

VOICES FROM THE WILDERNESS:
AN INTERPRETIVE STUDY DESCRIBING THE ROLE AND PRACTICE OF OUTPOST
NURSES

by

DENISE SUSAN TARLIER

B.S.N., The University of British Columbia, 1992

Diploma in Outpost and Community Health Nursing, Dalhousie University, 1996

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Department of Nursing

The University of British Columbia
Vancouver, Canada

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ABSTRACT

Outpost nurses are expected to function as both primary care providers and in a community health nursing role, to provide comprehensive primary health care in Canada's underserved northern and remote communities. However, little information exists informing us as to whether or how outpost nurses meet this expectation. The purpose of this study was to discover how experienced outpost nurses perceive and enact their role, and to explore the practical knowledge and clinical wisdom revealed in participants' practice narratives.

Nine experienced outpost nurses participated in this study by sharing their stories of clinical practice. Data analysis was conducted in accordance with Benner's (1984; 1994) model of interpretive phenomenology, a research methodology that effectively preserved the unique context of outpost nursing practice. Four main themes emerged from the data and were interpreted within the context of practice: (a) primary care competencies are fundamental to outpost nursing practice, (b) nurses evolve into the outpost nursing role by learning community health competencies and adapting to context-specific practice issues, (c) experienced outpost nurses build and maintain responsive relationships with communities, and (d) experienced outpost nurses become comfortable with the autonomy and responsibility of practice. Paradigm and exemplary cases served to ground the interpretation in the data. The domains and competencies of outpost nursing practice thus revealed were then related to domains and competencies of nursing and nurse practitioner practice, using adaptations of frameworks developed by Benner (1984) and Brykczynski (1989), resulting in a preliminary conceptual framework of outpost nursing practice.

A better understanding of the outpost nursing role has implications for outpost nursing practice and education and may provide direction for future research. Insight into the outpost nursing role may contribute to our understanding of evolving nursing roles, such as nurse practitioner and advanced practice nurse, which are currently the focus of much discord within

the nursing profession in Canada. Ultimately, giving 'voice' to the nurses who live and work in remote northern communities may help to make visible the nature of their practice, and clarify how their role may best contribute to improving the health status of northern communities.

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Your Average Northern Nurse

You would have to search for aeons, riding time's relentless tide,
To the corners of the Earth, to the globe's far-distant side,
Just to find a job as challenging, as daunting and diverse,
As the never-ending duties of your average northern nurse.

Kate endures the biting cold when it's forty-four below
And tackles blinding storms when polar winds begin to blow.
Liz gets a frantic, urgent call in the middle of the night
To a bloody, desperate case that would give ER a fright.

Leanne hopes to get a break and a taste of bigtown life
When she travels to the South - well, south to Yellowknife!
But before she gets her wish, she will have to wait a bit,
'Cause some caribou are grazing on the drifted landing strip.

Then there's Lona, fighting panic, as she flies to hell and back,
'Cause a patient's sinking fast and there's a need for Medivac.
And there's Jan, "Grandma Jan", who counsels, treats, consoles;
Thirty years dispensing love in a hundred different roles.

Chorus

She's an angel of mercy flying through the northern skies
With a frightened, pregnant woman - and a baby, oh, surprise!
She's a surgeon when its needed and she operates alone,
Guided through the angioplasty by a doctor on the phone.
She's a steady, patient healer who can manage to be cool
As she battles flu and scabies at the elementary school.
She's as sweet as maple syrup, so you'll never hear her curse;
She's a lot like SuperWoman; she's an outpost nurse!

Bob MacQuarrie
The Gumboots
Yellowknife, Northwest Territories
Reproduced with Permission

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I would like to acknowledge *The Gumboots*, who have kindly allowed me to reproduce their song *An Average Northern Nurse* as the preface to this work.

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Finally, I would like to especially thank each of the nine outpost nurses who participated in this study. Not only would the study have been impossible without their participation, but also their belief in and enthusiasm for my project convinced me of the merit of this study as something more than an academic exercise. They gave generously of their time, candidly sharing their stories and insights into practice and life in northern communities. I hope that in return I have been able to offer these participants a voice that serves to illustrate that there is nothing average about the “average” northern nurse!

CHAPTER I: INTRODUCTION

Across Canada, remote and often isolated communities rely on nurses as their first-line health care providers. Northern nurses have a long tradition of employing ingenuity and innovation to cope with any and all situations that present, from mixing their own intravenous solutions when supplies run out, to fixing the emergency generator when the lights go off. Their heroic and often life-saving exploits have become the stuff of legend in the north, gaining northern nurses a respect and status that is perhaps unique amongst Canadian nurses.

While it is the epic deeds performed by northern nurses that capture the imagination and which have come to be most readily identified with the role of the outpost nurse, these nurses are, in fact, mandated to function in a far broader and more complex nursing role than is generally recognized by those who are unfamiliar with the realities of life and health in remote areas of Canada. Often the only health resource in a community of several hundred people, nurses in outpost communities incorporate both nursing and medical knowledge to function in an expanded and advanced nursing role, as well as a physician replacement role, thereby ensuring community members access to a wide spectrum of health services. Combining the complementary approaches of primary care and primary health care, outpost nurses are ideally situated to provide holistic, comprehensive health services to their communities, ranging from primary medical care and treatment, to public health nursing services and health promotion, to community development.

Given the breadth and depth of knowledge and skills demanded by the position, and the autonomous nature of nursing practice in remote and isolated communities, nursing in the outposts has traditionally been considered the ultimate challenge for Canadian nurses. From suturing a laceration to acting as a resource to a citizen group interested in establishing a community food bank, the outpost nurse is “it” (MacLeod, 1999) – she is truly expected to be a ‘SuperWoman’, or at least a ‘SuperNurse’!

How realistic is the expectation that one nurse can function effectively in such a pluralistic role? Do nurses manage to live up to this expectation, and if so, how? How does the role of the outpost nurse fit with other evolving nursing roles in Canada that entail similar competencies and responsibilities? And perhaps most importantly, is this a nursing role through which nurses can in fact work to effect improvements in the health status of northern residents?

Outpost Communities: A Canadian Anomaly

Communities in the far northern reaches of Canada are generally recognized as being remote “outpost” communities, located, as they are, at great distances from the larger population centers of the country. Less readily recognized as remote are communities that, while not so far distant from larger centers, are isolated by geography, weather, or by virtue of a small population (Bell, Daly & Chang, 1997; MacLeod, Browne & Leipert, 1998). Lacking both easy access to larger centers and the resources that would be taken for granted in a larger center, these small communities may also be considered to be remote (MacLeod, 1999). For example, the community of Tatla Lake, in the Chilcotin region of British Columbia (B.C.), is only a few hundred air miles northeast of Vancouver, yet it is isolated by the Coast mountains, and the fact that its population is too small to support resources such as air service, a hospital, a physician, or even an ambulance service. Similar communities across Canada rely on nurses as their sole providers of health care.

Predominantly aboriginal, the residents of remote and northern communities in Canada experience relatively poorer health than do other Canadians. Health status indicators confirm that northern regions – where the proportion of aboriginal people is higher - experience higher rates of death, disease, and trauma. For example, data from the Statistics Canada 1996 census (Statistics Canada, 2000) reveal that life expectancy is lowest in these northern health regions: 75.7 years, compared to 78.6 years for the nation overall. Infant mortality rates also reflect the health status of a population. “In the health regions with low life expectancy and more than 20%

Aboriginal population, infant mortality rates were 1.3 to 2.8 times the national rate” (Statistics Canada, p. 3). Rates of mortality due to cancers and circulatory disease are also higher in the northern regions than the national average (Statistics Canada), and diabetes and cardiovascular disease have reached epidemic proportions in many aboriginal communities (National Forum on Health, 1997; Young, Reading, Elias, & O’Neil, 2000).

That the poor health status of aboriginal and northern Canadians is due in large part to the social inequities that exist in remote and aboriginal communities has become increasingly well recognized in recent years (Gregory, 1992; MacLeod et al., 1998; Royal Commission on Aboriginal Peoples [RCAP], 1996; York, 1989; Yukon Department of Health & Social Services [YHSS], 1999).

Aboriginal people in Canada endure ill health, insufficient and unsafe housing, polluted water supplies, inadequate education, poverty and family breakdown at levels usually associated with impoverished developing countries. The persistence of such social conditions in this country – which is judged by many to be the best place in the world to live – constitutes an embarrassment to Canadians, an assault on the self-esteem of Aboriginal people and a challenge to policy makers (RCAP, 1996, p. 1).

Compound issues such as these with the loss of cultural identity and self-esteem, soaring rates of suicide, and pervasive alcohol and drug dependence that have come to typify some northern communities (“Youth suicide near epidemic among natives,” 2000; York, 1989), and it becomes difficult to reconcile the United Nation’s decision to vote Canada the world’s best country in which to live... for the seventh consecutive year (Edwards, 2000).

Primary Health Care: A Concept for Better Health

Primary health care (PHC) is a conceptual model of health service delivery that may be viewed as “both a philosophy and an approach that provides a framework for health care delivery systems” (Canadian Nurses Association [CNA], 1998, p. 2). It incorporates the concepts of

disease prevention, health promotion, population health and community development within a holistic framework, with the aim of providing essential, community-focused health care (Shoultz & Hatcher, 1997; World Health Organization [WHO], 1978).

The World Health Organization identifies access, equity, essentiality, community participation and empowerment, appropriate technology, and multisectoral collaboration as fundamental principles of PHC (WHO, 1978). Working within a primary health care framework, nurses function as facilitators, advocates, educators, liaisons and change agents, and form collaborative partnerships with clients, with the goal of effecting lasting improvements in health. Primary health care was endorsed more than 20 years ago by the federal government as the most appropriate approach to improving the health status of aboriginal people (Doucette, 1989).

Disease prevention includes disease screening programs, and client education about anticipated or known health risks. Cervical cancer screening and educating adolescents about safe sexual practices are examples of preventive health approaches. Health promotion is the process of “enabling people to increase control over and to improve their health” (CNA, 1998, p. 2). An example of health promotion is a nurse facilitating a community-based initiative to persuade the only store in the community to offer healthier food choices.

What has become known as ‘population health’ focuses on populations, or targeted groups within larger populations, and the risks or conditions that determine the health of that population (CNA, 1998). In this way, the concept of population health is linked to the concept of the social determinants of health. The goal of population health strategies is to effect change in the social and economic conditions that impede good health. The Canadian Prenatal Nutrition Program is one example of a population health initiative.

The fundamental principles of PHC include community participation, empowerment, and working in partnerships with communities. These philosophical underpinnings dictate that client populations identify their own health needs (CNA, 1998; Glick, 1999). Community

development encompasses the principles of community participation and empowerment thus is congruent with the principles of PHC. “The fundamental premise [of community development] is that when people are given the opportunity to work out their own problems, they will find solutions that will have a more lasting effect than when they are not involved in such problem-solving” (Lindsey, Shields & Stajduhar, 1999, p. 1240-1241).

In my clinical experience, I have observed that the ability to clearly identify health needs may be compromised within significantly marginalized populations. Lack of education and literacy, poor knowledge of health issues, failure to comprehend the relationships between social conditions and health status, and denial of sensitive health issues within a community, such as abuse or alcohol use, are factors that impede a community’s ability to identify their actual health needs. Additionally, I have worked in outpost communities where responsibility for health has been so thoroughly usurped by a patriarchal and authoritative health care system that it has become difficult to persuade people to take back responsibility for their own health (Gregory, 1992). In one community, for instance, a member of the Health Council indignantly told me that deciding what health programs to offer in the community was “the nurse’s job, that’s what you get paid for”. In working with populations that evidence a low level of community function, it is important to remember that the inherent values of PHC ascribe expertise on community health problems to the community, and the nurse’s role may be that of a facilitator, assisting the community through the process of identifying and articulating the health issues that are significant to that community.

Primary health care is distinct from primary care. Shoultz and Hatcher (1997) define PHC as the provision of population-based public health services, while primary care refers to the delivery of personal or individual health services. The CNA (1998) differentiates PHC nursing from traditional nursing roles as a “notion of working *with* rather than caring *for*” (p. 5). The

WHO (1978) describes this shift in thinking as giving professional health workers “a new orientation” (p. 63).

While primary care and primary health care represent different approaches to health service delivery, they are not mutually exclusive of one another. It is, in fact, apparent in the 1978 WHO statement on PHC that the WHO envisioned essential primary care, including “appropriate treatment for common diseases and injuries” (p. 53) as an integral component within a comprehensive primary health care strategy. The CNA (1998) supports combining the two approaches, particularly in remote and underserved areas, where health providers are scarce: “When primary care is combined with illness prevention and health promotion, such as in Canada’s rural and isolated communities, holistic and comprehensive care can result” (p. 4). Their sanction is accompanied by a caveat, however, recognizing that urgent primary care demands may deflect resources away from primary health care, a tendency that has also been noted by other writers (Gregory, 1992; MacLeod et al., 1998).

The Role of the Outpost Nurse

Nursing sisters such as the Grey Nuns might fairly be considered to be the original outpost nurses, migrating, as they did, north and westwards with the early Canadian settlers. The Grey Nuns, for instance, arriving in the Northwest Territories (NWT) in 1867, were the first nurses in the new territory (Morewood-Northrop, 1994). It was not until 1945 that the federal government began to organize health services in northern and remote areas, eventually - in 1954 - settling the responsibility for health service delivery with Medical Services Branch (MSB) of Health and Welfare Canada (Morewood-Northrop). In the Yukon and Northwest Territories MSB carried the mandate to provide health services to all northern residents regardless of ethnicity, whereas in the provinces this mandate is limited to the health of aboriginal people. Since assuming responsibility for native and northern health care in the mid-1940’s, the federal government has managed to gradually but steadily divest itself of direct responsibility for health

care delivery, first as the territories took over responsibility for their own health care (the NWT in 1988, and the Yukon in 1997), and now as transfer of health authority for aboriginals devolves to tribal councils and individual bands throughout the provinces (MacLeod et al., 1998; Vukic, 1997).

As the principal employer of nurses in northern and remote communities, MSB formalized and gave definition to the role of the outpost nurse. Recognizing that nurses, as the only health care providers in outpost communities, were routinely called upon to function outside of traditional nursing roles and in fact, to provide primary medical diagnosis and treatment, a variety of post-basic educational programs were developed to better prepare nurses to work in a physician replacement role in the outpost setting. Foremost amongst these programs, which varied in duration from a few months to two years, was the Outpost Nursing (OPN) Program at Dalhousie University in Halifax, which opened in 1967, and operated for 30 years, finally closing in 1997 following the withdrawal of federal funding (Martin-Misener, Vukic, & May, 1999).

Medical Services Branch supports the extended role expectations of the nurses it employs in outpost settings by means of a scope of practice document (Health Canada, 1994) that delineates specific functions and responsibilities of the nurses. Interestingly, even though their physician replacement function is often recognized as the most visible aspect of the outpost nursing role, nurses employed in the extended role by MSB have continued to be classified simply as Community Health Nurses, reflecting the community focus of outpost nursing work, as well as the community and public health nursing responsibilities of the role.

Despite the devolution of accountability for health services in northern, remote, and aboriginal communities from MSB to the various territorial and aboriginal governments, the role of nurses in outpost communities has not changed significantly. It is evident, working as an outpost nurse for the various health authorities, that the framework established by MSB remains

the basis of employer expectation. Although the employers are changing, role expectations and the work itself remain consistent from the Yukon, to northern Manitoba, to Nunavut. It is moreover evident that communities and health care authorities throughout the north recognize the value of a primary health care approach to foster improvements in the health status of northern populations (Morewood-Northrop, 1994; RCAP, 1996; YHSS, 1999), and that this has become, along with primary care and prevention, an expectation of the outpost nursing role (Doucette, 1989; MacLeod et al., 1998; Martin-Misener et al., 1999; Morewood-Northrop; Sibbald, 1997). Martin-Misener et al. noted that in the decade since Doucette's 1989 article, the outpost nursing role had changed "to include community development as well as community participation" (p. 204).

The expanded role of the contemporary outpost nurse has, like other expanded nursing roles, developed through need and historical antecedent. As such, it is in certain regards specific to nursing practice in the remote and isolated communities of northern Canada. In many ways, however, the outpost nursing role is considered by some to be analogous to other evolving nursing roles, notably, that of nurse practitioner (NP) and advanced practice nurse (Martin-Misener et al, 1999). In fact, following the transfer of health services in the Yukon from MSB to YHSS in 1997, the position of outpost nurse became that of a Community Nurse Practitioner. Currently in the NWT, the Registered Nurses Association (NWTRNA) is developing competencies for "Primary Health Care Nurse Practitioners" (Cook, 2000).

The issue of nurses functioning in expanded and advanced roles has been a focus of controversy and confusion within the nursing profession for many years. Nurses have been debating the merits of expanded role functions for nurses for over three decades, struggling to differentiate advanced practice from expanded practice, and mired in a semantic bog of terminology (Allen, 1999; Buzzell, 1999; Pinelli, 1997). In May 2000, the Canadian Nurses Association published a national framework on Advanced Nursing Practice (CNA, 2000a).

Although still hotly debated, and subject to regional variations in interpretation, this document represents the closest we have come thus far in Canada to achieving consensus on defining and describing the language of advanced nursing practice. While it is beyond the scope of this work to enter into the debate over terminology, it is predictable that outpost nurses will use these terms in the course of being interviewed, therefore an understanding of the terminology is necessary. Recognizing its limitations, I will for the purpose of clarity and consistency use the definitions of advanced nursing practice and nurse practitioner provided in the CNA document (see Appendix A for Glossary). These nursing roles will be further examined in relation to the role of the outpost nurse in Chapter 2: Review of the Literature.

Problem Statement

Health issues in northern communities are not only complex and deeply rooted in the social determinants of health, but are also, in these predominantly aboriginal communities, overlaid with multifaceted cultural and mental health issues. Traditionally, health services to northern communities have followed a medical model of care, with care delivered primarily by nurses functioning in a physician replacement role. More recently, there has been growing acknowledgement amongst the key stakeholders – governments, health professionals, and within the communities themselves - of the failure of such a medicalized model of care to address the fundamental causes of poor health in northern communities; it has, at best, represented a band-aid solution that treats some of the symptoms, but leaves the disease uncured. Increasingly, primary health care is advocated as a more appropriate and hopeful approach to improving the health status of northern residents, and primary health care expertise is becoming an expectation of outpost nurses.

Is it possible, or realistic, to expect one nurse to function in a role that encompasses such diverse approaches to health as primary care and primary health care? Is PHC in fact a new role for outpost nurses, or has it formed a less visible part of their traditional practice in

communities? While supporting such a role for nurses in remote and underserved areas, the CNA recognizes that there may be difficulties in implementing it. They identify the need for descriptive studies “to understand whether or how one nurse can address a community’s prevention and illness care at the same time” (CNA, 1998, p.4).

Purpose of the Study

The purpose of this qualitative investigation was to address this identified gap in nursing knowledge by asking outpost nurses to reflect on their practices. As both health providers and members of the remote communities in which they live and work – which are markedly different from communities in other parts of Canada - outpost nurses were presumed to have key “insider” knowledge of the issues that influence health in their communities, and the nursing role that is most appropriate to addressing these issues. In examining the role of the outpost nurse through the eyes of experienced outpost nurses, I expected to gain valuable insights not only into issues that have traditionally plagued the delivery of health services in northern settings, but also into the ways in which outpost nurses develop competencies and expertise in all aspects of their role.

A better understanding of the outpost nursing role has implications for outpost nursing education, credentialing, and regulation, and may provide direction for future research. Insight into the outpost nursing role, which may be considered to be the original expanded and / or advanced nursing role in Canada, may contribute to our understanding of the evolving nursing roles, such as nurse practitioner and advanced practice nurse, which are currently the focus of much discord within the nursing profession in Canada. Ultimately, understanding the practice of outpost nurses may contribute to improving the health status of northern communities.

Research Question

This study explored the following research questions: How do experienced outpost nurses perceive and enact their role? How are practical knowledge and clinical wisdom revealed in the practice narratives of experienced outpost nurses?

CHAPTER II: REVIEW OF THE LITERATURE

This chapter presents a critical review of literature that has been selected on the basis of its relevance to understanding the role of the outpost nurse. While the body of outpost nursing literature per se is small, what literature is available directs investigators towards two related bodies of literature that may prove germane to outpost nursing role issues. This literature originates in the areas of primary health care and nurse practitioner practice. Representing current trends in nursing practice, each of these areas has generated a substantial body of research in recent times. This review aims to provide a synthesis of these three distinct yet related sources of literature – outpost nursing, primary health care nursing, and nurse practitioner practice - that may yield insights into the outpost nursing role and contribute to a better understanding of the complexities this role implies.

Outpost Nursing in the Literature

Significantly, little has been written about outpost nursing in Canada, and virtually none of what is available as published literature is research-based. Initially I obtained articles on outpost nursing through a computer search of the Cumulated Index to Nursing and Allied Health Literature (CINAHL) database (1966-2000), using the key words “outpost” and “nursing”, which generated only two articles. Using various combinations of the key words “northern”, “native Americans”, “Canada”, “community health nursing” and “rural”, I was able to discover additional articles, although few that address outpost nursing specifically. Following up works listed in the reference lists of the articles I had obtained eventually proved to be a more successful search strategy, albeit a frustrating one, as several of the articles referred to unpublished master’s theses or unpublished papers, which have proved difficult, if not impossible to obtain. For example, although the computer search generated a literature review by Vukic (1996) in the area of outpost nursing, four of the citations, representing all of the research-based work that was reviewed, were unpublished master’s theses, and three cited

unpublished papers. Additionally, much of the literature reviewed by Vukic pre-dates 1985, and thus may now be considered dated material, particularly in view of the significant changes that are taking place both in health care delivery to natives (e.g., transfer of health authority to native organizations from MSB) and within the profession and practice of nursing (e.g., the trend towards clarifying and recognizing expanded and advanced nursing roles). Thus, the first observation concerning the body of literature related to outpost nursing is that there is a lack of it, and of current and research-based works in particular.

Deficiencies in the Literature

Other writers have noted the deficiencies in the outpost nursing literature. In 1988, Gregory identified the lack of nursing research in the fields of northern, rural, and aboriginal health, and asserted that much of the available research had originated within other disciplines, such as medicine, anthropology, and the social sciences. This is problematic for nursing in that it perpetuates what many writers have identified as the “invisibility” of nursing practice in the community (Chaytor, 1994; Leipert, 1996; MacLeod, 1999; Mass & Whyte, 1997; Rafael, 1999; SmithBattle, Drake & Diekemper, 1997). It may also propagate a body of health-related literature that lacks a nursing perspective, or “voice” (Chaytor; Johnson, 1993; Macleod). Additionally, while Gregory (1992) cites a handful of nurses who are involved in research in outpost communities, I noted that this research focuses predominantly on disease management in outpost and aboriginal populations, rather than on nursing roles per se. While this research is undeniably valuable, and a step in the right direction, it is, for the purposes of this study, of limited relevance.

In a 1994 evaluation of the Dalhousie OPN Program, Chaytor (1994), who teaches program evaluation to graduate students at Dalhousie University, not only noted the lack of literature “by and about the outpost nurse” (p. 16), but also claimed “literature and data which accurately reflect functions and responsibilities of the outpost nurse was inaccessible” (p. 16).

Chaytor does not elaborate or speculate as to why such data was inaccessible. MacLeod (1999), in her chapter on rural nursing practice, briefly discusses both the lack of literature in general, and the lack of published research findings in particular.

I speculate that the dearth of literature written by and about outpost nurses is due to three factors. First, compared to the numbers of nurses working in other practice areas, there are relatively few nurses engaged in the practice of outpost nursing. While many nurses will “try” outpost nursing to find out what it is like, or to test him or herself in what is recognized as a challenging role, few choose to engage in outpost nursing as a primary and permanent area of practice. Second, those nurses who do live and work in remote communities are isolated in many ways from mainstream professional nursing issues, such as the trend in recent years to better articulate what nursing practice is and to promote nursing practice to the public. With improved communication technologies, such as Internet access, increasingly available in outpost communities, it is likely that nurses in remote practice settings will become less isolated from their peers and colleagues; however, these changes are as yet just emerging in many of the communities in the north. Third, nurses engaged in outpost practice tend to be clinically focused, perhaps at the expense of becoming actively involved in teaching, writing, research, or other academic pursuits. Often this is due to the intense demands of outpost practice: most outpost nurses not only work long hours but are on-call for emergencies, in some cases, 24 hours a day, seven days a week. Although I know personally of outpost nurses having graduate education, it is a commitment to clinical practice that keeps these nurses in outpost practice, instead of choosing to follow more academic career paths that might be open to them. Again, the isolated setting of outpost practice precludes, for most outpost nurses, practices that integrate clinical and academic practice, such as clinically focused nurses in urban centers often manage.

MacLeod (1999) describes the outpost nursing literature as consisting predominantly of “descriptions of patient care, nursing situations, or case studies of practice” (p. 168). Such

descriptive writings range from articles such as the one published for a lay audience in Reader's Digest (Pfeiff, 1999), to columns and letters published in nursing journals such as The Canadian Nurse (Boulanger, 1998; Roberts, 1998; Sibbald, 1997), to thoughtful analyses of outpost nursing issues appearing in nursing textbooks (Gregory, 1988, 1992; Martin-Misener et al., 1999).

These articles, while serving to publicize some of the issues that affect outpost nurses by painting a graphic picture of life and nursing in remote communities, sometimes exhibit a narrow, and at times misleading perspective. For example, Pfeiff (1999) focuses on the emergency response and physician replacement functions of two outpost nurses; the "dramatic medevacs" (p. 132), as she terms it, and fails to mention the community and public health nursing responsibilities of the nurses. Boulanger (1998), a First Nations nurse, tells of her disillusionment upon returning to her home community in northern Manitoba to find it wracked with crime, poverty, and drug and alcohol abuse; conditions that she was, in her role as an outpost nurse, unable to accept. Roberts (1998), another outpost nurse, responded to Boulanger's column with a letter to the editor, clarifying what she felt was a fallacious statement on Boulanger's part, and describing her own experience as an outpost nurse. Sibbald (1997) provides a more inclusive journalistic view of outpost nursing in a Yukon community, briefly discussing the community health aspects of the nursing role, which were emphasized by the two outpost nurses that she interviewed.

These articles, and others like them, have a common purpose, which is simply to describe outpost nursing to an audience that is largely unfamiliar with not only what outpost nursing is, but with the context in which it is carried out. This need for description is congruent with two core themes in the literature that are relevant to outpost nursing role issues. These are (a) the uniqueness of the outpost nursing role, and (b) the need for role definition. The first of these themes is consistent with Vukic's (1996) review of the literature, wherein she found four themes,

two of which relate to the unique context within which outpost nurses practice, and two of which relate to the unique role of outpost nurses.

A Unique Nursing Role Within a Unique Context

Outpost nursing is a unique nursing role that is carried out within a context that by definition is unique: that of remote and isolated Canadian communities. Historically, the role developed within this specific context to fill an unmet need, that of providing a multi-purpose health care provider in areas where few other providers would venture, and where resources are extremely limited. While in certain respects similar to the role and context of rural nursing practice that is described by MacLeod (1999), two important characteristics serve to differentiate outpost practice from rural nursing practice: (a) physicians and other health care workers, such as laboratory or radiology technicians, are resident in rural communities, therefore rural nurses have more supports available to them than do outpost nurses; and (b) rural nurses are usually either hospital-based or community-based, and thus their role does not integrate these two practice areas as does the outpost nursing role (Martin-Misener et al., 1999). For instance, the study described by Macleod involved rural nurses working in hospitals where physician support was available. Because the outpost nursing role is context-specific, it is logical to examine it within its context, and in fact, difficult to detach it from that context.

Vukic (1996) distinguished between the cultural context of practice in northern communities, and “nursing in the context of northern health care” (p. 5), a distinction also made by Gregory (1992). Both the cross-cultural aspects of nursing practice in communities that are predominantly aboriginal, and the factors that influence those aspects of work and life in northern communities that make it different from life in southern communities are well recognized in the literature. Vukic refers to the latter as “work life issues” (p. 6), and found that the research reported in the unpublished master’s theses that she reviewed tended to focus on such work life issues, involving “stress, burnout and occupational health” (p. 6). Many of these

issues are also identified in the descriptive writings, and include, for example, the stress associated with being “on call” for emergencies (Pfeiff, 1999; Sibbald, 1997), exposure to sometimes overwhelming levels of poverty, alcoholism, and violence (Boulanger, 1998; MacLeod et al., 1998), and the social factors that make it difficult for nurses to disassociate themselves from their work life and establish a private life within their communities (Boulanger; Sibbald). Sibbald quotes one of the Yukon nurses she interviewed: “‘There’s a strange perception about us,’ says Edwards. ‘They don’t believe that we have a life outside the [health] centre’” (p. 20).

Gregory (1992), an outpost nurse prior to joining the faculty at the University of Manitoba, discusses work life issues in some detail and from first-hand experience, as well as from an academic perspective. He presents a lucid discussion of how these issues are interrelated and affect nursing practice and health care in northern native communities. First establishing that outpost nursing takes place within a milieu of social, economic, and political health determinants and long-standing cultural oppression which has led to the “distressing level of native health” (p. 183), Gregory goes on to discuss how these factors contribute to the isolation experienced by outpost nurses. He describes isolation in terms of personal, professional, and social isolation related to living and working in an environment that is not only geographically isolated, but also unexpectedly foreign, and the “culture shock” (p. 188) this engenders. The lack of both personal and professional support in the community increases the sense of isolation experienced by outpost nurses; traditionally (and at one time a prerequisite to hiring) most nurses employed in outpost settings have been single women. The absence of other health care workers in the community, such as physicians, pharmacists, or social workers means that nurses take on these roles and responsibilities in addition to their nursing role, a phenomenon that Gregory refers to as “role diffusion” (p. 185) and relates to the possibly

paradoxical expectation placed on nurses that they fulfill such diverse roles yet continue to provide quality nursing care.

Nurses are frequently hindered from engaging in well orchestrated preventive programs because of demanding workloads involving patients who present for acute treatment. Greater investment in broad preventive programs would probably yield an improved health status, but there is frequently neither the time nor personnel to initiate or maintain these preventive activities on a large scale. As previously mentioned, native people are conditioned to expect a curative health system. Furthermore, socioeconomic conditions greatly contribute to the poor health status of the majority of Indian and Inuit communities. These abject conditions also impede the engagement and effectiveness of preventive health programming. Nurses are greatly challenged in their efforts given these constraints (Gregory, 1992, p. 187).

To contrast Gregory's view of the outpost nursing role with that of Pfeiff (1999), who based her article on journalistic interviews with experienced outpost nurses, reveals the disparity with which different authors have chosen to describe the role. This is significant in that it illustrates both the ambiguity that surrounds the role and the broad spectrum of sub-roles that are expected of outpost nurses.

Hodgson (1982), an anthropologist, was one of the earlier writers to point out the "Ambiguity and Paradox in Outpost Nursing" (p. 108), as her article is entitled, and in which she reinforces the complexity of the interrelationship between the outpost nurse's role and its context. A brief note about the author's background which prefaces the article states that Hodgson based the article on "fieldwork and research among hospital and outpost nurses" (p. 108), however, the article itself provides no information as to how Hodgson conducted her research, or how she developed her ideas. Yet her discussion is consistent with the literature as well as with my personal clinical experience in outpost nursing, and thus carries a sense of

validity. She identifies three sources of stress for outpost nurses: (a) role expectations, which encompasses the concept of role diffusion discussed by Gregory (1992), (b) living and social conditions and (c) living and working within a culture that nurses may not only perceive as foreign, but which may also place culturally biased and unfamiliar expectations upon nurses. Hodgson is not writing as a nurse, and does not discuss the effects that role ambiguity and conflicting expectations have on nursing practice directly; she focuses instead on the ways in which the identified stressors effect interpersonal relationships and communication, and thus indirectly influence practice.

There is unanimous agreement within the outpost nursing literature reviewed that the role and context of outpost nursing are unique. However, although authors demonstrate consistency and clarity in describing the context of practice, it remains less clear what the role of outpost nursing, while unique, actually is. Hodgson (1982) states, "Outpost nursing does not possess a precise definition with clear-cut boundaries" (p. 109). The second theme to emerge from the literature recognizes outpost nursing as a role that nurses are endeavouring to define.

Defining Practice

In one of the few research-based works pertaining to outpost nursing practice, Vukic (1997) conducted an institutional ethnography for the purpose of investigating "the true nature of outpost nursing work" (p. 6). This work, like most of the research in the area of outpost nursing, remains an unpublished master's thesis, and was therefore difficult to access. Vukic identified incongruities between the role expectations placed on outpost nurses by different key stakeholders. That is, the employer for whom the nurses work, and the communities, for whom the nurses also work, held different expectations of the nurses. Whereas the communities saw the nurses as primary medical care providers, the employer saw the nursing role as a primary health care role. Paradoxically, Vukic found that the organizational and social structure imposed by the employer perpetuated this disparity by focussing on the primary care tasks performed by

the nurses, and failing to recognize “the nurses’ invisible work of establishing trust and attempts at becoming involved with the community” (p. 102), work which is requisite to a primary health care approach. Vukic implicitly refers to the concept of embedded practice knowledge and claims that outpost nurses need to “build on the strength of these aspects” (p. 108) to fully realize their potential contributions to health care in remote communities.

The concept of role diffusion introduced by Gregory (1992) refers not only to the diffusion of nursing practice that results from nurses taking on the roles of other health care workers (such as physicians), but also to diffusion that occurs through taking on diverse nursing roles. Echoing Doucette (1989), Gregory describes outpost nursing as being both a generalist and specialist practice, while MacLeod et al. (1998) use the term “multispecialist ” (p. 75) to describe the practice of nurses in remote areas. For example, while the outpost nurse’s workday consists primarily of seeing patients of all ages for a broad spectrum of primary and preventive health care, she/he may, in a heartbeat, be required to become an emergency nursing specialist, and expected to provide secondary or even tertiary level care to a trauma victim; the same nurse may also be involved as a health center liaison to a community group involved in a community development initiative (Sibbald, 1997). Such diverse responsibilities are, in part, the basis of Hodgson’s (1982) assertion that outpost nursing lacks a clear definition and boundaries. The role diffusion created by outpost nurses taking on the roles of other health care workers, including that of physicians, pharmacists, social workers and lab and x-ray technicians, only compounds the ambiguity and confusion, making it yet more difficult to define the role of the outpost nurse. This ambiguity is reflected in the literature, as illustrated by my failure to uncover a concise definition of outpost nursing. Despite this, my review of the outpost nursing literature revealed a clear consensus amongst several of these authors in their conceptualization of the outpost nursing role.

Outpost nursing is recognized in the literature as an expanded nursing role (Gregory, 1992; MacLeod et al., 1998; Martin-Misener et al., 1999; Morewood-Northrop, 1994; Vukic, 1996). In fact, Vukic found this to be the prevailing theme in the outpost nursing literature she reviewed. Despite the term “expanded” being in itself poorly defined and subject to interpretation (CNA, 2000a), it is used fairly consistently in the outpost nursing literature to indicate nursing practice that expands within the domain of nursing as well as into other practice domains, that of medicine in particular. And while it is the physician replacement function that is perhaps most readily associated with the outpost nursing role (Hodgson, 1982; Pfeiff, 1999), most nurse-authors are diligent in asserting that outpost nursing is a broader role than merely serving as a physician replacement, and that the role remains grounded in the domain of nursing (Gregory; MacLeod et al.; Martin-Misener et al.; Vukic).

The nurse practitioner is a nursing role that, although widely implemented in the United States for more than three decades, has only recently gained greater recognition in Canada. I noted a trend in the more recent outpost nursing literature to compare the nurse practitioner role to the outpost nursing role (Gregory, 1992; Martin-Misener et al., 1999; Sibbald, 1997; Vukic, 1996). Like outpost nursing, the nurse practitioner is a non-traditional nursing role that is recognized as having expanded into the domain of medicine, which is the basis for comparison of the two roles. In comparing the roles, these authors are diligent in also differentiating between them, emphasizing that outpost nurses work with fewer resources and less support available to them than do nurse practitioners, and therefore outpost nurses require “an extensive knowledge base and astute clinical judgement” (Martin-Misener et al., p. 204).

Both Martin-Misener et al. (1999) and Vukic (1996) cite a paper presented in 1975 by Ruth May, who established the Dalhousie OPN Program at Dalhousie University in 1967 (Chaytor, 1994). May both compared and differentiated the role of the outpost nurse with that of the nurse practitioner. Recalling that there was an unsuccessful movement to introduce the nurse

practitioner role in Canada in the early 1970's (Buzzell, 1999; Pinelli, 1997), at the time May gave her paper in 1975, the nurse practitioner was possibly more widely recognized in Canada than at any time in the intervening 20 years. This is best evidenced, perhaps, by the existence of the Boudreau (1972) report, commissioned by the federal government to define the nurse practitioner role and propose educational guidelines. Despite the recommendation of this report "that the development of the nurse practitioner category be regarded as the highest priority in meeting the primary health care needs in Canada" (p. 13), the movement towards implementing a nurse practitioner role in Canada at that time lost momentum and eventually failed. This failure was in part attributed to "nurses fighting among themselves" as to whether the NP role was, in fact, a nursing role (Pinelli, p. 101).

It is not until 1992 that Gregory again identified "a substantial need for nurses who possess nurse practitioner skills" (p. 196) within a framework of primary health care, and including "an advanced knowledge base and clinical skills to competently practice primary health care nursing" (p. 196). Graduates of the Dalhousie OPN program also expressed their belief that they functioned in a nurse practitioner role during interviews with Chaytor (1994).

The role of outpost nurses in primary health care has been widely discussed in the literature. However, it is unclear whether this is a new and evolving aspect of the outpost nursing role, as claimed by some authors (Doucette, 1989; Martin-Misener et al., 1999; Vukic, 1996), or whether outpost nurses have traditionally incorporated the philosophy underlying primary health care into their practice within communities. Gregory (1992) wrote, "Nurses in the north have been providing primary health care for many years" (p. 196). Morewood-Northrop (1994) described outpost nurses in the NWT as "educators, facilitators and advocates" (p. 31), characteristics that are congruent with the tenets of primary health care. The possibility of primary health care forming part of the 'invisible' practice of outpost nurses within their

communities is consistent with the literature addressing the concept of invisible practice, as presented earlier in this chapter.

Regardless of when outpost nurses may have begun incorporating what has come to be called primary health care into their nursing practice, the literature supports outpost nursing practice within a primary health care framework as a role expectation of outpost nurses today (Chaytor, 1994; Doucette, 1989; Gregory, 1992; Martin-Misener et al., 1999; Vukic, 1996; 1997). The next section of this chapter reviews literature that has originated in the area of primary health care nursing that has been selected on the basis of its relevance to outpost nursing practice.

Primary Health Care Nursing: Research and Practice

Literature pertaining to primary health care nursing (PHCN) was retrieved through a computer search of the CINAHL database, using 'research', plus 'primary health care nursing', 'public health nursing, and 'community health nursing' as keywords. I also located articles by means of a hand search through selected journals. Because 'primary health care nursing' is a relatively new term that describes an area of nursing practice that is currently being redefined, I elected to restrict my search to articles published in the 1990's. Although I have included literature from American sources, I made a particular effort to search Canadian nursing journals, with the aim of discovering what the current body of knowledge might be as it pertains to PHCN in Canada.

Canadian nurses are well represented in the research literature pertaining to primary health care. This work is valuable, being specific to the Canadian health care system and the transitions it is experiencing in the name of health reform. While both Canadian and American researchers identify the influence that changes in health care have had on PHCN, American researchers emphasize the effect changes have on the delivery of health services in the community, whereas Canadian researchers emphasize the effect changes have on the role of

nurses. Both of these perspectives have value for directing PHCN practice, however, as this study proposes to explore nursing roles, the Canadian literature is especially relevant.

Two themes that emerged from the PHC literature are significant to an exploration of outpost nursing role issues in the context of the proposed study. These are (a) defining the role and examining the practice of PHC nurses, and (b) valuing PHCN practice. The literature will be reviewed in accordance with these themes.

PHCN: Defining the Role and Examining Practice

PHCN is in the process of evolving from its roots in public and community health nursing to a population-focused practice that integrates the principles of primary health care with public health nursing's traditional approach to caring for individuals and families in the context of community (Registered Nurses Association of British Columbia, 1998; Shoultz & Hatcher, 1997). To be recognized as a distinct area of nursing practice, PHC nurses need to articulate what their role is within the health care system, and what it is that makes their practice unique and valuable. If PHC is an expectation of the outpost nurse's role, then it follows that outpost nurses, too, need to better define and articulate this part of their practice.

Clarke, Beddome and Whyte (1993) asserted that Canadian public health nurses were experiencing difficulty in redefining their role and practice in terms of PHC concepts. They attributed this difficulty to a discrepancy between "the concepts of nursing's metaparadigm and the concepts of epidemiology, the traditional public health model" (p. 306). A modified two-phase Delphi study (n = 121, 108) of public health nurses in British Columbia was designed to rank order, interpret and describe concepts identified as central to the "preferred future" of public health nursing practice (p. 306). Thus grounded in practice, these concepts were developed into a conceptual model. The model integrated three paradigm concepts (health care, public health, and public health nursing) with four process concepts (community development, shared governance, accountability and research), within a framework of the principal strategies of public

health nursing (prevention, promotion and protection). By providing a framework for the synthesis of nursing and public health knowledge, the model was described by the authors as a first step in theory development and a new approach to public health nursing practice.

Purkis (1997) also examined the effect of Canadian health care reform on the practice of public health nurses. She presented a critical review of the rhetoric of a 'new' way of health promotion, claiming that it fails to integrate nurse's traditional knowledge and skills in health promotion. The ethnographic study conducted by Purkis suggested that effective health promotion was inherent in the "complex, sophisticated everyday encounters" (p. 49) between nurses and their clients. This corresponds to what SmithBattle et al. (1997) termed "responsive use of self" (p. 77). This concept arose from an interpretive phenomenological study and was discussed as an outcome of community health practice expertise, which nurses considered a defining aspect of their practice. These researchers suggested that the existing expertise of public health and community nurses needs to be clarified in the context of primary health care, and integrated into the new health care strategies. Similarly, if PHC has, as postulated by some authors (Gregory, 1992; Morewood-Northrop, 1994) formed part of the traditional practice of outpost nurses, then this existing expertise needs to be clarified and articulated.

In a phenomenological study of the perceptions of community health nurses, Leipter (1996) identified the need for "role clarity" (p. 50) as a prerequisite for advancing preventive health care. In her subsequent phenomenological study of women's health in northern British Columbia (Leipter, 1999), Leipter identified nurses' need to articulate their practice, which may be construed as an endeavour to clarify their role. In the same study, and of particular relevance to the study of outpost nursing roles, the nurses articulated their need for expanded practice roles to allow them to provide comprehensive care for women in the small and often isolated communities of the north, reflecting an appreciation of the inclusive nature of their role. Additionally, the northern public health nurses appeared to have a better understanding of their

role in primary health care, and were more assertive in identifying the strengths of their practice relative to PHCN, than were the nurses practicing in southern locales targeted by other studies (Purkis, 1997; Rafael, 1999).

Rafael (1999) undertook a feminist, post-modern oral history as a means of examining how public health nurses in southern Ontario redefined their practices in response to health care reform. She found that, ironically, while nurses had changed their practice to meet the imposed demands of a new public health ideology, one theoretically based on the philosophies of health promotion and primary health care, the nurses found themselves less able to meet the health promotion and preventive health needs of their clients. Consequently, they experienced “role ambiguity and confusion” and were left “without a sense of their own identity” (p. 58). Rafael concluded that to effectively deliver primary health care, public health nurses in southern Ontario needed to reclaim autonomy and decision-making power in the process of redefining their role and practice. This finding reflects the notion of listening to the nursing “voice” (Chaytor, 1994, p. 70; Johnson, 1993, p. 156; Macleod, 1999, p. 176), rather than allowing nursing roles to be defined by external forces.

Purkis (1997) and Rafael (1999) both identified a sub-theme related to defining and examining practice, which involved the tendency to remove the individual from the focus of care, in the guise of delivering the ‘new’ population-based health service. Purkis viewed this as a trend towards separating the nurse from the client. Rafael described the emphasis on replacing direct client clinical work with indirect work through community groups or committees. Both researchers identified this as problematic for nurses redefining their practice. In distancing themselves from their clients on an individual level, nurses were unable to utilize the interpersonal skills that they considered a critical aspect of their health promotion activities. This finding has significance for the study of outpost nursing roles, which by definition comprise client interaction at all levels, from individual through to populations.

The study by SmithBattle et al. (1997) is consistent with the work of Purkis (1997) and Rafael (1999). SmithBattle et al. stated that their “findings pertain to a misconception regarding CHN [Community Health Nursing] practice: namely, that individual- or family-level practice is inherently conservative (ie [sic], maintains the status quo) while aggregate-level practice (focused on policy and institutional change) is liberating and emancipatory” (p. 86). Like Rafael and Purkis, SmithBattle et al. found that nurses could incorporate within their practice both an individual and a population-based focus of care, and viewed these as complementary facets within their practice: “Both are indispensable to excellent practice” (p. 88).

Valuing PHCN

The second theme in the PHCN literature was that of valuing nursing practice in primary health care. Valuing nursing practice is contingent on the ability to first articulate what practice is, therefore valuing is related to defining practice. Primary health care involves, by definition, a multidisciplinary collaboration of health professionals and communities (Shoultz & Hatcher, 1997; WHO, 1978). This was validated by Hornberger and Cobb’s (1998) ethnographic study of a rural community’s “vision of a healthy community” (p. 363). Even though nurses have historical precedence as community health providers, unless nurses are able to articulate and demonstrate their value in primary health care, they are in danger of being pushed aside by other health providers. Rafael (1999) suggested that the withdrawal of public health nursing services in southern Ontario in 1996, to allow nurses to carry out the massive measles re-immunization campaign that took place that year, was a politically-motivated test to discover if nursing services could be withdrawn without creating public protest.

Several researchers have identified the ‘invisibility’ of nursing practice in the community as a phenomenon that contributes to the undervaluing of nursing (Coenen, Marek, & Lundeen, 1996; Hornberger & Cobb, 1998; Leipert, 1996; 1999; Rafael, 1999; SmithBattle et al., 1997). “Although its tenets are congruent with a nursing paradigm, nurses’ contributions to health

promotion were as invisible to health promoters as they were to public health medicine, both regarding nursing as an ancillary medical service.” (Rafael, 1999, p. 58). Purkis (1997) describes this invisibility as “blindness to how health effects are achieved” (p. 59). The necessity of identifying and promoting the value of nursing practice in the context of PHCN motivated the research of both SmithBattle et al. (1997) and Leipert (1996; 1999). Similarly, clarifying and valuing nursing as the basis of nurse practitioner practice becomes a prevalent theme in the discussion later in this chapter of the evolution of the NP role in the United States.

Many researchers have identified a pressing need for further research to clarify and substantiate the value of the nursing role in PHCN (Clarke et al., 1993; Leipert, 1996; SmithBattle et al., 1997). One problem inherent in the existing research literature is the predominance of qualitative work. Quantitative research is arguably one of the most powerful tools for measuring nursing outcomes and demonstrating the value of nurses’ work in the concrete language that impresses both the public and the decision-makers in society. Yet, there are few quantitative studies in the literature.

One of the few quantitative studies is that of Coenen et al. (1996). These researchers conducted a correlational study (n = 331) to examine the usefulness of nursing diagnoses as predictors of nurse utilization in a primary health care clinic in the U.S. Although this study represented an important step in quantifying, and thus validating, nursing practice in a PHC setting, it has limited generalizability because it was restricted to data gathered at one community nursing center. Additionally, while conventional standardized nursing diagnoses, such as those used by Coenen et al., are one method of describing nurse utilization in regard to individual- and family-focused interventions, they did not capture interventions delivered at the community level, or within a multidisciplinary context. There is still a need for preliminary work in regard to clarifying the unique aspects of PHCN practice before quantitative research can truly reflect the value of that practice.

Nurse Practitioners in the Literature: Justifying a New Role

The role of the outpost nurse has been compared to that of the nurse practitioner (Gregory, 1992; Martin-Misener et al., 1999; Vukic, 1996), and outpost nurses themselves see their role as analogous to the NP role (Chaytor, 1994; Sibbald, 1997). With increasing recognition of the NP role in Canada, the trend is towards identifying outpost nurses as NPs, as evidenced, for example, by the change of the position title to “Community Health Nurse Practitioner” recently implemented in the Yukon Territory. In the U.S., the NP role has been evolving over the past 35 years, and it is now well established as an advanced practice nursing role. Much of the early American literature on the developing role of the nurse practitioner has relevance to similar roles as they are presently developing in Canada, and consequently, to the outpost nursing role.

A computer search of the CINAHL database using various combinations of the search terms “nurse practitioner”, “role identity”, “primary health care”, and “community health nursing” generated literally thousands of articles. The majority of these articles and studies are concerned with examining the role of NPs relative to the role of physician practitioners and with demonstrating the efficacy of NP practice. Ford, a co-founder of the first NP program in the U.S., stated in 1992: “No professional role has been more thoroughly discussed, described, studied, and reported than that of the nurse practitioner” (p. 289). Judicious perusal of these articles, plus following up references in articles I obtained that proved relevant to outpost nursing roles, resulted in the selection of literature reviewed here. This literature will be discussed in relation to three themes that are pertinent to the outpost nursing role and are reflected in the outpost nursing literature. These themes are: (a) the NP role emerged amidst confusion and ambiguity, (b) the NP role is a nursing role, yet nurses experience a transition in identity in taking on the NP role, and (c) NPs have a role in primary health care.

Déjà vu and Debate

Tracing the evolution of the NP role in the U.S. provokes an eerie sense of history repeating itself. Not only are the issues similar to those facing NPs in Canada today, they are the same issues that proved to be insurmountable barriers to earlier efforts to implement the NP role in Canada. Two articles by Canadian nurses, originally published in 1976-77 and reprinted in 1999 as still relevant, offer insight into historical aspects of the NP role in Canada, illustrating the controversy and confusion that stymied the NP role in Canada in the 1970's and which still persists today (Allen, 1999; Buzzell, 1999).

In both the U.S. and Canada, the NP role has emerged in spite of controversy and conflict (Brown, 1989; Pinelli, 1997). In the U.S., these rocky beginnings stimulated a proliferation of research and literature by and about NPs. This large body of literature developed in response to criticism from within nursing that the NP was a physician assistant role and not a nursing role, as a means of justifying the role and providing evidence of its value to health care, largely through role definition and clarification (Brown; Brykczynski, 1989; Knafl, 1978).

Buzzell (1999) alleged that both nursing faculty and nursing regulatory bodies failed dismally to support the movement towards expanded nursing roles in Ontario in the mid-1970s. Pinelli (1997) identifies “‘horizontal violence’ within nursing” (p. 101) as an aspect of intra-professional relations that served to block the nurse practitioner role, and American nurses have also described both intra- and inter-professional conflict over the development of the NP role (Bennett, 1984; Bigbee, 1996; Ford, 1992). Much of the controversy has stemmed from confusion, ambivalence, and misperception about the role, both within the nursing profession itself and, notably, within the medical profession, with dissent particularly over whether the role is a nursing role or a pseudo-medical role (Brown, 1989; Brykczynski, 1996; De Leon-Demaré, Chalmers & Askin, 1999; Edmunds & Ruth, 1991; McLeod, 1995; van der Horst, 1992).

Allen, in an article originally published in 1976 and reprinted in 1999, distinguished between expanded nursing roles as they related to the practice of medicine, that is, a role had either a “replacement function”, as in physician replacement, or a “complemental function”, meaning complementing the physician’s role (Allen, 1999, p. 83). Nursing had not yet established a strong self-identity as a profession distinct from medicine, and the nursing leaders of the time defined nursing practice primarily in relationship to medical practice. While nursing faculty and regulatory bodies at the time balked at the thought of nurses in a physician replacement role, which they defined as the NP role, they were supportive of a nursing role that could be seen as complementary to medicine, and thus the role of clinical nurse specialist came into being (Gottlieb, 1994; Pinelli, 1997).

The Nurse Practitioner is a Nurse

In the U.S., uncertainty over the precise nature of the NP role prompted research to clarify the role and justify NP practice. Two outcomes of this research have been (a) support for the contention that the nurse practitioner is a nursing role – “deeply rooted in the enduring values and goals of professional nursing” (Ford, 1992, p. 287) - as opposed to a physician assistant role; and (b) that the NP role involves a complex transition in identity from a nursing identity to a physician-oriented identity, and back to a NP identity grounded in nursing. These two findings, reproduced across multiple studies, have helped American NPs clarify their role and practice and thereby establish a strong sense of identity within the nursing profession.

Knafl (1978) clearly described the transition process in an early qualitative, longitudinal study of a small sample of NP students. She found that despite an initial emphasis on learning new, medically-oriented knowledge and skills, the focus eventually shifted back to a nursing perspective as students became more comfortable with the new tasks and found them less overwhelming. “By the time they graduated, students equated the practitioner role with nursing, not medical, skills and interventions” (p. 652). The NP students in Knafl’s study also identified

that the NP preceptors they worked with had defined their own roles as NPs, through “blending certain medical and nursing activities” (p. 651). Students expected too, that their own role definition might depend on how they negotiated it in the context of their own work situation. At the time this study was conducted, the NP role had only recently been implemented in the U.S.; the role was still shrouded in ambiguity and thus the need for practicing NPs to determine their roles on an individual basis. This situation may parallel that of outpost nurses today, as they also work in context-specific environments, where role boundaries are fluid and often dependent on individual ability as well as situational context.

Oda (1977), a nursing educator, recognized the difficulty that NP graduates were experiencing in developing role identity and attributed this to diverse and sometimes conflicting role expectations – a situation that is comparable to that of outpost nurses - which contributed to role ambiguity. This was not a research article, but Oda did base her observations on her work as a consultant and faculty member with NP graduates. She designed a three-stage process to help new NPs develop their roles: (a) role identification, or clarification of the purpose and objectives of the role, (b) role transition, which Oda describes as communicating and “selling [the] role effectively” (p. 375), and (c) role confirmation, or gaining support for the role. Oda also presented the view that the ambiguous and poorly defined nature of NP practice at that time compelled NPs to determine, clarify and articulate their role boundaries as individuals, a view later supported by the work of both Knafl (1978) and Bennett (1984).

A more recent descriptive article by Roberts, Tabloski and Bova (1997), based on observations and the journals of over 100 NP students, supported Knafl’s (1978) finding that NP students experienced a transition in identity, first reorienting towards a medical perspective, and eventually returning to a nursing perspective as they gained confidence and competence in carrying out the medical aspects of the NP role. Roberts et al. explained that over time students “experienced a reemergence of their nursing knowledge and skills and began to combine them

with the new knowledge they had acquired from medical preceptors” (p. 68). Like Knafl, Roberts et al. noted that this transition was accompanied by a “regression in self-efficacy and self-esteem” (p. 72). Basing this theory loosely on Benner’s (1984) work, previously ‘expert’ practitioners were perceived to ‘regress’ upon entering into a new and unfamiliar role and thus again becoming ‘novice’ practitioners. Variations were noted in the ways students experienced the transition process, which the authors attributed to previous life and work experience, and discussed in a way that implied a maturational process. For example, the students who appeared to experience less stress and anxiety during the transition were identified as having “developed an ability to live with ambiguity and responsibility for their own decisions” (Roberts et al., p. 71).

As discussed previously in this chapter, Chaytor’s (1994) evaluative study of the Dalhousie OPN program revealed that some Dalhousie OPN graduates held the belief that they functioned in a NP role. Interestingly, one graduate is quoted as describing the Dalhousie program as being “the vehicle by which a nurse can travel from being a RN to a health provider in an isolated post” (Chaytor, 1994, p. 48). This graphically expresses the idea of a transition from a nursing identity to a role that although not clearly identified as such, may be surmised to be akin to a nurse practitioner role, and is consistent with the notion of a transitional process.

In a grounded theory study conducted in the early 1980’s, Bennett (1984) identified the NP role as a “marginal role”, which she defined as “one in which an individual occupies the social space between two cultures, tenuously affiliated with both but a fully incorporated member of neither” (p. 147). Bennett was referring to the placement of NP practice between nursing and medicine, and proposed that the marginal nature of the role was rooted in misunderstanding stemming from the ambivalence, confusion and controversy surrounding it. Three variables that affected the development of role identity were identified from the data: (a) personal attributes, (b) organizational factors, and (c) inter-personal factors. Of these, the need

to dominate (a personal attribute) was found to be the best predictor of the NP's ability to develop a clear role identity. Bennett concluded that, faced with the lack of precedent for the NP role, NPs having dominant characters were more likely to define and shape their roles themselves without relying on external role definitions. But as Bennett failed to define the NP role as other than a "physician extender" role (p. 145) and did not address the question of whether the role was grounded in nursing or medicine, it is uncertain how she evaluated the role identity developed by the NPs in her sample.

Interestingly, and of relevance to the study of outpost nursing roles, Bennett (1984) studied a population of rural family NPs in New Mexico who worked in similar conditions to outpost nurses in Canada, that is, with underserved populations in rural communities without full-time physician services. She states, "This group represents the least studied of nurse practitioners, although they represent those practitioners who are most fully meeting the original expectations of the role" (p. 149), thus substantiating comparisons between the outpost nurse and NP roles.

Lurie (1981) carried out a descriptive quantitative study of professional socialization into the NP role in one NP educational program, in response to faculty concerns that students were resocialized into a medically-oriented role during the course of the program, despite a curriculum that emphasized a nursing orientation. This investigation found that organizational and structural factors in the workplace, which were not supportive of a nursing orientation, had the greatest influence on the socialization process and thus the development of the NP role. In other words, graduates were rewarded for following a 'cure' versus a 'care' model. However, it was also found that NPs who had integrated and come to value nursing ideology did find ways to incorporate a nursing perspective into their role despite "constraints imposed by the work setting" (p. 46). This finding is consistent with the studies of Bennett (1984) and Knafl (1978) that showed that certain NPs might determine their own role.

In 1989 Brykczynski used Benner's (1984) model of interpretive phenomenology to study the 'clinical judgement' of experienced NPs, which she equated with clinical practice knowledge. Study findings were analyzed in relation to the practice domains and competencies identified by Benner, and a modified framework specific to NP practice was produced. Brykczynski described the practice of the NPs in her study as holistic nursing practice, thus helping to clarify both the NP role and practice.

Johnson (1993) used a combination of discourse analysis and ethnography to examine NP-patient interactions, in an attempt to better understand how NPs "incorporate traditionally held medical skills into the nursing perspective...how these perspectives co-exist, and how they are actualized in ...practice" (p. 144), and ultimately, contribute to positive outcomes of NP-managed care. NPs in this study demonstrated a strong sense of a role identity grounded in nursing and emphasized "whole person care" (p. 154); however, the sample size (n = 3) was very small. Johnson did not address the question of how the NPs in her sample developed their role identity. It is difficult to determine whether the differences between the NPs in this study and the NPs in Lurie's (1981) study are due to contextual differences within their respective workplaces, or to a more global evolution of the NP role in the 12 intervening years.

In Canada, the debate continues over whether the nurse practitioner is a nursing role or a pseudo-medical role, as evidenced by articles such as one that appeared in a Canadian medical journal in 1998 (Society of Rural Physicians of Canada, 1998), in which physicians in Newfoundland are portrayed as perceiving themselves to be responsible for the regulation of nurse practitioners in that province. It is clear that the nursing profession itself remains in turmoil over this question (CNA, 1997; De Leon-Demaré et al., 1999; Gottlieb, 1994). The Canadian literature related to the nurse practitioner role is devoid of research-based articles and remains rooted firmly in opinion. The CNA document Advanced Nursing Practice: A National Framework (2000), which provides a definition of the term "nurse practitioner", offers an

example: the references upon which this document is based fail to include a single research-based work. Perhaps a better understanding of the outpost nursing role will contribute to a clearer conceptualization of the NP role in Canada.

Nurse Practitioners in Primary Health Care

Caution must be exercised in evaluating the NP literature in regard to the NP's role in PHC, as authors have commonly failed to differentiate primary care from primary health care. This tendency to use the two terms interchangeably was more pronounced in the earlier literature than it is in more recent work, prompting speculation that the distinction between the two is becoming increasingly recognized as PHC evolves and becomes better understood. However, there is support in the literature that the NP role was originally envisioned as a PHC role, even though the term "primary health care" may not have been in common usage at the time. For example, Bennett (1984) attributed the growing demand for NP services to shifting values in health care, which she described in a manner that was congruent with the philosophy of PHC, although she did not identify it as such. As previously stated, Bennett also equated her sample of NPs with the "original expectations of the [NP] role" (p. 149), because they worked in rural, underserved communities.

In 1991, Fenton, Rounds and Anderson proposed combining the role of the NP with that of the community health nurse, a concept that has clear relevance to the dualistic role of the outpost nurse in Canada. These authors identified the inconsistency with which PHC was defined by various bodies, and endorsed the WHO (1978) definition. Their rationale for combining the two nursing roles was to enable NPs, who were already providing community-based primary care, "to make an impact on the health care system" (p. 101). This article fails to address the question of whether or how well one nurse can function in such a broad role, or any inherent role ambiguity that the combined role might engender.

Canadian authors are clear that they envision the NP as a primary health care provider, and interestingly, that they associate the NP role in primary health care with the outpost nursing role (De Leon-Demaré et al., 1999; Gregory, 1992; Pinelli, 1997). The recent implementation of nurse practitioners in primary health care settings in Ontario, Newfoundland, and Alberta substantiates the association in Canada between NPs and PHC. “The re-emergence of primary healthcare [sic] on the national and provincial health agenda is opportune for nursing organisations to promote the nurse practitioner role as a key provider of primary health care” (De Leon-Demaré et al., p. 52).

Orchard and Karmaliani (1999) also identified NPs as primary health care providers. They suggested creating a new role, which they have called “Community Development Nurse Specialists” (p. 297), by blending the roles of NP and clinical nurse specialist, and adding specialized skills in community development. Like Fenton et al. (1991), Orchard and Karmaliani do not address the issue of role ambiguity that might – based on this review of the literature – predictably arise from the expectation that nurses function in such diverse roles as primary care and community development.

Summary

Outpost nursing practice implies multiple and diverse expectations. These contribute to role diffusion, and confusion and ambiguity about the outpost nursing role (Gregory, 1992; Hodgson, 1982). The context of practice is conspicuously lacking in resources and support, and by definition further imposes unique and challenging expectations on outpost nurses (Gregory; Hodgson; Vukic, 1996). One expectation of outpost nurses is that they function as both primary care and primary health care providers. While there can be little question that each of these roles is essential to nursing practice in underserved ‘outpost’ communities, little information exists informing us as to whether or how outpost nurses meet the expectations that are placed upon

them (Chaytor, 1994), or whether it is feasible to expect one nurse to function in what has been described as a 'specialized generalist' role (Doucette, 1989; Gregory).

Many of the issues related to the outpost nursing role have been identified in other areas of nursing practice, notably in primary health care nursing and nurse practitioner practice. Outpost nursing incorporates aspects of each of these practice areas; therefore, they are of relevance to the study of outpost nursing role issues. These issues are related to role ambiguity and an inability to articulate the role. In primary health care nursing, this has led to what many investigators have referred to as the 'invisibility' of nursing practice (Chaytor, 1994; Leipert, 1996; MacLeod, 1999; Mass & Whyte, 1997; Rafael, 1999; SmithBattle et al., 1997), and subsequently, to a lack of valuing of the nursing role. As the nurse practitioner role evolved in the U.S., role confusion and conflicting expectations eventually led to the nurse practitioner identity becoming firmly grounded within a nursing perspective, to preserve those aspects of the role that nurses most valued. This reinforced the nurse practitioner role as a nursing role into which certain medical functions are integrated, and thus serves to differentiate it from a pseudo-physician, or physician substitute role (Brykczynski, 1989; Johnson, 1993; Knafl, 1978; Lurie, 1981; Roberts et al., 1997). Nurse practitioner students develop this role identity through a transitional process (Knafl; Roberts et al.), a finding that was reflected by an outpost nurse interviewed by Chaytor.

Studies of both primary health care nursing and nurse practitioner practice support the notion that nurses can and should define nursing roles (Bennett, 1984; Brykczynski, 1989; Knafl, 1978; Rafael, 1999). The concept of 'nursing voice' discussed by several authors reflects the value of autonomous role definition (Chaytor, 1994; Johnson, 1993; Macleod, 1999; Rafael). Speaking of outpost nurses, Chaytor claims, "The nurse's voice and way of knowing should be respected and included in the structuring of the knowledge base" (p. 70).

Most significantly, residents of the remote northern communities where outpost nurses practice experience the poorest health status of all Canadians (RCAP, 1996). It is imperative that the role and practice of these nurses be explored as a first step towards examining a model of health service delivery that is often perceived as falling short of its obligation to help northern communities become healthy communities. Giving 'voice' to the nurses who live and work in these communities may help to make visible the nature of their practice, and clarify how their role may best contribute to improved health.

CHAPTER III: RESEARCH METHODS

The purpose of this study was to explore the knowledge embedded in the clinical practice of outpost nurses, and to gain insight into the ways that nurses use this knowledge to influence health in the communities in which they work. The unique nature and context of the outpost nursing role suggested that outpost nurses themselves may best understand issues pertaining to their practice, although this understanding may be in the form of *unarticulated* or *tacit* knowledge (Fjelland & Gjengedal, 1994; MacLeod et al., 1998). Qualitative research methods allow researchers to examine phenomena from the point of view of the participants under investigation, thus facilitating an understanding of the phenomena from the emic perspective. Choosing a particular qualitative approach is dependent on a variety of factors, which are shaped in part by the ontological perspective of the researcher (Leonard, 1994; Morse & Field, 1995). My clinical experience as an outpost nurse suggested that a research method appropriate to the purpose of this study would necessarily preserve the context of practice, and encourage a holistic interpretation and description of nursing practice. Interpretive phenomenology is such a method and was therefore the approach that was utilized in this study.

Interpretive Phenomenology

The classic study addressing embedded practice knowledge in nursing is Benner's 1984 study of the practice of acute care nurses. Benner (1984) defines such knowledge as "that knowledge that accrues over time in the practice of an applied discipline" (p. 1). Benner extrapolated the "embedded" knowledge of the nurses she interviewed through the nurses' descriptions of paradigm and exemplary cases from their practice. She then applied the Dreyfus Model of Skill Acquisition to her interpretation of the data to develop and describe both levels and domains of practice; these have subsequently become a standard and universally recognized framework facilitating common understandings and communication of nursing practice.

From an interpretive phenomenological perspective, the relationship of theory to practice is one of generalities to particulars (Fjelland & Gjengedal, 1994). Whereas theory may suffice to guide practice in usual situations, unusual situations call for the wisdom, or clinical judgement that comes from practical experience (Brykczynski, 1989). Benner (1984) states:

...all practical situations are far more complex than can be described by formal models, theories, and text-book descriptions.... There is always more to a situation than the theory predicts. It is this learning about the exceptions and shades of meaning that only concrete experience can provide (p. 178).

Theory, rather than driving practice, is perceived as resulting from the revelation of embedded practice knowledge (Leonard, 1994).

Since her 1984 study, Benner has further refined and clarified her model of interpretive phenomenology (Benner, 1994). Other researchers have modeled their investigations on Benner's approach, thus imparting a sense of validity, as well as demonstrating the practical utility of this method (Brykczynski, 1989; SmithBattle et al., 1997; Wros, 1994). For example, in a study of the knowledge embedded in nurse practitioner practice, Brykczynski modeled her approach after Benner's work, and based her data analysis on the model of practice domains developed by Benner (1984). Brykczynski adapted Benner's domains to produce a framework that was specific to nurse practitioner practice.

Data Collection

This study employed purposive sampling (Cohen, Kahn, & Steeves, 2000) to identify nine informants who met pre-established inclusion criteria, and who were willing and able to participate in up to two interviews over the course of the five-month long study period. While the inclusion of 'expert' outpost nurses would have represented an ideal sample, the process of evaluating expert practice, in the absence of a clear role definition and understanding of practice boundaries, would have been a subjective exercise at best. Benner (1984) identified experience

as “a requisite for expertise” (p. 3), and both Benner and Brykczynski (1989) explicated practice experience as the basis of their sample selection. Practice experience can be evaluated by the use of objective criteria, thus increasing the likelihood that participants have developed personal nursing knowledge, while avoiding the subjective use of the term ‘expert’.

Inclusion criteria for this study were (a) a minimum of five years clinical practice as a registered nurse, (b) a minimum of three years practice as an outpost nurse (not necessarily on a continuous full-time basis, but as the individual’s primary area of practice during that time), (c) a minimum of eight months spent in one community on at least one occasion, and (d) clinical experience within the last two years. It was anticipated that study participants would be predominantly female Caucasians, therefore an effort was made to recruit male, non-Caucasian, and specifically First Nations nurses, in order to diversify and enrich the data (Cohen et al., 2000). While one study volunteer was male, no First Nations or non-Caucasian nurses volunteered for this study. Recruitment was conducted through word-of-mouth, primarily through personal and professional contacts of the investigator. Additionally, a recruitment and information notice was distributed to personal contacts of the investigator, by fax and electronic mail, with a request that the notice be shared with potential interviewees (see Appendix B). Participants were selected from communities around the country, to further ensure diversity of experience. A telephone pre-interview was conducted with potential participants to ensure that inclusion criteria were met and to facilitate selection of the most suitable candidates.

The initial interviews with the first four participants were conducted in-person, at a time and place mutually convenient to both the participant and the interviewer. Interviews with the last five participants were conducted over the telephone, at a time mutually agreed upon by the participant and the interviewer. All interviews were conducted by myself, audio-recorded and transcribed. Each interview took between one and two hours. Field notes were kept during each interview, which formed the basis of the initial analysis of each interview. Interviews were

unstructured, and employed “broad lines of enquiry” (Benner, 1994, p. 106), designed to elicit naturalistic narratives from participants (see Appendix C).

As data collection proceeded, the lines of enquiry were refined, based on “the theoretical background that grounds the study and from themes consistently emerging from the data” (Leonard, 1994, p. 59). As the interpretive plan emerged, it guided the interactive process of data collection and interpretation by shaping the focus of subsequent interviews and suggesting areas of commonalities and differences between interviews.

Four informants participated in a second interview. The main purpose of this interview was to discover if participants were able to clarify and validate study findings and interpretation, as a means of theoretical verification (Morse & Field, 1995). These four participants were presented with a summary of key findings and asked for their response. All four concurred with the findings and interpretation, and described how they “recognized” their own practice in the summary provided. One participant expressed this recognition as “you hit the nail on the head”, while another stated “you have really captured it well”, thus lending credibility to the study.

Data Analysis and Interpretation

Data analysis in interpretive phenomenology is a process wherein the interpreter shifts back and forth between analysis, or examination of the structure and elements (Oxford Dictionary of Current English [ODCE], 1998) of the data, to interpretation, or an understanding and explanation (ODCE) of the meaning contained in the data (Leonard, 1994). Benner (1994) describes this as “a systematic moving from the parts back to the whole text” (p. 113). Fundamental to this process is the interpreter’s aptitude for “engaged reasoning” (p. 101), which Benner compares to the clinical reasoning skills acquired by expert practitioners. Critical thinking, reflection, and an ability to move inductively between analysis and synthesis of information characterize engaged reasoning, and facilitate a progressively deeper understanding of the meaning contained in the data. The interpreter is guided in this process by the interpretive

plan, and by an ethical commitment to remain “true to the text” and “accurately present the voice of the participants” (Benner, p. 101).

As the interpreter gains progressively greater depth of understanding of the meaning of the text, commonalities and differences in the text are recognized. These are explored both in relation to source, and in terms of narrative strategies. Benner (1994) identifies five sources of commonalities: (a) situation, (b) embodiment, (c) temporality, (d) concerns, and (e) common meanings, and three narrative strategies: (a) paradigm cases, (b) thematic analysis, and (c) exemplars. Recognition of commonalities and differences evolves into identification of paradigm cases and thematic analysis, both of which represent patterns, or commonalities in the text. Exemplars “convey aspects of a paradigm case or a thematic analysis” (Benner, p. 117) and thus exemplify the meaning derived from the data. The identification of exemplars represents the final phase of data analysis. Ultimately, the objective of Benner’s model of interpretative phenomenology is the collection of a range of paradigm cases and exemplars that graphically illustrate the findings of the research.

Data analysis was conducted on a continuous basis throughout the data collection period. Reflecting upon each interview in the spirit of engaged reasoning enhanced my perception and sensitivity to data collection during successive interviews. As data collection and analysis proceeded, my reflections on both the data and the process were captured in writing, including field notes, informal jottings made while re-listening to the taped interviews and reading the transcripts, and the formal writings documenting the analysis of each interview. Additionally, critical reflections on my own familiarity with the clinical area under investigation and assumptions that arose from this background were recorded in a reflective journal (Cohen et al., 2000). Benner identifies writing as “part of the intellectual work of doing interpretation” (p. 101).

Reliability and Validity

The quality of an interpretive study relies largely on the skill and perception with which it is interpreted (Benner, 1994). Researcher familiarity with the phenomena being investigated is congruent with the philosophy of hermeneutic phenomenology, and is, in fact, essential to the process of interpretation (Plager, 1994).

We approach our research question with a point of view, from the perspective of a particular interpretive lens (the *fore-sight*) that orients us globally toward the phenomena in a particular way and is therefore critically important to the study (Leonard, 1994, p. 57).

Benner claims that the investigator's clinical practice knowledge enhances "perceptual recognition skills" (p. 103) and thus forms part of the interpretive lens. Thus, from an interpretive phenomenological perspective, my own clinical background as an outpost nurse may be considered to have been advantageous to this study.

Benner (1994) does add a caveat that it is necessary for clinicians to critically reflect on the influence their practice background, biases and assumptions may have on the study. "A profound shift in sense of agency and self-understanding" (p. 103) is required to allow consideration of multiple perspectives. Assumptions are explicated at the beginning of the study so they are visible and may be challenged as the researcher gains new understandings through the research experience (Cohen et al., 2000).

The fore-sight that I brought to this study was explicated in the assumptions I hold about the role and practice of outpost nurses:

1. The clinical practice of experienced outpost nurses contains embedded knowledge and understanding of their role in maintaining, improving and promoting health in northern communities.

2. The role and practice of outpost nursing is context-specific, therefore understanding outpost nursing practice is contingent upon understanding the physical, social, economic and political environment in which outpost nurses practice.
3. Outpost nursing practice that fails to integrate a primary health care approach represents “band-aid” health care and will not lead to improvements in health status over the long-term.
4. Inexperienced and/or inadequately prepared nurses practicing in an outpost nursing role tend to focus on the physician replacement role and miss “the big picture” of health and health determinants that typify many northern communities, whereas experienced and/or adequately prepared outpost nurses integrate multiple roles into their outpost nursing role and do see the big picture.
5. Experienced outpost nurses may see the big picture and understand the value of a primary health care approach, but may have difficulty incorporating this approach into practice due to structural or organizational barriers or lack of support from other key players.

One purpose of a reflective journal is to record and facilitate predicted shifts in self-knowledge, so that these insights become part of and contribute to the interpretive process (Cohen et al., 2000). The reflective journal I maintained through the course of data collection and analysis proved to be the source of many valuable insights that arose from the process of challenging my assumptions, eventually leading to a deeper understanding of practice.

As a further strategy to minimize the effect of my own assumptions and possible biases on data interpretation, my work was subject to on-going evaluation by the members of my thesis

committee. Committee members possessed recognized expertise in research methodology and primary health care, and were complemented by an external consultant with expertise in outpost nursing practice. An evaluation of the researcher's analysis by others having expertise in either the experience or the method is consistent with what Cohen et al. (2000) term "opening up inquiry" (p. 90). Opening up inquiry represents a strategy that may reduce researcher bias, as well as validate both the analytic process and application of the methodology. Committee members' critiques helped to "identify blind spots and areas of avoidance" (Benner, 1994, p. 112).

Second interviews with selected participants also presented an opportunity to clarify and follow up on salient data that was missed or avoided in the initial interview, and thus helped to increase the depth and accuracy of understanding. Study findings were shared with participants in the form of descriptions of clinical practice, presented as paradigm cases and exemplars. Data interpretation was validated when participants 'recognized' their own practice in the description of the key findings derived from the data.

Benner (1994) suggests that the quality of an interpretive phenomenological study is related to the size of the text. The 'size of the text' refers to the quantity of data collected, and is dependent on the number of participants and the number of interviews conducted with each participant, as well as the length of each interview. A large text that is generated by a large sample and multiple interviews with each participant is more likely to provide redundancy, or saturation, than is a small text (Benner). However, Leonard (1994) claims, "competing accounts do not negate each other" (p. 61), and serves a reminder that the objective of a phenomenological study is not to determine a single "true account of a phenomenon" (p. 61), but to foster fresh perspectives and an emic understanding. Thus, redundancy also depends upon the researcher's sensitivity and perception during data collection, as well as the depth and accuracy of interpretation. Multiple interviews offer the researcher opportunities to clarify and validate

interpretations, and thus provide for greater confidence in the interpretation (Benner). While logistical and time constraints precluded conducting more than two interviews with selected participants, the themes that emerged from the data and which subsequently formed the basis of the interpretation were repeated across several interviews, thus increasing confidence in the findings.

Ethical Considerations

This study employed the following measures to ensure that ethical standards were upheld. Prior to commencing the research, ethical approval was obtained from the Behavioural Research Ethics Board, Office of Research Services, at the University of British Columbia. A written informed consent was obtained from each of the study participants (see Appendix D). The study was explained to each participant verbally and in writing by the investigator. Participants understood that their participation in the study was voluntary, and that they were at liberty to withdraw from the study at any time. Identifying information was removed from the transcripts and pseudonyms were used to ensure the anonymity of participant's identities, responses, and communities. Only myself as the investigator knew participant identities. All identifying documentation was kept secure. All records and audio-recordings linking participants to the study were destroyed at the conclusion of the study. Written informed consent included permission of participants to keep transcripts for use in future studies.

CHAPTER IV – FINDINGS AND INTERPRETATION

The aim of this study was to explore how experienced outpost nurses perceive and enact their role, and how practical knowledge and clinical wisdom are revealed in the practice narratives of experienced outpost nurses. To preserve and illuminate the context of practice, this chapter begins with a description of the participants, followed by a discussion of the issues that emerged during the analysis of each interview, and which were recognized as key to understanding and interpreting each interview within context. As the analysis progressed, the context became increasingly important to interpreting the commonalities and differences revealed in the interviews (Benner, 1994).

Several themes emerged from the early data analysis. These gradually coalesced into four main themes that formed the basis of the interpretive plan, which was used to guide subsequent data collection and analysis. The thematic interpretation presents the findings of this investigation using paradigm and exemplary cases that were identified from the interviews, thus grounding the interpretation in the data.

Description of the Participants

The nine outpost nurses who participated in this study represent a variety of both geographical regions and employers of outpost nurses. The world of outpost nursing is small and interconnected. To ensure the anonymity and confidentiality of the participants, they are described in general terms only. When a participant is identified by name, a pseudonym has been used. While participants spoke both frankly and specifically, any details by which a participant, a patient, a community, or an employer might be identified have been disguised or deleted from the data presented here.

The most striking demographic fact about the participants in this study is the vast amount of accumulated nursing experience they possessed, both in nursing generally, and in outpost nursing more specifically. Ages of the participants ranged from the early 40's to the mid-50's,

with an average age of about 51 years, or somewhat older than the average age of nurses nationally (CNA, 2000b). Each participant had in excess of 15 years of nursing experience, with the average being about 26 years. While two participants had approximately three years each of outpost nursing experience, the other seven participants had between 10 and 20 years of outpost experience, with an average of over 15 years. Although one participant was male, all are portrayed as female, to maintain anonymity. Although an attempt was made to recruit a First Nations participant, none volunteered to participate in this study.

All participants were originally educated in a diploma RN program. Five participants had completed a BSN or BScN degree, three prior to working as an outpost nurse, and two subsequently. Three participants had also completed a certificate, diploma or other degree in a health-related discipline, but not specific to outpost practice. Most participants had some formal educational preparation for outpost practice, although many had worked for several years in the outpost role before being sponsored by their employers to take a primary care skills course. Six participants had completed a course of between three and six month's length, and one participant had taken a longer program. One participant had learned primary care skills through informal mentoring associations with physicians, and one participant did not identify either formal or informal preparation specific to the outpost nursing role. Three participants indicated that they are either currently enrolled or planning to enrol in a degree or second degree program.

The length of time each nurse had spent in one community and the number of different communities each nurse had worked in varied widely. Although two participants had spent more than 5 years in the same community, the majority averaged about 2.5 years as their longest stint. Two participants had worked primarily in short-term relief positions, but had spent sufficient time in one community to meet the inclusion criteria of the study. All except two participants had worked in several (i.e., more than two) different communities.

Participants had varied personal backgrounds. Two were single with no dependents. The other seven had a significant other and/or children. Some participants had family members with them during the time they lived and worked in an outpost community. Six participants identified “home” as being someplace other than the community in which they worked, even though they might have worked in that community for a considerable time.

General Characteristics of the Interviews

Four participants were interviewed in-person, during a time they were out of their outpost community and in a location that was mutually convenient to both the participant and myself. The other five participants were interviewed by telephone. While interviews were conducted under a variety of conditions, no problems or significant interruptions occurred during any of the interviews. Some time was spent initially establishing a sense of rapport and trust with each participant. It seemed important to participants to know something about my own experience as an outpost nurse, and to be assured that I had no affiliation with any of the outpost nursing employers. During each interview, I was privileged to feel that participants openly shared their experiences with me as a colleague, and as one of themselves.

Prior to their interviews, participants had received information by email or fax, to assist them in preparing the stories they wanted to share with me. While only two participants in fact came to the interview with stories prepared, the interviews with all participants were remarkably similar regardless of preparation. In general, participants tended to start out by telling me a “war story”. This is analogous to what Benner, Tanner and Chesla (1996) identified as the first major type of narrative theme, which they refer to as a constitutive and sustaining narrative. In common with the narrative subthemes described by these authors, participants usually began the interview by relating a story wherein the participant had literally saved a life, or otherwise made a significant difference to a patient. These stories generally focused on the skillful and competent provision of primary care by the participant, often in an emergency situation.

The other major type of narrative theme identified by Benner et al. (1996) is a narrative of learning. Learning narratives include the subthemes of learning the skill of involvement and being open to experience. Participants showed a tendency to follow up a “war” story with a learning narrative, revealing through this story more about how they had learned outpost practice. These stories often reflected a community health perspective, illustrating broader practice, or a broader understanding of practice, than did the initial “war stories”.

Some participants told stories from their practice easily and graphically, while others had more difficulty in telling a story as such, and found it easier to simply describe to me what their practice was and how they perceived their role. Differences as well as commonalities in how participants expressed their practice are most readily explained by a contextual understanding of outpost nursing practice.

Preserving Context

Conveying a sense of the context of practice is perhaps the most challenging aspect of a study of this nature. Context is what makes the phenomenological approach relevant; it is only through appreciating the “lived experience” that practice can be understood. To understand outpost nursing practice, it is important to appreciate that outpost nursing implies not merely a particular context of practice, but also a context of living and lifestyle. The context of practice pervades and affects literally every aspect of the nurse’s life every minute she is in an outpost community. Even when she is not on duty and not on-call, she remains “the nurse”. Hodgson (1982) and Gregory (1992) described this lack of boundary between work and the nurse’s personal life, a concept that is also supported by the interviews with participants in this study.

The overlap between practice and life issues further complicates the challenge of interpreting outpost practice, since participants generally failed to differentiate between practice and lifestyle issues in their stories: Outpost nursing practice *is* a lifestyle. Thus, the stories told by participants about their outpost nursing practice reflect a level of contextual integration

surpassing that noted in similar studies of nursing in other practice areas. SmithBattle et al. (1997) observed, "Clinical narratives resist conceptual clarity. They preserve the 'messy' complexities of the practice world, the significance of relationships, the importance of timing and context, and the crucial role of experience for acting skillfully in complex situations" (p. 76). A "messy" context becomes even messier when practice and lifestyle become irretrievably interwoven, as they are in outpost practice.

Context may be best interpreted and understood in terms of the five sources of commonality and differences described by Benner (1994), and Benner and Wrubel (1989): situation, embodiment, temporality, concerns and common meanings. Each of these terms will be defined and discussed as it pertains to the contextual interpretation of the data in this study.

Common Meanings

Like other specialized areas of nursing practice, outpost nursing has its own vocabulary, or collection of colloquialisms. These colloquialisms reflect the culture of outpost nursing, and thus are important to understanding the context of practice.

Outpost nurses recognize the dualistic nature of their work by differentiating between primary care and preventive care. "Treatment" refers to non-emergent illness-oriented primary care, such as the diagnosis and treatment of sore throats, ear aches, and coughs. Emergent primary care conditions may begin as "treatment", but are subtly different once they are identified as "emergencies". Emergencies take precedence over any other activity the nurse(s) may be engaged in. "Public health" refers to both preventive care and health promotion activities, and includes mandated public health programs such as immunization, newborn home visits, school health and communicable disease management, as well as preventive screening programs (e.g. Pap testing) and chronic disease monitoring. Nurses often refer to these programs as "clinics", and set times during the week are usually designated "Well Child Clinic", "Well Woman Clinic", "Prenatal Clinic" and "Chronic Clinic", in addition to daily "treatment clinics".

Treatment clinic is also referred to as “Sick Clinic”. “Home Visits” are usually considered to be part of the public health program, but are often treatment-oriented or involve primary care.

The physical facility in which outpost nurses work is variously referred to as a nursing station, health center, or clinic. Although MSB traditionally has differentiated between these facilities based on the level of service provided, in practice the terms are used interchangeably. Nurses may refer to a nursing station as a health center, feeling that the term health center reflects a less treatment-orientated and more community-based philosophy of care: *Here in the Health Center we do a lot of things in our public education room because I want people to see this as more than just a place to come when you're sick.*

A “medevac” refers to the air evacuation of a critically ill patient to the referral hospital. This involves chartering a designated medevac plane to fly into the community and pick up the patient. A “medevac” or flight nurse, and sometimes a physician, will escort the patient.

A “sched” is a scheduled flight in or out of the community. Patients who are not emergently ill are transported by sched whenever feasible, due to the much lower cost of a sched flight. Determining when a patient is well enough to travel by sched, and deciding to send a patient out by sched before he/she becomes ill enough to require a medevac, is one of the responsibilities of the outpost nurse. Any air service into remote northern communities is highly dependent upon weather, and flight times can be significant due to distance from the referral hospital and/or the air base. Other factors that may affect air service are darkness, the availability of an airstrip/personnel, use of floatplanes, and availability of a medevac plane.

Cathy describes waiting for a medevac plane to arrive to pick up a critically ill patient:

The plane has to come out. A plane never gets here in less than two hours, it just never happens and there's been nights when the plane never gets here because of the fog. You can hear them circling overhead of the health center and you're in the health center with a very sick client and you're just praying to God that the fog is going to lift so that they can land and then they don't ... and the plane goes back to base and you're here for eight hours with that client.

Situation

The nurses who participated in this study had diverse outpost experience, gained over varying lengths of time in communities that were often qualitatively different from one another. Some participants told stories of events that had occurred in the week immediately preceding our interview, whereas others reached back years into their past experience to find stories of their novice practice. Regardless of when a story might have taken place, it is told from the perspective of that individual's situation. Each participant's situation can be understood as a reflection of her amassed experience, and includes her present, or most recent experience (Benner & Wrubel, 1989). Benner (1994) describes situation as "an understanding of how the person is situated, both historically and currently. Questions related to situation are whether the situation is understood as a situation of smooth social functioning or as a breakdown situation of novelty, error, confusion, or conflict" (p. 104). An understanding of an individual's situation is pivotal to also understanding her concerns, temporality, and embodied intelligence (Benner & Wrubel).

Several factors emerged from the interviews as being key to understanding the situation of participants in this study. One key factor was the length of time a participant spent in a community, and whether she saw herself as being in a relatively permanent versus a temporary position. Some participants were long-time residents in the communities in which they worked. They saw their positions as being permanent, and were engaged with the community as "the nurse", as well as a community member:

One big mistake that I see in a lot of outpost nurses is that they restrict their lives to being the nurse. The biggest mistake you can make, not only for you, but for the people that you have to work with. They have to understand that you're not only "the nurse". They need to know that you're also the curler or the library volunteer, that you have other parts to you (Chris).

In contrast, Sue, another nurse with long-term experience in a community, described the reactions of nurses coming to the community on a short-term basis: *Some nurses were very open*

to getting to know more about the community and others (sighs) just found it so different that they were more comfortable staying in their own little world. Alex phrased this more bluntly: Some nurses will go in on relief and almost cold shoulder the community because they're only there to work.

Two participants in this study described themselves as being relief nurses, and even though these individuals were experienced in the outpost role, they viewed their role as a relief nurse as being different from that of the permanent nurse in the community: *I'm not a trained public health nurse, so that eliminates that whole aspect of what goes on in the nursing stations for my role because I'm a relief nurse, I'm in for short periods of time.* This participant saw her role as being essentially that of a primary care provider, rather than a community health provider, a perception that was validated by another participant who worked on a more "permanent" basis:

Coming in for those short stints is almost a disadvantage for nurses who come into the community because they don't buy into the long term. They are here mostly to just sort of see Susie and send her out the door.

It is unclear whether this is because short-term nurses have not had the opportunity to learn the community health role, or because they viewed their short-term status as a barrier to enacting the community health role.

Participants identified several other factors that revealed or elucidated their situation. These factors are the same work/life issues that other authors have identified and discussed as barriers to practice, and include work structure and / or administrative practices (Chaytor, 1994; Gregory, 1992), and the nurse as "other" in the community (Gregory; Hodgson, 1982; Vukic, 1997), a concept that embraces issues such as racial and cultural differences, culture shock, and isolation. These issues often represent situations that might be characterized as contributing to "breakdown situations" (Benner, 1994, p. 104). How, when and if individuals had experienced these issues in their outpost nursing practice influenced participants' situation.

Participants frequently referred to unsupportive work issues such as understaffing and staff transience, which often resulted in overwhelming workloads:

It was a very, very busy clinic; we were very overworked, very overworked...every third night we were first call, and then the fourth night we were on second call, and you still had to work those days, so it was nothing to be up all night and all the next day too...in two years we went through 40 nurses.

Heavy demand for treatment services was perceived as a barrier to delivering public health programs:

I think community health is starting to lose in the north, I really do. In the big communities the nurses don't have time, they just don't have time. No matter when you set your clinics, you've still got sick people wandering in, in the middle of well baby day or prenatal day... it just takes up all your time. The clinic nurses get backed up and don't have the time ... I'd like to see a community health nurse in every big community - who does nothing but TB testing, immunization, well women clinics, teaching these kids who come in pregnant when they're 13 (Alex).

In addition to being overworked and subsequently unable to deliver programs that they perceived to be important, some nurses talked about working in communities where conflict with clients, or abuse towards the nurses was commonplace:

There was a lot of verbal abuse toward the nurses...I reacted very little when people would swear at me because I would hope to God they'd pass out and then I wouldn't have to listen to them while I sutured them up (Joanne).

Despite, or in addition to working under less than ideal conditions, it was evident that several participants had at some time experienced a lack of support from their administrators. Speaking of a traumatic death in the community, one participant said, *we didn't have time to debrief. There's a critical incident and stress debriefing group in [name of city] that's supposed to give us a call and we still haven't heard from them.* Another participant remarked *things were so bad when I was there, the physicians refused to come.* Pat spoke of her management of a traumatic event in the community:

There were rumblings within management regarding the appropriateness of what I did and that was a difficult experience for me because I know I did the right thing because I saved his life...this incident exemplifies that the important thing here is not the person's

life, but the policy...and I find that rather disturbing. I was glad that I was there to do what I did.

Terry speaks of lack of administrative support in more general terms:

I'd always wanted to work in third world countries and then I thought why should I? I've got it right here in my own backyard and I'll do whatever I can here in Canada, because things can be better. But it needs to come from administration, the nurses at the bottom can't do it all without the proper support from the top.

Pat relates lack of administrative support to transient staffing: *Nurses are just coming and going like in a revolving door now and they are coming and leaving very dissatisfied...because of the way they're being treated.*

In contrast, some nurses described experiences where a zone nursing officer or key players in the community, such as band administrators or elders, played a supportive role: *So it opened a can of worms but the chief stood behind me 100%. He was just fantastic. He said - you do exactly what you have to do and I'll stand behind you.*

The other important factor in gaining a sense of the situation of each participant was to appreciate her experience as "other" in the community. Participants often vividly described their experience as "other" and their discourse was notably congruent in some respects with both Hodgson's study (1982) and what she terms nurses living in "the total institution" of the nursing station, and with Vukic's study (1997), in respect to the nurse as "other" in the community. Stories about being "other" generally followed the style of a learning narrative (Benner et al., 1996), wherein participants told of their early experiences in realizing they were "other" in the community, and how they subsequently learned to adapt to the issues that contribute to "other":

One of the things that I noticed over the years, if you were in a community that was strongly First Nation - aboriginal - there was always about 5% of the community that was Other. Some nurses would tend to only socialize with the 5%, other nurses would, as they got to know the people by helping them with their children, their health problems, they'd get invited to the house... they'd pop by and they'd slowly get to know some of the community people as well (Sue).

One participant who had worked in a community with a large non-native population did not address the issue of being “other”, and stated *I don't have any social relationships with anybody in the aboriginal community*, prompting speculation that she had not experienced being “other” in the community in the same way as other participants had. This participant did express her understanding of her practice in different ways than did most of the other participants. These differences may be explained in part by appreciating that this participant is situated differently than other participants.

The issues contributing to the nurse as “other” are largely racial and cultural issues, and thus highly dependent on the particular community or communities the participant had experienced. Since all the participants in this study were Caucasian and from characteristically mainstream Canadian backgrounds, most either directly or indirectly recognized the First Nations cultures of the communities they worked in as being distinctly different from their own. In speaking of their interactions with First Nations people, many participants used a “we” / “they” semantic style that reflected not only the distinction they made between themselves and the people they worked with, but which First Nations people apparently also made between themselves and the “white” nurses:

I had to learn some of the cultural differences...little things like, it was okay for a woman to get on a skidoo with her husband but it wasn't okay for her to get on with any other man unless it was her father or her brother. Of course, me as a kabloona, a white person, I could get away with going for a ride with one of the local men, and not get into trouble - but if one of the local ladies went on a skidoo with anyone who was not her husband, her father or her brother, she would be in serious social trouble with the rest of the family. And other little social customs...there were distinct cultural lines of how you could do these things (Sue).

Participants referred to cultural differences not only between themselves and the aboriginal people they worked with, but also between different First Nations groups, and different communities. They emphasized the importance of adapting to variations in culture:

You have to be culturally aware of that community and when you work in a lot of different communities, then there's a whole lot of different cultural things that you have to be aware of; the local customs aren't always the same from community to community.

The concept of culture in outpost communities is multi-dimensional and encompasses a broader understanding of culture than one based simply on racial and/or ethnic background. The culture of northern and remote communities includes the culture of living in isolation, not only in a geographic sense, but also for the nurse, a sense of isolation from her own culture:

What surprised me most was how much I was learning about another culture and how totally distinct it was from the cultures I knew in southern Canada. Northern Canada, its very different from southern Canada. You tended to interact on a social basis with that 5% of the community that was Other... though those people may have had personalities that you may not have become involved with in southern Canada...because they had similar cultures to yourself. It reminded you that you still had your own culture and your own home of origin that was different from the very distinct society that you were now living in (Sue).

Many outpost communities have devolved to a culture marked by poverty, unemployment, and illiteracy, while in some, violence, substance and physical abuse have become part of the culture of the community. Some participants had experienced culture shock as part of their introductory outpost experience: *I found it at times overwhelming.... I was totally shell shocked when I got out of there*, while others were surprised to realize the extent to which they were not merely "other", but also outsiders to the community: *You're not working in your own culture.... I wasn't culturally aware, I was thrown into it as green as grass - and you get your eyes opened quickly.*

Several participants referred to culture as it pertained to the nurses themselves, and identified that often their own experience in a community was influenced by the relationships of previous nurses with the community:

I felt a little sorry for the nurse that had to come after me because when a community has had the same nurse that they've trusted for a number of years, if the next nurse does anything at all different, the people were saying, "well, that's not how [the previous nurse] did it" (laughing) so it's really hard for someone to come after a nurse who has been there for a number of years because you're in the shadow of the person that has preceded you and been well liked (Sue).

Participants also referred to the idea of a nursing station culture that varied between communities and nursing staff: *I've noticed nurses who have come here that might be very rigid with the rules... maybe the communities that they've worked in before have done that.*

Temporality

Temporality is the third source of commonalities and differences. "The experience of lived time is the way one projects oneself into the future and understands oneself from the past. Temporality is more than a linear succession of moments. It includes the qualitative, lived experience of time or timelessness" (Benner, 1994, p.105). This is patently related to the individual's situation, which might be thought of in simplified and colloquial terms as "where one is coming from". To draw lines separating temporality, concerns and situation would be an arbitrary exercise, since they are essentially interdependent (Benner & Wrubel, 1989). For the purpose of this study, temporality is interpreted as a reflection of "where the nurse is at" in her life and career.

Most participants expressed themselves similarly in terms of temporality, and this is reflected in the commonalities found across interviews. However, the interviews with two participants reflected differences that may be explained by temporality. Of these two participants, one was at a point in her career where she was still learning outpost practice. Despite having decades of nursing experience, this participant was on the steep part of the learning curve of outpost practice, and still working towards the understanding and comfort with practice that marked the interviews with more experienced outpost nurses:

I'm new to this nurse practitioner game... I was on a very high learning curve. I mean, I'm glad I went and I'm glad I had the experience but there are times when I ask myself why almighty God, has this happened to me (laughing).

The other participant was at a point in her career where she was experiencing what might be construed as "burn-out", prompting her to reflect on her many years of outpost practice, and to question whether she would continue in outpost practice in the future. At the time of our

interview, many experiences from her practice brought back disturbing memories for this participant, which she found difficult to share with me. She did not tell stories rich with the vivid description and sense of connection that other participants with comparable experience had done. Instead, her stories contained a sense of disengagement. On one level, her stories are about how she has affected patients in her practice, but on a deeper level, they are about how she has been affected by her patients and her practice. This participant seemed to be at a point in her practice where, to paraphrase Benner (1994), she was trying to understand herself from the past (p. 105).

Concerns

Concerns represent something of a “catch – 22” in understanding context, in that while they arise out of an individual’s situation, they also confer structure to the individual’s understanding of the situation, thus allowing one to become situated, or “oriented meaningfully in the situation” (Benner, 1994, p. 105). Concerns enable the nurse to make sense out of her practice, through determining what is salient, directing how she will interpret events and relationships, and cueing her to focus on what is important (Benner & Wrubel, 1989). While an individual might have diverse concerns on many levels, and concerns might shift as situations shift, for the purposes of this study, concerns are interpreted in a broad sense as a reflection of the individual’s orientation to health and health care.

All the participants who took part in this study came to outpost nursing from an acute care background, rather than from previous community or public health experiences. It is possible that nurses tend to be initially attracted into outpost nursing by its treatment/ emergency/ trauma aspects. Most participants began outpost nursing with similar levels of nursing education. Not surprisingly, most participants expressed common concerns in regard to their practice in primary care, where concerns reflect an acute-care orientation, with the focus being

on “cure”: *I was very focused on his survival. Absolutely. That’s what we’re there for, that’s what we get paid for.*

These commonalities are most marked when participants described their early practice. As they gained more experience in the community health role, and became situated differently, they experienced a shift in their orientation towards health, and differences emerged in their expressed concerns. Shifting concerns also reflected shifting values:

People in the cities say, “oh, the natives, it’s the natives”.... If they could go into some of the communities and see the no running water and the wood stove and these kids with no self esteem whatsoever, you know... it’s got to change.... I’m one of the nurses that really believe community health is so important - I think it’s as important as the treatment aspect (Alex).

A participant’s orientation to health predictably influenced how she perceived and enacted her role. However, two participants, while expressing an understanding of the value of addressing health issues on a broader basis than primary care, indicated they did not perceive this as being an important part of their own role as an outpost nurse. These participants were the two “relief nurses”. The incongruity between orientation and role perception expressed by these participants may be attributable to their situation, as discussed previously. These participants tended to see their role as being essentially that of a primary care provider, rather than a community health provider:

That whole idea of the dependency, the lethargy, I guess that’s one of the things I find the hardest to deal with. I can deal with the trauma; I can deal with the blood up to my ankles - it’s the other things that I find harder to deal with I don’t think I can do anything about it directly, it’s a much larger problem than a community problem, it’s a national problem, there’s really not a whole lot that I think I can do at this level. And so basically I just accept it, tune it out, I focus on the things I enjoy, the things that I like about the work.

The interface between situation and concerns reflects the paradoxical nature of outpost practice identified by Gregory (1992), Hodgson (1982) and Vukic (1997).

Embodiment

I just knew there was something wrong.... I couldn't put my finger on anything... and I think that's what northern nursing is all about, common sense and good instinct.... I think it comes from confidence, from experience and sometimes you just get that sixth sense that there's something underlying that - and even if it doesn't present like that, you just get that feeling that something is going to happen (Alex).

You usually just know...whether its intuition or mentally you're just using all of the information you've got...you just know (Terry).

When you work in the north for a long time - or you nurse, period, for a long time, you're very comfortable with your skills and your knowledge (Cathy).

Benner (1994) defines embodiment as “an understanding of embodied knowing that encompasses skilful comportment and perceptual and emotional responses ... as a result of perceptual acuity and pattern recognition” (p. 104-105). Most of the participants in this study initially told a “war” story that attested to the skill and knowledge embedded in their primary care practice. While participants’ competencies in the primary care role will be explored in greater depth in the thematic analysis, it is notable that one of the most consistent sources of commonality in terms of embodiment was the way in which participants talked about their competencies in primary care. Relatively high-level competencies were spoken of in a casual, taken-for-granted manner, graphically implying a sense of embodiment:

I did a throat swab and then he explained to me that he also had this cough. His pulse was running around 120 or something What was going through my head was - because I knew that he did use drugs - was that maybe it's cocaine or something that he's taken and he's got this tachycardia. There's something here, there's something wrong with his pulse running at 120...so I decided right then to do the chest x-ray. But what was really going through my head was, it was the drugs. So I did the chest x-ray and got one of the other nurses to run the cardiogram.... When I put the chest x-ray up on the viewer, I could see something in one of the lungs. The other nurse came over and said, you know, there's some tachycardia here but everything else looks okay. So I said - well come and look at this chest x-ray... and she noticed the spot as well (Marianne).

In this excerpt, Marianne is describing a complex patient assessment, recognizing there is “something wrong”, or that something doesn't fit the expected pattern, formulating differential diagnoses, deciding what her next step will be, performing and interpreting diagnostic tests, and

arriving at a working diagnosis. She describes this as a fluid, intuitive and efficient process, consistent with Benner's definition of "expert" practice (Benner, 1984). Like Marianne, most participants told a story that described their primary care practice as embodied, expert practice.

In her discussion of perceptual acuity, Benner (1984) claims that expert practitioners evidence a sense of certainty about their clinical judgment. This sense of certainty, or confidence, emerged from the stories told by participants in this study: *The doc said it couldn't be meningitis and I said, if it's not, I'll pay \$10,000 out of my own pocket for this medevac.... That's how sure we were (Alex).*

Differences between participants in terms of embodiment became apparent in the ways in which they discussed skills and knowledge in regard to their role in community health. One participant, after telling a story that described an expert level of practice in a primary care scenario, described a concurrent experience as a novice learning community health skills:

For a long time I would say - well you need to give a bath to bring the baby's fever down but, you see, it didn't click in my brain for a long time that their water is restricted. They don't want to use water because it's trucked in and they have to pay for it. So whenever you're telling them to give the kid a bath, you have to qualify that with a question like what are you going to bathe the baby in? If they have to fill the bath tub, that's a lot of water.

In contrast, a nurse with more experience in the community health role describes a more embodied understanding of the social issues in the community and how this knowledge is incorporated into her practice:

So when somebody presents in the clinic room with some little complaint, it's never a little complaint, it's always - what started that and what are we going to change so that doesn't happen again and on and on.... And so you never just deal with one little issue, it's always - maybe there was no food in the house, maybe there's no running water, that's why we have head lice every week or scabies or whatever, or their clothes are never washed...and so why don't they have running water? Because their housing is poor ...and you just go on and on and on and almost every clinic visit is like that (Cathy).

The finding that participants' embodied knowledge and skill was described more commonly as it pertained to primary care skills, and more variously as it pertained to community

health knowledge and skills, is consistent with the finding that participants' concerns also tended to vary with their experience in the community health role. Presumably, as participants gained more experience in the community health role, and a correspondingly greater appreciation of the influence the broader determinants of health have on the communities in which they work, participants' orientation to health shifted, and they became more open to the knowledge and skills particular to community health nursing practice.

Summary

Participants in this study have become situated in their practice through diverse experiences that illustrate the multi-faceted and "messy" complexity of outpost practice. Other authors have characterized this as the ambiguity and paradox of practice (Gregory, 1992; Hodgson, 1982). Understanding this diversity of experience and how it has contributed to the participant becoming situated as she is, serves to shed light on some of the apparent differences in the way participants understood and described their outpost practice. These different perspectives provided a counterpoint that provoked analysis at a deeper level, and which ultimately resulted in many of the more elusive insights gained in the course of this study. Most remarkable, however, are the commonalities that emerged from the data, in spite of participants' diverse experiences.

Thematic Interpretation

Four main themes germane to the role and practice of outpost nurses emerged from the data provided by participants in this study. These four themes are:

1. Primary care competencies are fundamental to outpost nursing practice.
2. Nurses evolve into the outpost nursing role by learning community health competencies and adapting to context-specific practice issues.
3. Experienced outpost nurses build and maintain responsive relationships with the community.

4. Experienced outpost nurses become comfortable with the autonomy and responsibility of outpost practice.

Each of these themes will be discussed as it appeared in the data, using paradigm and exemplary cases described by participants to ground the interpretation in the data.

Primary care competencies are fundamental to outpost nursing practice

Primary care includes treatment and emergency care. The experienced outpost nurses who participated in this study described their primary care skills in a way that suggested they were comfortable with their skills in this area of practice, and confident of their competency. As discussed in the previous section, participants' clinical narratives evoked a sense of embodied knowledge and skill in regard to primary care provision.

It should be noted that this interpretation is not based on an evaluation, measurement, or confirmation of participants' practice, either generally, or in terms of specific competencies. Participants did not describe how they learned primary care competencies, nor did they discuss or describe specific competencies in detail. Instead, they revealed competencies by weaving them into stories of client-focused practice. Each story represents a particular situation grounded in a specific context. It would be inappropriate to judge these situations without having been there and having lived the situation as the participant lived it. It would be equally inappropriate to remove these stories from context and evaluate them based on theoretical standards of practice (Benner, 1984). Exploring participants' practice knowledge in particular situations may help to elucidate the relationship between theoretical and practical knowledge (Fjelland & Gjengedal, 1994).

In telling stories from their practice, participants referred to many different skills they used to provide primary care. Primary care skills included assessment, performing diagnostic tests (e.g., x-rays, cardiograms) and therapeutic interventions (e.g., starting intravenous lines, prescribing/administering medications) as well as teaching, counselling, supporting, diagnosing,

and monitoring. Participants often described situations wherein they used a variety of different primary care skills simultaneously, reflecting the integration of these skills in practice.

Participants necessarily learned the primary care aspects of the outpost role first. Demands for treatment and emergency services are more urgent in nature than are demands for public health services. In many communities, the demand for primary care services is overwhelming: *I learned treatment first, of course, because three quarters of (community X) is treatment, treatment, treatment.* Due to their previous experience in acute care settings, participants were already comfortable working within a primary care paradigm.

In their study of community health nursing practice, SmithBattle et al. (1997) suggested that inexperienced community health practitioners found community practice to be ambiguous and unstructured compared to the more concrete structure of working within an acute care institution, and that nurses' inexperience in the community setting provided "no framework with which to structure the situation" (p. 78). It may be that as new outpost practitioners, participants similarly focused on the more concrete primary care competencies because this was a part of their role that provided familiarity and structure in an unfamiliar environment.

Participants rarely attempted to explain or elaborate on their use of often high-level primary care skills (e.g., cardiac arrest management). Instead, their discourse tended to focus on skills such as teaching, or supporting patients in times of crisis. Key to understanding this difference is an appreciation of why participants told their stories in the ways they did. That is, it was important to figure out what the point of the story was - and the point was invariably how the participant had made a difference to the patient. While skilled assessments and life-saving interventions were related as critical background information to participants' stories, the point of even the most gruesome of the war stories was how the participant had been able to "make a difference". Interestingly, participants did not attribute the differences they made to patients to the fact that they had nailed a critical diagnosis or established a life-saving intravenous line, but

rather to establishing a relationship with the patient, by “really listening”, advocating, or even simply “being there” for the patient. Participants discussed these skills because they perceived that it was these skills that enabled them to make a difference to patients.

Some of the primary care skills, such as building relationships and advocating, are aligned with the other major themes that emerged from the data, and will be discussed in greater detail in the following sections of this chapter. However, skills such as teaching, supporting and monitoring were discussed by participants as basic primary care competencies. The paradigm case that follows illustrates how one participant integrated a variety of skills to provide care for a patient, as well as her perception that what made the difference to this patient was the support she provided by “really listening” to him. In a prelude to this paradigm, the participant had explained how another nurse had refused to see this patient after regular clinic hours on the previous evening, and had brushed off his complaints of a sore throat:

I came out of the treatment room and saw a very ill looking gentleman sitting on the bench, pale, sweating, he just looked dreadful. So I brought him into my treatment room right away. I said – what’s the matter? and he just pointed to his throat.... I looked in his throat – his tonsils were huge, he couldn’t swallow. We started an IV ... got IV antibiotics running right away and within 20 minutes, he could feel the relief. Now whether that’s psychological or what, I don’t know but at least he felt he was being cared for and that his throat was starting to ease. His breathing was better, he could almost swallow. This man was so grateful for the little bit of care that we had given him that, of course, it changed how we were practicing in our outlook because we realized we could hear what he was saying to us: “Nurse, I can’t swallow, nurse, my throat really hurts, I can’t stand it” (Terry).

While this participant made a rapid assessment and instituted timely intervention, she recognized that the success of her intervention was more due to the fact that she treated the patient respectfully, and provided the support he needed to feel that he was being cared for, in contrast to the nurse who had treated him disrespectfully and had not listened to him.

Supporting and counselling were competencies that participants discussed frequently, perceiving these as competencies that enabled them to make significant differences to patients.

The following exemplar describes a situation where a participant provided support and counselling to a patient and his family, to support the patient's wishes to die at home:

Look, he said, I don't want to go to the hospital anymore, don't send me back there...I could just die here. And I said, gee, it's going to be really hard on your family when you get really sick because they're gonna want you to go to the hospital. Yeah, yeah, he says, well maybe I'll have to talk to them.... So a month goes by and then he gets really sick again and I get called to the house and we chat a little bit. He was now in fairly bad heart failure, but he didn't want treatment. He had talked to his family and I talked to them as well and this was the plan, that we weren't sending him to the hospital again. This was something different – it was probably 20 years since someone had died in their house, in their community because people always went to the hospital. You didn't die at home - because they could make you better at the hospital - but this man knew that he was not going to get better so he didn't want to go back to the hospital. He was tired and I could see that he was tired. Later that day I went down to see him. There were a lot of people in the house and there were a lot of questions of why isn't he going? At that point he was in and out of consciousness. I said, this is what he wants. He died at about two that afternoon I think it made a difference to that patient. He got what he wanted (Marianne).

By listening to the patient and respecting him, this participant was able to make the ethical decision that it would not be appropriate to implement aggressive primary care intervention in this situation. This is consistent with Benner et al.'s (1996) finding that the dominant ethic guiding nursing practice is an ethic of caring. An ethic of care was described as “care, responsiveness to the other, and responsibility” (Benner et al., p. 233). Marianne's story exemplifies how an ethic of care, learned through experience in particular situations, directs the provision of primary care. She later stated: *I do have patients who want to see me and I don't think it's because I'm a better nurse, I think it's just the approach and the comfort level.*

By “really listening” to patients, participants could find out what patients “really wanted”, which was perceived as being important to making a difference. This participant tells a story that exemplifies the idea of making a difference to patients by listening to what they really want:

Don't you send me out to [hospital], he says, or I'll wreck this place. I said, what can I do for you then? Why are you even here? He said, just sew me fucking up and let me out of here. I said if that's all you want, that's what you've got. I had to chase him around with the needle driver and the sutures because he kept running around the clinic, first

he'd have to lay on his stomach, then he'd have to lay on his back, then he had to go have a smoke outside.... So, I just followed him around and stitched him up wherever he happened to park himself for a minute.... I put in around 100 stitches in his head. But he got what he wanted ... so I thought that the best had been done for him. He actually got what he wanted so he felt like he had some power and then he was easier to get along with (Terry).

Another participant who only realized several years later how she had made a difference to a patient related a paradigm case that illustrated how an ethic of care guided her interaction with a client:

When she was 15 she became pregnant. She had a long family history of sexual abuse, so her pregnancy at 15 was pretty questionable. She had pretty well no support within her family at all. Her female siblings and her mother were very ineffective and everybody wanted her to have an abortion. She came to talk to me about it because she knew me from the school. We talked for a long time and I gave her a number of options and she agreed that she would come back, she still had time to think this through, whether she really wanted to do this or not. And she decided eventually that she just couldn't go through with an abortion, that really wasn't what she wanted. So I gave her what support I could - most of it emotional because she was getting no emotional support from anybody. I did her check-ups on a regular basis. We didn't particularly have a bond as far as I was concerned but I learned after the fact that she felt quite bonded to me and I was not that aware of it. Years later she said to me, you know, you were the only person who believed I could do it. Everybody else told me I was useless and stupid and my baby was as big a waste of space as I was. She said, you were the only person who ever told me that I would do fine with this baby and I did. (laughing) And I thought to myself afterwards, Holy Cow, she remembered that after all these years and it had such a big impact on her that at the time I was completely unaware of, totally, totally unaware - and I thought my God, sometimes you do, you really do reach people when you have no idea that you did. And it has made a much bigger difference to them than I had ever realized. But I was just doing what seemed the right thing to do, and the true thing to do (Chris).

In discussing the ways in which they support, respect, and listen to patients, participants are talking about establishing a relationship based on trust with individual patients and their families. In the preceding story, Chris tells how she established a relationship with an individual by supporting her in a time of crisis. This relationship was initiated and subsequently developed through a primary care contact. Despite Chris's suspicion that the pregnancy may have resulted from sexual abuse within the family, and misgivings related to the marked lack of family support for the pregnancy, Chris listened to the patient, and respected and supported her decision. Thus, Chris's care of this patient was directed by her ethical sense of *the right and true thing to do*.

Participants saw teaching and patient education as another important way in which they could make a difference to patients, largely through empowering patients by offering them the knowledge and skills to increase their self-reliance and self-esteem. Participants consistently recognized that the medicalized model of care that has historically been the status quo in outpost communities has fostered dependency and a somewhat paradoxical mistrust in health services. One participant said, *I'm embarrassed for people in the health care field who can't get a message across simply so that the patient can take charge of whatever it is... that they somehow make things mysterious and keep the patients dependent.* In contrast, participants viewed teaching as a means by which they could improve the effectiveness of primary care interventions by empowering patients:

You have to be able to hear what they're asking for and if it's not justifiable then you've got to give them a good explanation of why... or they'll just go to the next nurse and the next nurse and they'll keep asking for the same thing until they get what they think they need, unless you can give a reasonable explanation of why you're not giving it. A good example is to explain to people why they don't need an antibiotic yet if you're doing a throat swab and there's no other symptoms and you're waiting for the results to come back. But I always encourage people to come back if they're having any trouble whatsoever with fever, with swelling, finding it difficult to swallow, anything like that. I feel that in that way I'm able to teach people about why they aren't getting the antibiotic they want. I find people are 100% receptive to that. If you're giving them back the power to care for themselves and to know why something is being done, they feel very empowered. If you don't talk down to people, if you're reasonable and you use their language, I find that's very important. It's important not to talk in technical and medical terminology that they don't understand (Terry).

Monitoring patients was another skill that participants described as being important to their primary care of patients. Some participants referred to monitoring as follow-up care, or “keeping out of trouble”. Sarah shared a paradigm case that changed her practice in regard to monitoring patients:

I saw a young mom. She was not feeding babe enough so he was almost a failure to thrive ...[with] weight loss, dehydration, severe jaundice.... I brought the babe into the nursing station in the day time, we fed him, we weighed him after each feed, and the mom came in too. Well the first day she just slept, she was exhausted and so we fed the babe, but once she saw the weight and the feeding changes she realized what needed to be done and we had her in for a couple of days like this and then she started coming in on a daily

basis for weights. Now, once a person returns to the community, we see those people daily either in the home or in the nursing station to monitor babe's weight, [and] mom's condition.... What with the lack of prenatal education, early discharge for postnatals and their newborns, the follow up that we do now is very, very close - like daily...to keep them out of trouble and avoid readmissions. It's quite an intense program and I guess it varies depending on the needs of the mom and the babe, but without that we would find we're in trouble (Sarah).

Sarah's story illustrates the relationship between primary care and population-focused preventive care that typifies outpost practice. She assessed the infant, made a diagnosis and intervened at a primary care level. The community-based monitoring program that was instituted could be considered preventive in nature. This is consistent with the findings in another interpretive study examining community health nursing practice, wherein it was found that family-focused interventions formed the basis of population-focused practice (Diekemper, SmithBattle & Drake, 1999).

The nurse practitioner literature reviewed for this study supported the idea that novice nurse practitioners experienced a transition process, wherein their initial focus on new, medically-oriented knowledge and skills gradually shifted back towards a nursing orientation as NPs became more comfortable with the medical tasks (Knafl, 1978; Roberts et al., 1997). I speculate that novice outpost nurses experience a similar transition, initially focusing on medically-oriented primary care skills, and eventually shifting back to a nursing orientation as they become comfortable with primary care. This might account for the way that the experienced participants who took part in this study tended to de-emphasize the primary care tasks (that tended to be those tasks associated with the physician extender part of the outpost role), and focused on the skills might be considered to have more of a nursing orientation. How participants experienced this transition and evolved into the outpost nursing role was the second major theme that emerged from the data in this study.

Nurses Evolve Into the Outpost Role

Coming to outpost practice from an acute care background, participants in this study evolved into the outpost nursing role by learning community health competencies and adapting to context-specific practice issues. Participants described experiencing a shift in role perception. They had entered outpost nursing with the expectation that it was an acute care role, but once in the community setting, they began to realize that it was also a community nursing role:

At first, I really didn't have a background in community health at all. In a smaller community, two thirds of your practice is community health and teaching prevention... and then treatment, of course, runny ears and sore throats or whatever. But now, community health is very important to me (Alex).

Community health competencies, like primary care competencies, comprise a variety of skills. These include tasks that are carried out on an individual level (e.g., immunizations, cervical cancer screening, communicable disease contact tracing) as well as those carried out on a community level (e.g., establishing relationships, advocacy). Like participants' discourse in regard to primary care competencies, their discourse relating to community health competencies tended to focus on those skills that confer a contextual understanding of the outpost nursing role and guide nurses' interactions with communities, and with outpost communities specifically.

The community health competencies that formed a significant part of participants' discourse reflected a shift in their orientation from illness treatment to health promotion. For clarity, this shift will be referred to as a shift from a primary care orientation to a primary health care orientation. Some participants articulated that they used a primary health care approach in their practice, while others expressed a conceptual understanding of the philosophy underlying primary health care. Remarkably similar language was used to refer to these concepts; phrases such as *getting to the root of the problem; band aid solutions; it's this bigger picture* were heard repeatedly during the interviews. Participants recognized the potential to influence health on a broader basis by integrating primary care into a primary health care approach. Like the

community health nurses in the study by Diekemper et al. (1999), participants in this study had “often simply discover[ed] ‘the big picture’, stumbl[ing] on it in practice” (p. 4), rather than through formal learning.

Participants voiced insight into the transition they had experienced since beginning their outpost practice:

At first I was just kind of holding the fort and did a lot of sick clinic kind of stuff.... And then as I got to know the local doctor who came one day every month and we talked about different things in the communities, I started to realize that people needed more well personal physicals and teaching in different areas of health.... The more experience I got, the better I knew what I perceive the job now to be, and the better I got at a variety of things that are part of the job. Now I usually try to see what there is in the community to help instead of always trying to bring in experts or specialists. When I have a problem I will talk to the local people - the local administrators, the local social workers, local leaders of the community - to see if they've got some of the answers because sometimes they're very creative and have answers I don't think of (laughing).... Sometimes the problems are big, sometimes they're little, but they have solutions that we don't always think of because of our southern way of thinking.... I guess I've just learnt a lot, from different communities, different people ...everything from herbal medicine to spirituality to different ways of thinking than I had as a hospital nurse many years ago (Sue).

Similarly, other participants told of learning community health competencies “on the job”, often through working with more experienced outpost nurses who acted as role models. Cathy eloquently expressed the contrast between her own perception of her role as an outpost nurse, and that of an inexperienced outpost nurse, as well as her own readiness to act as a role model and teacher:

I've worked with nurses who have had 20 years of ICU experience and I'd want to work right beside them if there was a cardiac arrest but put them in this kind of community health setting and it's a totally different ball game. It's not just signs and symptoms and let's treat that and out you go. It's this bigger picture. I had a nurse say to me, look I'm into the medical model, I'm not into the wellness model.... So, well women exams and breast self exams..., I really am not comfortable with that. I said, well, okay, I'm glad you identified that but that's five hours of our day so you're either going to have to get comfortable with it or you better decide this isn't where you want to be. And I don't mind working with you and teaching you - we'll do well women exams until you're comfortable with it - but you have to decide that you're going to wrap your head around the wellness model because that's what we're trying to do here.... Sick clinic is just a really tiny little part of our work (Cathy).

This participant's reference to *the wellness model* may be interpreted to mean a preventive/health promotive approach. It is evident that she sees it as part of her own role to ensure that clients don't fall through the gap between treatment and health prevention/ promotion that is left when a nurse works only from a treatment model. It is also clear that this participant sees "the big picture" and even though treatment is a part of her work, she works from a wellness, or primary health care orientation. Treatment might be thought of as just one tool in her "wellness toolbox".

Participants also learned community health competencies from local people with whom they worked, such as the health center clerks and CHRs, and from community members themselves, particularly the elders. Local support staff were seen as instrumental to learning cultural competency, which was an important aspect of becoming comfortable working within the unfamiliar context of outpost nursing:

The clerks were really good at filling the nurses in about cultural things. It was really helpful because it helped me readjust my view points on the people that I was working with. I think I went in there with a bit of a missionary type of attitude and then realized that these people didn't need missionaries, they needed people to help them do things with what they had as opposed to us trying to change them. I just had this sense that southern people probably knew all these things and had much better education and therefore I should be able to teach them all kinds of stuff and really help them, you know. And then as I started learning, and my clerk made sure that I learned fast, I realized that I [emphasis added] had a lot to learn, not them (Sue).

The concept of cultural competency was generally described in terms of being sensitive to and respectful of cultural differences. There was broad recognition, as discussed earlier, of the dynamic aspects of culture, as well as of the subtle differences that exist between communities and regions. Recognizing the influence of culture, whether it was the culture of ethnicity, isolation, or marginalization, guided participants in adapting their practice to particular situations, thereby increasing the effectiveness of interventions:

In a community that's as isolated as this one, groceries are extremely expensive - so there's no point in me going out there and talking about the four food groups because chips and pop are a food group here.... If milk is \$7 for two litres and three apples cost \$4, well, guess what, people are not buying milk and apples. They're going to buy the macaroni and if they get a caribou, well they might have some meat, or some fish in the

summer. You're faced with all these sorts of things so that you have to change your teaching method. You have to change what you would teach, not only how you would teach but what you would teach - so you tackle that in different ways (Cathy).

Cultural competency involved understanding that patients' world view was often distinct from that of participants', and therefore behaviour as well as language required interpretation:

There's something about northern communities that nurses are not always aware of at first. We don't realize that people think that because we're health professionals, we don't really need to be told what their problem is. They feel they can come in and say - my stomach is upset - and the nurse, being a health professional, will completely understand what's wrong with this person without getting a more complete story.... And sometimes it takes a bit of probing to understand that they've just eaten some dried meat that wasn't dried properly or maybe they didn't boil their water and have picked up some giardia or something like that. But you need to know what questions to ask, and in many of the communities, there's people who don't speak English, so you need to work through an interpreter a lot. And some interpreters are really good, but sometimes the interpreters don't translate what it is that you're saying because they know its either going to embarrass the patient or embarrass you if you knew what was going on (laughing) so sometimes the people who were interpreting for you would be very careful how they interpreted - not always tell you everything that was said (Sue).

When cultural competencies were incorporated into a primary health care orientation, participants described using interventions that were not only culturally appropriate, but also appropriate to the particular community, or situation. Skills such as collaboration, negotiation, and facilitation became an integral part of participants' practice, as the following exemplar illustrates:

It was several years ago in a community with an elder who was dying and the family elected to keep her at home and look after her. She was a respected elder, and it was something that the community wanted too. When the patient refused to go out and we recognized the amount of care that was required and that we couldn't take her in as an in-patient - because there were only two of us and it was a busy nursing station - we collaborated with our nursing officer and we came up with this plan of how we could do this. There was a lot of negotiation with the family, and this is what they came up with. We brought in some equipment from the nursing station, a bed, commode, and so forth, so that we could have like a small hospital room yet she was still in her own bedroom. We had to show the family how to do the care, and we would go over two, three times a day and PRN, to administer analgesic and to do a little bit of the care as well just to support the family, and that went on for probably at least a week, quite tiring. We mobilized the family so that they had a schedule of who was with her. They supported each other and so in the end she was able to die in her community with her family around her (Sarah).

Part of the perceptual shift from a primary care orientation to a primary health care orientation involved accepting the long-term nature of community-based work. In contrast to primary care, where interventions are short-term or even immediate, health promotion strategies imply planning over the long-term. The experienced outpost nurses in this study recognized that outpost practice requires the nurse to work from each of these perspectives concurrently:

When you're doing outpost nursing, you're seeing people when they're sick so you're doing acute care. You're also doing preventative health so you're treating the problems... and always in the back of your mind you're thinking, well, this is kind of a band aid, what's the real problem here? So you always have that opportunity to address the root problem. You get your satisfaction from dealing with the acute, you can see results in a few days. You give someone some antibiotics, they're better, whereas with getting to the root of the problem, we might never see what our effects are. They might not show up for years (Marianne).

Other participants described ways in which they adapted their approach to practice to be more consistent with a primary health care approach:

Sometimes you'd just as soon say - damn it, I've only got 12 minutes, I need to fix it, rather than - it's going to take me 25 minutes to help you fix it. But in the long run, that's what these patients have taught me. That they really don't need me to fix it. They only need me to help them fix it. Even if maybe they didn't realize that at the time. And it self-perpetuates, they then become better at problem solving than they were when they first came to me. And it's really difficult for short term nurses to surrender to the fact that these things take time (Chris).

Learning to function in multiple roles and adapting to the ambiguity of role diffusion was part of participants' experience evolving into the outpost role. The discourse of the experienced participants in this study reflected a level of comfort with this ambiguity, which might be interpreted as acceptance of the uncertainty and ambiguity of practice:

Probably 90% of the work that you do is education. Everything revolves around education and then you have this small percentage of actual trauma like emergency care, and it increases the difficulty to the nurse because, of course, if you were doing trauma everyday, then your skills would be fine honed, but you're out here and you have to be the obstetrical nurse and the pediatric nurse and the trauma nurse and you have to do psychiatry and you have to be the pharmacist and then you have to be the social worker and the housing officer and decide who gets wood this week and who gets water and on and on and on. You have to be prepared for everything. I've lived in communities where I've nursed the animals too.... Nobody hesitates to come to the nursing clinic and say, you know, my goat has got milk fever, what do you think I should do? When they hired

me for the job nobody said, oh, by the way, you're going to look after all these goats while you're there.... You just go into a community thinking you're gonna be the nurse but you're way more than the nurse, there's no question about that (Cathy).

This participant identified the difficulty of maintaining skills and competency in areas of practice that in a larger centre would be considered to be specialty practice, such as obstetrical or trauma nursing. An outpost nurse might have the opportunity to practice these skills relatively infrequently, yet be expected to perform them competently when the need arises, a paradox that Gregory (1992) identified as one of the challenges of outpost nursing. He characterized outpost nursing as a dual generalist/specialist practice, while MacLeod et al. (1998) referred to the same concept as a "multispecialist" nursing role. This participant also refers to the concept of role diffusion, or the diffusion of the nursing role caused by the nurse taking on the roles of other health providers (e.g., pharmacist), also identified by Gregory. While these authors associated role diffusion and multiple roles with role ambiguity, and claimed that these were problematic issues for outpost nurses, the more experienced participants who took part in this study appeared to have adapted to the ambiguity, and have accepted it as part of their practice context.

For the purpose of this interpretation, participants' practices have been conceptually divided between primary care and community health skills. However, participants themselves made no such distinction in their discourse; their narratives of practice moved fluidly between primary care and community health, addressing elements of each in a single story, and evidencing a strong integration of each within their concept of practice. These clinical narratives also convey a sense of the symbiotic relationship between the primary care and community health aspects of outpost practice, wherein each reinforces and supports the other. The symbiotic relationship between these two parts of practice is key to understanding participants' ability to function on both multiple client levels and with multiple levels of intervention, which emerged from the data as a highly-evolved form of outpost practice, and a mark of expertise amongst participants. The clinical narratives shared by these "expert" participants described highly

evolved practice, and illustrated how they in effect “exploded” care, by moving fluidly from a focused primary care situation with an individual, to a community focused preventive/health promotive intervention. The two stories that follow exemplify evolved outpost practice, or what participants referred to as “what outpost nursing is all about”:

We had a three year old present to the clinic with an upper respiratory infection ... [with] high fever, poor colour and dehydration. The mother is fairly young and is mentally challenged, but she is responsible for this child. They live with her parents in a very small one room old log house with wood stove heat, no running water. Mother tells us that she only gives him Tylenol once a day and she only gives him his amoxicillin once a day so, of course, the youngster is not improving, in fact, he's much worse than he was even the day before when we saw him - not sick enough to be medevaced but he's going to be a medevac very quickly if we don't get things under control. After speaking to the grandparents and finding that there's only water and caribou in the house and there's nothing else for the child to eat, we have to contact social services. I made arrangements for a medical foster home immediately - which means speaking to the chief and ensuring that he understands that you're not removing children from the community, that, in fact, there's a medical reason for this.... In most of the aboriginal communities, apprehension of any kind is a serious problem and, um, they can get pretty ugly about it.... And so anyhow, we apprehended the child and off he went to a foster parent. Now he comes in daily and we check to make sure that in the foster situation he is getting what he needs.... We still haven't solved the problem but we've got the youngster feeling a little bit better. But now we have the dilemma of sending this youngster back home to a situation that probably has not been good for a while. There has been no food and no integration with other children. He doesn't speak a word of English, has never played with another child. He's basically a prisoner in this house with a mentally challenged mother and two elderly grandparents. And so my job is to identify what we think we can do in the community either to try to keep him at home and see if we can fill in the gaps - or we look then at a foster home for a longer situation. We do have a daycare in our community so he could go there Monday to Friday for eight hours a day and get two hot meals and practice social skills with the other kids at the daycare. We can set up regular visits by myself and the CHR, and social services can also be doing some regular visits when they come to town. And there were a couple of other things that we thought we could try to do. We could get them into better housing, and get the mom into some kind of job training.... So in the long run we're probably going to get a whole bunch done for this family.... It's sort of a picture of what nursing entails in an outpost situation (Cathy).

This exemplar presents the complexity and interwoven nature of evolved high-level outpost nursing practice. Cathy used a primary care encounter with a sick toddler as an entry to broader family health issues. She intervened on multiple client levels using multiple levels of intervention, by providing direct primary care to the toddler as well as community-based care to the family as an entity, thus working to prevent further health problems and promote better

family health in the future. Competencies such as supporting, negotiating, collaborating and facilitating are implied in her interactions with the family and other key players, such as the chief (who represents the community) and other health professionals. Within her discourse, Cathy makes it clear that child apprehension, within the context of outpost communities, is viewed as a community matter, not merely a family matter, and thus her efforts to maintain this toddler in the community may be interpreted as interventions at the community level.

Another participant shared a story that similarly exemplifies how a primary care scenario with an individual was “exploded” to the community level:

We had a patient who became very sick. He needed to be medevaced. It was going to be a great challenge moving him, a real problem, for a variety of reasons ... but the local people pulled together. I told them I had a problem. I asked the family to help me with getting fluids into this man and when I couldn't be there pushing fluids, they pushed fluids. The community got together – by using local equipment and local knowledge and working together, they made this miracle happen. This community pulled together. They were supportive for the nurse, they were supportive for the patient, and they with their ingenuity made things happen. Just because they didn't have all the fancy stuff, they still made it happen and that's what community nursing is about. Taking what you have and your local people, getting them to help you make things happen - and they can if they're given the opportunity. And that's basically what northern nursing is about - getting the community to pull together to be part of the team (Sue).

It is vital to maintain a sense of context in interpreting this exemplar, and to remember the marginalization that typifies many outpost communities. *Getting the community to pull together* may well represent an event with implications for community health issues such as self-reliance and self-esteem, which in turn influence the community's sense of competency.

The evolved level of practice discussed here required a shift in perception, or orientation to health. How this shift in orientation occurred and the subsequent process of evolving practice appeared to be highly dependent on context, and thus was not experienced in the same way by every participant in this study. One of the contextual issues that influenced participants' experience was the way they experienced relationships with the communities they had worked in, which is the third main theme that emerged from the data.

Building and Maintaining Responsive Relationships

Building and maintaining responsive, trusting relationships was the most prevalent theme to emerge in this study. Responsive relationships (Appendix A) are conceptualized as containing the essential elements of trust, respect, and reciprocity. They are guided by an ethic of care (Benner, 1996). Although all participants described trusting relationships with clients at the individual level, those participants who had relatively more outpost experience appeared better able to recognize and describe their relationships at the community level. A few participants who had significant experience in building relationships described how they proactively and deliberately set about the process of gaining trust and building relationships in a community.

While participants described their relationships with clients as being in many respects qualitatively different from one another, trust emerged as the common essential element of therapeutic relationships between participants and clients on all levels, and was notably missing from discourse that concerned poor relationships, or situations characterized by the lack of a relationship. Several factors influenced whether or not a nurse or nurses were trusted in a particular community. These factors included familiarity, length of time in the community, respect, the community's previous experiences with nurses, how the nurse was involved in the community, and the skill with which the nurse built relationships. In some communities, trust appeared to be related to the culture of the nursing station and the historical relationships that had existed between nurses and that community. Speaking of her experience in a community having a high degree of nursing transience and generally poor relationships with the community, one participant noted, *they didn't always believe the nurse when she treated them*, which may be interpreted as a lack of trust in the nurse. In contrast, another participant working in a community that had a history of stable relationships with nurses commented:

The nurses here are seen as very trustworthy... and I think that's because the nurses have earned the trust of these people.... When people needed the nurse, the nurse has been there, the nurse hasn't taken advantage of them. The nurse doesn't ask for anything.

How a participant demonstrated respect for people, their community, and their culture was a key factor in establishing trust: *you have to remember that you're a guest in that community no matter how long you're there.... They can pick out the nurses that like them.* One way of being respectful was to be culturally aware and accepting of people and the community. It was important for participants to recognize and accept that a community's culture might include some parameter of marginalization:

Respect for people, yeah, it's a big one, it's huge. I think a lot of people, certainly aboriginal people but a lot of non-aboriginal people as well, most of the time they expect medical people not to think very much of them... that they're lacking something somehow, and they're easily made to feel that way by medical people. Especially aboriginal people who have been through the whole residential school thing, either at school themselves or suffered at the hands of people who were there, they assume right off the bat that they're inadequate, unworthy. They see normal kindness and respect as something remarkable (Chris).

The discourse of participants in this study is congruent with Browne's (1995) findings regarding respect as a vital aspect of satisfactory clinical interactions between First Nations people and outpost nurses. Participants in this study further identified reciprocity of respect as crucial to building and maintaining relationships. That is, a trusting relationship was predicated on the nurse not only demonstrating respect, but also gaining respect from the community.

Participants frequently described gaining the respect and trust of the community through competent management of primary care events. One participant, after sharing a particularly vivid war story in which she skillfully managed a critical situation, was asked how that event had affected her practice in that community. She responded:

I think that it really paved the way for me.... I'm sure that it made my life easier here. Because I don't get a lot of hassle or called names. I've managed in a very short time to earn the respect of people that count. And once you gain the respect of the people and they can see that you have their best care and interest at heart, they'll go with you. Because they know if they're sick, I'll look after them and they will get the treatment they need (Terry).

Providing competent primary care allows the nurse to first establish trust on an individual and family level. Being seen as a trustworthy nurse then facilitates the nurse's ability to build a trusting relationship on the community level. Conversely, if a nurse fails, or is perceived as having failed to provide competent primary care, trust may be withheld or withdrawn. One participant addressed this possibility in a story she told about an acute care event that resulted in an unsuccessful patient outcome despite her own competent practice:

I was devastated, I really felt badly that this child had to go through this for a learning experience for somebody [referring to an inexperienced physician who had misjudged a clinical situation]. I've learned over the years that the families can come back on the nurses very easily. This family, they were good about it - but you wonder if the family is going to come back on you. Even though I hadn't done anything wrong, it took a couple of weeks for it to get back to normal, really feel normal, you know (Alex).

Even though the family in this scenario accepted that the nurse had acted competently and the blame for a poor outcome lay with the physician, there was still a period of uneasiness or distrust in the nurse.

Participants suggested that individuals and communities trusted nurses who they knew and with whom they had become familiar. While participants perceived that building trust was a process that took place over time, it appeared that this process was influenced by factors in addition to the length of time a nurse had been in a particular community. Participants who worked as relief nurses became familiar to communities to which they returned on a regular basis, despite spending relatively short periods of time there. However, the transient and inconsistent staffing pattern that characterized some nursing stations was perceived as a barrier to building relationships. This is congruent with SmithBattle et al.'s (1997) finding that community health nursing practice is enhanced when nurses and clients are able to work together over time. Participants also viewed transience as a pattern that is becoming more prevalent in the north:

The lack of continuity in the north is really hard on relationships between nurses and people. I really think it's got to change. At one time, everybody knew the nurses and

could trust their nurses, 'cause they were there for a while, but not anymore. There's not much continuity at all now (Alex).

Participants recognized trusting relationships as central to their practice. The following exemplar describes the connection between trust and practice:

I had been in that community for at least a year when we had a whole pile of kids disclose sexual abuse. I think if there had been a nurse in there that the kids didn't know, it would never have come out. It was hard, it was devastating for everybody, but the kids felt that they could trust me enough to come to me and say, listen this man's been doing this to us since we were in kindergarten and its got to stop. These kids have to have somebody they can turn to and trust and I always let the kids know, listen I'm here for you and you can trust me and at any time if you don't want to come to the clinic, you can come knock on my door or we'll go for a walk or whatever.... You've got to gain their trust otherwise they'll just go right inside themselves and I think a lot of the suicides come from that (Alex).

Having a trusting relationship with the teenagers in this community enabled Alex to change a long-standing situation that was affecting health on a community-wide basis. Her last statement reinforces the relationship between primary care and primary health care, that is, by working on a primary health care level to change a situation in the community (i.e., stopping an abuser, getting help for his victims, and maintaining a connection with them when they returned to the community), she is decreasing the likelihood that these teens will attempt suicide and require her primary care services.

Participants who were more experienced in building relationships with communities suggested that getting involved in the community was an important strategy they used to establish contacts and become familiar to the community: *It's extremely important for nurses to participate in the community. Go to church if you're a church goer. If there's a feast happening or a dance, go to the dance, go to whatever is happening.* Getting involved in the community not only helps the to establish a relationship with a community; it also provides the nurse with an "insider perspective" that enhances the nurse's understanding of the community (SmithBattle et al., 1997, p. 82). For example, becoming involved in the community provided an opportunity for participants to discover how some traditional aboriginal communities value children and

childbearing, and to learn about family dynamics. This “insider perspective” guided participants’ interactions and allowed them to maximize relationship-building opportunities: *The other thing they really watched was how you dealt with their children. If you were kind to their children and the children trusted you during an exam, that also built the relationship.*

Several participants referred to a “snowball effect”, or the idea that trust is conferred by association and /or reputation: *it seems like if one person trusts you, they will tell somebody else... and the trust will build like that.* Participants also talked about targeting key players in the community, such as health center staff and band administrators, as a strategy to gain trust by association. One participant referred to the idea of conferred trust: *If the clerk or the community health rep went with the nurse and encouraged people to have their children immunized, they would do it because they felt that they were getting wise advice.*

Participants’ discourse revealed that building a relationship was a gradual process that could not be taken for granted by the nurse. They described situations where they had been “tested” by clients, either deliberately or subconsciously:

It isn't that you walk in and you're instantly trusted - they test you. I had a gentleman in one community who came in with a cough. I asked him a bit about his cough, I took his vital signs, did the ear, nose, throat check, checked for swollen lymph glands and listened to his lungs, percussed his chest, as well as a couple of other things, just to get a good idea of what was going on. Then we talked.... I gave him some options of what we could do for him. He said - finally, a nurse who knows what she's doing (laughing). It was like if I hadn't gone the whole nine yards, done a thorough exam, he would have just said - ok, well, just another nurse. But you could see that it was kind of a testing thing. And there were other times that they tested you as well. They would bring in different problems just to see how you were going to deal with it. They weren't always going to take your advice but they wanted to see how you were going to deal with it (Sue).

It is possible that “testing” represents a means to test the nurse’s acceptance of the culture and the community, as well as testing her expertise as a health care provider.

The following paradigm case portrays how one participant came to understand the concepts related to the process of building relationships:

*It was the fourth year I was in the community that they started to tell me some of their in-depth secrets or family relationships - things that they weren't going to tell just anyone. This community had started telling me about some of the spirits that they believed went from home to home and how they interacted with the spirits or how these spirits affected their family life. Or what some of the spirits did, some of the cultural stories that they had...about one spirit that went out helping the fisherman with their nets sometimes, that kind of story. Stories that they kept to themselves until I'd been around long enough to trust -which took four years in that community. I had been going into their homes on home visits and they were inviting me to visit them more frequently. It was around the third year that you could see this gradual opening up. They were starting to trust that I was their nurse; it really felt like they had adopted me. I was their Najanguaq...Inuktituk for nursing sister.... They called any nurse that came in Najanguaq - but by the time three years was finished, I was **their** [emphasis added] Najanguaq (laughing). There's some things that they share with you up front, but it's almost like an onion, there's different levels that they let you get to and once you've been with them through some of their births and their deaths and you've been there through good and bad times, and you're still there when they turn around, they start trusting you more and more. And I found through the years that as they start to trust you more, you're able to get them to do things that are good for them, that they weren't willing to do at first (Sue).*

In this story, Sue describes building trust in this community as a process that happened over several years. She uses colourful phrases that evoke a process of gradually peeling away layers: *it's almost like an onion*. Consistency, support and acceptance appear to be the foundation of trust, for example, she has supported the community through crisis and not abandoned them, which would be construed as acceptance. The sharing of spiritual stories might be viewed both as an act of demonstrating acceptance of Sue, and as a means of testing her acceptance of them.

A few participants who had significant experience in building relationships described how they proactively and deliberately set about the process of gaining trust and building relationships in a community. This was depicted as a skill that had been learned and refined through experience, and which these participants now used quite consciously. These participants shared a common background, in that each had spent comparatively long periods of time in a community, and had also worked in several different communities. The following exemplar portrays the expertise with which one participant set out to build a relationship once she arrived in a community:

I think that if you're going to make any changes at all - and I think this is true across any community - there has to be a level of trust there and unfortunately or fortunately, in most of these outpost communities, the nurse never stays for very long.... It's like a revolving door at the nursing station. And so it becomes very difficult for the people of the community to trust and that becomes an issue, it very quickly becomes an issue. When I come into a community, I find that it really is important for me to pay attention and to really be listening to the feel of the community. What is their language? What do they do? Do they hunt, do they trap, do they fish...what is it that they do? What are the problems in the community? Is it alcohol, is it drugs, is it STD's, is it lack of parenting skills?... And whatever it is, then try to work from there, because if you come in and you've got this - I'm the saviour attitude - they don't particularly see themselves as needing to be saved. So you want to be careful about that. You want to effect change, yes, that's true but you have to do it in such a way that they are going to comprehend what is it that you're doing and they're going to buy into it. If they don't buy into it, you might as well forget it. And some ways that I find work well for me: It's always important for me to get on really quickly with my staff, to really align myself with the staff at the very beginning. I don't change a lot of things as soon as I walk in the door. And I never have any opinion about the nurse who was here prior to me. I always go to the band office immediately and introduce myself to everybody who's in there that I'm going to need to know. In this community, I went to the RCMP, introduced myself there, went up to the school, went to the daycare. I spent about two days walking around just telling people who I was and how to pronounce my name and where they could find me and that sort of stuff. And now I would say that I have a very good relationship with my staff.... And then the other people in town see that and if Mary, Joe and Veronica think I'm not so bad, well then, ok, well I'm probably not that bad, you know. So that starts to build that trust. And if I say I'm going to follow up, then I follow up. If I say I'm going to do this, then I do that. Those kinds of little things go a long way and then when you're trying to do some teaching or make some change, then that trust has already been established and its like, ok, she does what she says she's going to do and she hasn't made any big changes and, you know, she seems to pay attention (Cathy).

Many of the key skills related to relationship-building are integrated in this exemplar; Cathy deliberately goes about building relationships by learning as much as she can about the community, by aligning herself with key players in the community, by anticipating the snowball effect, and by being trustworthy. Her efforts to establish a trusting relationship with the community are goal-directed: she understands that a trusting relationship will increase the effectiveness of her practice.

Participants clearly understood that a trusting relationship was a necessary prerequisite to the success of nursing interventions at all levels of client contact. From this perspective, it appears that a trusting relationship empowers the nurse by enhancing the effectiveness of her

interventions, whether in regard to increasing compliance with treatment at the primary care level of intervention, or in achieving “buy-in” at the community level. Empowering the nurse to practice more effectively reflects the reciprocal nature of the nurse-client relationship, in that effective nursing interventions planned from a primary health care orientation reciprocally empower clients. Participants viewed empowering individuals as a means of ultimately empowering the community. One participant described how she worked to empower individuals through relationships that were both mutually beneficial and addressed health issues at the “root” level:

When I'm trying to get something going in the community, I'm looking at the people in town – like, who could help me with that? When I set up my healthy snack program here for the prenatal moms, I could have easily gone down there and chopped the cheese and put out the crackers, that was a 10 minute job. But, no, let's see if somebody in town can do that.... So I got two of my young moms to take on that job. And they get paid for it, so it's a little bit of income in their pocket. When I'm called up to the school because they've got bugs in their food program over there, who can go up there and do that cleaning? Who would I give that job to?.... So there's another job up there. When I need a hammer and nails here in the clinic because there's a bunch of stuff to hang up, I have a hammer and nails, I could easily do the job myself (laughing) but I phone up a couple of guys in town – hey, would you like to come over and work for a couple of hours? Because there are no jobs here, so you need to share the wealth a little bit and that - all of that makes you feel like you're part of the community and makes them feel a part of the community too (Cathy).

Other participants described interventions that were empowering at the community level, such as the scenario previously recounted by the participant who claimed, *that's what northern nursing is all about - getting the community to pull together*. Helping communities to empower themselves is a fundamental concept of primary health care philosophy, thus a nurse's ability to build a trusting relationship with the community may be interpreted as a key primary health care competency.

Participants in this study spoke variously of their relationships with communities, indicating that each nurse-community relationship was unique, and that individual nurses engaged differently with communities. Some participants spoke of their relationship with a

community in a highly engaged fashion, while others implied a relatively disengaged relationship, and a few spoke maternalistically about *my community*. The degree of engagement between a nurse and a community appears to be largely dependent on contextual factors in the community, as well the situation of the nurse as an individual, as this paradigm illustrates:

When I first started working up north there was always the argument of well, that's not an important thing to see someone for at this time of the day, and you kept reinforcing that to people who weren't using the clinic at appropriate hours.... I came to learn that just put people on the defensive, people got upset.... So what seemed to be easier was to give people what they wanted and then talk to them later, after they got what they wanted - about when it was appropriate to come to the clinic (Marianne).

Experienced participants gauged situational factors and adapted their practice accordingly, using what SmithBattle et al. (1997) have referred to as “the responsive use of self” (p. 79). These authors viewed the responsive use of self on the part of the nurse as critical to building mutual relationships with clients based on an ethic of care, and recognized that this was a competency that evolved with experience. For the purposes of this interpretation, the concept of responsive use of self has been extrapolated from relationships with individuals and families to include the nurse’s relationships with communities, thus the use of the expression “responsive relationships”.

As discussed previously in relation to participants’ primary care practice, Benner et al. (1996) found care to be the dominant ethic of nursing practice. In a definition of caring that seems particularly relevant to outpost nursing practice with communities, care is conceptualized as encompassing responsibility and responsiveness to the other. Benner et al. described caring in terms of promoting growth and health, alleviating vulnerability and realizing human potential in individuals, families, communities, and interestingly, traditions. Moreover, “an ethic of care must be learned experientially because it is dependent on recognition of salient ethical comportment in specific situations located in specific communities, practices, and habits” (p. 233). The nurse’s ethical, caring responsiveness to the community directs her to engage

appropriately with the community and is the basis of a mutually responsive relationship (SmithBattle et al., 1997). This fluid, dynamic relationship may be characterized in analogical terms as a dance between nurse and community.

The reciprocal nature of the nurse-client relationship that empowers the nurse by allowing her to practice more effectively also confers upon her a certain amount of de facto power. Learning how to work appropriately with this power appeared to be a skill that the experienced outpost nurses who participated in this study learned, directed by an ethic of care and their responsive use of self. SmithBattle et al. (1997) found that the responsive use of self allowed the nurse to gain an insider perspective that fostered collaborative relationships and acted as “a safeguard to imposing the nurse’s goals, standards, or values on the situation” (p. 79). Participants in this study recognized the ethic of care that guided relationships with both individuals and communities, thereby shaping how they perceived and enacted their practice on multiple client levels:

I refuse to own power that people give me. Or want to give me or expect of me - rather than saying, okay you’ve got to do this and this and this, I find out from them what they think they can do and support their choices, and then just fill in what they don’t know. So part of what out post nursing is, to me anyway, is to dump your own ego about how you fix things... how you go in with a lot of knowledge, a lot of skill and the idea that you can fix things. People don’t need you to fix things, they really don’t. All they need you to do is to help them fix it. And my philosophy is - you own the problem, you just don’t know that you own the solutions, and we’re here to help you figure out your solution (Chris).

Sometimes what the community sees as their need and their goals aren’t the same as mine. And I have to accept that because that’s what they want now - and that can always change.... I can use my gentle persuasion to show them some differences but in the end I have to respect what they see as their goal, their needs. (Sarah).

Being appropriately engaged with the community and learning to balance power ethically are closely related to the fourth and final theme that will be examined in this interpretation.

Autonomy and Responsibility in Practice

The experienced outpost nurses in this study became comfortable with the autonomy and responsibility of outpost practice. Paradoxically, while the autonomous nature of outpost

practice appears to draw nurses to the role initially, recognizing and accepting the degree of responsibility inherent to autonomous practice in the outpost setting seemed to be part of the nurses' evolution into the expert outpost role. For example, one participant who was comparatively new to outpost practice shared the following paradigm:

I like to be autonomous...but the first night I was ever on call in my first outpost, I was called to a stabbing. I thought the first responders were like any old ambulance drivers that you and I have worked with - only to find out that they hardly knew how to get the stretcher in and out of the ambulance. They had no idea how to load anybody without direction. It was dark and the police wouldn't help because they were scared to death of getting hepatitis B if they touched anything. I couldn't start an intravenous because I couldn't see anything and everybody is standing around watching me.... So, you know, I've had to rethink that. Now I understand that I have to teach people the basics... like how to bag somebody. But that was so hard for me to understand when I first went there (Joanne).

This participant learned experientially the extent and reality of her responsibility in practice. In the outpost setting, autonomy implies working in isolation and with few supports (MacLeod, 1999). In the absence of other health practitioners, the nurses took on not only diverse roles, but also the responsibility attached to those roles. Autonomous practice implies taking ultimate responsibility and accountability for one's practice. Experienced participants in this study accepted and had attained a level of comfort with the realization that they were ultimately responsible for their practice:

The patient arrested. What are you going to do? You start CPR and you're bagging and you'd like to get to the meds but do you get the meds and stop the CPR or what are you going to do? So you just keep on going.... I knew the medevac team was coming, so we did work as a team once they got here.... We continued to work for another 30 minutes before the code was called off. That kind of situation puts you in a position where you're second guessing yourself - what else could I have done? What if I had done this?... and that sort of thing. When you work in the north for a long time or you nurse period, for a long time, you're very comfortable with your skills and your knowledge and what you think you could have done. But sometimes for nurses who've not been here for a long time, those kind of situations can make them leave nursing for a period of time and it's only because you second guess yourself. So much relies on your shoulders, and when something like that happens - the code is finally called, we've done all we can do - it really brings home just how much knowledge you have to have and how confident you have to be and how focused you have to be.... And that sense of isolation really hits you in those kinds of situations (Cathy).

This story illustrates how the outpost nurse takes responsibility for decisions she makes within a practice milieu of ambiguity and uncertainty. This participant describes accountability for practice decisions as being something that experienced outpost nurses have learned to accept. They will be less likely than inexperienced outpost nurses to second-guess themselves, or to question or doubt their decisions and actions. Learning how to practice within the context of being ultimately responsible is part of developing confidence in one's practice and evolving into the role. It may, perhaps, be regarded as a competency in and of itself.

Developing a degree of comfort with responsibility is contingent upon a nurse's confidence in her own competency, or expertise, in the outpost role. Once again, the clinical narratives of participants in this study illustrate the fundamental importance of primary care competencies by implicating these as the source of participants' confidence. These clinical narratives also convey the idea that along with learning how to enact responsibility, participants needed to learn practice boundaries, or where to set limits in a practice that is characterized by vague boundaries (Gregory, 1992; Hodgson, 1989). Some participants referred indirectly to what might be considered to be a maxim of northern nursing: "If you don't know what you've got, send it out". The concept underlying this maxim may help nurses to identify practice boundaries while ensuring boundaries remain relatively flexible, depending upon the skill level and competency of the nurse. Alex uses a paradigm case from her practice to express the balance and interplay between responsibility and autonomy, and to illustrate the primary care competency upon which nurses base confident clinical decision-making:

I think the hardest thing for a northern nurse to really, really learn is when they're going to get in over their heads and when they should get somebody out of the community into more specialized hands. One time I had a kid ... I couldn't put my finger on anything but I knew, I just knew there was something wrong... So I put him on the sched and sent him down. I had asked the doc to please do a lumbar puncture on him because I was querying early meningitis on the child. The child was sent back two days later on the sched with the diagnosis of an otitis, on amoxicillin.... He was kept home over the weekend because - if the Inuit mothers are told, this is what's wrong with your child, they believe it. The child was brought back to me on Monday morning with a fontanel so high

I could hardly touch it, almost comatose and seizing.... The same doctor said, no, no, this child does not have meningitis - but we sent him out again anyway.... He stroked on the plane and just about died. He had a lot of deficits after. It was pretty devastating and I often wonder how that little guy ever made out. But those are things that stick in your head, and you learned, you really learned to get assertive, to the point of almost aggressive sometimes - to get people out of the community. Because you're the one who's looking at them, not the doctor. I found a lot of the more inexperienced nurses go by what the doctor said instead of trusting their own instincts ...and I think that's what northern nursing is all about, common sense and good instinct. No matter how much experience you've got, if you're in doubt, get them out of the community completely, you can't think about money or anything else (Alex).

The foregoing maxim of northern nursing implies an expectation that outpost nurses have competent primary care skills, and that they are able to differentiate between problems they can appropriately treat in the community and problems that are more appropriately referred to a physician. Even more importantly, nurses must differentiate between non-problems and the kind of discreet problems that might go unrecognized by inexperienced providers, such as the early meningitis that Alex diagnosed.

The above paradigm reflects the autonomous nature of practice and the confidence that the participant had in her own primary care skills, and upon which she based her recognition of her practice boundary and her clinical decision to refer the patient out of the community. There is also evidence of the participant's assertive advocacy on behalf of the patient, which she identifies as an important aspect of enacting responsibility in practice.

The act of taking responsibility implies that the nurse has either the power or the authority to do so. I speculate that the trust that the community places in the nurse empowers her to practice more autonomously, and to make decisions that may fall outside or go beyond the actual authority she holds from her employer. The nurse may then enact this autonomous decision-making power in making clinical decisions in primary care situations. That is, the nurse may feel that her ultimate responsibility is not to the employing organization but to the community she works in. For example, participants spoke about circumventing the "rules" in order to effect optimal care of a patient. In order to circumvent the rules, the nurse must "know

the ropes”, or be familiar enough with the system to work it to the patients’ advantage, as this story illustrates:

Our sched is in at 3:30 and now its quarter after and I’m just looking at this guy thinking, we need to get him out of here. So I said to the new nurse, we can get him on the sched if you’ll play dumb with me and she said - what do you mean? I said, we’re not allowed to send anyone on the sched who’s serious (laughter). Okay, she said, I got you, do whatever it takes (Terry).

Working the system to the patient advantage may be understood as a skill that outpost nurses use to advocate on behalf of their patients. Other participants also described how they worked the system to ensure their clients received care. For example, one participant told about ordering twice as many glucometer strips as a particular patient required (and received funding for under a federal program), and using the excess to supply other patients who needed that strip but who couldn’t afford to purchase it.

The following exemplar illustrates the complex interrelationships between authority, power, responsibility, and the reciprocity of relationships. In this story, Alex made the decision to leave a community without a nurse while she accompanied the medevac nurse on a flight with a critically sick child. To understand the significance of this decision within context, it is important to understand that in many communities, leaving the community without a nurse for even a few hours is proscribed. Yet, Alex made this decision and the community supported her in it. The community trusted Alex’s judgment, and their trust empowered her to carry out her decision. There is also evidence of trust in the relationship between Alex and her zone nursing officer, who didn’t question her decision to leave the community:

I just said to Zone, that’s it, this community is going to be without a nurse for four hours because I’m going on this plane. There was no resistance to me leaving the community. I had an excellent nursing officer - she said, if you feel this kid needs you to escort him, go.... So we just did what we had to do. The community was really good, they practically threw me on the plane, they were more worried about him.... The community stood right behind me and said, go, we’ll manage (Alex).

While Alex did not in fact have the authority to decide that she could leave the community without a nurse, she had the power to do so by virtue of her relationships with both the community and her supervisor, and the trust they placed in her. In making this decision, Alex is taking ultimate responsibility for both the well-being of the patient, and the larger community.

Summary of the Findings

The nine experienced outpost nurses who participated in this interpretive study shared clinical narratives that revealed both embedded and articulated practical knowledge as well as the clinical wisdom that guided participants' practice. The unique context of outpost practice was discussed in relation to the five sources of commonalities and differences identified by Benner (1994), in an effort to understand variations in participants' stories, and to communicate a contextual understanding to the reader. Interpretation of four common themes that emerged from participants' discourse provided insight into how experienced participants perceive and enact their role. Role perception and enactment appear to be influenced by contextual factors that are based largely in participants' historic and current experience. The findings of this study reinforce the complex and diverse nature of outpost practice, its ambiguities and paradoxes, and the conjecture that it is an anomalous community health role grounded in primary care competency.

CHAPTER V: DISCUSSION OF THE FINDINGS

The findings of this study support the claim that outpost nursing is a unique nursing role that is carried out within specific and unique contexts, and that efforts to better understand outpost nursing practice must also incorporate an appreciation of these contexts. These findings also suggest that outpost nursing is a complex and multi-faceted nursing role that may be perceived and enacted through a range of levels by individual nurses. How a nurse perceives and enacts her role is influenced by diverse contextual factors, including the nature and length of her experience, specific work and life experiences, the structure of her work environment, and formal and informal educational preparation. The four major themes that emerged from participants' practice narratives revealed important insights into the ways that participants in this study perceive and enact their role, and into the practical knowledge and clinical wisdom they have gained through experience.

In this chapter, the significance and implications of these findings will be discussed in regard to nursing practice, education and research. A preliminary framework of the domains and competencies of outpost nursing practice will be presented, based on frameworks developed by researchers in comparable practice areas. The significance and implications of the research methodology will also be discussed in relation to the findings of this study.

Reflections on Methodology

Benner's model of interpretative phenomenology proved to be an effective means of studying the phenomena under investigation in this study. This method facilitated a contextual understanding of the phenomena by allowing the data to be interpreted through the "perceptual lens" (Benner, 1994, p. 103) of a researcher who is an experienced outpost nurse. As that researcher, I believe that both data collection and interpretation were enhanced by my own embodied knowledge of outpost nursing practice. Benner and Wrubel (1989) claimed that embodied intelligence enables people to "live in the world and recognize it as their world, a

world of meaning” (p. 44). From this perspective, I was able to recognize the world of participants and ascribe meaning to data that may have appeared meaningless to another researcher unfamiliar with the world of outpost nursing. Without this perspective, the study may have been limited. For example, Diekemper et al. (1999) identified the lack of researcher familiarity with the practice area under investigation as a limiting factor in their interpretive phenomenological study of community health nursing practice.

As a practitioner as well as a researcher, I was granted insider status when participants recognized and were reassured by my understanding of the contextual issues and my ability to “speak their language”. Consequently, they shared their stories with me openly. My interpretation was enriched because I was able to “hear” sometimes subtle nuances in the data and to accurately interpret the data within a contextual understanding. Knowing the context of practice prompted me to listen for data that seemed at times to be missing from participants’ stories, and to seek explanations of inconsistencies both from within the data and from the literature. My knowledge of practice allowed me to read between the lines, so to speak, guided by an ethos “to be true to the text” (Benner, 1994, p. 101). Knowing practice allowed me to distinguish paradigm and exemplary cases in the data with a degree of certainty, guided in part by my own embodied recognition of stories that “rang true”.

As Benner (1994) warned, I was continually challenged to reflect critically on my own assumptions and the influence my clinical background exerted on data interpretation. For example, I readily understood the taken-for-granted manner in which participants spoke of their primary care skills because it was congruent with my own assumptions about outpost nursing practice. It was only during the final stages of data analysis and through reflection upon the assumptions I had explicated at the start of this study, that I experienced the shift in understanding described by Benner and was able to recognize that even though participants spoke casually of their primary care skills, these skills were in fact the most fundamental part of

their practice. Through a process of engaged reasoning and by challenging myself to understand the data from multiple perspectives (Benner), my own views were reshaped, refined and clarified. This process was documented by the voluminous writings that preceded the final interpretation, comprised of initial analyses, writings in a reflective journal, and correspondence with colleagues and mentors.

Logistical considerations, notably time and financial constraints, precluded my carrying out data collection as extensively as I had originally planned. For example, five interviews were conducted over the telephone rather than in-person. In retrospect, I do not believe that conducting interviews by telephone affected the quality of the data generated in these interviews. If anything, perhaps because they were less distracted by the need to interact visually with the interviewer, participants interviewed by telephone tended to remain more focused on their stories. Participants who were interviewed by telephone were also in their communities at the time the interview took place, which may have influenced their level of engagement with their practice at the time of the interview, and which possibly made it easier for them to recall stories of their practice. Since it was the audible narrative of participants that comprised the data, the inability to directly observe those participants interviewed by telephone was not a significant factor affecting data collection.

Follow-up interviews were not carried out as extensively as originally planned, largely due to time constraints. However, the follow-up interviews that were conducted with selected participants proved a valuable strategy for validating the findings and their interpretation. The four participants who reviewed a summary of key study findings and interpretation and participated in a second interview were enthusiastic and unanimous in acknowledging that study findings truthfully reflected their own practice.

The relatively small number of interviews conducted for this study was to some extent a limiting factor, from the perspective that a larger text may have yielded greater redundancy

(Benner, 1994), particularly in regard to participants' description of the more specific skills or competencies. For example, although two participants unequivocally described how they employed specific skills to deliberately establish relationships, further interviews with other experienced participants may have elicited more data in relation to participants' use of these skills, as well as an opportunity to clarify and validate my interpretation of this finding. However, the fact that not all participants described these particular skills does not negate or devalue their use by some participants (Leonard, 1994). What is important, as well as consistent with a phenomenological approach, is that this knowledge enables insight and fresh perspectives on practice.

Of greater concern is the possibility that the small number of interviews that make up the text of this study may have been insufficient to elicit the full repertoire of competencies necessary to outpost nursing practice. Similarly, the lack of participant observation as a supplementary method of data collection represents a limitation of this study. Brykczynski (1989) asserts "participant observation is considered essential for this methodology because clinicians may not describe many aspects of their skill and knowledge that they take for granted or consider routine" (p. 80). These limitations suggest that this study most appropriately represents a preliminary study of outpost nursing practice that provides insights into certain aspects of practice, rather than an exhaustive cataloguing of specific practice competencies.

Significance of this Study

The dearth of research in relation to outpost nursing practice lends significance to this study, which may be regarded as a starting point for further research in this area of practice. By providing insight into the practice of nurses experienced in the outpost nursing role, this study suggests a preliminary understanding of the concepts that support expert outpost nursing practice and the ways in which nurses learn to integrate these concepts into their practice. An enhanced

understanding of outpost nursing practice may contribute to better health care in outpost communities, and ultimately, improvements in the health status of northern residents.

The practical knowledge and clinical wisdom revealed in the narratives of the experienced outpost nurses who participated in this study supports the contention that outpost practice that is perceived and enacted at an expert level shares domains and competencies of practice with both nurse practitioner and community health nursing practice, as described by other researchers. For example, the primary care / treatment competencies that emerged from the narratives of participants in this study corresponded with the NP practice domain *Management of Patient Health / Illness in Ambulatory Care Settings*, identified by Brykczynski (1989). Moreover, expert outpost nursing practice embraces characteristics and competencies identified with advanced practice nursing roles, such as the core competencies identified by Hamric (1996) and key characteristics described by Brown (1996), and which are discussed in greater detail later in this chapter. This study contributes to the growing evidence-base of nursing knowledge of advanced practice and nurse practitioner practice, currently an area of keen interest and controversy across Canada.

Implications for Nursing Practice

The trend in recent years towards identifying and articulating nursing practice is based on the assumption that by making “invisible” practice more “visible”, nurses can demonstrate and promote the value of their practice to administrators, politicians, and the public. More importantly, articulating nurses’ practice and reflecting it back to them may help nurses themselves to better understand how they practice, and how they may improve practice. Building and maintaining responsive relationships was one theme that emerged from this study that may have implications for improving practice.

The Magnifying Effects of Responsive Relationships

The findings of this study suggest that responsive nurse-client relationships are key to the practice of outpost nursing. Participants associated responsive relationships with *getting people to do things that are good for them, that they weren't willing to do at first*. Participants described scenarios wherein trust in the nurse was the critical element in predicting compliance with treatment, and thus with effective treatment outcomes. They also described how preventive health strategies, such as infant immunizations, were more successful when a relationship existed between the nurse and client/community.

The effectiveness of both treatment and prevention in outpost practice remains largely invisible, chiefly due to the lack of sensitive outcome measurement tools. However, I speculate that responsive relationships (see Figure 1) magnify, or intensify the effectiveness of nursing practice, by acting as the conduit through which primary and preventive care competencies (visible practice) are actualized into effective treatments and health promotion strategies (invisible or less visible practice).

Similarly, participants described how responsive relationships with individuals, established through primary care contact, are magnified into responsive relationships at the community level, a practice phenomenon that has also been described by other researchers (e.g., Diekemper et al., 1999). While building responsive relationships with individuals and families was part of the primary care competency described by participants, some participants also described how they deliberately set about establishing responsive relationships at the community level. These participants spoke about this as though it were a competency in itself, and explicated specific skills they used when they went about the process of building a responsive relationship. Specific skills participants described included getting to know key players in the community, using the snowball effect, and recognizing situations in which they were being "tested". Participants who were able to describe these skills and who recognized the value of

FIGURE 1: Magnifying Effects of Responsive Relationships

Magnifying Effects of Responsive Relationships

Visible Practice:

Primary Care &
Preventive
Competencies



Responsive Relationships

*Invisible /
Less Visible
Practice:*

Treatment
Effectiveness

Health
Promotion

Building
Responsive
Communities

their responsive relationship with the community also evinced a broad view of practice and recognized the potentiality of their role from a primary health care perspective, that is, they shared their understanding of how they worked to influence health on all levels.

To date, practitioners, employers and clients have tended to focus on the primary care competencies of the outpost nursing role. Articulating and defining relationship-building as a competency of outpost nursing practice may help to make this skill more visible to both outpost nurses and their employers. Recognizing relationship-building as a practice competency may direct nurses to develop and refine their skills in this area of practice, thus enabling them to build and use relationships in a mindful manner and to the benefit of their practice. Recognition of responsive relationships as key to practice in the primary health care role may direct employers to institute work structures that better support and value nurses' skills in relationship-building (Vukic, 1997). Moreover, increasing the visibility of responsive relationship-building as a competency may in turn increase the visibility of nurses' work in health promotion, particularly at the community level.

Domains and Competencies of Practice

While the findings of this small study are not comprehensive enough to support an exhaustive framework of practice domains and competencies unique to outpost nursing practice, they may be compared to existing frameworks of comparable practice areas developed by other researchers. Particularly relevant is the conceptual framework of domains and competencies of nurse practitioner practice developed by Brykczynski (1989), which was adapted from Benner's (1984) original work with acute care nurses. These frameworks will be discussed in relation to the main themes that emerged from this study and the competencies and skills described by participants. Using frameworks to conceptualize nursing practice helps to articulate and increase the visibility of practice. Table 1, while recognizing the limitations of this study, represents a

TABLE 1. Domains and Competencies of Outpost Nursing Practice^a**Domain 1. Management of Patient Health/Illness in Ambulatory Care Settings^b**

- ◇ Assessing, monitoring, coordinating and managing the health status of patients over time: Being a primary care provider
- ◇ Detecting *and/or diagnosing* acute and chronic diseases while attending to the experience of illness
- ◇ Providing anticipatory guidance for expected changes, potential changes, and situational changes
- ◇ Building and maintaining *responsive relationships with individuals and families*
- ◇ Scheduling follow-up visits to closely monitor patients in uncertain situations
- ◇ Selecting, recommending *and implementing* appropriate diagnostic and therapeutic interventions and regimens with attention to safety, cost, invasiveness, simplicity, acceptability, and efficacy
- ◇ *Working in a multispecialist role that encompasses both diverse nursing roles and roles normally belonging to other health care providers (e.g., lab tech, x-ray tech): Being a sole provider*

Domain 2. Effective Management of Rapidly Changing Situations

- ◇ Skilled performance in extreme life-threatening emergencies: Rapid grasp of a problem
- ◇ Contingency management: Rapid matching of demands and resources in emergency situations
- ◇ Identifying and managing a patient crisis until *care can be safely transferred to another qualified health provider (e.g., physician or medevac nurse/paramedic)*

Domain 3. Affirming Context: Integration of Work/Life/Context

- ◇ *Being comfortable with the ambiguity of outpost practice: Role diffusion and role diversity*
- ◇ *Being comfortable with working and living in isolation and within a distinctly different culture: Adapting to Being Other*
- ◇ *Managing work/lifestyle boundary issues*
- ◇ *Working through interpreters*

Domain 4. Caring for the Community

- ◇ *Building and maintaining responsive relationships with communities:*
 - *Aligning with key players*
 - *Using the snowball effect*
 - *Being tested*
 - *Participating in the community*
- ◇ *Working over the long-term / Working concurrently in two paradigms (i.e., short-term acute care and long-term health promotion)*
- ◇ *Partnering with the community:*
 - *Collaborating, facilitating, negotiating*
 - *Facilitating community action: Getting the community to pull together*

Adapted from Domains and Competencies of Nurse Practitioner Practice (Brykczynski, 1989)

^a Domains and competencies of practice are adapted from Benner (1984) unless otherwise noted

^b Indicates domains and competencies of nurse practitioner practice identified by Brykczynski (1989)

^c Competency identified by Fenton (1985)

Italicized text indicates domains and competencies of outpost nursing practice identified in this study

Continued on following page

TABLE 1. *continued***Domain 5. Monitoring and Ensuring the Quality of Health Care Practices**

- ◇ Providing a back-up system to ensure safe medical and nursing care
 - Self-monitoring and seeking consultation as necessary^b
 - Giving constructive feedback to physicians and other care providers to ensure safe and appropriate practices^b
 - Developing fail-safe strategies when concerns arise over physician consultation^b
- ◇ Using physician consultation effectively^b
 - Getting appropriately and timely responses from physicians
 - Assessing what can be safely omitted from or added to medical orders

Domain 6: Organizational and Work-Role Competencies

- ◇ *Being an autonomous practitioner / Being ultimately responsible*
- ◇ Coordinating, ordering, and meeting multiple patient needs and requests; setting priorities
- ◇ Building and maintaining *responsive relationships amongst health center staff*
- ◇ Coping with staff shortages and high turnover:
 - Contingency planning
 - Anticipating and preventing periods of extreme work overload
 - Using and maintaining team spirit; gaining social support from *co-workers*
 - Maintaining a flexible stance towards patients, technology and bureaucracy
- ◇ Making the bureaucracy respond to patient/ family^c / *community needs: Working the system, Knowing the ropes*
- ◇ Obtaining specialist care for patients while remaining the primary care provider^b

Domain 7: Helping Role of the Nurse

- ◇ Healing relationship: Creating a climate for and establishing a commitment to healing
- ◇ Providing comfort measures and preserving personhood in the face of extreme breakdown
- ◇ Presencing: Being with a patient
- ◇ Maximizing the patient's participation and control in his or her own health/illness care^b
- ◇ Interpreting kinds of pain and selecting appropriate strategies for pain management and pain control
- ◇ Providing comfort and communication through touch
- ◇ Providing emotional and informational support to patient's families
- ◇ Guiding a patient through emotional and developmental change
 - Providing new options, closing off old ones
 - Channelling, teaching, mediating
 - Acting as a psychological and cultural mediator
 - Using goals therapeutically
 - Working to build and maintain a therapeutic community

Domain 8: Teaching-Coaching Function of the Nurse

- ◇ Timing: Capturing a *client's* readiness to learn
- ◇ Motivating *clients* to change^b
- ◇ Assisting patients to integrate the implications of their illness and recovery into their lifestyle
- ◇ Assisting patients to alter their lifestyle to meet changing health care needs and capacities: Teaching for self-care^b
- ◇ Eliciting an understanding of the patient's interpretation of his or her illness: *Finding out what the patient really wants*
 - Negotiating agreement about how to proceed when priorities of patient and provider conflict^b
- ◇ Providing an interpretation of the patient's condition and giving a rationale for procedures
- ◇ Coaching function: Making culturally avoided and uncharted health and illness experiences approachable and understandable^b

preliminary conceptual framework of outpost nursing practice, based on adaptations of the models developed by Brykczynski and Benner.

The primary care/treatment competencies of outpost nursing practice are comparable to the first domain of NP practice identified by Brykczynski (1989): *Management of Patient Health/Illness in Ambulatory Care Settings*. This domain represented two of Benner's (1984) original domains (*The Diagnostic and Patient Monitoring Function* and *Administering and Monitoring Therapeutic Interventions and Regimens*), which Brykczynski consolidated to better reflect NP practice. This domain is described by competencies such as assessment, diagnosis, prescribing, recommending interventions, and managing and monitoring care over time. Brykczynski also identified in this domain a competency related to relationship-building, which she named "Building and maintaining a supportive and caring attitude towards patients" (p. 90). This statement does not precisely reflect the more comprehensive, reciprocal, trusting nature of the responsive relationship that outpost nurses described; therefore, "Building and maintaining responsive relationships with individuals and families" better characterizes this competency from the perspective of primary care outpost nursing practice.

An important part of the primary care competencies of outpost nurses that is not reflected in Brykczynski's (1989) first domain is competency in emergency situations. The nurse practitioners that participated in Brykczynski's study were not working in settings where emergency care was an expectation of their practice; therefore, Brykczynski was unable to gather sufficient data to develop NP competencies in this area. She did, nevertheless, retain a domain identified by Benner (1984): *Effective Management of Rapidly Changing Situations*. This domain explicates emergency-oriented competencies comparable to those described by the outpost nurses who participated in this study (see Table 1).

The primary care skills described by outpost nurses include additional competencies that are not addressed by either Benner (1984) or Brykczynski (1989). These competencies are

arguably not nursing competencies per se, but rather competencies more commonly associated with the practice of other health providers, whose roles are taken on by outpost nurses. Because these competencies become part of the practice of outpost nurses, I suggest they may be appropriately included in Brykczynski's first domain (*Management of Patient Health/Illness in Ambulatory Care Settings*). These competencies include skills such as taking x-rays, and performing laboratory tests and electrocardiograms.

The second theme that was identified in this study was that outpost nurses evolve into the role by developing community health competencies and adapting to work within the unique context of outpost nursing. Neither of these areas of competency is readily comparable to the domains and competencies identified in the frameworks of Brykczynski (1989) or Benner (1984). However, Diekemper et al. (1999) and SmithBattle et al. (1997) used Benner's model of interpretive phenomenology to study community health nursing practice. Although they did not develop a framework of domains and competencies of community health practice, their findings support some of the findings of this study with respect to the community health competencies described by participants. For example, they found that the community health nurses who participated in their studies worked on multiple client levels, and used relationships established through individual and family level contact to build responsive relationships at the community level. I have identified *Caring for the Community* as a preliminary practice domain inclusive of those competencies participants described in relation to their community health practice (see Table 1). This domain includes tasks such as communicable disease control, building and maintaining responsive relationships with communities, cultural competency, and facilitating community action), which I have characterized as "Partnering with Communities", and which are consistent with community development (Lindsey et al., 1999).

Participants also described competencies related to living and working within the specific context of outpost nursing. These competencies included feeling comfortable with the ambiguity

of outpost practice and role diffusion, accepting the autonomy and responsibility of practice, balancing power and responsibility, living and working in isolation, managing work/lifestyle boundary issues, and cultural competency from the perspective of being Other in the community, that is, from the perspective of living within an aboriginal, northern, and possibly marginalized culture. The findings of this study suggest that this set of competencies, although as yet only vaguely understood, is critical to the practice of outpost nursing and thereby represents an area of practice that invites further research. I have chosen to articulate these competencies as a domain of practice: *Affirming Context: Integration of Work/ Life/ Context* (see Table 1), to support the assertion that they are bona fide skills that support nurses' practice in outpost communities.

Four of Benner's (1984) original domains of practice (*Monitoring and Ensuring the Quality of Health Care Practices, Organizational and Work-Role Competencies, Helping Role of the Nurse* and *Teaching-Coaching Function of the Nurse*) may be considered to be generic to nursing practice generally and were retained by Brykczynski (1989) in her framework of NP practice. Many of the competencies referred to or implied by participants in this study are consistent with competencies described in these four domains (see Table 1). One of these domains: *Helping Role of the Nurse*, contains some elements of a responsive relationship but does not fully reflect the responsive relationships described by participants. This domain appears to be more relevant to nursing practice with individuals in acute or chronic care settings. While participants did imply their use of certain of these competencies, there is insufficient data in this study to confirm or disconfirm whether the *Helping Role of the Nurse*, as described by Benner and Brykczynski, represents an important practice domain of outpost nurses, or whether the competencies described by participants are more appropriately conceptualized as part of a different practice domain. However, it has been retained in Table 1 in the expectation that future studies may clarify this question.

By examining the domains and competencies of outpost nursing practice using Brykczynski's (1989) conceptual framework of NP practice as a basis for comparison, it is evident that outpost nurses share many practice competencies with NPs. This knowledge has reciprocal implications for both practice areas, and raises questions in regard to role preparation, regulation, and credentialing of nurses practicing in either role.

Expert Outpost Nursing Practice

While recognizing that not all of the practice described by participants in this study represents expert practice, study findings suggest that some participants were expert practitioners. The CNA defines expert practice as being "characterized by the ability to assess and understand complex client responses in a particular practice area; significant depth of knowledge and intervention skills, often acquired informally; and strong intuitive skills in the practice area" (RNABC, 1997, as cited by CNA, 2000a, p. 16). Findings also suggest that these expert outpost nursing practitioners evidenced certain characteristics of practice that have been associated with advanced nursing practice. A brief discussion of these characteristics may prove valuable to understanding both the outpost nursing role and advanced nursing practice.

According to Hamric (1996), the core competencies that define advanced nursing practice are: (a) expert clinical practice; (b) expert guidance and coaching of patients, families, and other care providers; (c) consultation; (d) research skills, including utilization, evaluation, and conduct; (e) clinical and professional leadership; (f) collaboration; (g) change agent skills; and (h) ethical decision-making skills (p. 50-51). Brown (1996) describes characteristics of advanced practice that complement these core competencies: holistic practice, forming partnerships with clients, using expert clinical reasoning, and using diverse approaches to manage care. These competencies and characteristics are similar to the competencies of advanced practice identified by the CNA (2000a), which are described under the headings of clinical competencies, research, leadership, collaboration, and change agent. The CNA also states "these competencies are

demonstrated in roles that require highly autonomous, independent, accountable, and ethical practice in complex, often ambiguous and rapidly changing environments” (p. 6). The clinical narratives shared by expert practitioners who participated in this study and which were presented in Chapter Four described many of these competencies and characteristics. Additional data contained in the interviews with participants but not included with the presentation of findings for this thesis support the contention that in fact, expert outpost nurses’ clinical narratives described all of the advanced practice competencies and characteristics delineated here.

Significantly, those participants in this study who described expert and advanced practice had learned these practice competencies through various combinations of experience and non-graduate level education. This supports the CNA’s (2000a) decision to recognize nurses who have acquired advanced practice competencies through experience and education outside of graduate education, but who demonstrate advanced practice competencies. Notably, the CNA document does state that graduate education is “the preferred educational level” (p. 9) to prepare nurses for advanced practice roles, in contrast to the stance taken by other key stakeholders (i.e., Canadian Association of Advanced Practice Nurses and Canadian Association of University Schools of Nursing) who advocate graduate level education as the only and mandatory preparation for advanced practice. This raises questions and speculation about outpost nursing practice, as well as about the way the nursing profession in Canada is conceptualizing and defining advanced nursing practice in view of the evolution of advanced practice roles in Canada to this point in time. For example, are advanced practice competencies necessary for expert outpost practice? If so, are outpost nurses being adequately prepared for the role? Is it possible to teach inexperienced nurses these competencies? Is graduate level education in fact the preferred or only method of teaching advanced practice competencies? Although the findings of this study raise several unanswered questions, they do support the view that while graduate education may be one way of acquiring advanced practice competencies, nurses may and do

acquire these competencies through combinations of experience and education, and therefore the mechanism by which advanced practice competency is evaluated needs to be competency-based.

Implications of Work/Life Issues

While the focus of this study was outpost nursing practice, several issues emerged from the data that are significant because of their influence on practice. These issues have been previously identified and described by other authors (Chaytor, 1994; Gregory, 1992; Hodgson, 1982; Vukic, 1997), and have been discussed at length in earlier sections of this thesis. Briefly, participants in this study described barriers to practice and unsupportive work environments and administrative structures as issues that significantly influenced their practice. These issues included nurses being inadequately prepared for the challenges of the role, high staff turnover, poorly defined practice boundaries, and a bureaucracy that is often perceived by nurses as being unsupportive. Participants also described many of the challenges they had encountered in learning to live and work within the unique context of outpost practice, such as living as Other, living in isolation from family and one's own culture, and setting and managing boundaries between work and personal life. Experienced participants described competencies they had developed to help them manage the challenges of context, which is reflected in the suggested practice domain *Affirming Context*.

Some participants in this study had lived and worked in a single community for several years and considered themselves members of that community, which might suggest that they had been exceptionally successful in coming to terms with the context of practice. Interestingly, however, these individuals appear to have managed context by minimizing its effect. These nurses had settled in less remote outpost communities where there was easier access in and out of the community, a supportive infrastructure, and a relatively large non-aboriginal population. In other words, they had managed to situate themselves in communities that allowed for a balance between work and personal life that participants were able to live with over the long term.

Despite being somewhat incidental, the findings related to work/life issues supports the work of other researchers who have focused their work more on work/life issues (Chaytor, 1994; Vukic, 1997), and who have suggested strategies and called for further research to find ways to make outpost work compatible with a viable lifestyle, to enable nurses to remain in communities for longer periods of time without “burning out”. Little appears to have changed since these issues first appeared in the literature almost 20 years ago. Although participants in this study described competencies they had developed to manage work/life issues, these participants represent a small number of outpost nurses who have found ways to remain in practice over many years in spite of the challenges. The attrition rate for nurses who begin outpost practice and leave it after only a few months or years is high, which contributes to the excessive turnover of nursing staff described by participants. Although no new strategies specifically directed to improving work/life issues are suggested by the findings of this study, these findings do reiterate the need to address work/life issues, both by implementing strategies identified in previous studies and through further research in the area of practice issues.

Implications for Nursing Education

This study supports the assertion that outpost nursing is a unique role and that nurses evolve into the role through experience. The participants in this study had little or no preparation for the outpost nursing role at the time they started practice, other than their basic nursing education and generalist acute care nursing experience. Although most participants eventually completed a short (i.e., three to six months’ duration) course to better prepare them to act as primary care providers, most had already practiced in outpost settings for a considerable length of time prior to taking a course. Only one participant described taking a course that provided specific community health content. In many cases, participants’ clinical narratives described how unprepared they had been when they began practice, and how they had learned skills “on the job”. Some described learning from informal mentors such as more experienced outpost

nurses, CHRs, and community physicians, while others remarked on the lack of mentors in their early career. Some participants noted that cultural issues in particular should be included as part of outpost nursing preparation. These findings echo those of Chaytor's (1994) evaluative study of the Dalhousie Outpost Nursing Program, where participants (community members as well as practicing outpost nurses) identified a need for nurses to be better prepared in community health skills and knowledge, including having a greater knowledge of cultural issues.

The findings of this study suggest that nurses would be better prepared to practice in the outpost role by completing outpost nursing education prior to taking up the role, or at least early on in their career. Moreover, education for outpost nursing should include preparation in all aspects of practice, not just primary care skills. Education that includes community health knowledge and skills is important, as is content on those work/life and cultural issues that have been shown to be germane to practice in outpost communities, such as aboriginal culture and living and working in remote areas. In her assessment of the Dalhousie program, Chaytor (1994) found that "the most important component [of the program] is the conceptual orientation to practice – the preparation of the graduate for remote practice" (p. 65). This conceptual orientation is perhaps comparable to the shift in orientation to health that participants in this study underwent as they learned outpost practice.

Becoming comfortable with the autonomy and responsibility of outpost practice was another aspect of practice that participants described having learned through experience, and which was predicated on their primary care competency. This is similar to the learning curve that NP students experience, however, NP students are able to develop this part of practice through formal educational preparation:

Students in graduate NP education programs must develop a solid foundation of knowledge in primary care and management skills in order to facilitate more autonomous clinical practice than was required in their previous generalist nursing roles. They must

understand the professional accountability that is assumed when undertaking this advanced practice role..." (Hanna, 1996, p. 347).

Although the participants in this study described evolving into the outpost role and shifting their orientation to health through years of experience, it is feasible and desirable that nurses begin practice with the knowledge, skills and conceptual orientation that practice demands. Comprehensive educational programs to prepare nurses for outpost nursing practice do exist but relatively few nurses have been able to take such programs, as most require sponsorship by an employer and places in such programs historically have tended to be limited in number. This study supports the view that appropriate education should be made more accessible to nurses embarking on a career in outpost nursing, and that nurses be better supported to acquire such education.

Implications for Nursing Research

This study represents a preliminary understanding of outpost nursing practice. The work of outpost nurses has been shown to be complex, involving multiple levels of intervention on multiple client levels, and encompassing knowledge and skills from such distinct areas of practice as acute care and community health. The conceptual framework of the domains and competencies of outpost practice that has been developed through this study is merely a beginning, and should by no means be considered a completed work. By presenting a beginning for conceptualizing practice, this framework suggests a need for further qualitative studies focusing on the domains and competencies that are most relevant or unique to outpost practice, exploring in greater depth, for example, how nurses build and maintain responsive relationships, or how they operationalize an ethic of care to balance power and responsibility. Future qualitative studies might also incorporate the perspectives of other key players, such as community members, who in keeping with the philosophical underpinnings of primary health care deserve a voice in shaping their health care.

Evaluative studies are needed to determine whether and how outpost nursing practice influences health outcomes. Is the practice of outpost nurses effective in improving the health of northern residents? How do nurses achieve desirable health outcomes? Evaluation suggests both qualitative and quantitative research methodologies. This may imply developing tools to measure health outcomes along parameters that are meaningful in outpost communities, for example, not only measuring the rate of cervical cancer screening, but also determining how improved rates were achieved. In this way, evaluative research may also contribute to future development of “best practice” guidelines for outpost practice.

Research in the area of outpost practice has reciprocal relevance for research in the areas of advanced practice and NP practice, as well as for other primary care / primary health care settings. These might include nurse-managed clinics targeting urban aboriginal or other marginalized populations or health care services provided to other culturally diverse groups, such

Summary

This chapter has presented a discussion of the more significant findings of this study and their implications for practice, education and research. A preliminary conceptual framework has also been presented, based on the domains and competencies of outpost practice that emerged from this study and adapted from conceptual frameworks of nursing and NP practice developed by other researchers. Providing a means by which to begin conceptualizing outpost practice will enable outpost nurses to better articulate and thus communicate their practice to others, thereby giving voice to nurses who – although practicing in a well-established and historic role in Canadian nursing – have long been hushed.

*When I was taking my BScNursing, I was asked what I wanted specialize in.
I said I wanted to specialize in being a generalist.
I was told this did not exist.
They were wrong.
That speciality is Outpost Nursing (Sue)*

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Appendix A

Glossary

Advanced Nursing Practice

ANP is an umbrella term. It describes an advanced level of nursing practice that maximizes the use of in-depth nursing knowledge and skill in meeting the health needs of clients (individuals, families, groups, populations, or entire communities). In this way, ANP extends the boundaries of nursing's scope of practice and contributes to nursing knowledge and advancement of the profession (CNA, 2000a, p. 15).

Expanded Practice

Nursing practice that includes the use of competencies required to perform activities that are outside of the current and/or legislated scope of nursing practice, and/or currently in the legislated scope of practice of another profession, usually medicine (CNA, 2000a).

Exemplar

Refers to an example that conveys more than one intent, meaning function or outcome and can easily be compared or translated to other clinical situations whose objective characteristics might be quite different. An *exemplar* might be a paradigm case for a clinician. Kuhn (1970) used the word *exemplar* for scientific experiments that guide subsequent scientific works. The term has a more heuristic import and conveys a more active stance than a specific example or instance (Benner, 1984, pp. 293-294).

Experience

Transactions count as *experience* only when the person actively refines preconceived notions and expectations. This "negative" view of *experience* has positive outcomes. Experience is gained

when theoretical knowledge is refined, challenged, or disconfirmed by actual clinical evidence that enhances or runs counter to the theoretical understanding (Benner, 1984, p. 294).

Expertise

Developed only when the clinician tests and refines theoretical and practical knowledge in actual clinical situations. *Expertise* develops through a process of comparing whole similar and dissimilar clinical situations with one another, so an expert has a deep background understanding of clinical situations based upon many past paradigm cases. *Expertise* is a hybrid of practical and theoretical knowledge (Benner, 1984, p. 294).

Expert practice

Expert practice is characterized by the ability to assess and understand complex client responses in a particular practice area; significant depth of knowledge and intervention skills, often acquired informally; and strong intuitive skills in the practice area (RNABC, 1997, cited in CNA, 2000a, p. 16).

Nurse practitioner

A registered nurse with advanced knowledge and decision-making skills in assessment, diagnosis and health care management. A nurse practitioner's practice is based on in-depth knowledge of nursing gained through advanced education and practice (CNO, 1995, cited in CNA, 2000a, p. 16).

Outpost Community

A community that is isolated by distance, geography, weather, transportation, or by virtue of a small population. *Outpost communities* lack both easy access to larger population centers and

the resources that are taken for granted in larger centers. *Outpost communities* are usually, although not necessarily, located in the northern regions of Canada. The populations of *outpost communities* are often, although not necessarily, predominantly aboriginal.

Outpost Nurse

A nurse whose primary practice area is in outpost communities without full-time physician services. *Outpost nurses* are the first and often only point of contact that residents of outpost communities have with the health care system. *Outpost nurses* work within an expanded scope of practice to provide both primary medical care and primary health care, to individuals of all ages, as well as to families, groups, and the community overall.

Paradigm case

A clinical episode that alters one's way of understanding and perceiving future clinical situations. These cases stand out in the clinician's mind; they are reference points in their current clinical practice. *Paradigm cases* form the bases for predictions and projections. They can easily be communicated if the lesson is simple (describing how an error might occur or be prevented), but if the knowledge is more complex and dependent upon many other *paradigm cases* or personal knowledge, it cannot be translated to another clinician, unless the other clinician has a similar fund of personal knowledge and *paradigm cases*. *Paradigm cases* are exemplars that become a part of the clinician's perceptual lens (Benner, 1984, pp. 296-297).

Primary Health Care

Primary Health Care is essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford. It forms an integral part both of the

country's health system of which it is the nucleus and of the overall social and economic development of the community (WHO, 1978).

Responsive Relationship

Responsive relationships are conceptualized as containing the essential elements of trust, respect, and reciprocity. They are guided by an ethic of care, which Benner et al. (1996) described as the dominant ethic of nursing practice. For the purposes of this interpretation, the concept of responsive use of self (SmithBattle et al., 1997) has been extrapolated from relationships with individuals and families to include the nurse's relationships with communities.

Appendix B

**RESEARCHER SEEKS
EXPERIENCED OUTPOST
NURSES**

An invitation to participate in a study about the role and practice of outpost nurses

My name is Denise Tarlier. I am an outpost nurse, presently working on a MSN degree from the University of British Columbia. For my thesis, I am conducting a study of the role and practice of outpost nurses. I am looking for experienced outpost nurses who are interested in talking with me about their work experiences. Confidentiality is assured.

A better understanding of the outpost nursing role has implications for outpost nursing education and may contribute to our understanding of the nurse practitioner and advanced practice nurse roles. Listening to what outpost nurses have to say may also clarify how our role contributes to the health status of northern residents.

If you have been (1) working as an RN for 5 or more years, (2) have at least 3 years experience working as an outpost nurse, (3) have worked within the last 2 years, (4) have at some time in your career spent at least 8 months in the same community, AND (5) you are interested in learning more about how you can

become involved in this study, please contact Denise @

(604) xxx-xxxx (call collect or lve. message)

or by email: dtarlier@xxxxxxxxxx

Appendix C

Trigger Questions

Certain patients, incidents, or cases often stand out or leave a deeper impression on us than the more routine cases we see on a day to day basis, perhaps because they were especially challenging, or rewarding, or frustrating, or demanding, or because we thought we did a really good job, or maybe that there was something we might have done differently, or better.

Can you tell me about a case or a situation that stands out for you because you felt that you really made a difference to the patient, or a family, or the community?

Can you tell me about a case or a situation that illustrates or epitomizes what your job here is all about, or what it means to you to be an outpost nurse? What the essence of outpost nursing is to you?

Tell me about a case that you remember because it was unusually challenging and how you managed that case.

Some of the frustrations that other outpost nurses have identified in their work involve that revolving door syndrome, where you see the same patients day after day, no matter what you do for them they're back again the next day with something, and patients who are "non-compliant", we give them antibiotics for their kid with a sore ear and the kid gets maybe 2 doses, or the situations when we know there's some kind of abuse going on but can't do anything about it... this often makes up the routine day to day stuff we see in clinics.

Can you tell me about a situation that would help me to understand how you manage to make sense of this type of work?

Appendix D

Consent Form

A

***An Interpretive Study Describing the Clinical Practice and Role of
Outpost Nurses***

Principal Investigator: Joy L. Johnson, PhD, RN
The University of British Columbia (UBC) School of Nursing
(604) 822-7435

Co-Investigator: Denise Tarlier, RN, BSN
MSN student, UBC School of Nursing
(604) xxx-xxxx

Purpose:

The purpose of this research project is to explore the role and practice of outpost nurses, from the perspective of experienced outpost nurses, and to gain insight into the ways that outpost nurses influence health in the communities in which they work.

Study Procedures:

Study participants will be interviewed at least once. Some participants may be asked to participate in a second or third interview. Participants will be asked to reflect upon their experience as an outpost nurse and to share their stories and knowledge with the interviewer.

Each interview will last approximately 60 to 90 minutes. All interviews will be conducted with the co-investigator, Denise Tarlier, RN. All interviews will be tape-recorded, then transcribed by a typist.

The first interview will be conducted in person, at a time and place that is mutually convenient to both the participant and the interviewer. In the event that an in-person interview is not feasible because of the remote location of a participant, the first interview may be conducted by telephone. Second and third interviews may be conducted by telephone or in person.

Participants have the right to refuse to answer questions, to stop the interview at any time, to decline second or third interviews, and to ask that the tape recorder be turned off during an interview.

Some participants may be asked to participate in a group interview with one or more of their outpost nursing colleagues; participation in a paired or group interview is completely at the discretion of the participants. There is an opportunity for one participant to be interviewed by electronic mail; again, this is completely at the discretion of the participant.

A summary of research findings will be available to participants upon request, at the conclusion of the study. Participants may also contact the co-investigator at any time during or following the study to clarify questions or concerns about the study.

Confidentiality:

Any information resulting from this research study will be kept strictly confidential. All documents will be identified only by pseudonyms and will be kept in a locked drawer. Participants will not be identified by name in any reports of the completed study. Transcripts of interviews will be kept for possible use in future studies, with the understanding that additional research projects that use this information will be approved by appropriate University committees.

Remuneration/Compensation:

I understand that there may be no direct benefits to me for participating in this study, but that the knowledge gained in this study may help to improve nursing practice.

Contact:

I understand that this research is being carried out by Denise Tarlier, RN, to meet the requirements of a graduate degree. If I have any questions or desire further information with respect to this study, I may contact Dr. Joy Johnson or one of her associates at (604) 822-7435.

If I have any concerns about my treatment or rights as a research subject I may contact the Director of Research Services at the University of British Columbia, Dr. Richard Spratley at (604) 822-8598.

Consent:

I understand that my participation in this study is entirely voluntary and that I may refuse to participate or withdraw from the study at any time. Withdrawal from the study or refusal to participate will in no way jeopardize my employment or professional standing.

I have received a copy of this consent form for my own records.

I consent to participate in this study.

Subject Signature

Date

Signature of a Witness

Date