or
• provide professional health care management in a rural health care facility

You are invited to participate in a research study which will be conducted in this facility to examine rural health care and nursing practice. If you would like further information about this study please contact:

Barbara Jean Buckley, RN, PhD(c)
1-xxx-xxx-xxxx or email at xxxxxxxx@xxxxxxx
Appendix C
Study Information Letter for Registered Nurses and Other Health Care Personnel
The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator:  
Dr. Patricia Rodney  
(XXX) XXX-XXXX  
XXXXXXXXXX

Co-Investigator and Contact for Study:  
Barbara Jean Buckley  
(XXX) XXX-XXXX  
XXXXXXXXXX

Study Information Letter for Registered Nurses and Other Health Care Personnel

Introduction:

My name is Barbara Jean Buckley, I am a resident of Kamloops, a Registered Nurse, and I am a doctoral student at the University of British Columbia in the School of Nursing. I am interested in learning more about rural nursing practice. I am particularly interested in the day-to-day experiences you, as a rural nurse, encounter in providing patient care in your facility and community. Health care provision in rural Canada has undergone many changes in recent years. Little is known about how rural nurses have been impacted by these changes, and even less is known about how rural nurses go about trying to provide safe, ethical, and equitable care in their communities within changing health care structures. Because you practice in a rural community, you have valuable knowledge and direct experience that I am hoping you would share with me to increase my understanding of the challenges and benefits of trying to provide safe, ethical, and equitable...
nursing care in your rural community. I would like to invite you to consider helping me learn about rural nursing by participating in this study. I am undertaking this research to complete part of my requirements for the University of British Columbia (UBC) School of Nursing Doctorate program. I have designed this study to contribute to nursing knowledge improvement in the areas of nursing ethics, rural nursing practice development, patient safety, and rural health policy creation.

**Study Purpose:**

I think that rural nurses and other health care personnel have a great deal of knowledge about how the structures that make up rural health care shape nursing practice and patient care. In this study I hope to explore and describe the everyday practice experiences, perspectives and actions of rural nurses as they go about providing care to patients. In doing so I hope to gain an understanding of how the structure of rural health care shapes rural nursing practice and how rural nurses go about enacting moral agency (that is, how nurses recognize, reflect, and make decisions around acting on their moral responsibilities as individual nurses and as a group) within those structures to provide safe, ethical, and equitable care for rural patients, families, and their community.

**So what exactly will happen?**

In this study I will be interviewing 10 Registered Nurses and 10 other health care personnel (total of 20 participants) who are willing to talk about their experience of practicing or working in a rural community. Interviews will be private, take place outside of the workplace, they will not last for more than two hours (maximum) with most lasting sixty to ninety minutes. All interviews will be tape-recorded then transcribed. At anytime during the interview you may stop the interview, refuse to answer or skip a question, and ask questions. Participation in the study is completely voluntary. Arrangements of a place, and time, for the interview are very flexible. As well, I am happy to accommodate interviews at my private office in Kamloops (near Costco) if this would be more convenient for you or coincide with a planned shopping trip to the city. Some nurses may be asked to participate in a second (or third) interview lasting no more than 30 minutes. This is also voluntary. The purpose of the additional interviews is to help me understand certain issues identified in the first interview, or explore some aspects in more depth. The total possible time commitment for interviews will not exceed 3 hours.

I will also be inviting Registered Nurses to allow me to “buddy” with them for several shifts so that I may observe and learn what it is like to be a rural nurse. I will take notes as I learn. Being able to “buddy” will also help me to learn what the policies, procedures, and health care structures are in rural nursing practice and how your workplace is connected to the community and the rest of the health authority. If you are willing to “buddy” with me and teach me what it is like to be a rural nurse it will not require any additional hours as I will partner with you on your scheduled shifts. During “buddy” shifts I will seek verbal consent from
patients, family members, or other health care providers that are encountered for their permission to observe and take notes of your interaction with them.

You may choose to participate in an interview only, in “buddy” shift observation only, participate in both interview and buddy observation, or not participate at all. You can also elect to participate in the study at anytime or change how you participate at anytime during the course of the research.

Risks and Benefits of Study:

No known risks are expected with this study. The “buddy” shift observation may make some people feel like they are being watched and this may cause some discomfort. If at anytime this occurs and you feel you need a break or need to discontinue, you are encouraged to do so without need of any explanation or notice. You may not personally benefit from participating in this project, but your input will help improve this study so it can better inform health care policy and rural health care practices. Refusal or withdrawal from the study will in no way affect your employment, or your participation in ongoing or future research studies.

Confidentiality:

Your interest or participation in this study is completely voluntary and confidential. I am committed to maintaining my ethical practice by making all efforts to ensure confidentiality is maintained. No actual names will be used in the notes I take during this study. If you do not wish to have your practice observed, I will not make any notes regarding activities that are connected to your practice. “Buddy” observation is impossible to conceal and other staff members will be aware of my presence as I follow participants. If this is a concern for you that others will be aware of the “buddy” shift observation please know that all information obtained through the observation (or interview sessions) will not be disclosed to anyone (including co-workers or employers) and no names or other identifying information will be included in the research final report or presentations. All possible steps will be taken to protect the identity of participants in this study including the use of aliases and the shifting of biographic and other details in order to mask and obscure persons, places, and events observed during “buddy” shifts and data collected through interviews so that all participants and communities in this study cannot be identified. If, however, at any time you decide you do not wish to continue participating in the study then all previous data collected from you will be destroyed.

All information pertaining to this study will be stored in a locked cabinet and destroyed by the co-investigator after 5 years. To further protect privacy all electronic devices and digital files will be password protected. Interview notes and paper transcripts will be kept in a locked cabinet at the office of the co-investigator until the completion of the dissertation and then securely transferred to the office of
the Principle Investigator at UBC in Vancouver and destroyed in a confidential manner after 10 years. To further protect your privacy only the project staff (Principle Investigator, Dr Paddy Rodney, UBC Doctoral Committee members Dr Colleen Varcoe and Dr Barb Pesut) and myself the co-investigator will have access to the data. All written reports, papers, and public presentations that will be created from this research will be altered in such a way so that no one person can be identified.

Consent:

All Registered Nurses and other health care personnel who participate in this study will be asked to give informed consent. Participation is voluntary and can be revoked at anytime without notice or reason. You are free to participate in any aspect of the study you choose or not at all. You may stop any part of your participation at anytime. You are encouraged to ask questions and seek clarification if any part of this research is unclear.

If you have any questions about this study at any time, please contact Dr. Paddy Rodney or Barbara Jean Buckley at the phone numbers or email addresses listed above.

If you have any concerns about your treatment or rights as a research subject, please contact the Research Subject Information Line located in the UBC Office of Research Services at (XXX) XXX-XXXX or toll free 1-XXX- XXX-XXXX, or by email at

Or you may contact the Chair of the IH REB at XXX-XXX-XXXX or

Or you may contact the Chair of the IH REB at XXX-XXX-XXXX or

The Interior Health Research Ethics Board carried out an ethics review for this research project and made a determination that it met ethical requirements for research involving human subjects.

If you are interested in participating in this study, or you would like more information about this research study please feel free to contact me directly at:

(XXX)-XXX-XXXX

Or you can email me at

Thank you for your time and consideration,
### Appendix D
### Study Field Work Calendar

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Interviews</th>
<th>Dissemination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb 2013</td>
<td>UBC BREB approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Onsite meeting with management for entry</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contact with Health Authority to begin process of ethics approval</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Meeting with knowledgeable rural health champion to discuss potential</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>secondary sites</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar 2013</td>
<td>Health Authority Approval received field work commenced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>April 2013</td>
<td>Management meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Field work continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 2013</td>
<td>Management meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Field work continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 2013</td>
<td>Management meeting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Field work continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 2013</td>
<td>Fieldwork continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2013</td>
<td>Fieldwork continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>September 2013</td>
<td>Fieldwork continued Entry to Site #2 initiated</td>
<td></td>
<td></td>
</tr>
<tr>
<td>October 2013</td>
<td>Fieldwork continued</td>
<td></td>
<td></td>
</tr>
<tr>
<td>November 2013</td>
<td>Entry to Site #2 on-going Fieldwork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>December 2013</td>
<td>Entry to Site #2 on-going Fieldwork</td>
<td></td>
<td></td>
</tr>
<tr>
<td>January 2014</td>
<td>Attempt for Entry to Site #2 refused UBC REB renewal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>February 2014</td>
<td>Fieldwork completed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2014</td>
<td>Renewal of REB approval</td>
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<td></td>
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<tr>
<td>April 2014</td>
<td>Participant advisor follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 2014</td>
<td>Participant advisor follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td>Participant advisor follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 2014</td>
<td>Participant advisor follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>August 2014</td>
<td>Participant advisor follow-up</td>
<td></td>
<td></td>
</tr>
<tr>
<td>September 2014</td>
<td>Dissertation completed</td>
<td></td>
<td>Planning for dissemination presentation for participants and hosted thank you luncheon</td>
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<tr>
<td>October 2014</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>November 2014</td>
<td></td>
<td></td>
<td>Prepare draft of articles</td>
</tr>
<tr>
<td>December 2014</td>
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<td></td>
</tr>
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</table>
**Appendix E**

**Table 2: Study Participant Demographics**

<table>
<thead>
<tr>
<th></th>
<th>Staff RNs</th>
<th>Other HCP</th>
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<tbody>
<tr>
<td><strong>Gender – Female</strong></td>
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<td></td>
</tr>
<tr>
<td>Age:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20s</td>
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<td>3</td>
</tr>
<tr>
<td>30s</td>
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<tr>
<td>60s</td>
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<td>1</td>
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<tr>
<td><strong>Highest Education:</strong></td>
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<td></td>
</tr>
<tr>
<td>Care Aide</td>
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<td>1</td>
</tr>
<tr>
<td>LPN</td>
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<td>Diploma RN</td>
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</tr>
<tr>
<td>BSN</td>
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</tr>
<tr>
<td>RPN</td>
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<td></td>
</tr>
<tr>
<td>NP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BSR</td>
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<tr>
<td><strong>Years in Rural Practice:</strong></td>
<td>Average 15.45 years</td>
<td>Average 15 years</td>
</tr>
<tr>
<td>Range</td>
<td>2-38 years</td>
<td>10-20 years</td>
</tr>
<tr>
<td><strong>Number of Participants with Experience in:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban Setting</td>
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<td>2</td>
</tr>
<tr>
<td>Work experience at more than one rural site</td>
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<td>2</td>
</tr>
<tr>
<td>Remote work experience</td>
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</tr>
<tr>
<td>Retired – returned to work</td>
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<td>1</td>
</tr>
<tr>
<td>Intent to Leave &gt; 10 yrs</td>
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<td>1</td>
</tr>
<tr>
<td>Intent to Leave 6-9 yrs</td>
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<td>1</td>
</tr>
<tr>
<td>Intent to Leave &lt; 5 yrs</td>
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<td>Intent to Leave &lt; 1 year</td>
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</tr>
<tr>
<td>Intent to Leave unknown</td>
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<td>1</td>
</tr>
<tr>
<td>Left by the close of the study</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
Appendix F

Participant Demographic Data Collection Tool

THE UNIVERSITY OF BRITISH COLUMBIA

The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator: Dr. Patricia Rodney
(XXX) XXX-xxxx
XXXXXXXXXXXXXXXXX

Co-Investigator and Contact for Study: Barbara Jean Buckley
(XXX) XXX-xxxx
XXXXXXXXXXXXXXXX

Participant Demographic Data Collection Tool

This form is kept securely and separately from all other research data

Name: __________________________________________ Assigned Code_______________________

Site: __________________________________________ Assigned Code_______________________

Electronic mail address (email)________________________________________________________

Contact telephone number___________________________________________________________

1. Nursing education / or other level of education_______________________________________
2. Work experience_________________________________________________________________
3. Total number of years in rural health care___________________________________________
4. Current Position____________________________________________________________________
5. Employment status/desired status____________________________________________________
6. Total time in current position_______________________________________________________
7. Total years till planned retirement or leaving position_________________________________

Please indicate by circling yes or no to the following requests for notification of study results:

I request a copy of my own interview transcripts Yes No
I request a copy of the completed dissertation Yes No
I request a copy of any future publications Yes No
I request____________________________________________________________________________
Appendix G

Registered Nurse Study Consent to be Observed and Consent to be Interviewed
School of Nursing
Faculty of Applied Science
T201-2211 Wesbrook Mall
Vancouver, B.C. V6T 2B5

The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator: Dr. Patricia Rodney
(XXX)-XXX-XXXX
XXXXXXXXXXXXXXXXXXXXXXXX

Co-Investigator and Contact for Study: Barbara Jean Buckley
(XXX)-XXX-XXXX
XXXXXXXXXXXXXXXXXXXX

Registered Nurse Consent To Be Observed

I have had an opportunity to read the study information sheet and this consent form. I have received satisfactory answers to any questions that I may have had. I understand my participation in this study is entirely voluntary and that I can refuse to participate or withdraw from the study at any time, without affecting my relationship to: the University of British Columbia; the Health Authority; or to the Nursing or medical staff of the hospital where the study is being conducted. The proposed number of participants for this study is twenty. By signing this form I confirm that I understand what is being asked of me, I consent to participate in this study, and I have received a copy of this consent form for my own records. I understand no addition time commitment is required to participate in this study, as observations sessions will occur during my regularly scheduled work shift. By signing this consent I also understand that I am giving voluntary permission to be observed by the Co-investigator (Barbara Jean Buckley) at this health care facility. I understand during “buddy” shifts the co-investigator will seek verbal consent from patients, family members, or other health care providers that are encountered for their
permission to observe and take notes of our interaction and that the co-investigator will not observe personal care of patients. I understand that data collected in this study is being used as part of the requirements towards completion of a PhD for Barbara Jean Buckley, and that the data collected from this study will also be used for future production of scholarly publications and presentations at Nursing and other conferences by the Co-investigator. I understand all possible steps will be taken to protect the identity of participants in this study including the use of aliases and the shifting of biographic and other details in order to mask and obscure persons, places, and events. I also understand that I may choose to withdraw from the study at any time or alter how I participate in the study without consequence, and that no one other than the Co-investigator (Barbara Jean Buckley) needs to know about my decision to withdraw.

If you have any questions about this study at any time, please contact Dr. Paddy Rodney or Barbara Jean Buckley at the phone numbers or email addresses listed above.

If you have any concerns about your treatment or rights as a research subject, please contact the Research Subject Information Line located in the UBC Office of Research Services at (XXX)-XXX-XXXX or toll free 1-(XXX)-XXX-XXXX, or by email at: [email protected]

Or you may contact the Chair of the IH REB at (XXX)-XXX-XXXX or [email protected]

The Interior Health Research Ethics Board carried out an ethics review for this research project and made a determination that it met ethical requirements for research involving human subjects.

Printed Name____________________ Signature____________________ Date____________________

I have received a copy of this form as indicated by my initials __________
The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator:
Dr. Patricia Rodney
(xxx) xxx-xxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx

Co-Investigator and Contact for Study:
Barbara Jean Buckley
(xxx) xxx-xxxx
xxxxxxxxxxxxxxxxxxxxxxxxxxxx

Registered Nurse Consent To Be Interviewed:

In signing this consent form I __________________________agree to be interviewed regarding my experiences and knowledge about the structures that make up rural health care and how those structures impact the rural context, nursing practice, and patient care. This study is being conducted by Barbara Jean Buckley, a graduate nursing student at the University of British Columbia under the supervision of her doctoral committee, of which Dr. Paddy Rodney is the chair and Principle Investigator for this research. This study is being conducted as part of the requirements towards completion of a PhD for Barbara Jean Buckley. Data collected from this study will also be used for future production of scholarly publications and presentations at Nursing and other conferences.

I have had an opportunity to read the study information sheet and this consent form. I have received satisfactory answers to any questions that I may have had. I understand my participation in this study is entirely voluntary and that I can refuse to participate or withdraw from the study at any time, without affecting my relationship to the University of British Columbia, the Health Authority, or to the hospital where the study is being conducted.
I understand the proposed total number of participants in this study is twenty. I understand that the interview will be a discussion, which will last 1-2 hours. The interview will take place at a location that is convenient for me. I understand interviews will take place outside of the workplace and are conducted on my own private time. I will discuss my experiences and perspectives about the structures that make up rural health care and how those structures impact the rural context, nursing practice and patient care. I further understand that these interviews will be digitally recorded so that an accurate transcription of the information provided will be available for analysis. I understand I have the right to refuse to answer any specific question. I understand that if at anytime I feel uncomfortable with what discussion has been recorded, that I have the right to have the recorded discussion of concern deleted in my presence. I also understand that I may be asked to participate in a second (or third) interview lasting no more than 30 minutes. I understand that this is also voluntary. The total time commitment will not exceed 3 hours.

I understand that the digital tapes, interview notes, and the paper transcripts derived from the interview tapes will be kept for further analysis, and will be kept secure until destroyed by the Co-investigator when any future analysis is completed. Interview notes, tapes, and paper transcripts will be kept in a locked cabinet at the office of the co-investigator until the completion of the dissertation and then securely transferred to the office of the Principle Investigator at UBC in Vancouver and destroyed in a confidential manner after 10 years. To further protect your privacy only the project staff (Principle Investigator, Dr Paddy Rodney, UBC Doctorial Committee members Dr Colleen Varcoe and Dr Barb Pesut) and myself the co-investigator will have access to the data. All other information including consent forms, and demographic data forms will be securely stored for 5 years and then confidentially destroyed. All written reports, papers, and public presentations created from this research will be altered so that no one person can be identified. I understand this will be done through the use of aliases and the shifting of biographic and other details in order to mask and obscure persons, places, and events so that participants and communities in this study cannot be identified.

I also understand that I may choose to withdraw from the study at any time. I understand I can choose to withdraw from the study with no negative consequences, and that no one other than the Co-investigator (Barbara Jean Buckley) needs to know about my decision to withdraw.

If you have any questions about this study at any time, please contact Dr. Paddy Rodney or Barbara Jean Buckley at the phone numbers or email addresses listed above.

If you have any concerns about your treatment or rights as a research subject, please contact the Research Subject Information Line located in the UBC Office of Research Services at (xxx) xxx-xxxx or toll free 1-xxx-xxx-xxxx, or by email at Or you may contact the Chair of the IH REB at (xxx) xxx-xxxx or [email protected]
The Interior Health Research Ethics Board carried out an ethics review for this research project and made a determination that it met ethical requirements for research involving human subjects.

By signing this form I confirm that I understand what is being asked of me, I consent to participate in this study, and I have received a copy of this consent form for my own records.

By signing this consent I also understand that I am giving voluntary permission to be interviewed by the Co-investigator (Barbara Jean Buckley).

________________________________________________________________________

Printed Name __________________________ Signature ______________

Date ______________

I have received a copy of this form as indicated by my initials __________
Appendix H

Study Information and Consent to be Observed and Consent to be Interviewed
Form for Non-Registered Nurse Health Care Providers
THE UNIVERSITY OF BRITISH COLUMBIA

The Structure and Enactment of Agency in the Context of Rural Nursing Practice

UBC School of Nursing
Faculty of Applied Science
T201-2211 Wesbrook Mall
Vancouver, B.C. V6T 2B5

Principal Investigator:  Co-Investigator and Contact for Study:
Dr. Patricia Rodney  Barbara Jean Buckley
(XXX) XXX-XXXX  (XXX) XXX-XXXX
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

STUDY INFORMATION AND CONSENT TO BE OBSERVED AND CONSENT TO BE INTERVIEWED
FORM FOR NON-NURSING HEALTH CARE PROVIDERS, ADMINISTRATORS, MANAGERS, OR
OTHER HEALTH CARE PROFESSIONALS

Introduction:

My name is Barbara Jean Buckley, I am a resident of Kamloops, a Registered Nurse, and I am a
doctoral student at the University of British Columbia in the School of Nursing. I am interested
in learning more about rural health care and rural nursing practice. I am particularly interested
in the day-to-day experiences rural nurses encounter in providing patient care in your local
health care facility and community. Health care provision in rural Canada has undergone many
changes in recent years. Little is known about how rural nurses have been impacted by these
changes, and even less is known about how rural nurses go about trying to provide safe, ethical,
and equitable care in their communities within changing health care structures. Because you
live in a rural community, and work in rural health care you have valuable knowledge and direct
experience that I am hoping you would share with me to increase my understanding of the
challenges and benefits of trying to provide safe, ethical, and equitable nursing care in your rural
community. I would like to invite you to consider helping me learn about rural health care by
participating in this study. I am undertaking this research to complete part of my requirements
for the University of British Columbia (UBC) School of Nursing Doctorate program. I have
designed this study to contribute to nursing knowledge improvement in the areas of nursing
ethics, rural nursing practice development, patient safety, and rural health policy creation.

Study Purpose:

I think that administrators and others in the health care system have a great deal of knowledge
about how the structures that make up rural health care shape nursing practice and patient care.
In this study I hope to explore and describe the everyday practice experiences, perspectives and
actions of rural nurses as they go about providing care to patients. In doing so I hope to gain an
understanding of how the structure of rural health care shapes rural nursing practice and how
rural nurses go about enacting moral agency (that is, how nurses recognize, reflect, and make decisions around acting on their moral responsibilities as individual nurses and as a group) within those structures to provide safe, ethical, and equitable care for rural patients, families, and their community. Your perspective as an administrator or manager within the health care system is vitally needed in order to help me learn about how the system functions from a non-nursing perspective.

**So what exactly will happen?**

In this study I will be inviting Registered Nurses to allow me to “buddy” with them for several of their shifts so that I may observe them and other allied health care workers as they go about providing nursing care to patients, families and the community. Being able to “buddy” will also help me to see and experience how patients receive health care in rural health care facilities. I will take notes as I learn.

I will also like to invite all administrators and health care managers to allow me to “buddy” with you as you go about performing the tasks of your position.

You may choose to participate and help me to learn what it is like to be an administrator or manager in a rural health care facility by allowing observation of the interaction between yourself and others during a “buddy” shift to be documented. If you are willing to “buddy” with me and teach me what it is like to be a rural health care administrator it will not require any additional hours, as I will partner with you on your regular workday. No names or identifying information will be recorded and your privacy will be respected at all times.

In this study I will be also be interviewing Registered Nurses and other health care personnel including administrators and managers who are willing to talk about their experience of practicing or working in providing rural health care. Interviews will be private, will not last for more then two hours (maximum) with most lasting sixty to ninety minutes, all interviews will be tape-recorded then transcribed. At anytime during the interview you may stop the interview, refuse to answer or skip a question, and ask questions. Participation in the study is completely voluntary. Arrangements of a place, and time, for the interview are very flexible. As well, I am happy to accommodate interviews at my private office in Kamloops (near Costco) if this would be more convenient for you or coincide with a planned shopping trip to the city. Some participants may be asked to take part in a second interview. This is also voluntary. The purpose of this second interview is to help me understand certain issues identified in the first interview, or explore some aspects in more depth.

You may choose to participate in an interview only, in “buddy” shift observation only, participate in both interview and buddy observation, or not participate at all-- in which case no observations will be recorded pertaining to your interactions with health care staff or others. You can also elect to participate in the study at anytime or change how you participate at anytime during the course of the research.

**Risks and Benefits of Study:**

No known risks are expected with this study. You may not personally benefit from participating in this project, but your input will help improve this study so it can better inform health care
policy and rural health care practices. Refusal or withdrawal from the study will in no way affect the health care you receive, or your participation in ongoing or future research studies.

Confidentiality:

Steps taken to protect your privacy include ensuring no names or identifying information will be on any notes. CDs of digital files will be stored in a locked cabinet for 5 years and then destroyed. Notes made from observations will be stored in a locked cabinet and a password-locked computer for up to 10 years and then destroyed. Signed consent forms will be stored separately from notes, in a locked cabinet. To further protect your privacy, information from the notes will be stored on password-protected computers, and only project staff will have access to this de-identified data. All reports presented from this project will only report information in ways that no one person can be identified.

Thank you for your cooperation and interest in this study.

If you are interested in being involved in this study by allowing yourself to be observed and notes taken as you interact with health care providers and others as you perform the tasks of your position, please read the following Consent to be Observed carefully on the following page.

If you are interested in being interviewed for this study you will be asked to give informed consent. Participation is voluntary and can be revoked at anytime without notice or reason. You are free to participate in any aspect of the study you choose or not at all. You may stop any part of your participation at anytime. You are encouraged to ask questions and seek clarification if any part of this research is unclear.

If you have any concerns or questions about the manner in which this research is being conducted or your rights as a research participant please contact the University of British Columbia Research Subject Information Line in the UBC Office of Research Services at (XXX) XXX-XXXX. You also have the right to contact my supervisor Dr. Patricia Rodney at the UBC School of Nursing directly if you have any questions or concerns. She can be reached at (XXX) XXX-XXXX.

If you are interested in participating in this study, or you would like more information about this research study please feel free to contact me directly at: XXXXXXXXXX

Or you can email me at XXXXXXXXXX

Thank you for your time and consideration,

Barbara Jean Buckley, RN, BSN, MSN, PhD (c)
The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator:  
Dr. Patricia Rodney  
(XXX) XXX-XXXX  
xxxxxxxxxxxxxxxxxxxx

Co-Investigator and Contact for Study:  
Barbara Jean Buckley  
(XXX) XXX-XXXX  
xxxxxxxxxxxxxxxxxxxx

Participant Consent To Be Observed

I have had an opportunity to read the study information sheet and this consent form. I have received satisfactory answers to any questions that I may have had. I understand my participation in this study is entirely voluntary and that I can refuse to participate or withdraw from the study at any time, without affecting my relationship to: the University of British Columbia; the Health Authority; or to the Nursing or medical staff of the hospital where the study is being conducted. By signing this form I confirm that I understand what is being asked of me, I consent to participate in this study, and I have received a copy of this consent form for my own records. By signing this consent I also understand that I am giving voluntary permission to be observed by the Co-investigator (Barbara Jean Buckley) at this health care facility. I also understand that I may choose to withdraw from the study at any time or alter how I participate in the study without consequence, and that no one other than the Co-investigator (Barbara Jean Buckley) needs to know about my decision to withdraw.

Printed Name  
Signature  
Date

I have received a copy of this form as indicated by my initials __________
The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator: Dr. Patricia Rodney
(XXX) XXX-XXXX
xxxxxxxxxxxxxxxx

Co-Investigator and Contact for Study: Barbara Jean Buckley
(XXX) XXX-XXXX
xxxxxxxxxxxxxxxx

Participant Consent To Be Interviewed:

In signing this consent form I ________________________________ agree to be interviewed regarding my experiences and knowledge about the structures that make up rural health care and how those structures impact the rural context and patient care. This study is being conducted by Barbara Jean Buckley, a graduate nursing student at the University of British Columbia under the supervision of her doctoral committee, of which Dr. Paddy Rodney is the chair and Principle Investigator for this research. This study is being conducted as part of the requirements towards completion of a PhD for Barbara Jean Buckley.

I have had an opportunity to read the study information sheet and this consent form. I have received satisfactory answers to any questions that I may have had. I understand my participation in this study is entirely voluntary and that I can refuse to participate or withdraw from the study at any time, without affecting my relationship to the University of British Columbia, the Health Authority, or to the hospital where the study is being conducted.

I understand that the interview will be a discussion, which will last 1-2 hours. The interview will take place at a location that is convenient for me. I will discuss my experiences and perspectives about the structures that make up rural health care and how those structures impact the rural context and patient care. I further understand that these interviews will be digitally recorded so that an accurate transcription of the information provided will be available for analysis. I understand I have the right to refuse to answer any specific question. I understand that if at anytime I feel uncomfortable with what discussion has been recorded, that I have the right to have the recorded discussion of concern deleted in my presence. I understand I may be asked to participate in a second (or third) interview lasting no more than 30 minutes. I understand that this is also voluntary.
I understand that the digital tapes, interview notes, and the paper transcripts derived from the interview tapes will be kept for further analysis, and will be kept secure until destroyed by the Co-investigator when any future analysis is completed. All interview tapes, notes, and transcripts will be confidentially destroyed after 10 years. All other information including consent forms, and demographic data forms will be securely stored for 5 years and then confidentially destroyed. All written reports, papers, and public presentations created from this research will be altered so that no one person can be identified.

I also understand that I may choose to withdraw from the study at any time. I understand I can choose to withdraw from the study with no negative consequences, and that no one other than the Co-investigator (Barbara Jean Buckley) needs to know about my decision to withdraw.

By signing this form I confirm that I understand what is being asked of me, I consent to participate in this study, and I have received a copy of this consent form for my own records.

By signing this consent I also understand that I am giving voluntary permission to be interviewed by the Co-investigator (Barbara Jean Buckley).

---

I have received a copy of this form as indicated by my initials __________
Appendix I

Study Information and Verbal Consent to be Observed Letter for Patients and Families
Dear Patient and Family

Introduction:

My name is Barbara Jean Buckley, I am a resident of Kamloops, a Registered Nurse, and I am a doctoral student at the University of British Columbia in the School of Nursing. For my dissertation, I am interested in learning more about rural health care and rural nursing practice. Because you live in a rural community, you have valuable knowledge and direct experience that I am hoping you would share with me to increase my understanding. I would like to invite you to consider helping me learn about rural nursing and rural health care by participating in this study.

In this study in order to understand rural health care I will be observing Registered Nurses as they work.

I WILL BE ASKING PATIENTS AND FAMILY MEMBERS FOR THEIR VERBAL CONSENT TO OBSERVE THE INTERACTION THAT OCCURS AS THE NURSE PROVIDES CARE. If I have your permission I will observe the nurse and watch how he/she works. I will take notes as I learn about the interaction including what actions and activities occur, and what verbal and non-verbal communications. Please note I will not observe any private procedures or personal care. No time commitment is required on your part to participate in this research.

The decision to allow me to observe is entirely your own. Please know that even if you agree to let me observe you that you are under no obligation to allow me to continue to observe if you change your mind. You can ask me to stop observing at anytime without needing to give a reason. Please understand that you are under no obligation to allow me to observe you, and if you decline to participate please know that your interactions, or communications with the nurse will not be recorded. Please understand that if you decline to participate the nursing care you receive here will not be affected nor will there be any negative consequences to you for not participating.

Confidentiality:

Confidentiality and privacy will be strictly maintained and no actual names or identifying information will be used in the notes I take for this study.
If you have any questions about this study at any time, please contact Dr. Paddy Rodney or Barbara Jean Buckley at the phone numbers or email addresses listed above.

If you have any concerns about your treatment or rights as a research subject, please contact the Research Subject Information Line located in the UBC Office of Research Services at (XXX) XXX-XXXX or toll free 1-(XXX) XXX-XXXX, or by email at [blank].

Or, you may contact the Chair of the Interior Health Research Ethics Board at (XXX) XXX-XXXX or [blank].

The Interior Health Research Ethics Board carried out an ethics review for this research project and made a determination that it met ethical requirements for research involving human subjects.

If you are interested in being involved in this study by allowing yourself to be observed and notes taken as you interact with nursing staff providing care, please indicate your consent verbally when asked by the Co-investigator Barbara Jean Buckley. Again your participation is strictly voluntary.

Thank you for your cooperation and interest in this study.
Appendix J
Observation Guide

1. Note the use of the space and other physical aspects of the environment.
2. Note the flow of the environment and who enters and leaves the space.
3. Note what different types of care providers are present.
4. Note what activities are being organized and engaged in.
5. Observe the nurse/ or non-nursing participant within the setting including mannerisms, movements, actions, activities, verbal and non-verbal communications and interactions.
6. Observe others present in the environment. What actions, movements, activities, and verbal or non-verbal communications and interactions are occurring?
7. What seems to be the pattern in this environment to provide rural health care services?
8. What appears to hinder or support the actions of the nurse or non-nursing participant?
9. What appears to be missing from the environment?
10. What are the impressions you have of this environment?
11. What impressions do you have of the nurses’ or non-nursing participants practice in this environment?
12. Is there safety concerns in this environment?
13. Are all persons being treated in an equitable manner?
14. Are there any ethical concerns being expressed?
Appendix K

Fieldnote Example

The parking lot is divided into visitor and staff parking. The facility has three distinctive areas: emergency and other related health care services, family practice clinic, and long term care.

The waiting room is plain beige in color. The floor is industrial battle ship linoleum in plain light gray. There are 14 vinyl-covered chairs placed in a square around a table covered in old magazines and health literature brochures. The entrance way has a sliding glass door monitored by a video surveillance camera. The walls contain posters like child find and health programs offered in the community and cheap massed produced replica artwork. No staff are visible in the facility the office is dark and the halls are bare. Two middle aged or older men are pacing in the waiting area. They do not speak. The public address system blasts a country western music station, which seems too loud for this environment.

The waiting area is not unpleasant. There are two patient and visitor washrooms located in a hallway off the main waiting area. The hall to the right goes to the hospital emergency department. There is hall that appears to lead to administration offices and a connecting corridor to the general practice medical clinic. The laboratory and diagnostic services are located off the waiting area. From where I sit I can see a connecting hallway to what appears to be public health, home care, mental health and other services. The sign indicates it is by appointment. I wander down the hall to explore.

The hallway to emergency divides to provide access to the long-term care facility through locked steel doors. An elevator offers access to the lower level of the facility. A cleaning staff person is seen working and an office staff member is now visible. The facility is small but uncluttered and the space appears very clean and well cared for.

People begin to enter the building and there is some curiosity as to who I am by a small child who appears to be around age 3. She engages me in a book while I wait. I am called to my meeting and I receive a “bye” from the little girl. Some gentleman comments on my fancy shoes as I walk away towards the voice calling my name. There is a comfortable atmosphere in this facility.
Appendix L

Institutional Document Collection Form

THE UNIVERSITY OF BRITISH COLUMBIA

The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator: Dr. Patricia Rodney
(XXX) XXX-XXXX
xxxxxxxxxxxxxxxxxxxxx

Co-Investigator and Contact for Study: Barbara Jean Buckley
(XXX) XXX-XXXX
xxxxxxxxxxxxxxxxxxxxx

Institutional Document Collection Form

Date________________________

Institution Code________________________

Name of Document ____________________________________________________________

Location or Policy Binder where document is kept in the institution________________________

Copy of document made and original returned by Co-investigator:

Date________
Initials________
Appendix M

Transcription Services Confidentiality Form

THE UNIVERSITY OF BRITISH COLUMBIA

School of Nursing
Faculty of Applied Science
T201-2211 Wesbrook Mall
Vancouver, B.C. V6T 2B5

The Structure and Enactment of Agency in the Context of Rural Nursing Practice

Principal Investigator:  Co-Investigator and Contact for Study:
Dr. Patricia Rodney  Barbara Jean Buckley
(XXX) XXX-XXXX  (XXX) XXX-XXXX
xxxxxxxxxxxxxxxxxxxx  xxxxxxxxxxxxxxxxx

Transcription Services Confidentiality Form

I have been contacted to provide confidential transcription services for the above named study. I understand I will be transcribing interview materials in the form of digital recordings. I will protect the confidentiality of this research study at all times and will not disclose any names of individuals, institutions, or agencies I may encounter in the conduct of my work. I will replace any identifiable individuals names with the codes provided by the co-investigator. I will keep all materials in a secure locked cabinet or locked drawer while in my possession. I will return all materials upon completion of the transcription process. I will ensure any materials downloaded to my computers hard drive will be erased and permanently deleted from my computers trash bin. I have discussed in detail the confidentiality requirements for this study with the co-researcher, and I agree by my signature on this form to abide by all requirements.

Signed  

Date  

I have received a copy of this form as indicated by my initials __________
Appendix N

Rural Registered Nurse Participant Interview Guide
(Interview Guide for all non-nursing participants use page 2)

Prior to beginning the interview I will clarify with the participant the purpose of the research, I will outline the process, and I will answer any questions. Informed consent will be obtained prior to the collection of any data.

After the consent process has been explained and informed consent received I will provide a demographic questionnaire (see Appendix F) to the participant. Following the collection of demographic data I will open with a broad question:

1). Could you please tell me a little bit about your nursing career and your background?

2). What does "rural" mean to you?  
What does “rural nursing practice” mean to you?  
What is the routine here? Can you describe a typical shift?  
What is an atypical shift like?  
What advantages do you feel you have in your practice here that you might now have in other places? What disadvantages?

3). Has anything changed recently in how health care is being provided to the people of Smallville/ Tiny Town70? If so, what?
Have you ever been in the position where you decided to take a stand on behalf of a patient or family so they could receive better care?  
If so, could you tell me about what happened?

4). What are the main issues or concerns you have in providing care?  
How do you feel about working in a rural setting?  
What do you struggle with in terms of providing care? What helps you provide care?  
What do you consider important for providing care?  
What changes would you make to care provision here and why?

In our conversation so far is there anything that comes to mind about living and working in Smallville/Tiny Town that you would like to share with me? Are there any experiences you have had as a rural nurse that you would like to share with me that you think will help me to better understand rural nursing practice? Is there anything that we have already touched on that you would like to talk more about? Is there anything else you would like to talk about today?

70 Smallville and Tiny Town are pseudonyms for the rural health care facilities where the research was being conducted and for the other rural or remote work places where participants had current or previous work histories.
Non-Nursing Participant Interview Guide

Prior to beginning the interview I will clarify with the participant the purpose of the research, I will outline the process, and I will answer any questions. Informed consent will be obtained prior to the collection of any data.

After the consent process has been explained and informed consent received I will provide a demographic questionnaire (see Appendix F) to the participant. Following the collection of demographic data I will open with a broad question:

1). Could you please tell me a little bit about your career and your background?

2). What does “rural” mean to you?
What does “rural health care” mean to you?
What is the routine here? Can you describe a typical day?
What is an atypical day like?
What advantages do you feel you have in your career here that you might now have in other places? What disadvantages?

3). Has anything changed recently in how health care is being provided to the people of Smallville/Tiny Town? If so, what?
Have you ever been in the position where you decided to take a stand on behalf of your facility, a patient or family so they could receive better care?
If so, could you tell me about what happened?

4). What are the main issues or concerns you have in providing health care in Smallville/Tiny Town?
How do you feel about working in a rural setting?
What do you struggle with in terms of providing health care services?
What do you consider important for providing health care in rural communities?
What changes would you make to care provision here and why?

In our conversation so far is there anything that comes to mind about living and working in Smallville/Tiny Town that you would like to share with me? Are there any experiences you have had as a rural health care administrator or manager that you would like to share with me that you think will help me to better understand rural health care? Is there anything that we have already touched on that you would like to talk more about? Is there anything else you would like to talk about today?
Appendix O

Map of Specialty Cardiac Service Hospitals in British Columbia and Travel Time from Randomly Selected Rural Centres

Legend

H – Specialty Cardiac Services Hospital Location
KGH – Kelowna General Hospital, Kelowna, BC
VGH – Vancouver General Hospital, Vancouver, BC
SPH – St Paul’s Hospital, Vancouver, BC
RCH – Royal Columbian Hospital, Vancouver, BC
RJH – Royal Jubilee Hospital, Victoria, BC
F – Fernie, BC
Q – Quesnel, BC
P – Port Hardy, BC
T – Terrace, BC

Travel Time

Fernie - Kelowna: 8h 10m
Quesnel - Kelowna: 7h 15m
Terrace - Vancouver: 17h 16m
Port Hardy - Victoria: 5h 59m