Rural Acute Care Nursing in British Columbia and Alberta: 
An Interpretive Description of Professionalism

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Abstract

Delivery of health care services in rural areas of Canada is challenging due to geographic and economic factors, and persistent problems with recruiting and retaining nurses. Registered Nurses in acute care represent the largest cohort of health care workers in rural Canada, and little is known about their professional experiences. The purpose of this study was to understand how rural acute care nurses in British Columbia and Alberta experience professionalism and professional practice. Eight interview transcripts from a national study entitled, *The Nature of Nursing Practice in Rural and Remote Canada* were analyzed using an interpretive description method. Analysis and interpretation revealed that rural nurses experience professionalism in the community and workplace contexts. Being visible and embracing reality emerged as central themes in rural nurses’ experiences of professionalism. Findings from this study contribute a greater understanding of professionalism in rural nursing, and its relationship to job satisfaction, recruitment, and retention.
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Chapter One: Introduction

Contextualizing the Problem

Based on total area, Canada is the second-largest country in the world, encompassing some of the most geographically diverse terrain, climate zones, and population distributions found anywhere on earth. Of the estimated 33.5 million people living in Canada (Statistics Canada, 2008a), approximately 6.3 million (19%) reside in rural areas of the country (Statistics Canada, 2008b, 2008c). Rural Canada comprises approximately 9.5 million square kilometres, or approximately 95% of Canada’s total land mass (Public Health Agency of Canada, 2008).

In a country as geographically large and diverse as Canada, meeting the unique needs of the population in both urban and rural areas can be a daunting task. Rural residents are often faced with challenges associated with the delivery of basic services such as health care, potable water, food and supplies, education, and utilities. For many years, both rural and urban areas have been experiencing the effects of the current national shortage of health care providers. Rural locations are perhaps more affected, owing to the relative unpopularity of rural living and working among health care professionals.

Nurses are the primary group of professionals responsible for providing health care to Canadians living in rural areas of the country. In 2005, there were an estimated 314,900 regulated nurses\(^1\) employed in Canada, 80% of whom were Registered Nurses (RNs) (Statistics Canada, 2006). Of these RNs, an estimated 41,500 (16% of the total Canadian RN workforce) were practicing in rural areas of the country, providing health care to approximately 19% of the nation’s population.

\(^1\) 'Regulated' nurses include: Registered Nurses (RNs), Licensed Practical Nurses (LPNs), and Registered Psychiatric Nurses (RPNs) (Statistics Canada, 2006).
Rural nursing is often characterized by demanding workloads, staff recruitment and retention issues, geographical isolation, high levels of job-related stress, and a lack of educational, professional, and organizational supports (Lee, 1991; Long & Weinert, 1989; MacLeod, 1998; Shellian, 2002; Thompson & Chambers, 1993). Despite these factors, rural nursing is also highly regarded for its rewarding opportunities, in which nurses can utilize advanced nursing knowledge, engage in an expanded scope of practice, and assume greater responsibility and autonomy (Bigbee, 1993; Bushy, 2005). Other recognized benefits include the diversity in practice, continuity of care with the community and with clients, and enhanced professional relationships with other members of the interdisciplinary health care team (Bigbee, 1993; Davis & Droes, 1993).

In recent years, federal and provincial financial cutbacks and restructuring have forced the closure of many rural community health care facilities, which has decreased or even removed access to consistent health care in some rural Canadian communities (Pong et al., 2000). This has resulted in increased pressure on existing rural and regional health care facilities in terms of client volume, staff workload, and other related health service demands. These problems are compounded by the fact that Canada’s absolute population is increasing, and the absolute numbers of RNs in the workforce is decreasing, leading to greater disparity in nurse to population ratios (Canadian Institute for Health Information [CIHI], 2002; Statistics Canada, 2008c). Health Canada (2007) reported that in 2004, there were 77.9 nurses per 10,000 population, a decrease from 82.5 nurses per 10,000 population in 1992.

Recruitment and retention of nursing staff (as well as other health care providers) in rural areas are well recognized as problematic issues in countries such as Australia, Canada, and the United States; countries which all have sizeable proportions of rural land mass and
rural populations (Baumann, Hunsberger, Blythe, & Crea, 2006; Bushy, 2005; Duffield &
O’Brien-Pallas, 2002; Hegney, McCarthy, Rogers-Clark, & Gorman, 2002). There is an
urgent need to gain a clearer understanding of the factors that attract nurses to work in rural
communities, as well as the factors that influence their decisions to stay or leave. There is a
considerable amount of literature available which suggests that there is a strong relationship
between job satisfaction\(^2\) and the ability of rural health care facilities to recruit and retain
nursing staff (Fuszard, Green, Kujala, & Talley, 1994b; Hegney & McCarthy, 2000; Molinari

One of the specific elements often cited as a predictor of overall job satisfaction is the
existence of professional practice environments - settings where nurses are able to function in
professional roles (American Association of Colleges of Nursing, 2002; Blegen, 1993;
College of Registered Nurses of British Columbia [CRNBC], 2005; McNeese-Smith, 1999).
Existing research supports the claim that nurses who work in environments that are
conducive to exercising professional roles such as autonomy, specialized knowledge,
collegiality, and teamwork generally experience greater overall job satisfaction (Baumann et
al., 2001; Manojlovich, 2005; Miller, Adams, & Beck, 1993; Wynd, 2003). This research is
largely based on studies in urban areas, and little is actually known about professional
practice environments in rural areas, including how nurses in rural settings experience
professional practice.

The concept of professionalism has not been well-researched in any nursing context,
and extremely little is known about how nurses experience being professional, and how
professionalism is related to concepts such as job satisfaction. The complexity and

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\(^2\) Job satisfaction in nursing can be defined as “the difference between the amount of rewards received and the amount nurses believe they should receive” (Molinari & Monserud, 2008, p. 4).
ambiguous nature of professionalism and job satisfaction are significant barriers toward demystifying these concepts. There are several nursing studies which include items such as "professionalism" and "professional status" (e.g., Blegen, 1993; Cowin, 2002) as ranked factors that are reported to contribute to job satisfaction and retention, however these terms are not described in great detail. Understanding what it means for nurses to be professional will help define how professionalism is researched and understood in a nursing context, and will also provide more information regarding its specific relationship to job satisfaction.

Statement of Purpose

The purpose of this research study is to understand the nature and dimensions of professional practice as it exists for nurses in rural, western Canadian, acute care settings. Eliciting a conception of how rural nurses experience professionalism enhances our understanding of the unique roles and functions of these nurses, and also provides direct insight as to how professionalism manifests in a rural practice environment.

Overview of the Study

Data for this research project were produced as part of a three-year, multi-method national research study entitled, The Nature of Nursing Practice in Rural and Remote Canada. Spearheaded by Canadian nursing researchers MacLeod, Kulig, Stewart, and Pitblado, this study commenced in May 2001 with the aim of developing an understanding and definition of the nature of rural and remote nursing practice in Canada (MacLeod, Kulig, Stewart, & Pitblado, 2004). This research project employed four separate avenues of inquiry: 1) an analysis of the Registered Nurses Database to obtain geographical and statistical information about rural nursing; 2) document analysis of relevant nursing policies and standards; 3) a survey of rural and remote nurses regarding practice; and 4) a narrative study.
Each avenue of inquiry was led by one of the four Principal Investigators in the overall *Nature of Nursing Practice in Rural and Remote Canada* study.

In the narrative study, 151 Registered Nurses from rural and remote areas across all provinces and territories in the country were invited to share their descriptions of rural and remote nursing practice. The narrative inquiry was directed at eliciting the roles and functions of rural nurses, nursing expertise in relation to practice environment, as well as organizational and policy issues in nursing practice (MacLeod et al., 2004). Though the questions in this narrative study were not specifically aimed at eliciting how nurses experienced professionalism, the present inquiry sits within the original scope of *The Nature of Nursing Practice in Rural and Remote Canada* study. The nurses who were interviewed provided full descriptions of their day-to-day workplace experiences. These narratives provide candid, detailed accounts of their daily interactions and experiences, which can be interpreted to draw out an understanding of how these nurses experience professionalism.

This research project focuses on a specific subset of the interview data from the narrative study, utilizing eight interviews with acute care Registered Nurses from British Columbia and Alberta. Acute care nurses from British Columbia and Alberta were selected primarily because these nurses comprise the largest cohort of rural practicing nurses (CIHI, 2002), and on the basis of the researcher’s familiarity with acute care nursing practice and the structure of provincial health care in western Canada.

This study utilizes an interpretive description research approach developed by Canadian nursing researchers Thorne, Reimer Kirkham, and MacDonald-Emes (1997) in response to “discipline-specific inadequacies with traditional quantitative and qualitative descriptive research methodologies” (Buissink-Smith & McIntosh, 1999, p. 116). Interpretive
description is recognized as a credible, methodologically rigorous, and theoretically sound method of contributing to the body of nursing knowledge (Thorne et al., 1997). Interpretive description is a method aligned with naturalistic inquiry and the “values associated with phenomenological approaches inherent in the methods of data collection” (Thorne, Reimer Kirkham, & O’Flynn-Magee, 2004, p. 6). In the original proposal for the narrative study, MacLeod et al. (2004) noted that an interpretive or hermeneutic phenomenological approach would be employed in data analysis. The use of descriptive interpretation in this inquiry is therefore aligned with, and supported by the research design of the original narrative study.

Nearly 88% of Canadian nurses work in positions involving direct patient care, and nurses employed in acute care settings represent the largest cohort of practicing nurses in Canada (Statistics Canada, 2006). Gaining an understanding of how acute care, rural nurses in British Columbia and Alberta experience professionalism has significant implications for nursing research, practice, and education in Canada and abroad. A dedicated inquiry into how professional practice is experienced by these nurses informs our understanding of this phenomenon, and can lead to further action in supporting this valuable and irreplaceable cohort that provides health care to millions of Canadians. As recruitment and retention are consistently identified as key challenges in rural health care in Canada and internationally (Aiken et al., 2001; Duffield & O’Brien-Pallas, 2002; Stratton et al., 1991; Turner & Gunn, 1991), it seems that dedicated inquiry toward understanding the nature of professionalism in rural workplaces is long overdue.

\footnote{Acute care is taken to include nurses working in medicine/surgery, maternity/newborn, operating room/recovery room, emergency care, and critical care areas (Statistics Canada, 2006).}
Thesis Organization

In this chapter, I have presented background information relating to nursing issues in rural Canada and abroad, highlighted key reasons which support the purpose of undertaking this study, and provided a brief overview of the study as a whole. Chapter Two examines the literature on professional practice and rural nursing. In part one of Chapter Two, I present a review of current literature on the elusive and evolving concepts of professions, professionals, and professionalism, and situate these in the context of nursing practice. In part two, I address the issues and characteristics of acute care, and rural nursing practice in both Canadian and international contexts. Chapter Three focuses on the research design and methodological issues such as participant selection, data collection, data analysis, ethics, and rigor. I also discuss my reasons for selecting a qualitative, interpretive description approach, and acknowledge the role of my personal location within this research study. Chapter Four is a presentation of the findings as detailed, interpretive descriptive accounts of rural nurses’ experiences of professionalism. In Chapter Five, the findings are discussed in the context of the current literature. Chapter Six provides a summary and conclusion of this study as a whole, as well as implications for future nursing research, nursing practice, and education.
Chapter Two: Review of Rural and Professional Literature

Introduction

The literature review is presented in two sections. In the first section, the concept of professionalism and its related terms are explored, beginning with an examination of the concept of a profession from a historical standpoint. A discussion of the historical origins of professions, as well as an examination of the evolution and significance of professionalism in the discipline of nursing is also presented. In the second section, rural nursing practice is explored from both international and Canadian perspectives, with specific focus on the activities and roles of acute care nurses. Throughout the following discussion, the concepts of professionalism and rural nursing practice are synthesized, revealing the significance of professionalism in the context of rural acute care nursing in Canada.

Professions, Professionals, and Professionalism

The term profession is a broad concept which has several meanings in the English language, though it is most commonly used in reference to a distinct discipline, domain of work, skill, vocation, or trade (The New Merriam-Webster Dictionary, 2004). By adding the suffixes -al, -alism, -ally, -alize, -ized, -izing, or -ization to the noun profession, it is possible to extend the application of this word even further, and use it as an adjective or verb (The New Merriam-Webster Dictionary). Most dictionaries provide circuitous definitions for the succession of entries related to profession, as it seems there are few synonyms in the English language which adequately capture and embody the prestige and socio-historical connotations of the actual word. Millerson (1964) notes that the term profession is commonly used as a polite synonym for words such as job, occupation, and work. He suggests that the
widespread, indiscriminate use of the term only further promulgates the extant societal confusion regarding the definition of a profession (Millerson, 1964).

The term *professional* can be used to describe the conduct, knowledge, ethics, and personal qualities of individuals or groups who are engaged in a specialized domain of work (The New Merriam-Webster Dictionary, 2004). Being professional therefore, can be understood as embodying or practicing the qualities of a professional, and it is important to establish a distinction between the terms professional and *professionalism*. The word professional, used as either noun or adjective, relates to the degree in which certain indicators and characteristics of a profession exist (Hughes, 1965). Professionalism, on the other hand, represents the specific “conduct, goals or qualities” (Schwirian, 1998, p. 8), that are indicative of a profession, or which designate someone as a professional. For the purposes of this research, the concept of professionalism will be the primary focus, however it is important to acknowledge and discuss the etymological connections and meaningful interdependence of all three of these terms.

*Professional Organization and Definitions*

According to the Oxford English Dictionary, the word professional has etymological origins in Latin, and entered Middle English language via the French language (Oxford English Dictionary, 2007). The first recorded use of the word professional occurred circa 1470, and was used to describe “pertaining or making entrance into a religious order” (Oxford English Dictionary, 2007, ¶ 1). The origins of professional organization can be traced back to the late 12th century in England, at a time when the Church held substantial control over the wealth, property, and intellectual activity of the country (Millerson, 1964). Occupations such as medicine, law, teaching, and architecture were controlled by the Church,
and "anyone seeking entrance to, or promotion in these occupations, automatically took holy
orders" (Millerson, 1964, p. 16). Over subsequent centuries, prohibitions on clergy to
practice medicine and law, and the formation of gentlemen’s societies led to the progressive
secularization of these occupations and ultimately paved the way for the beginning of our
modern understanding of professions by the turn of the 18th century (Millerson, 1964).
However, the evolution of professions did not proceed without its challenges. The
secularization of occupations in the preceding centuries had led to a loss of control and
regulation of services such as law and medicine. By the mid-18th century, society was at the
mercy of “quacks and pettifoggers, exploiting other people’s misfortunes for their own
betterment … they were conniving untrustworthy rascals” (Millerson, 1964, p. 20).

The arrival of the 19th century brought new impetus for reorganization and
reformation of professions and professional societies. Membership in gentlemen’s clubs and
organizations in London became more than casual meetings of elite individuals for leisure
and social pleasure; it became increasingly “professional” (Millerson, 1964). Having
membership in more than one society became increasingly rare by the end of the 19th century,
as organizations were favored as meeting places for trained specialists and experts to
exchange current ideas and knowledge (Millerson, 1964).

In the early 20th century, prominent American educator Abraham Flexner wrote his
seminal work describing the characteristics of a profession. Before this time, the distinction
between occupations and professions was still not well defined. As noted by Schwirian
(1998), “all professions are occupations, but not all occupations are professions” (p. 4). To
differentiate an occupation from a profession, Flexner proposed the following six criteria of
professions:
- Essentially intellectual operations with large individual responsibility
- They derive their raw material from science and learning
- This material they work up to a practical and definite end
- They possess an educationally communicable technique
- They tend to self-organization
- They are becoming increasingly altruistic in motivation (Flexner, 1915, ¶ 1).

Flexner’s ideas on the characteristics of a profession hold true today, though additional concepts such as self-regulation, self-control, self-identification, and ethical responsibility were contributed by sociologists in the 1950s and 1960s (Schwirian, 1998). A more modern definition of a profession which incorporates these additions can be related as:

A prestigious occupation with a high degree of identification among the members that requires a lengthy and rigorous education in an intellectually demanding and theoretically based course of study; that engages in rigorous self-regulation and control; that holds authority over clients; and that puts service to society above simple self-interest (Schwirian, 1998, p. 6).

Despite the apparent comprehensiveness of this definition, there exists little consensus in the literature on how to define a profession, and there is even less clarity on how to approach the study of professionals and professionalism.

Eliot Freidson is perhaps one of the most influential contemporary scholars on the subject of professions and professionalism. Over the last three decades, Freidson’s writing has heavily shaped our current understandings of the issues and complexities associated with the concepts of professions and professionalism. Freidson recognizes the 1960s as “the critical period” in the historical evolution of professional literature, citing this era as “an intellectual watershed for the study of the professions” (Freidson, 1994, p. 3). He notes that, “until the 1960s, the tenor of writings by scholars on the professions was, by and large, neutral. If it was not critical of the professions, neither was it laudatory” (Freidson, 1994, p. 2). During the 1960s, there was marked resurgence in the study of professions, owing to “ideological influences” of the period (Freidson, 1994, p. 3). Scholars found renewed
interest in the study of professions and professional theory for political and economic reasons related to job security, social status, and the privilege of not competing in an open market (Freidson, 1994).

In his book, *Professionalism Reborn: Theory, Prophesy and Policy*, Freidson (1994) notes that, “we seem to be no nearer consensus [on defining professions] than we were in 1915 ... usage varies substantively, logically and conceptually, [and] some analysts have given the impression of condemning the very practice of seeking a definition” (p. 15). While Freidson suggests that condemnation is an “inappropriate” approach to the subject, he does point out that there are inherent difficulties in developing “professional” theory using “empirical and intellectual analysis” (Freidson, 1994, p. 15) when the subject-matter is not clearly delimited. Freidson notes, “we cannot develop theory if we are not certain what we are talking about” (Freidson, 1994, p. 15).

The concept of a profession is perhaps one of the most difficult sociological ideas to understand and define, and competing definitions have only served to further muddle the discourse (Freidson, 1994; Millerson, 1964). Millerson (1964) attributes the “confusion and uncertainty” (p. 1) regarding the definition of a profession to three fundamental problems:

Firstly, there is the semantic confusion, resulting from the wide and excessive use of the word. Secondly, there are the structural limitations enforced by attempts to devise fundamental characteristics of a profession. Thirdly, there is the adherence to a static model, rather than an appreciation of the dynamic process involved in professionalism (Millerson, 1964, p. 1).

The obvious problems with attempting to incorporate such an ambiguous concept in a research study has necessitated some decision making on my part in order to ensure consistency in both understanding and being able to identify the nature of professionalism within the data, and subsequent application of the term within the findings. The preceding
discussion has addressed the definitions of these terms as they are understood in the context of this research study.

*How to Study a Profession*

The problems with ascertaining a universally accepted definition of a profession have been largely responsible for promulgating the ongoing disagreement as to whether nursing has achieved the indicators associated with professional status. It is interesting to note that there is no real numerical consensus in the literature on how many professions actually exist. Wilensky (1962) suggests that there are between 30 and 40 professions, however depending on the definition that is used, this estimate could easily be argued as either too small or too large. Schwirian (1998) suggests the existence of an “occupation-profession continuum … anchored at one end by ‘occupation’ and at the other end by ‘profession’” (p. 6). As Schwirian (1998) explains:

To be at the full professional end, an occupation must manifest all the characteristics of a profession. If some characteristics are absent, then the occupation is considered a semiprofession. It may well be in a transitional status from occupation to profession, or society may have locked it into a permanent semiprofessional status by denying it such things as legal control over the practice of its members. If few or none of the characteristics of a profession are present, the occupation is at the occupation end (p. 6).

Schwirian’s excerpt outlines one of the few concrete conceptions about the degrees of separation between an occupation and a profession. The transition process from either occupation or semiprofession toward profession is termed *professionalization*, and it is characterized by a series of events that alter the mandate and structure of the occupation (Wilensky, 1962).

If the ultimate goal were to classify every known occupation as either: occupation, semiprofession, or profession, it could theoretically be done using a checklist of professional
characteristics, and a schematic of the "occupation-profession continuum" as suggested by Schwirian (1998, p. 6). Unfortunately, one problem that would immediately arise is the lack of agreement as to which core characteristics must be included on such a list. The crux of the occupation-profession conundrum is more to do with the co-dependence of these terms (in that either cannot exist without the other as a basis for comparison), and also that both concepts are so loosely defined.

The professional status of physicians, dentists, architects, chemists, lawyers, accountants, and engineers is largely uncontested (Burrage, 1990; Freidson, 1994; Millerson, 1964; Schwirian, 1998), and this draws interesting attention to the position of nursing. Historical and modern literature reveals that the notion of nursing as a profession is a pervasive subject of discussion, and one that is characterized by a variety of opinions.

The Profession of Nursing?

At face value, Schwirian's (1998) definition of a profession (see p. 11) would appear to be applicable to the discipline of nursing. However, there is considerable debate both in and outside academic circles as to whether nursing actually has the qualities of a professional occupation. Wuest (1994) suggests that professionalism is a patriarchal ideal, forced upon a traditionally feminine occupation which has not only failed to deliver prestige and power, but also alienated women and hindered our ability to appreciate the value of knowledge acquired through caring by imposing traditional methods of knowledge development. Cook (1992) argues that the pursuit of professionalization in nursing is a self-serving mission to promulgate superiority, misguided by the belief that increased status will equate with better patient care and higher standards. He warns that the professionalization of nursing is a dangerous venture, which ultimately threatens to exploit society (Cook, 1992).
The discipline of nursing evolved from ideologies of the Victorian and Progressive eras, and through the pioneering efforts of women such as Florence Nightingale and Lady Aberdeen\(^4\) (Chitty, 2005; Du Gas, Esson, & Ronaldson, 1999). In Canada, the history of nursing relates back to missionary and health care work done by the Grey Nuns\(^5\) and the Sisters of Charity of the Hôpital Général, in Montréal (Government of Canada, 2008; The Canadian Encyclopedia, 2008). Nightingale is credited with founding the “first training school for nurses at St. Thomas’s Hospital in London (1860) … [which became] the model for nursing education in the United States” (Chitty, 2005, p. 4). Nursing education in Canada was also based on Nightingale’s hospital training model, and “the first formal nurse training programme based on the hospital apprenticeship model was established in 1874 at the General and Marine hospital in St. Catharine’s, Ontario, spawning a proliferation of schools in every major hospital across Canada” (Canadian Museum of Civilization Corporation, 2005, ¶ 5). The rise of hospital-based nursing schools triggered a cascade of professionalizing events for nursing in Canada, as more attention was directed toward “lobbying for licensing legislation and establishing professional organizations” (Canadian Museum of Civilization Corporation, 2005, ¶ 6). Professional journals such as the Canadian Nurse (est. 1905), organizations such as The Canadian Nurses’ Association (est. 1908), and the establishment of university-based nurse training programs (the first was at the University of British Columbia in 1918) have significantly impacted the professionalization of nursing in Canada (Canadian Museum of Civilization Corporation, 2005; Canadian Nurses Association [CNA], 2008b).

\(^4\) Lady Aberdeen (wife of the Governor General of Canada and President of the National Council of Women) is credited with establishing the Victorian Order of Nurses of Canada in 1897, a service which provided home and maternity care for many Canadians (Canadian Museum of Civilization Corporation, 2005).

\(^5\) The Grey Nuns of Montréal were a Roman Catholic organization founded by Marguerite d’Youville in 1737 (Government of Canada, 2008).
Membership in the practice of nursing has traditionally been female-dominated (Wynd, 2003), though recent trends show increasing numbers of males entering the profession (Statistics Canada, 2006). Chitty (2005) suggests reasons for the traditional female-gender dominance in nursing:

The widely held Victorian belief in women’s innate sensitivity and high morals led to the early requirements that applicants to these programs be female, for it was thought that only these feminine qualities could improve the quality of nursing care. Thus sensitivity, breeding, intelligence, and “ladylike” behavior, including submission to authority, were highly desired personal characteristics for applicants. The feminization of nursing took root (p. 9).

Coupled with the feminization of nursing, the historical evolution of professions predominantly favored male attributes and values, and consequently, nursing has faced major challenges in asserting its rightful place among other, independent professions (Wynd, 2003). Overcoming societal perceptions of nursing’s subservience to the medical profession has been, and will continue to be an ongoing issue. Some authors would argue that nursing is still in the process of becoming a profession and that realistically, nursing can only rightfully be considered a “semiprofession” at this time (Schwirian, 1998; Wynd, 2003; Yam, 2004). Kidder and Cornelius (2006), and Schwirian (1998) caution that nursing licensure is not synonymous with professionalism, and argue that mandated, specific multilevel entry into practice holds immense benefits for the professional status of nursing.

In Canadian textbooks, most authors offer little doubt as to whether nursing is a profession (Baylis, Downie, Hoffmaster, & Sherwin, 2004; Du Gas et al., 1999; Hibberd & Smith, 1999). Canadian author David Coburn argues that nursing in Canada is undergoing processes of both professionalism and proletarianization. Coburn (1988) suggests that:

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^6 Proletarianization is a concept from Marxism and Marxist sociology referring to “the social process whereby people move from being either an employer, self-employed or unemployed to being employed as wage labor by an employer” (Society and Culture Research Guide, 2009, ¶ 1).
This historical trajectory of nursing shows an increasing occupational autonomy but continuing struggles over control of the labor process. Nursing is now using theory, organizational changes in health care, and credentialism to help make nursing "separate from but equal to" medicine and to gain control over the day-to-day work of the nurse (p. 1).

Even though Coburn’s (1988) words are somewhat dated, there is evidence to suggest that nursing is still very much entrenched in this process (e.g., 2008 Centennial Edition Code of Ethics For Registered Nurses, CNA, 2008a; Practice Standards, CRNBC, 2008a; Professional Standards, CRNBC, 2008b; Scope of Practice Standards, CRNBC, 2008c).

As shown by the previous discussion on the events which contributed to the professionalization of nursing in Canada, it is important for professional occupations to have internal structure, organization, and processes in place, so as to promote their professional status. Some authors argue that it is equally important that members of external groups, (e.g., other affirmed professions and society as a whole) also perceive certain occupations as professions (Millerson, 1964; Schwirian, 1998). Millerson (1964) suggests that a profession can also be thought of as a designation awarded to an occupation by society, out of respect and recognition of their specialized knowledge and services, and unselfish commitment to serve the community. In essence, a dynamic, ongoing social contract exists between professions and society. As stated by Sills (1998), "professions ‘fix’ something for the society ... professions profess to know something better than the peoples they serve and who thus need their service" (p. 168), but this statement really only captures part of the social contract. In exchange for specialized services, society grants special rights and privileges to a profession. Recognition of professional status may assume the form of "high remuneration, delegation of power and authority, use of services in preference to others, official acknowledgement of a separate existence, requests for advice, presentation of special status
symbols and honours” (Millerson, 1964, p. 13). Professions then, also have a reciprocal duty to maintain society’s trust, by regulating entry, ensuring high standards of service, upholding high ethical and moral standards, and disciplinary actions when standards are not met (Sills, 1998). In order for professions to accomplish these tasks, they must be mostly self-regulated, with the ability to define the scope and standards of practice of their individual members, thus, defining their social contract with society (Sills, 1998).

There is substantial evidence to show that nursing is a profession, and that nurses do exhibit professional behaviors. Canadian nurses are publicly recognized as professionals in the laws and Acts set out by our government. In Canada, the Regulated Health Professions Act (1991) clearly states that a person must be recognized by the Health Professions Act in order to perform specific “controlled acts” regarding the provision of health care to individuals (Regulated Health Professions Act, 1991). In British Columbia, a health profession is “a profession in which a person exercises skill or judgment or provides a service related to: (a) the preservation or improvement of the health of individuals, or (b) the treatment or care of individuals who are injured, sick, disabled or infirm” (Health Professions Act, 1996, ¶ 1). According to Canadian law, it is clear that nurses are regarded as professionals, and that the practice of nursing is professional.

In addition, nurses have established standards for education, practice, and licensing of members. Nursing care across all provincial and territorial areas in Canada is regulated by professional licensing bodies which dictate the standards for competent, ethical, and safe nursing care and outline the profession’s social contract with society. A review of these standards reveals that each Canadian jurisdiction mandates very similar “professional practice standards” for Registered Nurses (Association of Registered Nurses of
Newfoundland and Labrador [ARNNL], n.d.; College and Association of Registered Nurses of Alberta, 2007; CRNBC, 2008b; College of Registered Nurses of Manitoba, 2004; College of Registered Nurses of Nova Scotia, 2004; Registered Nurses Association of Northwest Territories and Nunavut, 2006; Saskatchewan Registered Nurses Association, 2007; Yukon Registered Nurses Association, 2005). Canadian standards for professional nursing practice, regardless of jurisdiction, all include reference to the following: accountability, knowledge, competence, ethics, service, and self-regulation (CRNBC, 2008b). Each of these standards represents a professional activity, which has a clear relationship with, and irrefutable origins in the work of Abraham Flexner in the early 20th century. As noted by the Association of Registered Nurses of Newfoundland and Labrador:

1. Professional practice is based on a specialized body of knowledge
2. Professionals competently apply knowledge
3. A profession provides a service to the public
4. Professionals are bound by a code of ethics
5. A profession is self-regulating
6. Professionals are responsible and accountable to the public for their work (ARNNL, n.d., ¶ 1).

There are many reasons that all Canadian provinces and territories have adopted written, professional practice standards. The most relevant pertains to protection and safety of the public. The ARNNL (n.d.) recognizes that “the public has given the nursing profession the mandate to protect the public from incompetent, impaired or unethical practice of nursing” (¶ 1).

Professionalism and Nursing

As part of a project entitled Nursing Best Practice Guidelines, the Registered Nurses Association of Ontario (RNAO, 2006, 2007a, 2007b) recently released a series of six evidence-based workplace guidelines promoting Healthy Work Environments. The RNAO
(2007b) document, “Professionalism in Nursing” is a Best Practice Guideline to aid in the creation and evaluation of healthy work environments for nurses. This guideline represents the most current, best available evidence related to the attributes of professionalism in nursing, and was developed through collaboration from the nursing community in Ontario, and panel members from across Canada (RNAO, 2007b). The RNAO (2007b) identifies the following eight attributes that “signify professionalism of the nurse” (p. 23): Knowledge, Spirit of Inquiry, Accountability, Autonomy, Advocacy, Innovation and Visionary, Collegiality and Collaboration, Ethics and Values. For the purpose of this research, these attributes will comprise a working definition and understanding of professionalism.

Research studies on professionalism in nursing have traditionally focused on professional image, specifically as it pertains to nursing attire, as well as communication and collegial relations (Apker, Propp, Zabava-Ford, & Hofmeister, 2006; Campbell-Heider, Hart, & Bergren, 1994). Over the last twenty years, themes such as autonomy, authority, attitude, and accountability have been identified and added to the inventory of professional nursing practice characteristics (Fuszard, Green, Kujala, & Talley, 1994a; Miller et al., 1993; Newman, 1995; Oermann, 1997; Valentine, 1992; Wynd, 2003). Manojlovich (2005) found that some of the greatest predictors of professional practice in nursing were the availability of support, resources, and information in the workplace environment, and these factors have also consistently been linked to nurses’ job satisfaction (Hegney & McCarthy, 2000; Winslow, 2001).

The importance of identifying the characteristics and presence of professionalism for any nursing group, whether urban or rural, is largely related to evidence which indicates that nurses derive a great deal of job satisfaction from exercising professional behaviors
Nurses place high value on the perception of nursing as a professional occupation (Valentine, 1992), and often cite professional status, pride, and recognition as important factors in job satisfaction (Anderko, Robertson, & Lewis, 1999; Henderson Betkus & MacLeod, 2004; Johnston, 1991; Molinari & Monserud, 2008; Seymour & Buscherhof, 1991). A review of the literature reveals that there has been little attention directed specifically at eliciting the nature of professionalism as it exists in rural nursing practice, and this is problematic because professionalism is commonly associated with job satisfaction.

In urban-based nursing research, autonomy is often cited as a key element relating to professional practice and nurses’ job-satisfaction (Adams & Miller, 2001; Schutzenhofer & Musser, 1994; Wade, 1999). Seymour and Buscherhof (1991) found that lack of autonomy was the most common reason that nurses chose to leave hospital-based settings in favor of other practice areas. Bushy and Banik (1991) looked at factors related to nurse satisfaction with employment in rural hospitals, and found that professional status was rated second-highest (after salary) in terms of importance. A study by Johnston (1991) examined sources of work satisfaction and dissatisfaction among hospital-based RNs in a southwestern US state and concluded that “professional status remained the component that demonstrated the greatest amount of satisfaction” (p. 510). Stewart et al. (2005) analyzed data from The Nature of Nursing Practice in Rural and Remote Canada study, and found that job satisfaction among rural nurses was highest in the provinces with the highest pay scales. In Australia, a study by Cowin (2002) found that professional status, as indicated by personal appraisal of the nurse-participants, was the most significant indicator of retention. Bryan-Brown and Dracup (2003) suggest that “when professionals are left feeling like they are no

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7 Indicators of “professional status” were not explicitly defined in this study (Bushy & Banik, 1991).
longer valued for their professionalism, altruism will wither away and society is the loser” (p. 395).

Rural Nursing Practice – Issues and Characteristics

Defining Rural Nursing

Perhaps one of the biggest challenges in undertaking rural research is the lack of consensus on how to define a rural area. Rural nursing literature often commences with a disclaimer or lament about the lack of agreement on a consistently applied definition of the term. Statistics Canada has recently released a paper with six definitions of rural (Mitura & Bollman, 2003). Depending on which rural definition is applied, Canada has between 6 and 11 million people living in rural areas (Mitura & Bollman, 2003). Statistics Canada strongly recommends the use of the “rural and small town definition” to understand Canada’s rural population (du Plessis, Beshiri, Bollman, & Clemenson, 2001), and this was the definition used in The Nature of Nursing Practice in Rural and Remote Canada study by MacLeod et al. (2004). In this research study, rural will be defined as: “population[s] living in towns and municipalities outside the commuting zone of larger urban centres … with [a] population of 10,000 or more” (du Plessis et al., 2001, p. 1). In rural Canada, there are approximately 6.3 million people, and nurses are the primary health care providers in these areas (Duffield & O’Brien-Pallas, 2002; Statistics Canada, 2008c).

Across the country, there is considerable variability in the nature of nurses’ roles in delivering health care to Canadians. Akin to their urban counterparts, rural nurses in Canada have roles in many areas of practice including: acute care, long-term care, home care, community care, mental health, outpost nursing, education, industry; and in facilities such as hospitals, clinics, and doctor’s offices (CIHI, 2002; Stewart et al., 2005). Statistics Canada
(2006) suggests that the vast majority of practicing nurses in Canada are involved in hospital-based, direct-patient care (88%), and also that nurses employed in acute care settings represent the largest cohort of practicing nurses in Canada. Stewart et al. (2005) found that hospital-based, acute care nurses constitute the largest group of rural nurses in Canada (39%). In 2002, the CIHI, as part of The Nature of Nursing Practice in Rural and Remote Canada study (MacLeod et al., 2004) released a document entitled, “Supply and Distribution of Registered Nurses in Rural and Small Town Canada, 2000”, a report based on the Registered Nurses Database8 in Canada (CIHI, 2002). This document is of key importance in Canadian nursing literature, as it provides (some of the only available) statistical data about the demographics, characteristics, and workplace roles of rural nurses. From the CIHI (2002) report, we know that as a whole, the nurse to population ratio in rural areas of Canada is on the decline, and also that there is an east to west decrease in the number of nurses per capita across the country. In the year 2000, the majority of rural nurses in Canada were practicing in hospitals (53.8%), and they also tended to have more role overlap and multiple responsibilities in their workplace compared to urban nurses (CIHI, 2002).

Acute Care Nursing

The concept of acute care nursing (whether urban or rural) is multi-faceted, and it has inherent connotations with the notion of a wide and varied scope of practice (Baumann et al., 2006). Acute care nursing is based on the care of individuals who experience acute illnesses and conditions such as heart attacks, stroke, musculo-skeletal injury, and infection, and it is also rooted in the premise of responding to, and managing rapidly changing adverse health situations. Though most acute care nurses are concentrated in hospital-based settings,
virtually all types of nursing practice demand some degree of acute care nursing knowledge, judgment, and skill. It is widely regarded as a generalist area of practice, as nursing care in these areas is not necessarily defined by an age cohort or a specific range of diseases or diagnoses. Acute care nurses can be found working in many practice areas in urban and rural settings, including emergency rooms, clinics, critical care units, medical/surgical units, and operating rooms.

Conceptions of Rural Nursing

One of the perpetuated myths of rural nursing is that it is somehow less important, less sophisticated, or substandard compared to urban nursing care (Shellian, 2002), and that nurses working in rural settings are the product of being “unable to make it in the big city” (Thompson & Chambers, 1993, p. 177). Rural nursing and urban nursing, though they share many of the same basic qualities, are fundamentally different in many regards (Biegel, 1983; Hegney & McCarthy, 2000; Long & Weinert, 1989; MacLeod, 1998; Stratton, et al., 1991). Rural nursing in both Canada and the United States is characterized by several distinct indicators including: varied scope of practice, isolation, community ties, autonomy, and relationships with other health professionals (Baumann et al., 2006; Bigbee, 1993; Bushy, 2005). Among the benefits, opportunities, and rewards, rural nursing also presents unique challenges for nurses.

The conceptions of rural nursing are largely based on American stereotypes and values, owing to a relative lack of Canadian literature and research on rural nursing. American literature on rural nursing has a tendency to portray rural communities and nursing as exceptionally conservative and traditionalist (Bigbee, 1993; Bushy, 2005). Canadian authors such as Baumann et al. (2006), MacLeod (1998) and MacLeod et al. (2004) form the
basis of the growing body of rural literature, and their research has been referenced wherever possible. A recent analysis of *The Nature of Nursing Practice in Rural and Remote Canada* national survey data by Kulig et al. (2008) suggests that RNs in Canada associate the terms rural and remote with four themes: "community characteristics, geographical location, health human and technical resources, and nursing practice characteristics" (p. 30). Within the theme of community characteristics, researchers noted that nurses placed "a strong emphasis on positive rural community characteristics" (Kulig et al., 2008, p. 30), however these positive rural community characteristics were not explicitly identified in their study.

*Rural Nursing Theory*

Rural nursing theory describes the key characteristics commonly associated with rural practice, and provides a basis of understanding for this unique type of nursing. "The theory for rural nursing evolved because of a recognized need for a framework for practice that considers perceptions and needs of persons from whom care is being provided" (Lee & Winters, 2004, ¶3). Long and Weinert’s (1989) article entitled, "Rural Nursing: Developing the Theory Base" is widely referenced by the nursing community, and it represents one of the few pieces of literature which details a conception of rural nursing theory, based on a review of qualitative and quantitative research data. Long and Weinert (1989) identified key concepts in rural nursing, such as: "work beliefs and health beliefs; isolation and distance; self-reliance; lack of anonymity; outsider/insider; and old-timer/newcomer" (p. 257). Even though these concepts are based on American research data, they are relevant to rural nursing practice in Canada.

A qualitative study by Lee and Winters (2004) sought to validate Long and Weinert’s (1989) theoretical conceptions of rural nursing. Lee and Winters’ study revealed the
previously unidentified concept of choice within rural nursing theory, and they also suggested that Long and Weinert's theory of rural nursing has been incorrectly generalized to the rural nursing population as a whole. Whether rural nursing is currently with or without theory is open to question, but what is evident is that more rural nursing theory is needed.

The unique professional challenges and rewards of rural nursing have been well-defined and documented in countries such as Australia (e.g., Hegney & McCarthy, 2000; Hegney et al., 2002) and the United States (e.g., Bigbee, 1993; Bushy, 2005). It has only been within the last decade that researchers in Canada have made concerted efforts to better understand rural nursing practice (Baumann et al., 2006; CIHI, 2002; Kulig, 2003; MacLeod, 1998; MacLeod et al., 2004; Stewart et al., 2005). Duffield and O'Brien-Pallas (2002) suggest that the nursing workforce in both Australia and Canada are very similar in terms of age of the nursing workforce, remuneration, and access to education; however it is not clear if this is meant to apply to the rural nursing contingent as well. What is clear, is the persistent lack of nursing theory about how rural nurses practice (Turner & Gunn, 1991; Weinert & Long, 1991), and this is directly related to the need for more dedicated rural nursing research worldwide (Bigbee, 1993; MacLeod, Browne, & Leipert, 1998).

Practice. Rural acute care nurses are widely regarded as self-reliant, "generalist-specialists", and "expert generalists", as they must have diverse knowledge and skills to care for individuals of all ages with a wide range of health issues (Baumann et al., 2006; Bushy, 1998; MacLeod, 1998; Thobaden & Weingard, 1983; Weinert & Long, 1991). They are also noted as being highly flexible and adaptable to a vast array of practice areas and multiple nursing roles (Baumann et al., 2006; Long & Weinert, 1989; Thobaden & Weingard, 1983). Rural nursing can be grossly defined as "the provision of health care by professional nurses
to persons living in sparsely populated areas” (Long & Weinert, 1989, p. 258). Rural nursing is considered to be a specialty area of practice by several authors, because of the inherently unique nursing opportunities and characteristics (Bigbee, 1993; Crooks, 2004; Stuart-Burchardt, 1982), although MacLeod et al. (1998) suggest that rural nursing practice is “not yet fully recognized in Canada as a specialty area of practice” (p. 76). The University of Northern British Columbia (UNBC) recently started offering a specialist, “Rural Acute Care Nursing Certificate” as part of a post-RN and BScN degree completion for RNs (MacLeod, Lindsey, Ulrich, Fulton, & John, 2008; UNBC, 2007). This certification provides additional skills to nurses who want certification in rural nursing, and it suggests that the acute care component of rural nursing is gaining recognition as specialty area of practice.

*Isolation.* Perhaps the most prominent feature of rural nursing is the geographic and professional isolation with which practitioners must cope (Baumann et al., 2006; Long & Weinert, 1989). Referral centres can often be several hundred kilometres away, and sometimes rural acute care nurses must provide care without the on-site support and expertise of a physician. Rural nurses also face challenges associated with lack of access to collegial support, difficulties in accessing continuing education, and a lack of professional and organizational support (Long & Weinert, 1989). Rural nurses in northern British Columbia, Canada, identified the phrase “we’re it,” to describe “the pattern which constitutes their practice and experience” (MacLeod, 1998, p. iii). In only two words, this simple phrase captures so many facets of the isolated nature and challenges associated with rural nursing practice. Working and living in a rural community has its own unique benefits, and certainly connotes a different lifestyle as compared to an urban one. Other factors such as geographic isolation, weather, gaps in utility/service provision, and a relative lack of access to social,
entertainment, and shopping venues are variables that may also compound the challenges of rural nursing.

*Community.* Traditional differences in the social organization of rural and urban communities have been related to the human association concepts of *Gemeinschaft* and *Gesellschaft*, developed by German sociologist Ferdinand Tönnies (Tönnies, 1957, 2002). In the *Gemeinschaft* concept, “the primary unit of interaction is bound by close personal long-term relationships with family and friends” (Bigbee, 1993, p. 133), whereas the *Gesellschaft* concept connotes “short-term, less intense, more formal relationships and less family involvement” (Bigbee, 1993, p. 133). One of the characteristic features of rural nursing is the *Gemeinschaft*-type of social organization (Bigbee, 1993). Many rural nurses enjoy the benefits of high visibility and close social relationships with the community (Turner & Gunn, 1991), whereas other nurses regard the lack of anonymity as a somewhat challenging aspect of rural practice (Long & Weinert, 1989; Raph & Buehler, 2006; Weinert & Long, 1991). Rural communities often also embrace traditional rural values such as the spirit of community, family, religiosity, independence, and individualism (Bigbee, 1993). American author Jeri Bigbee (1993) also notes that “rural residents tend to be morally and politically conservative, traditionalist and work-oriented” (p. 133). Traditional community values regarding gender-roles may also affect the nursing role within the community, as nursing may be perceived as “women’s work,” hindering rural nursing’s attainment of full professional status (Bushy, 2005). From a Canadian standpoint, it is apparent that the adequacy and applicability of these descriptions is questionable. Further research is needed to formulate accurate representations of rural communities and nurses in Canada.
**Autonomy.** Another hallmark of rural nursing is autonomy, characterized by increased decision-making capacity and independence (Baumann, et al., 2006; Bigbee, 1993; Stuart-Burchardt, 1982). Rural nurses also enjoy the benefits of being able to actively participate in decision-making in health policy and community projects (Turner & Gunn, 1991). A research study by Hanson, Jenkins, and Ryan (1990) found that autonomy was the greatest predictor of nurses' job satisfaction in 10 rural Georgia hospitals. Stewart et al. (2005), measured job satisfaction in rural nurses across Canada as part of *The Nature of Nursing Practice in Rural and Remote Canada* study, and found that nurses in British Columbia and Alberta reported higher job satisfaction than nurses in other provinces, however this study did not explicitly mention how measured factors such as autonomy and “decision latitude” (p. 135) affected job satisfaction.

**Staff relationships and responsibility.** Rural nursing is also generally characterized by greater staff cohesiveness and camaraderie, as well as increased collegiality between members of the interdisciplinary health care team (Bigbee, 1993; MacLeod, 1998; Thompson & Chambers, 1993; Turner & Gunn, 1991). As staffing resources are often limited in rural settings, it is not uncommon for nurses to feel as though they are “always on duty” (Bigbee, 1993, p. 137); spending long hours at work with only a short time off (MacLeod, 1998; Skillman, Palazzo, Keepnews, & Hart, 2006; Turner & Gunn, 1991; Weinert & Long, 1991). In addition to managing client care, rural nurses must often assume the roles of other health care providers such as pharmacists, dieticians, and lab technicians, as well as numerous ancillary duties such as housekeeping and secretarial roles (Davis & Droes, 1993).

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9 Autonomy can be defined as individual self-governance or “personal rule of the self while remaining free from both controlling interferences by others and personal limitations … that prevent meaningful choice” (Beauchamp & Childress, 1989, p. 68).

10 This study used a modified version of the Index of Work Satisfaction (IWS) scale to measure the experiences and satisfaction of rural nurses in Canada (Stewart et al., 2005).
Recruitment and retention in a rural context. One area of research that has received considerable attention concerns recruitment and retention of nurses in rural areas. The problems with rural recruitment and retention in nursing are well documented in literature from Canada and worldwide (Baumann et al., 2006; Bigbee, 1993; Bushy, 2005; Bushy & Banik, 1991; Davis & Droes, 1993; Hegney & McCarthy, 2000; Hegney et al., 2002; Henderson-Betkus & MacLeod, 2004; Stratton, Dunkin, & Juhl, 1995; Stratton et al., 1991; Thobaden & Weingard, 1983; Thompson & Chambers, 1993; Turner & Gunn, 1991).

Though research in rural nursing continues to expand and diversify, it is rather telling that the bulk of rural literature to-date is largely concerned with issues related to job satisfaction, recruitment, and retention. Low job satisfaction is among the most frequently cited causes of recruitment and retention problems in rural nursing, yet we understand very little about what actually contributes to job satisfaction in a rural context.

Job Satisfaction

Health care nation-wide is feeling the effects of the nursing shortage, owing to the aging nursing workforce and the worldwide decline in recruitment into the profession (Cowin, 2002; Duffield & O’Brien-Pallas, 2002; O’Brien-Pallas, Baumann, Murphy, Lochhaas-Gerlach, & Luba, 2001; O’Brien-Pallas, Hirschfield, Baumann, Shamian, Adams, Bajnok, et al., 1999). A study on the nursing labor market by Brewer (1996) concluded that the “roller coaster of supply and demand in nursing labor is far from over” (p. 355), and that it is plausible that current forecasts of nursing supply are inaccurate. The CNA (2001) states that “Canada’s nursing shortage is at least in part due to inadequate and inferior work environments” (¶ 2). A Canadian study in 2005 on “The Work and Health of Nurses”, reported that nurses had the highest levels of job-dissatisfaction (12%) as compared to all
other employed individuals (8%) in Canada (Statistics Canada, 2006). According to several authors, low levels of job satisfaction among nurses is also strongly associated with intent to leave and staff turnover (Lu, While, & Barriball, 2007; Mrayyan, 2006; Zeytinoglu, Denton, Davies, Baumann, Blythe, & Boos, 2007). O’Brien-Pallas, Duffield, and Hayes (2006) studied nurses who had left the profession, and found that a lack of professional practice environments, legal, and employer issues (which specifically included good working relationships with other nurses and working in a supportive environment) were among the most significant reasons that nurses elected to leave the profession.

A dissatisfied nursing workforce has dire consequences in terms of recruitment and retention efforts, and similarly, for the future of Canadian health care. Registered Nurses represent the largest cohort of health care workers in Canada (Statistics Canada, 2006), and much of the accessibility and fundamental operation of Canadian health care is dependent on the availability of Registered Nurses. Due to continuing concerns about nurse recruitment and retention in both urban and rural areas, the last decade has seen an enormous influx of nursing research focused on eliciting an understanding of the complex factors contributing to nurses’ job satisfaction in very specific work environments (e.g., Li & Lambert, 2008; Ramrup & Pacis, 2008; Russell & Van Gelder, 2008; Sharp, 2008). Gaining a better understanding of professionalism (and the other complex factors associated with nurses’ job satisfaction) in rural acute care settings can provide important insights into the ways in which job satisfaction contributes to more nurses coming and more nurses staying in rural practice.
Summary of the Literature

The concepts of professions and professionalism are extremely ambiguous, and there is little consensus as to how to apply these terms in a research study. Despite the controversy regarding the professional status of nursing, there is overwhelming evidence that nursing is a profession.

Rural nurses are known to face many unique professional challenges and rewards in their day-to-day practice. The differences between urban and rural nursing are frequently characterized in terms of scope of practice, professional isolation, familiarity with the community, autonomy, staff relationships, and responsibility. There is a growing body of rural-based nursing literature in Canada (e.g., Baumann et al., 2006; MacLeod et al., 2004), but none which specifically addresses the concept of professionalism in a rural context. The need for committed inquiry into understanding professionalism in a rural environment is evident, given the connections to concepts such as job satisfaction. Developing a further awareness and appreciation of the unique aspects of professional nursing practice in rural settings can benefit recruitment and retention efforts directed at nurses in rural Canada.

In this study, an interpretive description approach was used to analyze data to elicit how rural nurses in British Columbia and Alberta experience professionalism. Interpretive description is a qualitative research method founded in the discipline of nursing, and is consistent with the research approach used in the narrative portion of MacLeod et al.'s (2004) The Nature of Nursing Practice in Rural and Remote Canada study.
Chapter Three: Methodology

Introduction

In this chapter, the foundations of the qualitative research tradition are discussed, and the interpretive description method is located within this tradition. A detailed discussion of the research design and methodology used in this research study is provided, with specific attention to participant selection, data collection and analysis, ethics, rigor, and strengths and limitations of the design. This chapter is also an opportunity to situate myself as a researcher in the context of this study, and address some of unique challenges and opportunities I encountered throughout the research process.

The Qualitative Paradigm

Qualitative methodology is a tradition that is continually evolving, as researchers and academics seek new and improved ways to understand the phenomena of our world. Qualitative research places high importance on words, descriptions, and images from participants which are contained in interviews, observations, and documents (Patton, 2002). Qualitative epistemology and ontology recognize the existence of multiple truths or understandings of the world, and the inherent value of individual experience (Patton, 2002). Research in the qualitative tradition is an approach that is primarily used when little is known about a phenomenon, and a researcher seeks to gain insight and understanding from an emic, or insider’s point of view (Morse & Field, 1995).

The naturalistic, ontological position found in qualitative research is particularly accommodating in the study of peoples’ dynamic realities, and their experiences and perceptions of the world on a day-to-day basis. Van Manen (1990) notes that, “from a phenomenological point of view, to do research is always to question the way we experience
the world, to want to know the world in which we live as human beings” (p. 5). Even though Van Manen’s words may be prefaced with a phenomenological caveat, these words are in many ways, very relevant to the overarching goals inherent in qualitative research as a whole. While Van Manen’s work is contextualized almost entirely in reference to interpretive phenomenology, the relevance to the study at hand becomes very clear in his delineation of the fundamental differences between studying human social science as opposed to natural science.

In the sense that traditional, hypothesizing, or experimental research is largely interested in knowledge that is generalizable, true for one and all, it is not entirely wrong to say that there is a certain spirit inherent in such a research atmosphere. Actions and interventions, like exercises, are seen as repeatable; while subjects and examples, like soldiers, are replaceable. In contrast, phenomenology is, in a broad sense, a philosophy or theory of the unique; it is interested in what is essentially not replaceable (Van Manen, 1990, pp. 6-7, emphasis original).

Qualitative Methods

The qualitative tradition encompasses several different research approaches, each with discipline-specific origins. Grounded theory is rooted in the discipline of sociology, ethnography developed in cultural anthropology, phenomenology has its origins in philosophy (Streubert Speziale & Carpenter, 2003), and interpretive description was founded in nursing (Thorne et al., 1997). The flexibility of the qualitative tradition offers researchers many choices in terms of being able to tailor their approach to suit what is being studied. Between approaches, the degree of abstractness and interpretation can vary quite substantially, as can the prescriptive nature or freedom within the procedural steps.

In accordance with the pursuit of disciplinary knowledge and the clear need for tailored methods to approach inquiry, interpretive description was developed by Canadian nursing researchers Sally Thorne, Sheryl Reimer Kirkham, and Janet MacDonald-Emes in
1997. Interpretive description was developed out of response to the need for “an alternate method of generating grounded knowledge pertaining to clinical nursing contexts” (Thorne et al., 2004, p. 2). Interpretive description “reflects the kinds of variations on traditional methodological choices that nurses were already making” (Thorne et al., 2004, p. 3) as they sought to understand the “subjectivity of experience within the commonly understood” (Thorne et al., 2004, p. 3), and the context-dependent nature of human experience.

Interpretive description is a method aligned with naturalistic inquiry and the “values associated with phenomenological approaches inherent in the methods of data collection” (Thorne et al., 2004, p. 6). Methodologically, interpretive description is a good fit with the narrative data from MacLeod et al.’s (2004) *The Nature of Nursing Practice in Rural and Remote Canada* study.

Interpretive description generally incorporates small, purposively-selected research samples of participants who share some degree of similarity in their experiences (Thorne et al., 1997). Interpretive description utilizes data collection techniques which facilitate the documentation of meaningful accounts of experience, such as interviewing, participant observation, and documentary analysis (Thorne et al., 1997; Thorne et al., 2004). It is not uncommon for researchers to use multiple data collection strategies as a way to contextualize the interpretation and ensure a comprehensive account of the phenomenon (Thorne et al., 2004).

Inductive analysis is the required basis of any analytical framework employed within the qualitative research tradition (Silverman, 2000). Inductive reasoning is a process of moving from the specific, to procure statements of a general nature. Stated another way, inductive reasoning means that general principles are derived from observations obtained in
particular cases (Streubert Speziale & Carpenter, 2003). According to Thorne et al. (1997), asking questions of the data, such as “what is happening here? and what am I learning about this? will typically stimulate more coherent analytic frameworks” (p. 174). Interpretive description requires that the researcher approach the data with no a priori theories, as to allow for unimpeded, rich interpretations of the data (Thorne et al., 2004).

Location of Self

I graduated in 2002 with a Bachelor of Science degree in Nursing from the University of British Columbia. Since then, I have worked as an acute care nurse in both hospital and ambulatory-care settings in an urban area of southwestern British Columbia. In the fall of 2006, I worked as a research assistant for a Toronto-based nursing study examining nursing interruptions, where I performed approximately 50 hours of data collection. This experience provided me with a first-hand opportunity to learn about the process of gathering data, and helped me discover a greater appreciation for the processes involved in moving from raw data to finished product. I believe that from this experience, I am better able to understand that with regard to data, “it is what it is,” and that in order to be true to the qualitative tradition, you cannot manipulate or interpret data to be something that it is not.

From the outset of this study, I regarded nursing as a profession. Having practiced as an acute care nurse for the last seven years, I have my own opinions about what I feel are professional roles, actions, and responsibilities in the workplace. As I regard my own nursing career as a “professional” one, this preconception has likely influenced the lens with which I have approached the data.
Description of Participants

Participants in this study included eight female nurses from the western Canadian provinces of British Columbia and Alberta. Amanda, Kimberly, Shannon, Emilia, Sara, Catherine, Heather, and Rebecca (all pseudonyms) are all Registered Nurses who worked in a rural hospital setting, and were self-identified as having a practice focus in acute care nursing. The main industries within their communities included: oil and gas, forestry, lumber and pulp mills, recreation, and tourism. The average population of the rural communities was 7700 people, though many participants described that their hospitals also provided service to surrounding towns and areas. This means that they may also be responsible for as many as 10,000 additional people from outlying areas. None of these communities are located along commuting routes of large, urban centres. The average time to travel by road to an urban hospital or referral centre from these communities was 3 hours (range: 1.5 – 8.5 hours), and one nurse noted that in her community, referrals are not usually done by road, but via 1.5 hour aircraft transport.

Nurses described the hospitals in which they were employed as ranging in size from 5 – 24 acute care beds, with the average size being 12.8 beds. On average, these participants had been employed as Registered Nurses for 20 years (range: 10 – 30 years), and had an average of 16.5 years of experience in a rural acute care practice setting (range: 8 – 25 years). Most of the nurses reported working rotating, 12-hour day and night shifts, though two worked day shifts only, and one nurse worked a combination of days and evenings only. Four of the eight participants worked full-time at one job, one nurse worked full-time and casual, and three nurses worked part-time and casual. Two of the eight nurses had a degree in nursing, six possessed a diploma in nursing, and several nurses mentioned having extra
certification in Basic Cardiac Life Support (BCLS), Advanced Cardiac Life Support (ACLS),
Basic Trauma Life Support (BTLS), Advanced Trauma Life Support (ATLS), and the
Neonatal Resuscitation Program (NRP).

Data Collection

Data for this research project were generated as part of a three-year national research
study entitled, *The Nature of Nursing Practice in Rural and Remote Canada*. Initiated in May
2001 by four Canadian nursing researchers, MacLeod, Kulig, Stewart, and Pitblado, this
study was aimed at developing an understanding and definition of the nature of rural and
remote nursing practice in Canada (MacLeod et al., 2004). Researchers in this study used
Statistics Canada’s (du Plessis et al., 2001) definition of rural outlined previously, to delimit
the inclusion criteria for rural nurse participants. In this research project, each of the Principal
Investigators was responsible for leading one of the four avenues of inquiry: 1) analysis of
the Registered Nurses Database to obtain geographical and statistical information about rural
nursing (CIHI, 2002; Pitblado, 2005); 2) document analysis of relevant nursing policies and
standards (Kulig et al., 2003); 3) a survey of rural and remote nurses regarding practice
(Stewart et al., 2005); and 4) a narrative study (MacLeod, Misener, Banks, Morton, Vogt, &
Bentham, 2008). In the narrative study led by Dr. Martha MacLeod, 151 Registered Nurses
from rural and remote areas across all provinces and territories of the country were invited to
share their descriptions of rural and remote nursing practice. This research study utilized the
interview data from eight female acute care nurses from rural areas in British Columbia and
Alberta. This data was obtained as part of MacLeod’s narrative study, and forms the basis of
a sub-analysis that is within the scope of the original narrative inquiry.
Participant Selection, Recruitment, and Interview Process

Potential nurse participants for *The Nature of Nursing Practice in Rural and Remote Canada* study were notified about the study via word-of-mouth and through advertising in provincial and national nursing newsletters and magazines. Nurses who were interested in participating contacted the study investigators and a mutually agreeable time was arranged to conduct a telephone interview. Prior to the interview, written informed consent was obtained from each participant. Interview data were collected from September 2001 to June 2003 by the Principal Investigator (MacLeod) and two research coordinators. Of the 151 interviews completed, 142 were conducted in the English language, and 9 were done in French by a Francophone research assistant in Quebec. The interviews were conducted with nurses from many areas of practice, including primary care (*n* = 44), acute care (*n* = 35), community health (*n* = 34), home care (*n* = 12), long-term care (*n* = 18), and other settings (*n* = 8).

A purposeful sample of eight interviews with western Canadian acute care nurses was selected for logistical purposes relating to data management and analysis, as well as convenience and familiarity of the researcher with acute care nursing practice. Data saturation describes the point at which the researcher is not hearing or seeing any new information, and this was achieved after reviewing approximately six interviews. Rather than exclude the remaining two interviews (which were the only other acute care interviews from MacLeod’s data pool for western Canada), I decided to include these in order to capture a slightly wider range of stories, experiences, and voices.

This inquiry is guided by the research questions: “how do acute care nurses in rural areas of British Columbia and Alberta describe their experiences of professionalism and
professional practice?” and, “what are the indicators/elements of professionalism and professional practice environments in rural health care settings?”

Interviews were audio taped, transcribed verbatim and then burned to compact disc. Interview times ranged from 45 minutes to 180 minutes, though most interviews lasted an average of approximately 75 minutes. A semi-structured, phenomenological interview format was utilized, which serves to guide the interview, but allows for informal, free-flowing conversation and ideas (Benner, 1994). An interview guide was created by the Principal Investigator (MacLeod), which contained open-ended questions such as: “what is a typical day like for you at work?” During the interviews, nurses were invited to share examples of situations they had experienced in their practice. A copy of the interview guidelines for the narrative study is included in Appendix A.

Data Analysis

As suggested by Thorne et al. (1997), data analysis in the interpretive description can be accomplished using techniques in the naturalistic tradition, such as those explicated by Lincoln and Guba (1985), as “these analytic procedures capitalize on such processes as synthesizing, theorizing and recontextualizing rather than simply sorting and coding” (Thorne et al., 1997, p. 175). Lincoln and Guba’s (1985) data analysis strategy of unitizing and categorizing was used in this study to analyze the interview data for thematic elements of professionalism in rural acute care practice.

Unitizing. In the first step of this strategy, units of data are first extracted from the text, and subsequently transcribed onto index cards (Lincoln & Guba, 1985). In this research study, the units of data comprised words, sentences, phrases, and anecdotes, and these units were carefully transcribed by hand from the transcripts onto index cards. A simple
referencing system was created and included with each piece of data on the index card so that each and every piece of transcribed material could be easily located in the original transcript. Units of data represented “the smallest piece of information about something that can [sic] stand by itself … interpretable in the absence of any additional information other than a broad understanding of the context in which the inquiry is carried out” (Lincoln & Guba, 1985, p. 345). Though it was extremely time consuming, I erred on the side of “overinclusion” of data units on the index cards, as subsequent analytic stages and the quality of the overall study are highly dependent on the quality of the researchers’ effort during the unitizing process (Lincoln & Guba, 1985, p. 346).

**Categorizing.** The second step is described as categorizing, a process which aims “to bring together into provisional categories those cards that apparently relate to the same content; to devise rules that describe category properties and that can, ultimately, be used to justify the inclusion of each card” (Lincoln & Guba, 1985, p. 347). At the beginning, I devised a slight variation of this technique, which involved laying out the cards in a rainbow fashion, and applying any variety of temporary rules for where a card should go on the spectrum. I would then draw a schematic of the zones in my notebook, and use this as a record of the different ways that I was looking at inclusion or exclusion criteria and relative placement for each card. After a few rounds of this over several weeks, I started to feel comfortable with stacking the “alike” cards directly on top of each other, so long as they fit the provisional rules of the cards below them (Lincoln & Guba, 1985, p. 347). The categorizing process was operationally carried out using a “look-alike” or “feel-alike” strategy to determine (either tacitly or intuitively) whether subsequent cards have “essential”
similarity to the previous cards that have been drawn from the pile (Lincoln & Guba, 1985, p. 347).

*Working Through the Analytical Process*

Though I was encouraged by the recurrence of categories on different occasions, I was careful not to let myself become closed in or limited by these first categories that began to appear. Thorne et al. (2004) mention that researchers must be aware of common pitfalls in data analysis, such as those associated with premature categorization, and tendencies to organize and “fit” (p. 10) data into preconceived categories based on the analytic and theoretical framework and premature closure of ideas. I was also careful to spend time getting to know each of the participants’ narratives individually - in terms of their specific voice and stories, before moving back to consider the voices and stories of these nurses as a whole. I believe that this back and forth process allowed several significant categories to surface, because sometimes it was not until a really obvious example of something surfaced, that I was able to see it emerge in other narratives. After about the sixth interview, I found that new words, ideas, implicit themes, and phrases were not emerging from the narratives, which led me to believe that I had definitely achieved the requisite of data saturation.

I learned that engaging in a process of constantly asking questions of my data, such as “why is this here?” “what does this mean?” and “how is this important?” was a helpful activity in terms of freeing myself from any preconceptions I had about rural nursing and professionalism, and allowing the voices of the participants to emerge from the data instead. As the process of data analysis in interpretive inquiry can often be a challenge for neophyte researchers, analysis of these data was also guided by investigators with expertise in interpretive traditions. Through regular communication with my committee members via
telephone, email, and in-person meetings during the data analysis process, I was prompted to
ask questions about my data to elicit new understandings and to explore other possibilities
within my current interpretation.

The unitizing and categorizing approach to data analysis by Lincoln and Guba (1985)
worked very well for me. It was a surprisingly good fit with my own organizational
tendencies, and my known desires for employing logical and efficient systems when working
with, and reducing large quantities of data. Tackling the sheer volume of data included in the
eight transcripts that I worked with could have been an overwhelming experience, were it not
for employing a data analysis strategy that was so compatible with my own natural
approaches to organization.

**Strengths and Limitations of the Design**

The discipline-specific orientation and clear, accessible description of the method are
strengths of the research design, particularly for novice researchers. Interpretive description
offers researchers a unique approach to utilizing the interpretive aspects of phenomenology,
coupled with description which is useful when researching a relatively unknown topic.

Interestingly, Thorne et al.'s (1997) clear descriptions also draw attention to the
somewhat positivistic nature of the interpretive description method, and this can also be
construed as a limitation of the design. Despite the authors' stated intents to align with
traditional interpretive qualitative methodologies such as phenomenology, the descriptions
provided for researchers using the interpretive description method are noticeably
prescriptive, and this is somewhat inconsistent with the tenets of interpretive methods
(Thorne et al., 1997; Thorne et al., 2004). Intentional or not, this observation resonated with
me, and I felt very strongly about keeping the thought about the prescriptive aspects of the
method at the forefront, particularly when undertaking my analysis.

Thorne et al. (1997) suggest the use of Lincoln and Guba’s (1985) strategy for data
analysis, but it is apparent to an inexperienced researcher, that even this strategy is somewhat
rigid and linear. I desperately wanted to avoid strict adherence to a “how-to” model of
qualitative data analysis, so as not to adversely impact or limit the inherent freedoms
associated with the interpretive process. This is not to say that I disregarded the very nature
of, or rigorous demands of the analytic process, but exclusive of Thorne et al.’s (1997)
method, I was also cognizant of the information contained in the wider body of qualitative
interpretive literature and the freedoms associated therein. Mason (1996) cautions that the
organizing and sorting processes of data analysis are not “conceptually neutral activities” and
that researchers “must be aware of the kinds of analytical and explanatory possibilities not
only that you open up, but also that you close off, by organizing your data in certain ways”
(Mason, 1996, p. 135).

Thorne et al. (2004) suggest that researchers using the interpretive description method
should utilize an analytic framework based on a critical review of the current literature to
launch their analysis. However, it seems that they also implicitly suggest that researchers
may encounter problems with these suggested overly-prescriptive procedures, and that they
should feel free to modify the analytical procedure so they are able to maximize the
interpretive aspect of their analysis.
Methodological Rigor

Ensuring methodological rigor in any kind of research study is of utmost importance. In research, rigor promotes transparency in the research procedures, and helps to ensure that findings are reported as truthfully as possible (Roberts, Priest, & Traynor, 2006).

Validity

When reporting my findings from the data, I learned very quickly how tempting anecdotalism was (Silverman, 2000). In academia, students learn to cite the most convincing examples to create an argument, yet in this process this is exactly what should be avoided, as anecdotalism “questions the validity of much qualitative research” (Silverman, 2000, pp. 176-177, emphasis original).

Surrounded by a myriad of excerpts of data and the notion that you cannot include everything in the findings, I think it is only natural to gravitate towards a preference for the richer, more detailed excerpts from the data, as these obviously require less work to show an example of a theme. One strategy that I did use in reporting my findings was to provide excerpts showing the absence of the theme I was describing, because I felt this was an effective means to help elucidate and draw out more attention to the presence of the theme. This strategy reinforces Mason’s (1996) “validity of interpretation” (p. 149, emphasis original), by showing how my decisions and interpretations are transparent and appear logical to the audience, and that alternate interpretive perspectives have been considered (Mason, 1996).

Another avenue that was used to help establish validity of interpretation in this study involved reviewing the findings of this study with a group of rural acute care nurses from northern British Columbia via telephone, as it was not possible to re-establish contact with
the nurses who participated in the original interviews. Through a connection with a nursing colleague, three rural nurses who worked in an acute care, hospital-based setting volunteered to be contacted at home to discuss the findings of my research on an individual basis. This is similar to the process of respondent validation, where research findings are reviewed with participants from the study (Silverman, 2000). Care and critical judgment were employed when using this technique; Silverman (2000) notes that respondent validation is flawed because it can lead researchers to "attribute privileged status to that [sic] account" (p. 177).

Themes from the community and workplace contexts were shared and validated with the nurses. When asked specifically about professional satisfaction derived from interacting with members of the community, nurses expressed general agreement that this was not something they consciously acknowledged, but that it did affirm their sense of being knowledgeable, respected, and helpful.

Reliability

In qualitative research, reliability can be thought of as the trustworthiness of the procedures and the data generated (Mason, 2006; Patton, 2002). Silverman (2000) also notes that reliability in qualitative research pertains to how consistently data is "assigned to the same category by different observers or the same observer on different occasions" (p. 188). In the beginning, it only felt safe to put together cards with a likeness that I felt would appear obvious to anyone, such as cards with identical words and similar topics or phrases. As I became more familiar with the data, I was able to make connections between data using more in-depth reasoning and on the basis of asking questions about the contents of the index cards.

Throughout the unitizing and categorizing processes, I kept a journal of the ideas and questions that I had about the data that I was transcribing and sorting, as a means to keep
track of the different ways that I was thinking about the data. I found this to be a useful exercise because I could in effect, pause, rewind, or fast-forward my thinking, and always feel safe knowing that I would not lose any thoughts or provisional categories. The researcher should maintain consistent use of categories and keep detailed notes on the categories and decision making, as these factors “will add to the project’s auditability and, therefore, reliability” (Roberts et al., 2006, p. 43). Every transcribed copy of an interview used in this study was compared with the original audio recording for accuracy, as Roberts et al. (2006) suggest that technical accuracy in recording and transcribing data are other methods which can increase the reliability of a qualitative research study.

*Preconceptions and the Analytical Process*

Thorne et al. (1997), note that in qualitative research it is naïve for researchers to try and eliminate all potential preconceptions that may affect interpretation of the data. They suggest that researchers should instead, openly acknowledge biases related to researching from a nursing perspective as well as the “inherent or substantive biases” (Thorne et al., 1997, p. 175).

For the duration of this research study, I maintained a reflective journal of my thoughts and ideas about the study and the data, as well as brief notations about events that were happening in my immediate social world. I also tried to keep my own preconceptions in check on an ongoing basis, by acknowledging the existence of my own perceptions and opinions of how nurses acted (or told stories of how they acted) as professionals in the narratives. Paterson (1994) and Thorne et al. (1997) suggest that reflective journaling is a useful method for recording personal reactions to the data, tracking analytic decisions and identifying sources of bias. I look back on the evolution of my understandings of the data
over the past year, and I am amazed at the transformation that has occurred. Through sketches, bubble-diagrams, and pages upon pages of margins riddled with lists, doodles, questions, arrows, and lines, I have sincerely come to respect the challenges of undertaking data analysis and findings write-up in accordance with an interpretive methodology. Van Manen (1990) stated “there is no guarantee … that all students of the human sciences will be able to produce work that is ‘very good’” (p. 3), and through my analytic journey, I have come full-circle to realize the rigorous nature of this undertaking. On one of my first meetings with my supervisor, I was asked (with regard to opting to write a qualitative thesis), “are you sure you want to do this?” This question, (along with Van Manen’s haunting words) has resulted in many sleepless nights and countless episodes of writing stalls and anxiety. What I have learned (and now embrace), is that data analysis is truly an ongoing, lengthy process, and it cannot easily be hurried along. Basically, I have learned that you “get there” when you get there, and more often than not, time spent away from the analysis is as productive as time spent engaged at full depth in the data. Throughout the course of my data analysis, this journaling process was a means to record my analytic decisions, the interpretive process and inductive reasoning, and a tangible indicator of how my analyses were moving forward.

Working Through the Data

The process of capturing a complex and dynamic concept such as the experience of professionalism, and then interpreting and reporting it in a meaningful way has been challenging, as the concept is inherently elusive.

After an extensive period of exploring the data in relation to various descriptive metaphors, I found myself starting to consider the words experience of professionalism
carefully, focusing primarily on understanding the enabling factors that allowed a nurse to experience professionalism. I began to ask questions like, “how does professionalism occur for these nurses within this data?” and, “what is this nurse’s story telling me about being a professional?” Often, I found that making the distinction between the *experiences* versus the *indicators* of professionalism in the data was extremely challenging. Not only did I previously regard them as one and the same, but the more I worked with the concept of professionalism in the context of my data, I produced more and more questions about the distinction, eventually arriving at a new understanding of how they are different. The way that I understand the experience of professionalism, is that because it is an experience, it is contextually-dependent, and therefore must manifest from within the individuals’ own ideas, perceptions, and words. Indicators, on the other hand, while they can also be voiced as part of an experience, can also be somewhat more objectified, and can often be artificially created within the environment to facilitate an experience. Indicators are the decontextualized labels which are attached to an experience, by someone other than the person reporting the experience. To clarify, consider the concept of autonomy as an experience and as an indicator in the following example. As an experience, a nurse makes contextual reference to autonomy using language such as: “I made a nursing decision to change this patient’s dressing,” whereas as an indicator, this statement can be processed decontextually by a researcher and also reveal the existence of autonomy. Experiences and indicators differ in the sense that they are dependent on the proximity of the individual to the original experience. Experiences are always first-hand, whereas an indicator represents how someone else (external to the original experience) understands, classifies, and reports that experience. In this study, nurses’ narratives are the original experiences. My analysis and interpretation provide a distilled
conceptualization that can be used to delineate the indicators of professionalism in a rural acute care setting.

As researchers, recognizing the distinction between experiences and indicators is important. Indicators are frequently measured as evidence of a phenomenon, and this observation warrants some re-evaluation of our approaches toward researching concepts such as job satisfaction and professionalism in nursing practice.

**Ethical Considerations**

Participants were informed of the voluntary nature of their participation in this study, and their right to withdraw at any time or refuse to answer any of the interview questions. No remuneration was offered to participants, though participants were able to receive copies of their transcribed interview if they so wished. Confidentiality of interview participants was maintained, as audio tapes and transcriptions were accessed only by research personnel. Anonymity of participants was maintained through letter coding of all identifying names of people and places, and pseudonyms have been used in this study to reference participants and narrative excerpts from the interview data. Data have been securely stored under lock and key, and will remain stored for an indefinite amount of time. Ethics approval for the narrative study was obtained in August 2000 from the University of Northern British Columbia Ethics Review Committee, and this current sub-analysis project falls within the scope of the original ethics approval (see Appendix B).

**Other Considerations**

All interview data in this participant sample were collected through telephone interviewing, and by persons other than this researcher. Both of these issues impose some degree of limitation on the data. By conducting interviews over the telephone, researchers are
not able to observe and make note of facial expressions, hand gestures, body positioning, or other cues that may alert the researcher to signs of participant fatigue or distraction, or to probe for more information (Rubin & Rubin, 1995). Silverman (2000) suggests that “when people’s activities are tape-recorded and transcribed, the reliability of the interpretation of transcripts may be gravely weakened by a failure to transcribe the apparently trivial, but often crucial, pauses and overlaps” (p. 187). As the interviews were collected by other researchers, the opportunities to create personal field notes or ask specific probing questions of the research participants is an inherent limitation that must also be acknowledged. In a few instances, I found myself wishing that further probing and clarification questions were asked of the participants in reference to certain situations. In addition, the fact that the data were collected prior to determining the focus of this research project also imposes some degree of limitation in the analysis.

Field notes were recorded by the research coordinator, who was the primary interviewer responsible for approximately 70% of the total interviews. Field notes are generally personal notes recorded by a researcher during or after an interaction that help to contextualize the data and record the research experience (Streubert Speziale & Carpenter, 2003). Though I did not use the original field notes, I was able to take advantage of access to the original interview audio tapes to clean the transcribed data. During this time, I produced my own field notes for each of the eight interviews. Hearing the data and making careful notations about specific characteristics of the voices of these participants provided me with the opportunity to yield new perspectives and illuminate emerging ideas about how rural nurses experience professionalism.
Summary of the Research Design and Methodology

In this chapter, the research design was discussed in the context of qualitative epistemology. The interpretive description method is described as a useful, "noncategorical alternative" for researchers who desire "understandings of clinical phenomena that illuminate their characteristics, patterns and structure in some theoretically useful manner" (Thorne et al., 2004, p. 6). As the very root of the nursing discipline is situated around knowledge development and the continued pursuit of professional development, the analysis derived from these interviews will yield some valuable insight into the nature of professional nursing practice as it exists in the everyday work experiences of rural acute care nurses in western Canada.

This interpretive description inquiry (Thorne et al., 1997) was guided by an inductive analytical approach in the naturalist paradigm as described by Lincoln and Guba (1985). A detailed discussion of the data analysis process, decision-making, and inductive reasoning was highlighted, with specific attention to my experiences in engaging in the research process in the context of the literature.

In the following chapter, the emergent findings from the analysis process will be presented. These findings capture rural acute care nurses' experiences of thematic elements that support rural nurses' experiences of being a professional, and the existence of professional practice environments.
Chapter Four: Being Professional in the Community and Workplace

Introduction

In this chapter, I discuss the findings of my research, and share my interpretation of how rural acute care nurses in western Canada experience professionalism. Examples of unprofessionalism are also presented, as sometimes highlighting the absence of a concept can help to show the idea in its presence. The data collected in the original study were primarily workplace centred and as such, nurses' experiences of professionalism in this context comprise the largest proportion of the findings. However, within this (re)presentation of the data, there is an appreciably strong notion that being a professional nurse in a rural setting is an experience that extends beyond the physical boundaries of the hospital environment. When nurses were asked to describe their day-to-day work, responses were frequently intertwined and embedded with descriptions of interactions and experiences occurring external to the workplace. There is an apparent degree of permeability between the rural workplace and the community setting, and it seems to add another very interesting dimension to the lives and experiences of rural nurses; it can enhance, and at times, also compound the unique challenges of being a professional.

Overall Interpretations

The overarching day-to-day experience of professionalism for rural acute care nurses in western Canada can be best conceptualized and described in terms of nurses' interactions in two major contexts: the community and the workplace. In the narratives, nurses' descriptions of being a professional were contextually situated in reference to their experiences and interactions in the community environment, or in the workplace environment. It is my understanding from the data that the experience of being a professional
nurse in a rural setting is a product of interaction between nurses and their immediate physical environment and social surroundings within either of these two contexts. The experience of being a professional nurse does not appear to be limited to nurses’ roles and activities in the workplace. It seems evident that rural nurses must also maintain their professionalism in the community setting, and this appears to reinforce the overall experience of being a professional nurse.

The interpretations of the data will be presented in terms of nurses’ interactions within the community and in the workplace. It is important to note that these constructs of the community and the workplace should not be considered as absolutes or mutually exclusive; there is a considerable degree of interaction and co-dependence between the two contexts. Within the community and workplace contexts there are also identifiable physical and social factors which are equally critical in fostering the experience of being a professional. Physical factors include, but are not limited to, the hospital workplace, equipment and staffing resources, access to continuing education, and geographic location. Social factors include nurses’ interactions with colleagues, other health care providers, family, friends, and members of the community. It was clear from the data that the community context was as much a factor in rural nurses’ experience of professionalism as the workplace context, and that these two contexts are inextricably intertwined. Quotes from the interviews highlight examples of how rural acute care nurses experience being a professional in the context of the community and the workplace.
The Community Context

The unique physical and social aspects of rural communities are a part of how rural nurses describe their experience of being a professional. Rural nurses are socially embedded within their communities, and this means that their voices and actions are under constant observation by the public eye. The theme of being visible emerged from the narratives, and describes physical and social elements of how nurses experience being a professional within a rural community environment. A rural nurse’s sense of being visible can be considered a unique characteristic of community interaction, as even the physical recognition of being a nurse was sufficient reason for community members to initiate a social exchange. Within the context of interactions with the community, the theme of being visible and several related themes emerged: managing obligations and expectations, maintaining confidentiality, and balancing personal-professional relationships.

Being Visible

“Nowhere to run, nowhere to hide, got nowhere to run to…” Martha Reeves and The Vandellas (2000, track 2) will probably never realize how well their famous lyrics capture the inherent visibility of rural nursing. Rural nurses are subject to a high degree of visibility within the community environment, and the feeling of being constantly watched was related by many of the participants. Catherine described that when living and working in a rural community, she is well aware that “as a nurse, you’re kind of in a fish bowl.”

All of the participants made reference to the notion that their position as nurses made them very visible within their communities. For these nurses, being recognized as a nurse often meant that they were unable to set aside their duties and roles as nurses, and interact with other community members in a way where their professional knowledge and expertise
was not the basis of the relationship. As Catherine related, “people do know who the nurses are, and you will be approached in various places for advice and information.” For many nurses, this visibility within the community made it difficult to escape from work. As Rebecca explained:

The bad thing is sometimes you just can’t get away from work. You know, you walk down the street … that’s what my husband says to me all the time, if we walk down the street together and everybody’s like: “Hi, how are you? Do you remember me?”

One nurse recalled how being publicly recognized as a nurse meant that she did “a lot of consultation at the Overwaitea” and that this made it hard for her to change roles and assume a separate, non-professional identity within the community. Unlike urban nurses, who are able to enjoy relative anonymity, invisibility, and freedom within their communities, the visibility of being a nurse in rural community can be prohibitive. The experience of being a professional in an environment where one is constantly visible adds a degree of stress and pressure, as there is a heightened awareness of the notion that even when they are off duty, the watchful eyes and attentive ears of the public are still present.

Rural nurses related that being visible outside of work made them feel obliged to interact with former clients in the community, remember specific details about them, and to always maintain a caring and professional disposition. The basis of nurses’ relationships with many community members was about remembering patients and their family members and friends. As Amanda related:

Well, I guess when I go downtown and go shopping or something, lots of people will say, “Oh hello, remember this baby?” And lots of times I really don’t remember … just kind of remember. So I just ask how they’re doing and stuff. And a lot of times I really don’t feel like going downtown shopping when I know that there are going to be a lot of people.
In this excerpt, Amanda expressed how her visibility as a nurse can be prohibitive in terms of her own social life, and can be a hindrance in her ability to go into public without being seen and approached as a nurse. Amanda’s words seem to also convey her acknowledgment of the fact that she does have a special elevated status in the community, and it seems that her lament about not wanting to go shopping when there are a lot of people also references a subtle admission of pride (as evidenced by tonal changes on the audio tape) about her career and community regard. Interestingly, Amanda made another comment which seems to stand in opposition to her stated dislike for being seen in the community, when she makes this comparison between urban nursing and rural nursing:

I think there’s something to be said about working in a big facility in a big city ... nobody knows you ... you go in, do your work and then you go home and nobody notices you. Whereas here, a lot of times ... you know that people know who you are.

This sentiment was also related by most of the other participants, and it seems to send a strong message that rural nurses prefer the status that visibility gives them in the community, when invisibility or anonymity is the alternative.

Nurses’ stories expressed the term visibility instead of lack of anonymity, even though lack of anonymity is a well-known characteristic and theme commonly associated with rural nursing (Long & Weinert, 1989; Raph & Buehler, 2006). The nurses’ reference to always being seen was a prominent, recurring theme throughout their stories and implicit in their descriptions of experiences. First and foremost, nurses’ visibility preceded subsequent activities also known to characterize lack of anonymity, such as the nurse being approached for advice because community members knew her as a nurse. Visibility is very closely related to the notion of lack of anonymity; however visibility in the context of these findings represents a more defined, specific element of the catch-all phrase, “lack of anonymity.”
notion of visibility is an underlying theme in the community context, acting somewhat like precursor to a cascade of related experiential themes such as obligations and expectations, and confidentiality. These themes surface from an unmistakable understanding that each exists because the nurse herself is speaking from a place where she is aware that others react to her visible status as a nurse.

Managing Obligations and Expectations

Aside from not being able to escape the permanent identity of being a nurse, many nurses perceived visibility as an inherent benefit, and related that they felt it helped them feel like a professional. Knowing that people would approach them for advice or ask them questions outside of work helped these nurses affirm their position as a respected and trusted member of the community. Many nurses said that community members held an expectation of how nurses ought to act, and that they were obligated to maintain a professional disposition at all times. As Sara said, “you want to do your best because you know that people look up to you and everybody knows everybody.”

In the narratives, it was evident that rural nurses felt a pressure to behave professionally, and always interact with community members in a courteous, helpful, and friendly manner. The issue of knowing members of the community on a personal level (i.e., as neighbors or friends), also adds extra demand on rural nurses to ensure that they are always professionally mannered and personable. Many nurses expressed the sentiment that they felt obliged to be extra accommodating to clients from the community, as public perceptions could destroy their reputation within the community.

Sara: And, you know, it’s important to you to do your best for them.
Interviewer: And why do you feel that?
Sara: Why do I feel it’s important? Like I say, you live in this community. I mean, you know how word of mouth ... you know, if so and so went into the hospital and I
treated her as a real bag … You know that’s going to get around the whole town. I mean … you know, you want to be respected, to a degree.

The visibility of nurses within rural communities means that they are also seen as leaders within their communities, and many participants expressed that they were expected to set a good example for the community. As Catherine said, not only is there “no place to hide,” but she also explained how she felt that her actions were observed, and perhaps mirrored by members of the community:

I try to lead or provide a healthy example. I’m not someone who goes to the bar or that kind of thing. We do, my husband and I, go for walks frequently so they see us out walking and trying to lead a healthy lifestyle which I think is trying to present a good example for everyone really. Because I think in a lot of times the nurses are watched as to what they are doing, and maybe people try to follow what they’re doing.

It is unclear whether it is the nurse who actually consciously defines the active interest in living life by the “healthy example,” or whether this is an associated obligation and expectation imposed on the nurses by the community. What is apparent are the undertones of pride and perhaps even the nurses’ knowledge of their elevated professional status and leadership role within the community.

Maintaining Confidentiality

Visibility in the community also meant that nurses were sometimes approached by other people and questioned or pressed to provide personal information about clients that were, or had been admitted to the hospital. Nurses in rural settings must be able to maintain a degree of strictly professional knowledge, or insider information that is known only between members of the staff and is not shared with the public. Part of a nurses’ professional role is the ability to maintain the anonymity and confidentiality of their clients, and to safeguard private information. Navigating this issue, without coming off as rude can be especially
challenging in smaller communities when there has been a previous nurse-client relationship, or there are mutual friendships involved. As Heather stated, “you have to be careful because people will stop and ask you if somebody is in the hospital, or how they are or what ever. So with the confidentiality thing you have to not say what’s going on.” Sara also mentioned that “confidentiality is super important, really important in a rural community.”

Rural nurses, by virtue of the fact that they straddle two very different positions within their community (one as peer, the other as professional), are practically unable to wholly put aside, or bracket these community relationships and knowledge, and act independently in their professional roles. Though there are certainly noticeable limitations on the degree of mutual transfer between the relationships, this element is not necessarily detrimental to the professional experience of rural nurses. For example, the professional obligation of confidentiality to clients ensures that certain information is not shared from within the internal workplace environment to members of the community at large.

It is also up to the nurse to manage her own confidential knowledge about a client, and to not let that interfere with her personal relationship with that person. Understandably, this can be difficult when nurses are privy to such intimate physical, emotional, and psychosocial knowledge about another person. Holding this information separately and maintaining more or less dual roles in their interactions with a person (one as a professional, the other as a peer) takes enormous talent and skill. Rebecca captured the essence of this relationship in the following excerpt:

You kind of know the history of some of the people, so when you’re out in a social situation you’re thinking, “Oh, I shouldn’t have been here ... or, I know that person and I know what they’re going through and they’re not handling it very well ...” That kind of thing.
As a nurse in a rural community, having too much personal knowledge about another person can be as beneficial as it is prohibitive. Amanda’s comment about not wanting to go out shopping downtown when it was busy is echoed in the above quote by Rebecca, who expressed the challenges of balancing this relationship in a social setting.

**Balancing Personal – Professional Relationships**

The eight nurses in this study related that part of being a nurse in a rural hospital setting is the experience of having close relationships with people in the community. The smaller staff pools in rural facilities also dictates that staff members develop much closer working relationships and familiarity with their colleagues. While this familiarity can sometimes heighten the pressure on rural nurses, it can also be a source of strength and cohesiveness. Nurses in this study acknowledged that knowing members of the community was a challenge in their day-to-day experiences, both at work and away from work.

Each and every nurse participant in this study alluded to the inherent challenges of knowing her clients, and the family members of clients on a personal basis. In smaller rural communities especially, it can be understandably difficult to separate personal and professional relationships, even more so during times of crisis. In the data, the quality of care given did not appear to be compromised because of these factors, but the emotional burden of knowing the clients in the community context seemed to weigh heavily on workplace morale. Shannon was candid with her acknowledgment that “in a town this size, everybody is related to everybody, either through blood or through marriage.” She also mentioned that “the hard part about working here is the longer you’re here, the closer the ties. The longer you’re here, the closer people feel to you. That’s the demanding part ... the personal demand.” Sara noted how in her workplace, “you know most of ... a lot about almost everybody that comes in
here.” Amanda related that a current stress in her workplace was also due to knowing the client: “Right at the moment, our maintenance man is in there, he has terminal cancer as well, which is kind of taking its whole toll on us as well.” Catherine shared a particularly moving description of how knowing her clients made the situation more stressful:

We’ve had patients … trauma victims that we have worked on that have passed away and I guess one of the saddest ones was just a few weeks ago. And actually the gal, the first gal that I was talking about; the asthmatic gal- it was actually her new husband who was fatally injured by heavy machinery. And I walked in to work that morning hearing her on the phone yelling “Sam’s gone!” And I went in to see that they were doing a full arrest procedure trying to save this fellow. And, as I say, it was unsuccessful. So then we had, again, knowing both of these people it was very stressful on everybody; physicians, nurses and actually everybody in the hospital, because they were all well-known to us. And that also brought another element of worry to people because our highway rescue had gone to the accident as well. So we had all the rescue people standing around being upset and trying to help as well.

Amanda commented on how she perceived that the challenges of working as a rural nurse increased the longer she was a member of the community:

I know more people in this town and they know me, [laughter] and it’s quite hard sometimes. You know, I would definitely … I’ve talked about that lots and that’s probably one of the reasons why I chose to do this study. I think the longer you are in a rural setting, it does get harder. You just … you know so many people and you know so much about everyone and … and it does get difficult after a while.

Catherine and Amanda’s narratives offer some interesting insight into the unique and emotionally difficult position of rural nurses when health crises arise. It is apparent in these excerpts that there is a delicate balance between the nurses’ professional obligations, personal relationships, and emotional involvement, even at the best of times. The tone of these narratives of crisis echoes an admission of the difficulties involved, and that nurses function as the caretakers in their communities. Catherine expressed concern about the involvement of uninjured peripheral players such as the highway rescue crew, and this comment reflects the close-knit relationships in rural communities.
The complexities of community relationships and how they affect the actions, emotions, lifestyles, and work of nurses, are an undeniable unique aspect of rural settings. The familiarity of rural nurses with members of their community offers challenge and reward to the professional experience within the community. The nurses' inherent visibility within the community brings with it obligations and expectations, as well as the need to address issues of confidentiality, all within the context of balancing personal-professional relationships.

The Workplace Context

As in the community, the workplace context seems to be mediated by interactions between the nurse and the physical environment (i.e., hospital equipment and resources) as well as members of the social environment (i.e., other members of the health care team). Rural nurses discussed these interactions as either contributing to or detracting from their experience of being a professional in the workplace. Part of the professional experience for rural nurses in their inherently unpredictable practice, is recognizing the need to be flexible and being prepared to manage unrehearsed events to the best of their ability. Not only does this require quick-thinking, but it also demands a considerable amount of teamwork and collaboration among the nursing staff. Embracing reality was interpreted as a significant, recurring notion within the themes of the workplace context, relating to the casual-yet-professional, roll-with-the punches, dynamic attitude that rural nurses adopted as part of their professional demeanor and professional practice. Within the workplace context, themes such as: improvising and adapting, being versatile, being prepared, teamwork, positive feedback and professional pride, and equipment, education, and staffing are presented. Selected themes which appear to highlight the absence of professional behavior are also discussed, with the
intent to share a rich and detailed understanding of the experience of being a professional rural nurse.

*Embracing Reality*

Among the participants, there was an acute, even somewhat darkly humorous awareness of the reality of their workplace situations. Many nurses made very specific, matter-of-fact references to the way things were for them. Most participants spoke very candidly about the often hectic, and sometimes difficult and downright challenging aspects of their work as rural nurses. The ability of rural nurses to improvise and adapt to rapidly changing situations and to be versatile and prepared, emerged as prominent, recurring themes in the narratives. The overarching theme of embracing reality describes how, in spite of the fact that rural nurses battled immense challenges each and every day, they were not necessarily discouraged by this. Embracing reality is a theme that captures rural nurses’ awareness of the demanding nature of their roles, and how instead of engaging in a constant, frustrating battle with the challenges of rural nursing, they have learned to improvise and adapt, be prepared and be flexible and find enjoyment in their work. Humor and sarcasm were detectable in nurses’ descriptions of their workplaces throughout the narratives, and in the following excerpt, Rebecca described how she dealt with a particularly hectic day at work:

> What helped? Like afterwards? Coming home and having a really long shower. And a great big cup of tea! [laughter] And venting to my husband. The staff works well together in those kinds of crisis situations. There was lots of, not laughing going on, but you know, you get to that point of giddiness or something when you’re stressed. And there was lots of like, “Oh, what else is going to come through the door?” That kind of thing. And then, sure enough, it’s like, “Who said it? I’m going to kill that person who said that!” And you know, it was a lot of just kind of joking, like in a lighthearted way … I don’t know how to describe it other than … yeah, that kind of giddy … not giddiness … that kind of, you’ve got to vent somehow, so if you can’t laugh about it, what can you do, right?
Sara referred to the challenges in her job as a “juggling act,” but she also felt that rural nursing “is an art when you get it all figured out.” In this brief comment, Sara speaks from a place of experience about the many challenges of being a rural acute care nurse, and there is an evident sentiment of self-importance and satisfaction that is derived in knowing that she is able to handle these situations with confidence. Catherine shared her thoughts about why it is also important for rural nurses to be flexible and open-minded when approaching a shift:

You have to be flexible in the way that the workload often changes quickly ... you may have to respond to the post-anaesthetic recovery room [PAR], or the buzzer. Even on the ward it’s not just ten medical patients. It might be a medical patient and a surgical patient and a palliative care and a child and a relatively fresh surgery, because some of our surgeries are inpatients. Or, somebody post-stroke. So, the workload and the acuity can be quite varied. And then you can add in a couple of long-term care wanderers that are waiting somewhere else to go, and are with us. So you sort of need to be alert to all sorts of things like, “Where is Mr. Jones, and has he wandered toward the front door?”

Catherine’s description of the nature of her work is honest and frank, and she seems not to lament how varied the workload and acuity can be. Her confidence in sharing what her work is like is also interpreted here as a source of professional pride in embracing her reality.

Shannon also spoke of the fast pace in her workplace, “when you have emergencies come in, if you get two ambulances back to back with only two of you working, you really ... you really have to run to keep up with that, you know.” The matter-of-fact undertones also emerge here, showing elements of pride and satisfaction in her ability to teach the interviewer so confidently about the busy nature of her job. Embracing reality was a theme that surfaced in the narratives of all participants, and was interpreted as a vital component of being a professional in an acute care nursing setting. The nurses commonly acknowledged that they belonged to an elite culture of seasoned specialists, and this acknowledgement reinforced nurses’ personal beliefs about their professional status.
Improvising and Adapting

Acute care nurses have a certain timeline of anticipated events during the course of a shift, as well as certain ways of doing things, and certain tools that they depend on in order to do their job well. Sometimes though, the ideal equipment and resources are simply not available, and this means that rural nurses often have to use their knowledge and expertise to improvise a temporary fix, using available knowledge and resources to manage the problem. Even more interesting is how rural nurses describe managing these incidents not with an undertone of frustration, but with a mostly cheerful air of pride and a take-it-in-stride, matter-of-fact attitude about their own reality. Shannon described candidly how, "we run out of IV poles, we end up using coat racks, you know ... [laughs]." Catherine characterized rural nurses as being "very good about making things work with what we have." The ability to adapt, and be adaptable, was also cited as a key asset of how to manage the professional yet dynamic role of a rural nurse. In the following quotation, Rebecca shared her view on how to overcome the challenges of being a rural nurse: "In here, it’s general. So just being able to adapt, changing and adapting. Adapting is a big thing down here."

Not only are rural nurses often faced with having to make creative improvisations with medical equipment, but part of the experience of being a professional in this setting is learning to play many different roles. Shortages in staffing, sick calls, and especially the arrival of unexpected emergencies and critical events during a shift, can necessitate that rural nurses assume unrehearsed or unfamiliar roles at work. Sometimes these changes are announced in advance, but often times, the nurses must adapt to their new roles with very little advance notice. Catherine noted that in a rural facility, "you need to have the ability to change gears quickly ... even though you might be the ward nurse, you may have to come
and help downstairs in an emergency.” Sara related how “all of a sudden, what you’re doing, you’ve gotta drop and you’ve gotta go help somewhere else, and another nurse has to pick up and take over your workload.”

The demand on rural nurses to assume so many different roles means that there is little chance to do physical, mental, or emotional preparation for the shift ahead. Rural nurses seem to balance these constantly shifting role demands in a rather fluid manner, and accept this as another part of the rural nursing reality. Even for seasoned professionals, the physical and emotional demands of constant role-changes can be overwhelming and potentially defeating. Despite these challenges, rural nurses are still able to perform their job, and this speaks volumes about the degree of knowledge, dedication, and skill that these nurses possess. Emilia shared her experience with role changes as part of a regular occurrence in her place of work:

Emilia: See, what I have now is a float position, and I float all over, or wherever I’m needed if somebody’s off. But I don’t do the intensive care unit [ICU] and I don’t do maternity. I can start off on unit A and end up on unit B. It depends who’s off. I could end up in extended care that day and then the next day turn around and be on unit A again. I could be in charge ... Interviewer: So you have a regular schedule? Emilia: I have a regular schedule. Interviewer: And then you sort of fill in whatever blanks are there for that day, as a float? Emilia: Yeah, yeah. I have had my schedule change ... once. They gave me ten days’ notice, so instead of working days I was going to do an extra night. Interviewer: So how often do you get consistency from one day to the next? Emilia: Oh ... not very often. [laughs]. Not very often. I can be ... you know, different ... within a two days, two nights period I could be in three different areas. Three different ... how can I say it ... I could be in charge one day, then just be on the floor the next day, and I could be in extended care the next night and then be in charge again back on the acute side the next one.

Rebecca also related an example of the variety of work that she experienced, and the expectation that her role was to manage what came through the door, despite staff reductions.
In a small place, you work everywhere. You deal with ... usually two nurses on per shift and well, we had three on days but that one’s being taken away, removed as well. So, there’ll be two nurses per shift and you work everywhere, so you deal with what comes through the door or whatever ... if it’s a car accident or somebody’s in labor or a cardiac.

In terms of the demands that are placed on her at work, Sara describes that “nothing really shocks me anymore.” Like Rebecca, Sara said that regardless of what comes through the doors of the hospital “you have to deal with it.” Regarding her workload at the hospital, Amanda said “things are going to bother you, but you know, ‘That’s life!’ Hopefully it’ll make you a better person.” Acceptance rather than apathy seems to appropriately capture the essence of the experience here, as rural nurses are simply expected to manage anything and everything. Amanda’s comment also carries the subtle undertones of pride and an acknowledgment of her own embracing of the realities of her workplace. Her notion of being able to grow and learn from the experiences related to a demanding workload is interesting, and also speaks to her own degree of perseverance and dedication to the nursing profession.

Being Versatile: “Jack of all trades, master of none.”

Many participants described their role as rural nurses akin to being a specialist in general nursing. Two nurses, Rebecca and Sara characterized the work of rural nurses using the same phrase, “Jack of all trades, master of none.” This phrase was used in the context of describing the varied types of tasks, knowledge, and roles that a rural nurse must be able to assume on any given day. This statement also represents a notion that these rural nurses feel as though they are expected to be able to change roles as the situation requires, and also that there is a detectable degree of pride attached to the wealth of knowledge that they have. Several others also alluded to this idea within their narratives, using phrases such as “I feel
that I know a little bit about everything” (Heather) and, “you need to know a little bit about everything” (Shannon).

Rebecca described the talent and experience of the nurses that she worked with and the varied scope of practice in her workplace:

Rebecca: It’s just challenging and yeah ... it’s just challenging some days!
Interviewer: Challenging in what way?
Rebecca: Well, just the variety that comes through the doors, and keeping up-to-date on your skills and being kind of a jack of all trades, master of nothing. Like we all can handle it and you can deliver a baby, deal with a myocardial infarction [MI] or whatever happens to come through the doors. But like I said, we’re not all intensive care unit [ICU] nurses or all cardiac nurses or all obstetrical nurses. We don’t have all that ... we’ve all got a variety of experience. And I think that’s one thing with rural nurses, we all come from a variety of experiences. So you know, some lean a little bit more towards ... some nurses really like maternity and some really like cardiac. We do it all, but you have your little favorites that you like doing.

Though there were many examples of role changes in the data, one of the most interesting features of the descriptions is how there were few expressions of complaint or sentiments of resistance when this happened. In an almost ‘we did it because we had to’ or ‘it’s up to us’ mentality, these nurses realized that in most cases, there was no one to fall back on or assume their role. In some instances it seemed apparent that nurses may have derived a sense of satisfaction, self-importance, and pride in knowing that there was no one else around to do the job. For these nurses, being versatile was just another facet of how they embraced the realities of their workplace and shared their experience of being a professional.

In the narratives, nurses expressed their enjoyment of the challenges associated with versatility, but it became quite clear that being an acute care nurse in a rural setting is not a role for everyone. Catherine’s belief was that “a small place attracts nurses that want a greater variety of experiences.” These rural nurses are quite conscious of the fact that the job can only be done by a certain people, and they are keenly aware of their responsibility to the
hospital, to their colleagues and to their communities. Earlier in this discussion, I interpreted nurses’ sense of being a generalist as an enabling factor toward their personal beliefs about being a professional. In terms of being versatile, this sense of being a knowledge generalist (i.e., being a “Jack of all trades”) was also interpreted as a supportive element of a rural nurses’ experience of professionalism.

In many cases, nurses expressed that they were the ones who assumed responsibility for keeping the hospital running. Emilia noted that “you run that place because there’s nobody else but you.” Sara described her experience as:

You know, who are you going to call? Who’s going to help you? It’s up to you tonight and there’s nobody right there handy to come in and help you, you’ve gotta make the decisions by yourself.

As Sara’s words show, rural acute care nurses are keenly aware of their enormous responsibilities and professional autonomy on a day-to-day basis. Part of this awareness gives way to an unusual form of acceptance of the notion that a rural nurses’ reality is unlike any other.

**Being Prepared: “the Boy Scout school of nursing”**

It was clear in the stories from this cohort of rural nurses that unexpected events are to be expected in this line of work, and that being prepared for anything is the best course of action. Catherine described that one of the challenges of her job was related to the variety of patients, and not knowing what could or might happen in the course of a day. She expressed how being prepared like a Boy Scout was one way she responded to the challenge of not knowing what was coming.

I guess, the variety of patients that come in the doorway is challenging. Sometimes we have warning of what’s coming and sometimes we don’t. The ambulance people are very good about giving us as much information as they can and as much warning of what they are bringing in. So trying to get prepared for what they are bringing us. I
always say that I went to the Boy Scout school of nursing and so I tend to have everything ready that I’m going to need. On my recovery room days I don’t leave until the room is absolutely set up for the next morning. So that if something happens and I get called in during the night I know where things are and that everything is ready to go ...

Sara’s words also speak to the theme of being prepared in the following excerpt:

But, anyway, what I’m saying is you never know what’s going to happen in a rural hospital. And regardless of what happens, you’ve gotta be ready because that’s why you’re there. You are expected to know something about all of these things.

She also goes on to describe how, despite the unknown event or situation that could be coming, how being prepared helps her feel like she did the best she could, even if the outcome was not ideal.

And so you don’t know if it’s gonna be maternity, you don’t know if it’s gonna be a stroke, you don’t know if it’s cardiac, you don’t know if it’s pediatric, you don’t have a clue what it’s going to be. So you sit there, it’s like emergency, but they don’t really tell you, and plus, you’re looking after a caseload as well. So it’s really a lot like working in an emergency department ... And you know, you’re constantly anticipating, well, your meds are done ahead of time. You do whatever you can ahead of time. Your whole ... everything is planned ... just in case ... And it’s such a high, you know, when you come off a night that’s just been absolutely wild, or a day for that matter. I remember at West Ridge, I mean it would take me two hours to settle down ‘till I could go to sleep. And it might not have gone well, but the fact that you did the best you could and the team worked well for you, that’s important.

The notion of being prepared was also highlighted by Heather, who described how she took extra time to familiarize herself with an unknown space, in the event that she was called to work there:

Whenever there’s a slack spot I like to go down to Emergency and I like to go through the crash carts. Because I’m casual, I’m not as familiar as the other girls, so I go through it and go through it and go through it and I go through the cupboards to see what’s there, what’s not there, what’s expired, in case I have an emergency, so that I am familiar again where everything is and the protocols, if I find protocols that I’m not familiar with. I go through the labour and delivery room. I go through the nursery again just to see where everything is again, to make sure that I remember where everything is. Now, if I get a chance in the night, I’ll do a kind of little mock resuscitation on their little practice babies, to practice neonatal resuscitation so that I’m prepared...
The repeated emphasis on being familiar with protocols and equipment seems to capture another facet of this nurse's understanding of her expectations and responsibilities as a professional. Heather's narrative tells of the voluntary and perhaps relatively routine nature in which she engages in refining her skills and knowledge of her workplace. This seems to suggest that being prepared is a normal activity in her reality of being a professional nurse in a rural setting.

**Teamwork**

One of the most talked about aspects of being a rural acute care nurse was the existence of strong teamwork in the workplace environment, and the notion of nurses working together. Within every interview, nurses had very positive comments about their colleagues and they frequently mentioned that helping each other out was an integral part of the enjoyment of rural acute care nursing. The cohesiveness among the staff was often referenced as a highlight of the workplace environment, and teamwork was often cited as a key reason why emergency situations resulted in good outcomes. Sara discussed how "teamwork is so essential" and that "where there is true teamwork, it is so ... fulfilling. So fulfilling ... it's wonderful." Sara also felt that the essence of teamwork was about "helping each other accomplish the work that needs to be done in a time frame" and someone else "anticipating the needs ... going here and picking up where I left off because I can't get to it" as well as "supporting each other ... and looking out for each other. That's teamwork."

Shannon related how teamwork was not necessarily a given in a rural hospital, and that in her community, she felt "lucky" because "everybody works together." Teamwork was also viewed as a factor which fostered good working conditions, regardless of the specific people who were participating in the care. Several nurses recalled how even non-hospital
staff were sometimes called over to assist with acute situations when there weren’t enough hands to manage. Catherine noted how on her unit, she “works very closely with the ambulance attendants. When they bring patients in, they stay with us if it’s somebody that’s critical, if they can be of help to us because we are very limited in staff members.” Kimberly recalls how one time on her unit, “we had the policeman bag the patient” because there weren’t enough hospital staff around. Kimberly describes how in emergency situations such as codes, every available person is used, and how a plan was often made so that each member of the team knew their role:

When you’re at the code, you had to participate, because there just weren’t enough people for someone to stand and watch usually. Everybody did something. You had a couple of minutes to say, “Okay, person A is going to record, person B is going to do the drugs, person C is going to do compressions and so forth.” So we had a few ... a couple of minutes usually to get ourselves organized.

The lack of external staffing resources often meant that it was up to the on-duty staff nurses and other health care providers to support each other and to work together as a team to resolve problems. When equipment and other physical resources are lacking, the presence of good nursing teamwork and collaboration can sometimes be the saving grace on particularly demanding shifts. Shannon noted the strength of teamwork among her colleagues in the following two excerpts:

Interviewer: And if an accident was called in and they needed an extra pair of hands, you would have to ...
Shannon: We can call ... yeah, I’d go in and help, and everybody ... all of the nursing staff are great that way. You know, it’s your day off, but whether you’re on call or not, if you get called in, they don’t call you in to have coffee ... you know it’s serious. I’ve only worked ... I’ve been here since the beginning of 1991, I’ve only worked with two people who are no longer here who have actually said “Well, it’s my day off, I’m not coming.” Anybody else I’ve ever called, they’ve said “Okay, I’ll be right there.” And they are.

Shannon: And the only thing that saves us is that you have people on call and people just come ... it’s okay, because they work the same way. And that’s what saves us, is
that everybody will come in. I’ve only ever had two people out and out refuse or complain about coming in. Everybody else says, “Okay, I’ll be right there.”

Key elements of teamwork for all of these nurses are related to being helpful in a physical sense, such as coming in on a day off, but also being helpful by passing along information, sharing experiences, and engaging in dialogue with their colleagues. Catherine explained how her experience with a client enabled her to share helpful knowledge with other health care professionals, so that they did not encounter similar problems with the client:

I’ve had many transfers with this gal as her being the patient and we’ve worked out things that work on transfers. We discovered that her asthma would get worse in the back of the ambulance just because it was dry, I think. But if we ran continuous saline in her nebulizer then we didn’t run into problems. Usually we had a crisis by the time … more of a crisis by the time we got to A-Town, which is a half an hour down the road. So just the little things that you can work out and sort of write down or remember that work and pass on to the next guy.

Catherine commented on how she felt that on her unit, “the nurses for the most part are very supportive of each other, and work together very well, and they are good about making suggestions and sharing ideas on what might work.” Kimberly shared a rich example of how another nurse talked her through the tasks involved in managing a new situation:

Interviewer: So were you the primary nurse for this lady?
Kimberly: Yes, I was.
Interviewer: And how long had you been with her?
Kimberly: It was during a day shift, I think it was a Saturday, because it was a birthday party this doctor was missing, so I’d probably been with her for five or six hours. She’d had a really nice, normal labor, because nothing sticks out about the labor that was extraordinary or difficult. It was just very, very fast in the end.
Interviewer: So what were you thinking as she was pushing?
Kimberly: Well, the first thought I had was, “My goodness, that’s a head there!” And then I remember being very, very focused on just remembering what to do with my hands to help the baby come out, to the point that the other nurse actually coached the Mom in such a way that she was also telling me what to do without scaring the mother, which was really helpful for me.
Interviewer: And how did she do that?
Kimberly: She just said well, “Kimberly is going to do this now, and the baby’s head is coming out now, Kimberly is going to check for a cord around the neck.” So she was telling the Mom what was happening and at the same time reminding me what I
had to do next, which helped me stay calm, because I was having quite a big adrenaline rush at the time.

Interviewer: I would expect so.
Kimberly: Yeah. So it ... it was good. It was a good experience.

Interviewer: Was there anything that you found demanding about the situation?
Kimberly: [long pause] I usually ... I don’t specifically remember this one, but I usually found the first sort of few moments with the baby a bit stressful. Just because the one thing I didn’t personally like as much about maternity nursing was resuscitating newborns ... just because I found it personally to be quite stressful. So just to suction the baby out, making sure that the baby was, you know, taking breaths and turning pink and doing all the things that they’re supposed to do. That would have been stressful for me. But again, there were two of us in the room, so it was a team effort.

Rebecca felt that on her unit that “the staff members work well together in crisis situations” and she shared a story about how nursing and interdisciplinary teamwork was a predominant feature during a busy day:

There was an incident where ... well, it was one of those crazy days at the hospital, and I was thinking of nursing making a difference by working as a team, and also where patient outcome was good. I came in for a delivery, got called in at 4 o’clock in the morning for a delivery, so I had managed that, and then she proceeded to have a postpartum hemorrhage with retained placenta, so we managed that, and as we were just kind of like finishing up with this patient, this was 9 or 10 o’clock in the morning, getting her settled because she had bled quite a bit and so we were watching her closely. Then somebody in ante-partum hemorrhage came in the door and she was 36 weeks, I believe. So she went immediately for a crash section, the other one was stable so we put her on a monitor, parked her near the nurse’s station and took this other girl for ultrasound and crash section. And managed that like that was just a day of catch up, and so the outcome of those two things was good, and just before shift change at 6:30 at night, a cardiac patient came in with a myocardial infarction [MI], who within an hour and a half, we had shipped to B-Town. So think being part of a team, I think nursing made a difference that way. As far as myself, we worked as a team totally that day, physicians, nurses, lab, x-ray, whatever, and just the positive patient outcomes for everybody ... healthy babies, healthy Moms left the hospital, and the cardiac patient that had streptokinase and was shipped out, he came back for rehab.

Kimberly felt that sometimes, the sheer volume of workload could be prohibitive in working as a team, just because there were too many things going on. “There were certainly times when we couldn’t work as a team ... so much because there was too much to do.”
From my own experiences, there are times on nursing units when things just get out of control, and it is hard for team members to coordinate themselves in the midst of chaos. Kimberly’s words hint at the suggestion that even though society has these somewhat idealist views on what a professional is and is not, we are all human, and that the nature of reality in rural nursing is that it exists basically unscripted. The theme of improvising and adapting, which was presented earlier, emerges repeatedly as an underlying thread that is woven throughout the data as a whole.

Nurses placed a considerable amount of emphasis on the importance of teamwork in the workplace context. The notions of teamwork, working together, and helping each other out seemed to foster a culture of respect, collegiality, and courtesy between nurses and other health care providers. Besides promoting a nurses’ sense of being a professional, it is apparent that the existence of teamwork in a rural workplace environment could also relate to nurses’ sense of satisfaction and happiness in the workplace.

*Encounters with the Unprofessional Professional*

In about half of the interviews, nurses discussed times when teamwork was not present, and how this hindered their perception of themselves and their colleagues as respected professionals. Sometimes, exploring examples of the absence of a concept can help illuminate the presence of the concept. In this case, the experience of being a professional is shown through interpreted examples of nurses’ experiences with unprofessional behaviors. While there were not many, there were some examples of competitiveness, lack of teamwork, and tales of the cutthroat nature of interpersonal relationships. Emilia related a description of how one of her colleagues was purposefully not helpful to another staff member, in order to help the new staff member learn.
Interviewer: Have you worked with very many new nurses?
Emilia: Oh yeah, yeah ... quite a few, actually. The one girl I noticed ... I notice she’s not getting any help. Then I heard the story about the one nurse, what she did to her and I thought oh, how mean! She let her send somebody down to the operating room [OR] for a transurethral prostatic resection [TUPR] that was supposed to have specific pre stuff. And she didn’t do it. I guess no one had told her.

Interviewer: There are no standing orders or pre-op checklist that has all this stuff?
Emilia: There is, but you know, with a TUPR you have to wear ... have to have anti-embolism stockings [TED stockings] on. They have ... no underwear, the TED stockings ... lots of people, we let them wear their underwear down to the OR, then they take them off there if they need to. The TED stockings ... he should have had the Fleet the night before ... it’s just the regular stuff. Well ... she didn’t do it, she didn’t put the TED stockings on, she never thought to. She was brand new. And he never had the Fleet. And Carol let her send the guy. She knew that she didn’t do it and she let her send him down to the OR so that she would learn.

Even though Emilia’s unfortunate story is not one of first-hand experience, the fact that she chose to mention it shows how strongly the malicious intent of the other nurse resonated with her. This story speaks to some of the professional shortcomings that rural nurses have to deal with when working with their nurse colleagues. Something that is very evident in this story is Emilia’s constant reference to the status of the new nurse. Emilia’s words convey support for the new nurse and recognition of the fact that “she was brand new” and that “she’s not getting any help.”

Shannon shared a personal account of unprofessional behaviours which involved a client and her charge nurse. She related very passionately how the experience left her feeling unsupported and disrespected as a professional, and how since the incident, she has made a point of being a team player and helping new staff members avoid getting caught up in similar situations. Due to the intricacies of this situation, and the possibility of recognition, Shannon’s account has been summarized, and includes direct quotations where possible.

The precipitating event in the situation involved a man named Tom who had been admitted to the hospital for treatment. Shannon described Tom as “very demanding, very
manipulative ... with well known ... well known practices,” and that on this occasion, he refused his treatment on the grounds that he just “didn’t want” the treatment. Subsequent to this event, Tom apparently reported to his wife Joan that Shannon had said he should “go home and die.” Tom and Joan then wrote a letter to the hospital, demanding severe punitive action against Shannon:

They demanded that I be fired and apologize. I did not apologize because I did nothing wrong. I said, “I am sorry there was such a misunderstanding that you would actually think that I would say this, I did not say that, I would not say that, and those aren’t part of my working ethics or moral ethics.” And I didn’t write an apology, nor did I apologize. I was pretty offended by that event.

Interviewer: On a personal or professional level?
Shannon: Both. That they would actually incriminate me professionally, to suggest it, let alone put it in writing that I would say that to someone ... “Why don’t you go home and die?” And then, present it to the hospital without notifying me, and then they know this and don’t notify me? I was offended professionally. I was offended personally because the person [Anne] who made me aware of this was related to me, and she was also my manager! She brought Tom’s chart to me, here at my house, and demanded that I write a letter of apology.

Interviewer: Oh, my goodness. How did that make you feel?
Shannon: Oh, I was mad, I was mad! And I told Anne that she wasn’t fit to be a manager, because for one thing, you don’t remove those charts from the hospital, it was a breach of confidentiality, and as the manager, she has an obligation to me as a staff member to work with me, not against me. She was on her own self-promotion agenda and she’s afraid of Tom and Joan, I’m not. I did nothing wrong and I won’t ... and I don’t have to bow to ... I don’t have to cater to someone who’s manipulative. That isn’t part of my job description. So I didn’t ... I didn’t back down, I didn’t become aggressive about it, but I didn’t back down. And, oh, within three months they had to ... they came around and they apologized because I wouldn’t deal with them. As soon as they came in I called Anne, because I wouldn’t deal with them. If Tom needed a shot, I called Anne, and I said “You’ll have to come in.” “What’s going on?” “Well, your friend Tom is here, he needs an injection and I’m not touching him.” I can remove myself from that job and I did. And after about three months it got ... it became too tedious, so Tom and Joan apologized for their actions. And they actually treat me really nice; in fact, I’m Tom’s best nurse now. Mind you, it’s taken about eight years for this to transpire. But I do deal with him honestly; I’m not rude or mean to him, and I treat him no different than anyone else. But I won’t tolerate that behavior. I won’t be accused of things that I haven’t done. That was ... that was the worst ... that was probably the worst I’ve ever been treated. And I was offended ... I was really offended, personally and professionally. But it’s over, not that I trust them, but I don’t treat them any different than anyone else. I do tell new staff to be aware of them because they seem to think it’s their responsibility to be
mean and miserable to anybody new, so I tell the new staff this is how you deal with it. Things that have happened to me, with different patients or different people in the community, when there’s new staff come on, we get new staff. I don’t want them to be blindsided, and I’ll tell them, be aware of this, and watch for this, just because I don’t think it’s fair to let somebody get sniped, you know?

Not only does Shannon’s experience reveal the complexities of managing a difficult situation, but her own integrity and accountability were very evident throughout the story line. Shannon’s tenacity is also an indicator of her professionalism, and this also helped her to successfully navigate this very difficult situation. She cannot really leave her community; she cannot change wards or hospitals to avoid working with Tom, Joan, and Anne. Whereas an urban nurse might opt to just move on to a new worksite, and would seldom, if ever be reporting to a relative, Shannon had to work through the situation with the people involved and continue to interact with the individuals in a professional manner.

Many examples of Shannon’s strong personal and professional ethics were woven into the story, (e.g., “for one thing, you don’t remove those charts from the hospital, it was a breach of confidentiality” and “I treat her no different than anyone else”) illuminate some of the principles of professional nursing, such as confidentiality and duty of care. There are many other elements of “being” a professional, and “acting” as a professional that emerged in this narrative. Communication strategies can sometimes make all the difference in the level of professionalism exhibited by an individual. Shannon related how “I didn’t back down, I didn’t become aggressive about it, but I didn’t back down,” and this shows an important professional quality given the degree of insult in this particular situation. Shannon used the words “she was on her own self-promotion agenda”, in reference to her manager, and commented that this made her feel wholly unsupported. Shannon experienced her manager as manipulative and unprofessional in her approach to resolving the issue, not only
by taking sides, but also by addressing it outside of the work environment and by demanding that Shannon assume responsibility for something that she had not done. Despite how poorly she was treated, Shannon persisted with a team-oriented attitude, and a responsibility to look out for new staff members, and orient them accordingly. Compounding this situation was the nature of the personal relationships in this story. Shannon knew these clients from previous hospital visits, and from personal relationships within the community. Though Shannon’s narrative straddles both the community and workplace contexts, most of the issues relate to her interactions within the hospital setting. The lack of support, respect, teamwork, and collegiality in this narrative highlight what is meant by a lack of professional behavior.

Positive Feedback and Professional Pride

Generally speaking, the receipt of positive feedback for a job well done acts as an affirmation and motivation for the people to whom it was directed. In the same way, many nurses expressed that receiving compliments from other health care professionals, particularly doctors, was especially affirming of a professional job well done. Amanda related a short scenario about a time when she felt that things went well at the hospital:

Amanda: A few months ago, the husband of one of our LPNs had a massive coronary and we gave him, I think it’s called Retaplase, and he did fantastic. He’s alive, he’s back at work and everything. And I was the main RN on when he came in, so I feel quite proud of that.
Interviewer: When you say you were the main RN, were you the one who admitted him and stayed with him throughout the crisis?
Amanda: Well, yes. We have to have two RNs there to double check all the medications. So, yes. There were two of us, but I’ll say that I was probably in charge on evening shift.
Interviewer: So that situation went unusually well?
Amanda: I think it’s one that stands out in my mind because I knew him so well. The city also told us that he was probably treated better here than he ever would be in the city because from the time he came in to the hospital until he was treated with this clot-busting agent, it was 12 minutes. So that’s pretty good statistics.
Interviewer: You are quite proud of that?
Amanda: Yes. I think... well, we also have a cardiologist coming out and he tells us that we’re doing very well. So we believe him.
Interviewer: Very positive feedback then from the specialist?
Amanda: Yes. Yes. I think mainly we do have positive feedback.

Rebecca made reference to how positive comments from the doctors helped enhance the feeling that her nursing care was making a difference, and that her care had good “flow.” She felt that the “positive comments from the doctors were ... were quite ... quite significant.” Kimberly specifically mentioned how her nursing actions (in the absence of the doctor) resulted in the doctor being pleased with the client outcome:

She sort of directed me through delivering this baby and we delivered the baby and delivered the placenta and got everything cleaned up. Then the doctor walked in and we told him it was a girl and he twirled around and left and went back to his birthday party! So he was ... he was quite pleased.

Kimberly used the phrase: “we told him it was a girl and he twirled around and left” to describe the brief interaction with the doctor. The brevity of the exchange and the general nature of the information communicated suggests that the doctor has confidence in Kimberly’s (and the other nurse’s) competence and ability to have managed the birth event and to continue to oversee the post-partum care. This would certainly pay a silent compliment to Kimberly and her co-worker, and at the same time affirm her own understanding of the doctor’s regard for her professional nursing skills.

*Equipment, Education, and Adequate Staffing Makes a Professional?*

In addition to having to be prepared for anything, the rural nurses often did not have the luxury of modern hospital equipment and other resources with which to do their work. Part of being a professional is having access to the specialized tools and machines that are needed in order to perform the job. Access to specialized equipment, education, and adequate staffing resources not only help reinforce a nurse’s perception of herself as a professional,
but also indirectly support the public and other health care providers’ impression of rural nurses as professionals.

One participant felt that because rural nurses often did not have the same access to ongoing education, or new equipment and supplies, “sometimes you sort of feel looked down upon by girls who work in the intensive care unit [ICU] or critical care in the big hospitals” (Emilia). Another nurse stated that she felt that rural nurses “sort of get put down by the referring hospital in the bigger place because we haven’t done it quite the way they do” (Heather). Catherine related a similar sentiment when she talked about her job, the challenging realities of nursing in a rural environment, and how her work is perceived as somewhat less sophisticated by urban nurses. Catherine said that, “my line lately [to urban nurses] has been: ‘Come play with us and see what you have to work with.’” In reference to urban nurses and hospitals, she also mentioned that “they don’t understand that we’ve done the best that we can with what we have.” Amanda shared her thoughts, adding that she felt that as a rural nurse, “you just have to know what you’re doing a lot more than in the city” which seems to offer a rebuttal to urban nurses, and an affirmation to herself about the professional competence and abilities of rural nurses.

The nurses felt that having the modern versions of supplies and equipment not only helped them do the physical aspects of their job better, but that it also helped them to feel like professionals. Having to rely on old or dated equipment, or having to use obviously worn or damaged tools seemed to detract from the prestige that should be associated with being a professional. As nurses told their stories about their equipment, there was an unmistakable blend of sarcasm and embarrassment in their voices, as nurses seemed to lament (often humorously) the fact that they had to use such dated machinery and equipment. The ‘just deal
with it' attitude about the nature of their reality was also evident here, as nurses expressed that their practice was somewhat constrained by the lack of modern or properly functioning equipment. Six of the eight participants made explicit reference to the fact that they felt the hospital equipment provided was insufficient, unsatisfactory, and outdated, and from their comments, it seems apparent that new equipment could also play a vital role in improving their self-perceptions of being a professional practitioner and possibly their enjoyment of work. Each of the eight nurses talked about equipment that they wished for:

- "Our crash cart, unfortunately is kind of old, and if it dies, there’s no parts to replace it, so we need to get a new crash cart."
- "The monitor defibrillator ... it’s so old that if one more piece breaks they can’t replace it any more because they don’t manufacture it."
- "We don’t even have an automated BP cuff"
- "So we have one O₂ sat machine, but that’s not enough"
- "I’d like more sterilized instruments"
- "I have a whole list of things I’d like, but that BP cuff machine, that’s top of the list."
- "I need more stretchers that I can pump up or down for patient and staff ease"
- "It’s a horrible thing trying to code somebody on those tall stretchers."
- "I’d like some new wheelchairs that the wheels don’t stick on."
- "I’d like some bedpans that aren’t stained."

It is highly likely that nurses in urban settings would express similar desires for newer and more modern equipment. However my sense after reading and interpreting these data, and based on personal experience, is that the perceived baseline standard of equipment is consistently higher in urban hospital settings than in rural hospitals. For the nurses, equipment was often used in reference to the physical presence of tools that helped the nurse perform her job.

Along with the desire for equipment, many of the participants felt that they did not receive enough support for ongoing educational preparation from their employer, and that continuing education was not treated as a priority by their managers. Amanda related that "we’ve sort of been at a standstill as far as education and stuff is concerned for you know,
quite a few years.” Rebecca also shared her experience with submitting applications for continued education funding “As far as courses go, it’s kind of hit and miss. Now there’s a freeze, for us there’s a freeze on education. So you can apply ... to go to a course, but you won’t get the money for it.” She also related some other concerns about nursing education in rural settings:

Unfortunately, in all the places I’ve worked in the last 17 years, that’s been a perpetual thing, education, nursing education. Unless you do it on your own, with your own money or your own time, it’s always been an issue ... I mean I’ve always mostly worked in rural facilities, so I don’t really have anything to compare by as far as urban centers go, but it’s always been a bit of an issue (Rebecca).

In the narratives from the eight nurses, reference to inadequate equipment and education was interpreted as a challenge to professional nursing practice in a rural acute care setting. Heather noted how she thought that “things change on a fairly fast basis, and the most challenging thing for me is keeping my skills up at a point where I am still comfortable.”

Many of the nurses also indicated that the experience of having available relief staff members or adequate staffing levels on shift was like having another dimension of reliable, functional equipment and tools. Staff shortages contributed to rural nurses feeling less like professionals because their physical resources were so few, and nurses’ energies and satisfaction with their work could be quickly drained. Catherine and Shannon spoke quite frankly and repeatedly about the realities of “limited staff members” and “short staffing” in a rural hospital environment, and how this pressured all nursing staff to be available to help, even on their days off. All of the nurses made direct reference to the lack of staff in their facilities, and the notion of just working without was a recurring attitude in the narratives. Sara characterized the staffing realities at her facility as: “There was no point calling for
extra staff because there was nobody else around, there was nobody around to work extra, nobody.” Though urban nurses also commonly relate challenges with inadequate relief staff, the situation is actually much different in rural settings. In some rural communities, there are no casual staff pools at all, and the reality is that when there are only two nurses staffing an entire rural hospital, there is simply no option to float a nurse from another area of the facility.

Several nurses noted how the lack of hospital staff in general would require nurses to pick up and “do the little extras that nobody knows about” (Emilia). This meant that in order to keep things running, nurses assumed responsibility for ancillary duties such as answering phone calls, placing phone calls for relief staff, filling out administrative paperwork, and processing orders, as well as porter duties between departments. As Sara mentioned, “you find yourself running down to the pharmacy, picking up their prescriptions, running them back”. When Sara (and other nurses) mentioned having to do the extras, there were tonal changes on the audiotape which suggested frustration and annoyance about accepting these duties in addition to their regular, professional nursing workload.

Shannon talked of work duties going “on the back burner until we’re better staffed” and Sara spoke jokingly about the realities of how “you are allowed to call in somebody, if you can find them.” Kimberly noted how if the situation called for one-on-one nursing, “we usually didn’t have enough staff to do any kind of one-on-one.” The reality of not being able to physically supply nurses could understandably detract from a nurse’s satisfaction with her job and perception of the professional nature of the shift’s performance as a whole.

Despite that many of these nurses expressed feeling as though they were “always on call” and always at work, most remained quite candid and matter-of-fact about their realities
with staffing difficulties. Calls for more staff could happen at any time of the day, as Rebecca related: “I’m casual so it was your typical 4 o’clock in the morning phone call!” Statements like these seem to be neither positive nor negative, but rather a simple affirmation of the nature of their specialized role as rural acute care nurses. As much as the nurses had their wishes for more ideal work environments in terms of equipment, education, and staffing, statements like Rebecca’s were common and offered further insight about the professionally challenging aspects of being in a rural practice setting.

Summary of the Findings

Overall, participants in this study described their roles as rural acute care nurses as both challenging and rewarding. Themes were discussed in community and workplace contexts, as the narratives suggested that a strong sense of being professional was also derived from nurses’ interactions with physical and social elements of the community. In the narratives, there was somewhat of an inherent rawness, and a rather frank undertone of, ‘this is my reality’ from the nurses, but interestingly, these elements were more often interpreted as a source of uniqueness and pride, rather than frustration.

For these rural nurses, the experience of being a professional in the community was earmarked by the overarching theme of visibility, which was woven throughout the themes of managing obligations and expectations and maintaining confidentiality. Balancing personal-professional relationships also surfaced as an important theme in the community context. In the workplace context, embracing reality emerged as the prominent theme, unifying the related themes: improvising and adapting, being versatile, and being prepared. The idea of embracing reality was recurrent throughout the other workplace themes of teamwork,
encounters with the unprofessional professional, positive feedback and professional pride, and equipment, education, and staffing.

In both the community and workplace contexts, nurses' sense of being professional and being perceived as professional seemed to directly affect their appraisal of job satisfaction. When rural nurses in this study were given the opportunity to act like professionals and when they were treated as professionals, this seemed to reinforce the undertones of happiness and satisfaction in their narratives. It was apparent that when nurses encountered unprofessional behaviours or situations, their personal sense of feeling like a professional was diminished.

In the next chapter, the discussion will explore the idea that professionalism in rural workplaces and community settings is an essential, yet seldom referenced component in conceptions of quality professional practice environments and job satisfaction for nurses. Professional practice environments and job satisfaction have been associated with greater levels of workplace commitment, and more successful recruitment and retention.
Chapter 5: Discussion of the Findings

Introduction

In this chapter, I discuss some of the findings presented in Chapter Four in greater detail and situate these findings in the context of the current literature. Several of the findings of this study will be discussed alongside the RNAO’s (2007b) healthy work environments Best Practice Guideline entitled, “Professionalism in Nursing” as this document represents the most comprehensive understanding of professionalism in Canada to date. While the document was not specifically developed with rural nurses in mind, several findings of this study are strongly supported by the indicators contained in the guideline. Specific attention to the significance of the community context in rural nurses’ experiences of professionalism will be discussed, as well as implications for professional practice in the workplace setting.

It is clear from the findings in this study that rural nurses in British Columbia and Alberta experience a strong sense of professionalism on a day-to-day basis, evidenced by the emergence of two prominent themes: visibility in the community context, and embracing reality in the workplace context. The experience of being a professional nurse in a rural setting appears to be an enduring experience which does not seem to lapse when nurses are away from the workplace setting. Nurses’ narratives described interactions within the community and the workplace which could positively or negatively reinforce perceptions of themselves and their colleagues as professional practitioners. Nurses’ self-appraisal of being professional is a key piece in enhancing our understanding of the complex and dynamic factors which ultimately contribute to job satisfaction, recruitment, and retention among rural nurses.
**The Importance of Visibility**

The current literature offers a few suggestions about how rural nurses' interactions within the community environment are potentially beneficial in terms of mediating nurses' self perceptions and experiences of being professional. Generally speaking, rural nursing is known to be characterized by a “lack of anonymity” (Davis & Droes, 1993, p. 167; Long & Weinert, 1989, p. 120), and this catch-all term is often uncritically and negatively applied to situations concerning rural nurses’ interactions and experiences with members of the community (Davis & Droes, 1993; Shellian, 2002). The findings of this study however, suggest that rural nurses derive a great deal of professional pride and reinforcement of professional values through their interactions with community members, and that this can, in turn, positively affect nurses’ conceptions of their professional status. A qualitative study by Raph and Buehler (2006) revealed four responses to rural health professionals’ perceptions of lack of anonymity. Two of these responses, entitled, “personally affirming” and “professionally affirming” reflected positive interactions with the community which “offered staff a sense of professional growth, [and] personal satisfaction” (Raph & Buehler, 2006, p. 203), and this seems to be consistent with the findings of this study.

The significance of the theme, visibility, as opposed to lack of anonymity, is that visibility represents many of the positive professional reinforcing elements, as opposed to the negative connotations that seem to be firmly entrenched with lack of anonymity. Visibility speaks to the rural nurses’ own sense of knowledge that she is viewed as a professional, and how this subsequently influences her actions in a rural community setting. In the community context, nurses’ narratives revealed striking similarities and patterns related to the ideas of being seen and being approached because of their publicly known status as a nurse. The
predominant theme of visibility was apparent within nurses’ rich descriptions of interaction with the community, and appeared to surface not just once, but repeatedly in each of the eight nurses’ narratives. Of particular and recurring interest was the extent and strength with which nurses expressed their experiences of professionalism as occurring within the community context. For interview data that was collected with the intent to capture typical workday experiences, it is surprising that nurses’ emphasis on the community context should emerge with the frequency and magnitude that it did.

Barber (2007), Bigbee (1993), and Bushy (1998) are some of the very few authors who use the term “visibility” in describing attributes of rural nursing. Bigbee (1993) cites visibility as one of the top five hallmarks of rural nursing, and she suggests that there are several inherent benefits and potential downsides for nurses:

Rural nurses also enjoy a high degree of positive visibility in the community. This contributes to professional pride, self-esteem and potential power in influencing health policy. This visibility also contributes to potential burn-out owing to the lack of personal anonymity (p. 137).

Bushy (1998) agrees that rural nurses are subject to a high degree of visibility in their communities, and that this can be “appealing and gratifying to many people” (p. 68), but neither she nor Bigbee (1993) specifically elaborate on the mechanisms of visibility that contribute to the potential for professional pride and positive career reinforcement. In the narratives from this study, rural nurses’ descriptions of being visible and interacting in the community were interpreted as positive experiences. However this is contrary to the findings of a rural public health nurse study by Henderson Betkus and MacLeod (2004), which found that “being easily recognized in the rural community does not seem to be of concern but being asked work-related questions, a by-product of lack of anonymity, is an issue” (p. 56) contributing to less satisfaction. In this study, being visible was a source of being treated as a
professional and of feeling and acting professional, as community interactions frequently prompted the nurses to respond in a manner that reinforced their professional values, principles, and satisfaction with being a nurse.

Allan, Ball, and Alston (2008) recently conducted a qualitative research study with pharmacists and social workers working in six rural Australian communities. This study was focused on eliciting a greater understanding of the personal factors and professional roles of health care providers which could affect access to rural health care. Of particular interest was the repeated attention drawn to the notion that rural pharmacists and social workers experienced a high degree of visibility in the community, but the notion of visibility in this study was not described in terms of professional rewards or benefits (Allan et al.). On the contrary, visibility was associated with participants’ negative concerns. As stated in the title of their study, “You have to face your mistakes in the street”, participants in this study practiced avoidance of certain community members related to fear of reprisal and confrontation, and related apprehension about personal safety related to drug administration and access (Allan et al.). Nurses in my study also made mention of avoidance strategies, such as not going out shopping on weekends when it was likely to be busy, however this did not seem to be related to concerns or threats regarding personal safety.

There is very little evidence in the literature that directly supports the notion that rural community members play any role whatsoever in contributing to a rural nurses’ sense of feeling like a professional, and none that examines how, or which community elements might support nurses’ sense of being a professional. Thus, it is difficult to substantiate the significance of this finding, given the current state of the literature. However, in the context of this study, it seems entirely reasonable to suggest that community members play a very
active and important role in positively reinforcing rural nurses’ experiences of being professional.

_The Professional Ethics of Visibility_

In the data, the themes of obligations and expectations, and confidentiality were preceded by the overarching notion of visibility. The literature does not have much to report about how rural nurses’ sense of community obligations and expectations (in terms of what they say or do), affects the experience of being a professional, however it is known that nurses derive a sense of satisfaction with their work when they are able to apply professional principles, and conform to the philosophies of the nursing profession (Baumann et al., 2001; Biton & Tabak, 2003). Nurses’ desire to be looked upon and regarded favorably by members of their community might also drive their motivation to be positive role models who lead by courteous, healthy example. Positive role modeling in turn, is also likely to affirm nurses’ professional experience.

In order for nurses to exercise professionalism, nurses first and foremost had to understand their own visibility, and this understanding was therefore, the basis for their actions. That nurses felt both obliged and expected to “do” or “say” certain things in the community context was a positive affirmation of the nurses’ professional role modeling in the community. Nurses knew that they were approached on the basis that community members regarded them as knowledgeable and accessible experts in their field, and this also reinforces community members’ roles in promulgating rural nurses’ experiences of being professional. Barber (2007) relates that “the community places certain expectations on the nurse and these expectations formed the unwritten rules the nurse was obliged to work within, if they were to succeed in their RNs [sic] role” (p. 23). Barber’s (2007) comment also
has relevance in this study, in terms of rural nurses’ success, as these participants related feeling obliged and expected to do their “best” for community members by treating them well, so as to avoid unpleasant rumors, being negatively labeled, and to ensure a continued position of respect in the eyes of community members.

The Visible Ethics of Confidentiality

The theme of confidentiality is another theme related to visibility. Nurses’ sense of the importance of maintaining confidentiality is rooted alongside many of the same reasons that nurses desire to interact within the framework of the community’s obligations and expectations. Nurses are aware that their visibility in the community is enduring, and with this, they are expected to be both professional and social in the community, regardless of the situation. Not only does exercising the professional principle of confidentiality reinforce self-perceptions of “being” a professional, but also, it fosters a culture of community respect for nurses.

The visibility of nurses within rural communities was often the basis for being approached by members of the community. These encounters frequently led to situations where a nurse had to exercise the professional role of maintaining confidentiality. All participants in this study spoke about the importance of maintaining confidentiality of clients’ illnesses or hospitalizations, and safeguarding clients’ personal health information during encounters external to the workplace environment. What is intriguing here is how nurses’ discussions of confidentiality were almost entirely based on interactions away from the work site. This stands in contrast to the notion that confidentiality in nursing is a professional ideal which is generally cited to apply in the context of professional, workplace relationships (CNA, 2008a). Owing to the need for confidentiality, rural nurses seem to be
constantly engaged in a professional relationship with members of the community, even though the basis for a particular interaction may be of a personal nature.

Confidentiality is cited as one of eight key elements of the Canadian Nurses’ Association Code of Ethics for Registered Nurses (CNA, 2008a), a document which outlines Canadian nurses’ moral and ethical obligations and commitments to the profession and to the public. With regard to confidentiality, Canadian nurses are obligated to “recognize the importance of privacy and confidentiality and safeguard personal, family and community information obtained in the context of a professional relationship” (CNA, 2008a, p. 15).

The Colleges of Registered Nurses in both British Columbia and Alberta (CARNA, 2007; CRNBC, 2008a) endorse the CNA’s Code of Ethics (2008a), citing it as an essential document in defining professional roles and practice standards. The RNAO (2007b) “Professionalism in Nursing” guideline suggests that professionalism includes accountability, specifically nurses “using legislation, standards of practice and a code of ethics to clarify one’s scope of practice” (p. 26), as well as ethics and values, whereby nurses are “knowledgeable about ethical values, concepts and decision-making” (p. 27). Nurses in this study actively engaged in exercising the attributes of accountability, ethics, and values in the community setting. The ongoing professional engagement of rural acute care nurses in their communities offers some interesting insight into the shortcomings of the RNAO (2007b) guideline, which suggests that professionalism in nursing supports the existence of healthy workplace environments.

An Israeli nursing study by Biton and Tabak (2003), suggests that nurses derive a considerable degree of job satisfaction from exercising and applying a nursing code of ethics in a hospital workplace setting. They note that “the gap between ethical requirements (as
perceived by the nurse) and the perceived extent to which they are applied will influence work satisfaction through the mediating effect of role conflict" (Biton & Tabak, 2003, p. 140). It could be reasonably assumed that this type of positive reinforcement and job satisfaction might also apply in a rural community setting, as nurses in this study frequently and proudly used language relating to the importance of maintaining confidentiality. There was subtle inference in some of the narratives, that people who were not nurses might be expected to gossip and share private details about others people’s health conditions, but nurses in this study expressed a strong awareness of how their adherence to confidentiality was largely due to their own sense of professional expectations and obligations to the community.

The pervasive theme of visibility which emerged from the data suggests that community interaction plays a critical role in reinforcing rural nurses’ experiences and perceptions of being a professional. The current literature addressing professional nursing practice standards such as confidentiality is primarily communicated in terms of its application in workplace environments and in the context of professional relationships. Nurses’ narratives suggested that managing community obligations and expectations, and preserving confidentiality contributed positively to perceptions of themselves as professional practitioners.

“Things are going to bother you, but you know, that’s life!”

Embracing Reality in the Rural Workplace...

For rural acute care nurses in British Columbia and Alberta, a great majority of the professional experience in the workplace was facilitated by nurses’ interaction with nurse colleagues, other health care professionals, and responses to the physical hospital
environment. Themes such as teamwork, access to appropriate resources (such as equipment, staffing, and education), and encounters with the unprofessional professional, surfaced very strongly within the narratives of all participants, and were reported as positively or negatively influencing nurses' expressed experiences of being a professional. In the workplace context, there were several instances where nurses discussed situations and interactions where they did not feel like professionals, and that this negatively impacted their perceptions of themselves, their colleagues, and their work as professionals.

Rural nurses are acutely aware of the unique challenges in their workplaces, which were often expressed in the narratives through use of humor, sarcasm, and matter-of-fact statements. Even though nurses spoke of the challenges in their workplaces with some frequency, the experiences were generally embedded in a positive context, indicating that nurses truly embraced the realities of their unique workplace. Nurses in this study had a keen awareness that some things just are what they are, and that finding innovative ways to work with these challenges as best as possible, could often reinforce their own sense of professionalism.

Working as a Team

The RNAO “Professionalism in Nursing” Best Practice Guideline (2007b) uses the terms, “collegiality and collaboration” to describe collaborative partnerships, mentorship, and interdependence between care providers in professional workplace environments. The RNAO (2007b) guideline suggests that professionalism in terms of collegiality and collaboration includes nurses “developing collaborative partnerships within a professional context” (p. 27) as well as “acknowledging and recognizing interdependence between health care providers” (p. 27). The need for good teamwork was highlighted by participants when the hospital units
became especially busy, and nurses had to collaborate, communicate, and work together in order to keep up with patient care demands. The "fulfilling" aspect of the experience of teamwork suggests that teamwork positively contributes to a nurses' sense of satisfaction and happiness with their job. Nurses expressed that experiencing teamwork by way of knowing they could rely on their colleagues to come in during overwhelmingly busy times, helped them feel like professionals and fostered good patient outcomes, which in turn, reinforced their feelings of professional satisfaction by allowing them to provide good patient care. The participants' emphasis on teamwork supports the interdependence between health care providers frequently discussed in the literature in regard to professionalism and job satisfaction (e.g., Apker et al., 2006; Leveck & Jones, 1996). Whereas an urban nurse might find alternate resources to accomplish a task, the rural reality of a much more limited resource pool reinforces the critical importance of teamwork, cooperation, and collaboration between health care providers.

In the literature, specific reference to the importance of teamwork and job satisfaction in a rural nursing setting is scarce (Hegney et al., 2002), but urban studies on the positive relationship between teamwork, job satisfaction, and professionalism are plentiful (Day, Minichiello, & Madison, 2007; Dunn, Wilson, & Esterman, 2005; Hegney, Eley, Plank, Buikstra, & Parker, 2006). Participants in this study repeatedly affirmed how teamwork was a critical element in their experience of being a professional, and that ultimately it helped foster their own perceptions of a satisfying workplace.

The RNAO (2007b) guideline notes that, "before nurses can function effectively as team members they must be secure in their professional roles. Nurses need to have a clear understanding of their own roles as well as [the roles of] other health care team members"
The confidence and assertiveness with which nurses in this study expressed their roles in being part of a team and working together is indicative of their security in a professional role. While delineation of the role of teamwork in nursing practice settings is limited in the RNAO’s (2007b) “Professionalism in Nursing” guideline, the RNAO (2006) has published a separate best practice guideline entitled, “Collaborative Practice Among Nursing Teams” which more effectively captures the significance of teamwork and collaborative practice.

A rural nursing study by MacLeod (1998) described the existence of “smooth teamwork and clear communication” (p. 13) as critical in ensuring that patients were able to receive the care they needed. Nurses in this study talked about having clear team communication as well, alluding to how working together often manifested as a verbal plan that was communicated between health care providers. For nurses in this study, teamwork meant that efforts were directed toward a common goal that positively reinforced the collaborative nature of being a professional. Specific reference to the importance of clear team communication among health care providers is noticeably absent from the RNAO (2007b) “Professionalism in Nursing” guideline, despite the growing popularity of literature which contends that communication among health care team members is a contributing factor to nurse professionalism and positive nursing practice environments (Apker et al., 2006; Ohlen & Segesten, 1998; Wade, 1999). Teamwork at its essence is rooted in clear and respectful communication, and it seems rather apparent that the synergy of these elements is a powerful predictor of nurses’ positive professional experiences. In a recent report funded by the Canadian Health Services Research Foundation (CHSRF), a team was defined as:

A collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an
intact social entity embedded in one or more larger social systems and who manage their relationships across organizational borders (Oandasan et al., 2006, p. 3, emphasis original).

In cases where nurses discussed the absence of teamwork owing to overwhelming workloads, the undeniable sense of being on a team seemed to persist. Even though each nurse might be working primarily as an individual in activities and decision-making related to care delivery, the unifying thread of each nurse effectually pulling their weight and working toward a common goal reinforced the existence of macro-level teamwork and professionalism in the workplace setting.

Teamwork, as expressed by rural acute care nurses in this study, echoes Xyrichis and Reams’ (2008) concept analysis paper on teamwork in a health care environment. Based on their analysis, Xyrichis and Ream (2008) propose that:

Teamwork is ... a dynamic process involving two or more healthcare professionals with complimentary backgrounds and skills, sharing common health goals and exercising concerted physical and mental effort in assessing, planning or evaluating patient care. This is accomplished through interdependent collaboration, open communication and shared decision-making, and generates value-added patient, organization and staff outcomes (p. 232).

This definition appears to be well aligned with the expressed accounts of rural nurses’ experiences of teamwork. The significance of teamwork being a “dynamic process” as noted by Xyrichis and Ream (2008) is supported in the narratives of rural nurses in this study.

Rural nurses in this study expressed that their experiences of good teamwork and collaboration in the workplace reinforced perceptions of themselves as professionals. Several nurses alluded to the notion that teamwork can be transient in nature, and dependent on contextual factors such as access to resources and interpersonal relationships.

Sedgwick and Yonge (2008) conducted an ethnographic study with nursing students and preceptors in rural settings in northern Alberta and the Yukon. These authors described
how rural nursing students’ perception of “belonging” on the unit, is ultimately important in
nursing students’ sense of feeling like a member of “the team” (Sedgwick & Yonge, 2008, p. 1). Sedgwick and Yonge (2008) reported that when nursing students did not feel as though they belonged, “feelings of anger and confusion [surfaced], and ultimately resulted in [students] feeling ostracized from the team. In the end, these students were left to feel uncertain about themselves as nurses, and about the nursing profession in general” (p. 5).

Based on the findings of Sedgwick and Yonge’s study, it would be reasonable to suggest that rural acute care nurses who do not experience teamwork and a sense of belonging might also question the professional nature of their work. Teamwork seems to be an integral component of how rural nurses perceive themselves and their work as professional.

Just as a nurse’s sense of being part of a team is integral to feeling like a professional, communication between health care providers also plays an important role. Molinari and Monserud (2008) surveyed rural nurses in the northwestern United States and found that “the majority of nurses mentioned that interactions with the hospital staff made a difference in job satisfaction. Supportive, encouraging, helpful, cheerful, and positive co-workers were variables listed among the most satisfying aspects of work” (p. 6). A study by Duddle and Boughton (2007) entitled, “Intraprofessional Relations in Nursing” discovered three predominant patterns of nurses’ communication, and ultimately suggested that more research is needed to understand how nurse relations and behaviours influence the workplace atmosphere. This may lend support for the reasoning that teamwork is a cultural factor that is created and constantly mediated by the personalities, attitudes, and moods of the unit or hospital employees - an important point which I will return to in the upcoming pages.
Though there were relatively few examples in the data, perceived lack of teamwork among nurses and their colleagues seemed to detract from participants’ personal opinions about being a professional. Nurses who did share examples of encounters with unprofessional behaviour related that it made them feel disrespected as professionals, devalued, and distrustful of other members of the health care team which ultimately led to low morale, anger, and resentment. Baumann et al. (2001) note that good working relationships among caregivers leads to an increase in workplace morale, and I would suggest in turn, given the earlier discussion on teamwork, that good workplace morale could positively affect nurses’ perceptions of themselves as professionals.

*Embarrassing Equipment: “I’d like some bedpans that aren’t stained.”*

In this study, nurses expressed many concerns about the lack of functional equipment, lack of modern equipment, and the poor aesthetics of existing equipment. Hospital equipment such as stretchers and wheelchairs, diagnostic medical equipment such as sphygmomanometers and oxygen saturation monitors, and patient-care equipment such as bedpans, were some examples of equipment cited by nurses as being inadequate. These concerns were interpreted as detracting factors in participants’ views of themselves and their work as that of a professional. A recent analysis of *The Nature of Nursing Practice in Rural and Remote Canada* national study data by Penz, Stewart, D’Arcy, and Morgan (2008) found that among rural acute care nurses, “having available, maintained, up-to-date equipment and supplies was highly related to rural RNs’ job satisfaction” (p. 795). Aside from the study by Penz et al. (2008), there is an absence of rural research on how equipment and supplies affect nurses’ job satisfaction; however there are several urban studies which support this connection. A study in the United Kingdom by West, Barron, and Reeves (2005) found that
only 50% of nurses were able to access desired supplies and tools needed for patient care, and suggested that nurses felt this was a significant barrier to being able to provide high-quality patient care, a factor which has also been consistently linked to job satisfaction (Baumann, et al., 2001; Letvak & Buck, 2008; Shamian & El-Jardali, 2007). Hegney et al. (2006) found that a lack of equipment in the workplace had a significant negative association on workplace morale, and a study by Khowaja, Merchant, and Hirani (2005) noted that when required equipment and material was readily available, nurses expressed a strong sense of work satisfaction. Petzäll, Berglund, and Lundberg (2001) conducted a study on Swedish nurses’ opinions on the adequacy of hospital beds, and found that “beds and bed equipment are major elements in the working environment, [and] well-functioning hospital equipment will contribute to creating a cheerful atmosphere on the wards, which is critical for successful recruitment of staffs for the wards” (p. 56). The RNAO (2007b) “Professionalism” guideline does not offer any specific mention of how nurses’ access to equipment might fit into the attributes model, however under “knowledge,” indicators suggest that professionalism includes being able to apply “a body of knowledge that is theoretical, practical and clinical” (p. 26). While this is, at best, a stretch on a reference to the important role that adequate and aesthetically appealing equipment might play in a nurses’ experience of being a professional, it is a start.

Staffing Woes and Workplace Lows...

In this study, lack of staffing resources was related as a chronic issue by participants. Nurses in this study told of how having a small pool of staff resources and a lack of casuals could affect on-duty nurses’ workload, stress, and quality of care. The heavy reliance of nurses on each other because of lack of staff was also interpreted as an enabling factor that
fostered the experience of teamwork and helping each other out when the hospital workload was simply too busy. Some nurses made mention of how a lack of hospital staff in general meant that nurses had to assume ancillary duties in order to accomplish their own nursing work. An urban based study by Jordan (1992) found that the more time nephrology nurses spent doing non-nursing tasks, the more likely they were to report job dissatisfaction.

Urban nursing literature has positively associated job satisfaction with the availability of staff (e.g., Adams & Bond, 2003a, 2003b), and likewise, lack of staff has been associated with job dissatisfaction (e.g., Dunn et al., 2005; Jasper, 2007; West et al., 2005). Penz et al.'s (2008) study, "Predictors of Job Satisfaction for Rural Acute Care Registered Nurses in Canada" suggests that adequate and appropriate staffing levels "may positively influence the quality of the working environment and the levels of job satisfaction for rural acute care RNs" (p. 796). Rural literature has little else to offer with regard to staffing adequacy, nurses' professionalism, and job satisfaction. However, given that staffing issues affect both rural nurses and their urban counterparts, it is reasonable to assume that the existing urban literature is not that far off in providing a very general understanding of how adequate staffing influences professionalism in rural nursing.

The RNAO (2007b) "Professionalism in Nursing" guideline lacks specific reference to the importance of nurse resources such as staffing in nurses' professionalism, however a separate best practice guideline entitled, "Developing and Sustaining Effective Staffing and Workload Practices" (RNAO, 2007a) elaborates specifically on this element in relation to healthy work environments for nurses. If lack of staffing is viewed by the RNAO (2007b) through the ethical lens in terms of professionalism, then it could be reasoned that lack of staffing is considered under the attribute of "ethics and values," and the indicators such as
“being able to identify ethical concerns, issues and dilemmas” (p. 27). Whether this is so, is not outwardly apparent, and again leaves some questions about the comprehensiveness of the RNAO (2007b) guideline in light of nursing literature related to staffing and nursing professionalism.

The Realities of Accessing Continuing Education in a Rural Setting

Rural nurses in this study felt that continuing education was not deemed to be a sufficiently high priority by hospital managers and people in charge of financial allocation. They expressed that not having regular access to education, in-services, and skills upgrading made them feel professionally devalued and that they were not being afforded the same opportunities as urban nurses. Nurses made reference of their awareness of how practice standards could change, and that keeping professional skills up-to-date was very challenging in an atmosphere where there was very little extra time or resources available to enable nurses to participate in continuing education. Participants in this study cited lack of funding, geographic distance, and lack of replacement staff as major barriers to accessing continuing education. These factors are very well aligned with findings from a study (based on The Nature of Nursing Practice in Rural and Remote Canada national survey data) by Penz, D'Arcy, Stewart, Kosteniuk, Morgan, and Smith (2007) which noted themes such as “rural community and work life, time constraints and financial constraints” (p. 60) as the most frequently cited barriers to nurses’ participation in continuing education. Similarly, MacLeod and Lindsey et al. (2008) related that “rural nurses experience an inequitable access to [continuing] education due to inadequate communication systems, geographical isolation, limited resources within health facilities, increasing workloads and professional responsibilities, and limited staff replacement” (p. 299). MacLeod and Lindsey et al. (2008)
suggest that continuing education for rural acute care nurses in their “multispecialist” roles is crucial in the recruitment and retention of rural nurses (p. 299). Curran, Fleet, and Kirby’s (2006) study on barriers to Canadian rural nurses’ access to education found that a lack of continuing professional education contributed to poor retention of nurses. Another rural study by Australian researchers Hegney and McCarthy (2000) found that nursing staff are more likely to be satisfied with their jobs when they have access to continuing education.

The RNAO (2007b) uses the term, “spirit of inquiry” to discuss nurses’ “commitment to lifelong learning” and “having the desire to explore new knowledge” (p. 30). In this study, nurses made consistent reference to their desire for specific skills training, in-services related to client care management and education on machinery and equipment, indicating that their wishes for more access to educational opportunities were more than just obligatory responses rooted in professional standards for nursing practice. The RNAO (2007b) “Professionalism” guideline seems to be missing a statement regarding the importance of nurses’ access to continuing education as a component of professionalism, as it is clear in this study that continued professional education is not a given across all nursing workplaces.

Distinctly Unprofessional?

The bulk of the experiences discussed by nurses in this study suggested that when professionalism was present in interactions, nurses derived positive reinforcement from being treated as professionals and had a sense of contentment and satisfaction with their work. There were several instances where nurses recalled situations where they or their colleagues were not treated as professionals. These accounts were shared in response to the interviewer’s inquiry as to whether nurses had ever experienced something that did not go as planned. That many of the nurses talked about experiences with people who acted
unprofessionally is interesting, as it could be reasonably anticipated that this question would more likely stimulate a response relating to an adverse patient or event outcome, rather than an event related to being treated as a professional.

Nurses who described encounters with unprofessional behaviour indicated that these experiences left them feeling devalued and dissatisfied as professionals. Nurses were somewhat surprised that they could be treated so poorly by their colleagues and clients, and the narratives suggest that these incidents made them feel upset and angry. There was also indication that these situations contributed to nurses’ negative perceptions of themselves, their colleagues, and their workplaces as being professional. In the narratives, there was palpable energy and emotion entrenched in the words describing how nurses or their colleagues had been treated poorly, and this implies that nurses place considerable value on being respectfully treated as professionals.

Nurses’ descriptions of unprofessional behavior are alarmingly similar to literature related to workplace bullying, and the negative effect of bullying on retention and job satisfaction of nurses (e.g., Longo & Sherman, 2007; Simons, 2008; Spiers, 2007; Stevens, 2002; Sweet, 2005). MacIntosh (2005) conducted a study of bullying among rural nurses in an eastern Canadian province and found that often times, the targets of bullying behaviour “were incredulous concerning their treatment” (p. 900), and also that nurses were reluctant to leave the workplace because “they usually liked the work, had responsible roles, or could identify few viable job alternatives nearby” (p. 900). Participants in MacIntosh’s (2005) study unanimously related that “bullying affects the whole person, impinges on all aspects of life, and leaves a residual effect, even when it is over” (p. 902), and this supports the notion that nurses in the present study attached a great deal of personal importance to being treated
as professionals (i.e., not being “sniped” or bullied) in the workplace. The statements expressed in MacIntosh’s study on bullying are remarkably similar to the sentiments expressed by Shannon in the excerpt regarding experiences with unprofessional behaviour (see pp. 78-79), and this offers some further evidence as to how unprofessional behaviors negatively impact nurses’ job satisfaction.

There is further question as to how much unprofessional behaviour a rural nurse will tolerate before an unprofessional or bullying incident tends to cast a negative shadow on other aspects of the workplace as well. In working in such close quarters with people under fairly constant pressure, it is reasonable to expect that working relationships can become strained. It is not known how many unprofessional encounters these participants may have experienced, and it is also unclear from the situations described whether unprofessional encounters have a transitory or enduring negative effect on nurses’ experiences of being a professional. The data suggests that nurses’ encounters with unprofessional behavior leaves a lasting impression on perceptions of being a professional. Shannon, for example, noted how she is on the lookout now so that similar things do not happen to other nurses.

If, owing to negative personal experiences, nurses do not have high regard for their work as professionals and their colleagues as professionals, this may contribute to a lack of satisfaction with their work. Nurses’ experiences with unprofessional behaviours also suggests that they may not be working in high-quality professional practice environments, where respect and collaborative practice are present, and this has dire consequences with regard to recruitment and retention of nurses.
Nurses’ experiences of professionalism can positively or negatively reinforce perceptions of their professional status, and this self-appraisal in turn, ultimately influences the degree of pride and satisfaction that nurses associate with their jobs. Unfortunately, the apparent simplicity of this connection is not as straightforward as it seems. It requires linkages between bodies of literature that have not yet been well connected. It is apparent from the literature that professionalism and job satisfaction are related to quality practice environments, but the link between professionalism and job satisfaction is poorly understood. In the following section, the relationship between professionalism and job satisfaction is discussed.

Extant literature provides a strong impetus for the notion that nurses who practice according to professional standards and are treated as a professionals, are likely working and interacting in a quality practice environment (Baumann et al., 2001, CNA, 2001, CRNBC, 2005). The RNAO (2007b) makes a bold assertion that “professionalism in nursing is an essential ingredient in achieving a healthy work environment for nurses” (p. 23). While the literature clearly states that there are linkages between quality practice environments and professionalism, the nature and directionality of those linkages are not yet clear.

In Canada, quality practice environments are also commonly referred to as professional practice environments (Girard, Linton, & Besner, 2005) and healthy workplace environments (RNAO, 2006, 2007b), however the term quality practice environment seems to be the most widely adopted terminology (CNA & CFNU, 2006; CNA, 2001; CRNBC, 2005; Nurses Association of New Brunswick, 2005; Registered Nurses Association of British Columbia, 2001, 2002). Although these three terms are virtually synonymous, the competing
terminology even among Canadian authors presents yet another barrier to ascertaining an understanding of the significance of quality practice environments for nurses. For the purposes of this discussion:

A quality nursing professional practice environment is one in which the needs and goals of the individual nurse are met at the same time as the patient or client is assisted to reach his or her individual health goals, within the costs and quality framework mandated by the organization where the care is provided (O'Brien-Pallas, Baumann, & Villeneuve, 1994, p. 14).

The importance of quality practice environments for nurses cannot be overstated. A study by O'Brien-Pallas et al. (2006) of nurses who had left the profession reported that nurses rated lack of professional practice most highly in their decisions to leave. Shamian and El-Jardali (2007) note that healthy workplace environments are associated with increased recruitment and retention, and Shamian, Kerr, Laschinger, and Thomson (2002) suggest that nurses who rate their work environment highly also have higher personal health indicator scores.

Other than the occasional mention of comments such as the hospital being “a good place to work”, nurses in this study did not make direct reference to, or elaborate specifically on the quality of their practice environments. In this study, the quality of the practice environment was interpreted based on how nurses discussed being a professional through their interactions in the community and workplace contexts.

Definitions of professionalism and the corresponding elements of professional practice are a collection of characteristics which can vary from study to study. Commonly, nurses’ professionalism is discussed in relation to professional values and attributes, and these concepts in turn are frequently used as measures of nurses’ job satisfaction.
Manojlovich and Laschinger (2007) note how “distinct elements of professional practice environments are interrelated and have the capacity to predict job satisfaction” (p. 261).

Several meta-analyses on the concept of job satisfaction in nursing (e.g., Blegen, 1993; Irvine & Evans, 1995; Zangaro & Soeken, 2007) have concluded that job satisfaction is a very complex phenomenon related to a multitude of factors such as job stress (Blegen, 1993; Zangaro & Soeken, 2007), autonomy (Blegen, 1993), as well as work content and work environment (Irvine & Evans, 1995).

Job satisfaction has been linked with nurses’ perceptions of, and interactions with, their work environment, and this includes factors such as nurses’ perceptions of professional status (Best & Thurston, 2006; Johnston, 1991), job content (Cortese, 2007), professionalism (McNeese-Smith, 1999), workload (Khowaja et al., 2005), quality of work environment (Irvine & Evans, 1995; McNeese-Smith, 1999), autonomy (Blegen, 1993; Scott, Sochalski, & Aiken, 1999), management style (Leveck & Jones, 1996), and quality of patient care (McGillis-Hall & Doran, 2007; McNeese-Smith, 1999).

Some authors (e.g., Tovey & Adams, 1999) suggest that due to generational differences, shifting values, new sources of job satisfaction and dissatisfaction and heterogeneity of the nursing workforce, that the concept of job satisfaction is a dynamic entity and will therefore always be challenging to study. A recent literature review by Caers, Du Bois, Jegers, De Gieter, De Cooman, and Pepermans (2008) on community nurses’ job satisfaction suggests there is little value in trying to compare nursing studies on job satisfaction, as there is no consistency between studies regarding methods, instrumentation, and definitions. So where does this leave us?
Extensive research by Canadian nurse researcher Heather Laschinger has focused on Rosabeth Moss Kanter's 1977 concept of *structural empowerment*, and its relevance to nurses' feelings of trust, respect, job strain, and organizational commitment (Faulkner & Laschinger, 2008; Laschinger & Finegan, 2005; Laschinger, Finegan, & Shamian, 2001a, 2001b). Laschinger et al. (2001b) note that, “Kanter maintains that work environments that provide access to information, resources, support and the opportunity to learn and develop are empowering and enable employees to accomplish their work .... as a result, employees are more satisfied with their work” (p. 7). Manojlovich and Laschinger (2002, 2007) report that nurses who perceive workplace empowerment are more likely to be satisfied with their jobs and report having positive feelings about their workplace. This claim is further supported by Khowaja et al. (2005), who recommend that empowering nurses will also help to increase retention on nursing units.

The concept of empowerment is arguably aligned with professionalism and the ideals of quality workplace environments, as these arise from nurses' self-perceptions, formulated via their experiences and interactions. The nurses in this study experienced being a professional in the community and workplace through interactions with physical and social factors in either context. The majority of these experiences related positively to affirming nurses' sense of being a professional, and nurses placed great emphasis on the importance of both the community and workplace in this regard. Experiences are considered to be the result of a process of self-reflection and interpretation of being in everyday situations (MacLeod, 1996), and it is precisely in this way that nurses' feelings about the professional nature of their work are linked to job satisfaction.
Much of Laschinger’s work is based on Kanter’s theory of structural empowerment, which at its essence is underscored by the notion that conditions for empowerment and job satisfaction are created by, and are the responsibility of employers, managers, and nurse leaders (Laschinger, Almost, & Tuer-Hodes, 2003; Laschinger & Finegan, 2005). According to Laschinger and Finegan (2005), “work settings that are structurally empowering are more likely to have management practices that increase employees’ feelings of organizational justice, respect, and trust in management” (p. 7). This point is critical with regard to the findings of this study for two reasons: it suggests that empowering conditions leading to job satisfaction can be simply created and instituted in the workplace, and that professional empowerment is a product of the workplace. In light of the findings of this study however, it is apparent that empowerment related to nurses’ experiences of being a professional may extend beyond the physical boundaries of the workplace.

The findings of this study suggest limitations to current contentions that creating empowering conditions within nursing workplaces alone can lead to job satisfaction for rural nurses. Firstly, it is apparent that rural nurses derive a strong sense of professional reinforcement and satisfaction from interacting with members of the community, and that due to a myriad of factors, it would be impossible to create uniformly empowering conditions within rural communities themselves. Secondly, only certain aspects of the workplace can be moderated to create a structurally empowering environment. Improving the quality of hospital equipment, increasing staffing quotas and budgets, as well as increasing rural nurses’ access to continuing education are tangible, structural elements that can be modified by physical and monetary means. Elements such as teamwork, morale, and intra-professional relationships may be fostered by management-led structures and processes, but the results of
this study show that in very small rural hospitals, these elements are largely influenced by personal characteristics and attitudes. Ultimately, the theory of structural empowerment has its limitations, especially in rural settings, as nurses’ perceptions of being a professional are influenced by diverse and complex experiences both within and outside of the hospital itself.

The RNAO (2007b) “Professionalism in Nursing” guideline takes a somewhat different approach in suggesting how to facilitate quality workplace environments for nurses. While there is mention of how the “physical/structural policy components” (RNAO, 2007b, p. 18) affect a quality workplace, the majority of this guideline is aimed at nurses as individuals and how they can promote quality workplaces by practicing the attributes of professionalism. The RNAO (2007b) has developed at conceptual model for healthy work environments, which is highlighted by the opinion that:

[An] individual’s functioning is mediated and influenced by interactions between the individual and her/his environment. Thus, interventions to promote healthy work environments must be aimed at multiple levels and components of the system. Similarly, interventions must influence not only the factors within the system and the interactions among these factors but also influence the system itself (p. 17).

In essence, the RNAO (2007b) guideline recognizes that healthy work environments for nurses are the product of much more than simply structural entities and policies. The findings of this study have revealed the importance of less tangible factors of healthy workplaces, such as teamwork and collegiality, and the significance of community interaction in fostering rural nurses’ sense of professionalism and in turn, job satisfaction.

Summary of the Discussion

In light of the discussion presented in this chapter, it is clear that rural acute care nurses in British Columbia and Alberta experience professionalism in the community and the workplace, and experiences in both of these contexts are dynamic and contribute both
positively and negatively to being a professional. The professional affirmation that nurses
derive from being visible in the community is of great significance for our present and future
understandings of professionalism in a rural setting, as there is extremely little
acknowledgement of this phenomenon in the present nursing literature. Themes from the
workplace context were well-supported by current nursing literature, and the RNAO (2007b)
"Professionalism in Nursing" guideline was discussed alongside the findings in this study.
The findings of this study draw attention to several areas which are in need of further
research, as well as implications that will undoubtedly impact nursing practice and education.
Chapter Six: Summary, Conclusions, and Implications

Summary of the Study

Recruitment and retention of nurses in rural areas is an issue of ongoing concern for Canadians, and rural researchers have only started to unearth the complex multitude of factors that influence nurses’ job satisfaction and the relationship to recruitment and retention. The purpose of this research study was to elicit an understanding of how rural nurses in British Columbia and Alberta experience being a professional. This study utilized interview data from eight female rural acute care nurses in western Canada who participated in the narrative component of The Nature of Nursing Practice in Rural and Remote Canada study (MacLeod et al., 2004). An interpretive description methodology, developed by Canadian nurse researchers Thorne et al. (1997) was used, and data interpretation was guided by Lincoln and Guba’s (1985) data analysis strategy. Findings from this study revealed that rural nurses experience professionalism in two key contexts: the community and the workplace, and this has significant implications for our current understanding of the factors that influence job satisfaction, recruitment, and retention of nurses in rural areas.

Conclusions

In this study, rural acute care nurses from the western Canadian provinces of British Columbia and Alberta experienced professionalism in the contexts of the community and the workplace. In the community, the theme of visibility surfaced as an important contributing factor in nurses’ sense of being a professional. Rural nurses’ inherent visibility within the community influences every interaction with community members, and visibility was found to play a significant role in creating a perception of leadership status and reinforcing nurses’ sense of being a professional.
Many of the professional experiences shared by this group of rural nurses are echoed in existing literature relating to quality work environments and job satisfaction, and this suggests intriguing potential in terms of framing an understanding of these findings in the context of the current nursing shortage in Canada. The literature suggests that professionalism is manifested by applying professional principles in practice, and application of professional principles has in turn been linked to quality workplace environments and nurses' perceptions of job satisfaction.

At the outset of this study, it was not anticipated that nurses' interactions with the community would significantly factor into their experiences of being a professional. Although nurses were primarily asked to describe typical workplace experiences, it is rather striking how much emphasis nurses placed on their experiences in the community as well. While the findings of this study suggest that community members play an integral role in rural nurses' experiences of being a professional, it difficult to elicit a clear understanding of exactly how significant rural nurses' interactions with the community are, relative to workplace experiences.

There was little directly said about professionalism in the interviews, particularly in relation to the community. Much of the insight into professionalism in rural nursing surfaced through interpretations of nurses' descriptions of rather casual interactions with community members. It was not evident in the interviews that community members intentionally set out to foster nurses' sense of professionalism. It is difficult to forecast at this point if community members might also contribute to other forms of professional support and job satisfaction for rural nurses, and thus unclear as to whether strategies could be utilized by community members to knowingly enhance nurses' professional experiences.
In the workplace context, the theme of embracing reality was significant in terms of rural nurses' experiences of being a professional. Nurses in this study openly acknowledged the unpredictability of their workplaces, and consistently identified staffing levels, equipment, and access to continuing education as sub-par. Despite these challenges, rural nurses often spoke highly of their colleagues and workplaces, and the theme of embracing reality seemed to capture nurses' subtle admissions of pride, satisfaction, and confidence in knowing they could handle the demands of being a rural acute care nurse. The dynamic nature of professionalism in rural acute care nursing was evident in this study when nurses relayed rich descriptions of how physical and social aspects of their work environment were constantly changing. Nurses' descriptive and emotional experiences with unprofessional behaviour suggests that positive perceptions of being a professional are easily displaced, and that these encounters can be quite enduring and powerful in detracting from self-perceptions of being a professional.

In order for rural nurses to experience being a professional, it is clear that certain conditions are necessary in the community and workplace contexts. In the rural community, it seems that nurses must earn the respect and regard of the community members. Nurses are visible within the community, and must conduct their social interactions in ways that enhance their experiences of being professional. Nurses must also be aware of how they are perceived by community members, and understand that their actions outside of work are observed by community members, and that these are a reflection of nursing's professionalism.

In the workplace context, nurses related that the experience of being professional is supported by having access to continuing education, good quality equipment to do the job, and the presence of teamwork on the nursing unit. In this study, rural nurses spoke candidly
about their opinions on the importance of continuing education in terms of being professional. Participants expressed a keen interest in making their own nursing education more of a priority in the workplace, and lamented the fact that barriers such as lack of funding and lack of replacement staff made it nearly impossible for them to engage in as much continuing education as they would like. Similarly, rural nurses repeatedly expressed their desire for access to modern equipment and supplies, as these tools play an undeniable role in enhancing the experience of being a professional. While having to use out-dated or visibly shabby equipment does not necessarily threaten the ability of rural nurses to provide quality patient care, nurses in this study expressed a clear desire to be provided with equipment that could reflect their perception of themselves and their work as professional.

The findings of this study show that there is a clear relationship between job satisfaction and how nurses experience professionalism. This study suggests that nurses who perceive themselves as professional practitioners are also more satisfied with their work. There is considerable recognition of the notion that job satisfaction is strongly related to nurse recruitment and retention, and that critical elements of job satisfaction are quality practice environments, and the ability of a nurse to experience and exercise a professional role. Identifying how professionalism exists in rural nursing practice can provide managers, educators, and policy makers with information on to how best offer support and/or make changes to create professional practice environments, so that nurses are able to better function in their roles as professional practitioners.

The existence of professionalism among this cohort of rural nurses suggests that some of the physical and social elements of quality practice environments are present. It is clear that professionalism is one of many important contributing factors to nurses’ appraisals of
job satisfaction. The findings of this study also highlight the role of the community context in nurses’ experiences of professionalism.

The findings of this study point out the strengths and limitations of the RNAO’s (2007b) Best Practice Guideline, “Professionalism in Nursing”. This document is based on a comprehensive review of the literature by the nursing community “to provide the best available evidence to support the creation of thriving work environments” (RNAO, 2007b, p. i). The professional experiences of rural acute care nurses are not reflected in the RNAO’s (2007b) attributes of professionalism. In fact, several of my findings are more closely aligned with one or more of the other Best Practice Guideline publications by the RNAO. It seems that the “Professionalism in Nursing” guideline falls somewhat short of its stated goal to “assist educators to relay the concept of professionalism .... [and to] guide administrators in providing environmental supports that reinforce the attributes of professionalism” (RNAO, 2007b, p. 22). Based on the findings of this study, indicators of professionalism such as teamwork and collaborative practice, equipment and human resources, and continuing education should be present within the RNAO’s (2007b) “Professionalism” guideline. The RNAO (2007b) acknowledge that the “Professionalism” Best Practice Guideline was challenging to write, owing to “its multifaceted nature .... [and] broad descriptors” (p. 22), and that the attributes included in the guideline are a product of a literature review and input from a diverse panel of experts. The findings of this study have led me to conclude that the attributes of professionalism represented in the RNAO’s (2007b) guideline need to be augmented in order to adequately represent key aspects of professionalism in rural practice.

This study has confirmed that professionalism in rural nursing remains a multi-dimensional, dynamic concept which is frequently characterized by the presence of
teamwork, communication, collaboration, adequate equipment, and staffing as well as access to continuing education. These characteristics are also commonly associated with studies that assess nurses' job satisfaction, workplace commitment, recruitment, and retention. Findings of this study showed that nurses' experiences of visibility in the community are significant in terms of affirming professionalism and perceptions of job satisfaction; this phenomenon has not been attended to in detail by any previous studies. Professionalism in rural nursing is a complex and enduring concept and it is clear that accurate representations of professionalism in a rural setting must reflect the important role of interactions with community members as well.

This study of rural nurses' experiences of professionalism serves to strengthen our understanding of the relationships between professionalism and job satisfaction. While researchers have studied the various concepts, we need a firmer grasp on how the concept of professionalism can ultimately translate into recruitment and retention of Canadian nurses. Picture this dilemma much like a deep, wide river with prominent banks on either side; you want to join one side to the other, but you'll need to build a bridge in order to do that. On one side of the bank is the concept of professionalism and on the other is recruitment and retention. The existing literature represents the planks of the bridge, and currently, we have what might amount to a half-built bridge, with various steps here and there. You could cross it somewhat safely using intuitive knowledge, but it might require some precarious leaps across the gaps where the literature is absent. This study has attempted to elicit rural nurses' experiences of professionalism, and how these experiences can ultimately contribute to recruitment and retention via concepts such as quality practice environments and job satisfaction, by linking the current literature in the context of this study, to create a logical
and safe crossing of that bridge. It is quite evident that there is a link between professionalism and quality practice environments, as well as between professionalism and job satisfaction, however the conceptual and theoretical relationships between these concepts needs to be better understood.

Implications

Ultimately, understanding the nature of professionalism among rural nurses has significant implications with regard to strategies for recruitment and retention of nurses in Canada, and the findings of this study also have important implications for future nursing research, nursing practice, and education.

Implications for Future Nursing Research

The literature provides a plethora of confusing synonyms, ambiguous definitions, and multi-dimensional studies which all hint at a relationship between aspects professionalism (e.g., autonomy, teamwork, and collegiality), quality practice environments, job satisfaction, recruitment, and retention. This study has demonstrated that there is a clear need to explore the interconnectedness of all of these concepts, and consider how professionalism directly affects recruitment and retention of rural nurses.

The potential benefits of visibility may offer some impetus for countering the notion that lack of anonymity is necessarily, a negative aspect of being a rural nurse. In addition, it can encourage nurses to embrace more of the possible benefits of living and working as a nurse in a rural community, and potentially be used in nurse recruiting strategies for rural areas. Findings of this study suggest that there would be inherent value in eliciting a further understanding of how rural nurses experience professionalism in the community context. This could potentially alter our present understanding of nurses’ work/life experiences in
rural communities, and reveal significant findings in terms of how we currently understand the role of the community in rural nursing. Nurses' community interactions might also be a source of other important experiences which influence nurses' decisions to commence or continue working in a rural setting. In the same vein, urban nursing might also benefit from further inquiry in this regard, as perhaps there are also undiscovered roles for the community in terms of nurses' professional identity and job satisfaction. The findings of this research have revealed that we do not fully understand the significance or precise roles of community members in relation to nurses' experiences of professionalism and job satisfaction, and the ways in which nurses handle multiple community roles. In addition, understanding more about the nature of visibility in a rural community context has the potential to yield further important insights about professionalism and job satisfaction as it relates to recruitment and retention of rural nurses.

It is imperative that future nursing research focus on the differences between experiences and indicators of professionalism, as it is clear that these cannot be regarded as one and the same. The professional experiences of these rural nurses arise from within; contextually-dependent experiences described in terms of their own words, reflection, and stories. On the other hand, indicators are objective, decontextualized assessments, and labels derived from an experience by a third party for the purpose of classifying and quantifying. While the degrees of separation are decidedly small and probably open to further debate, the difference is found primarily in the notion that an experience is largely the product of interactions between the individual and other entities, which combines with personal factors to produce an experience from within. An indicator of professionalism is the label attached to
an experience (e.g., specialized knowledge, autonomy, ethics, and accountability), and this provides less abstract terms to explain how, or the degree to which, professionalism exists.

Implications for Nursing Practice

In terms of nursing practice, the findings reinforce the need for rural nurses to be continually aware of, and uphold core nursing values such as confidentiality and other professional obligations when interacting with members of the community. Nurses in rural practice may stand to benefit from the knowledge that interaction with members of the community is often based on their inherent visibility, which can be a potential source of job satisfaction as well as reinforcement of professional knowledge, expertise, and skills.

The findings of this study suggest that if nurses are to maximize their experience of being a professional, more concerted efforts must be made to assure rural nurses’ access to continuing academic and practical education, and skill certification. It is evident that more funding needs to be specifically allocated to hospitals in rural communities in British Columbia and Alberta so that nurses have access to the tools that both foster and enhance the experience of being a professional. Rural nurses need to have reliable access to continuing professional education and good quality equipment with which to perform diagnostic tests and patient assessments, as these can significantly influence nurses’ sense of professional pride, sense of being valued, contentment, and satisfaction with work. Further development of rural-based specialty programs, such as the post-RN rural acute care certificate program in British Columbia (MacLeod & Lindsey et al., 2008; UNBC 2007), are needed to show our commitment and support for the continued education and professional development of rural nurses. As many areas of Canada face critical nursing shortages in rural areas, it seems these
factors would cost little in relation to the expenses associated with ongoing problems with recruitment and retention.

Implications for Nursing Education

From a pragmatic standpoint, the findings of this study have the potential to enhance nursing education in a couple of different ways. Undergraduate nursing education as a whole stands to benefit from further discussion of the concept of professionalism. Having completed my own undergraduate nursing degree within the last seven years and having worked as a teaching assistant, it is apparent that nursing programs sometimes spoon-feed students the idea that nursing is a profession, rather than help students understand the reasoning behind the rhetoric. There are over 36,000 nurses in British Columbia (CRNBC, 2008d), and each year several hundred more will graduate and begin their nursing careers. It is important for nurses entering the profession to understand the fundamental ideology of professionalism, and why nursing has, and continues to work at securing its professional status. Older generations of nurses have been witness to nursing’s shift from subservient to autonomous, professional practitioner, and this has greatly impacted models of care delivery, and public perceptions of nursing. All nurses need to understand and appreciate the significance of being a professional and the inherent responsibilities that accompany it, because even as individuals, we are a reflection of our profession as a whole. In effect, this is the link between the individual and the group; of being a professional and being a profession. As the findings of this study show, nurses who consider themselves to be professional are not only more satisfied with their jobs, they are also in a better position to provide high-quality patient care.
In this study, the visibility of rural nurses and their interactions in the community led to the frequent potential for conflict between professional ethics and personal relationships. Schank and Skovholt (2006) point out that similar conflict occurs among psychologists who practice in small-community areas, and Campbell and Gordon (2003) suggest that multiple relationships with community members, and "role conflict" (p. 430) are inevitable for psychologists practicing in rural settings. Schank and Skovholt (2006) recommend that academic institutions incorporate basic training for students on how to manage "multiple-level relationships" and "conflicting obligations" in small community practice settings (p. 194). Similar training should be implemented for nurses, as this would draw further attention to the importance of ethical practice in nursing, help nurses manage multiple relationships in the community, and benefit the overall perception of nursing as a profession.

Engaging students, nurses, and nurse educators in a broader dialogue about what it means to be professional, specifically in terms of rural nursing might also help lessen the opinion of both the public and urban nurses, that rural nursing is somehow easier, less prestigious, or less sophisticated. Rural nursing is inherently different, offering sometimes little basis for comparison with urban nursing; however that does not mean it is any less important. MacLeod and Misener et al. (2008) examined narrative data from The Nature of Nursing Practice in Rural and Remote Canada study and found that rural nurses' advice to policy makers and professional practice organizations was to "recognize the uniqueness of rural and remote nursing practice and to support that scope of practice adequately" (p. 47). As rural areas are such a large proportion of Canada's landmass, educators would be wise to emphasize the unique professional opportunities available in rural practice, and to include
classroom discussions on rural nursing as part of ensuring a holistic approach to nursing in Canada.

*Further Thoughts on the Research Process*

As I worked through the research process, I became ever more aware of interesting issues related to my chosen methodology, and the strengths, weaknesses, and utter challenges of incorporating ambiguous concepts into a research study. If I were to do a study like this again, I would still consider using existing narrative data, as long as the original research was designed to elicit very broad and general understandings of an experience.

One of the interesting things that I noticed about the nurses in my study was that all of the nurses possessed what I would consider a significant amount of rural practice experience (all had at least eight years experience in rural settings). This, along with the fact that my participant sample was entirely female, leads me to believe that the findings from this study might be highly unique for several reasons. Penz et al. (2008) found that “female RNs practicing in rural acute care settings may experience greater job satisfaction than do their male counterparts” (p. 795), and Molinari and Monserud (2008) reported that the most dissatisfied rural nurses in their study had between 1–3 years of practice experience. Nurses who chose to participate in this study might be nurses who overall, are satisfied with their jobs and therefore are able and desire to share the nature of their nursing practice. It is also plausible that possessing a significant amount of rural practice experience is an enabling factor in the ability to experience professionalism. Experience breeds confidence, and I know from my own practice experiences when starting new jobs, that it is difficult to feel like a knowledgeable and resourceful professional when everything is new and unfamiliar.
At the outset of this study, I made the presumption that neighboring provinces might be more alike than not. This presumption turned out to be supported, as Registered Nurses in British Columbia and Alberta are among the highest paid in the country, and are more similar in terms of rural statistics such as nurse to population ratios, gender proportions, education, and place of employment, as compared to nurses in mid-western, eastern, or northern Canadian provinces and territories (CIHI, 2002; CTV Globe Media, 2008). In a future study, using data from MacLeod et al. (2004), it might be interesting to interpret the narratives of rural acute care nurses in other parts of Canada to elicit how these nurses experience being professional. Similarly, there would be merit to undertaking a study which looked at the professional experiences of rural nurses in other practice areas such as long-term care, home care, community, outpost, and nurse practitioner, and compare these findings. Rural acute care nursing is likely different from home care or long-term care nursing, and further inquiry could offer some interesting additional insight as to whether rural RNs across the country experience professionalism in similar ways, and potentially support generalization of rural nursing studies in Canada. Though the data generated by MacLeod et al. (2004) provided a wealth of information about the professional experiences of rural acute care nurses, a study which specifically and directly asks rural nurses about professionalism may also yield a greater depth of understanding about the phenomenon.

My attempt to examine and interpret an ambiguous concept such as professionalism proved to be no less challenging than I had anticipated. If I were to do a similar qualitative study again employing ambiguous concepts, I would likely employ a similar approach of discussing the findings in comparison to an already existing piece of literature. Using the interpretive description method was a wise choice in terms of the freedom that I was afforded
in making my interpretations. This method was relatively easy for a neophyte researcher to understand because the creators offered guidelines and suggestions for using the method.

Lastly, I realize that I will never again to be able to approach a qualitative research study as a true novice, as this experience has afforded me a wealth of challenges and rewarding experiences that I will ultimately draw on in the future. Quite possibly one of the biggest challenges I created for myself was opting to carry out the writing of my thesis as a distance student. I found that there were innumerable, but not insurmountable challenges in not having the luxury of proximity (a.k.a. motivation) to my supervisor and committee members, and regular, physical contact with the other elements of an academic environment. For a novice researcher, I feel that physical distance adds unnecessary challenge to the research process, and in hindsight, writing a thesis as an on-campus student would have probably seen me finish the work in a much shorter timeframe. The opportunity to conduct this study has encompassed a personal journey of much joy, excitement, and apprehension, and I have learned a tremendous amount about myself and the challenges associated with undertaking a qualitative research study.

**Final Thoughts**

In this study, I investigated how rural acute care nurses in British Columbia and Alberta experienced professionalism in everyday nursing practice. The findings of this study revealed that rural nurses experience professionalism through interaction in both the community and workplace contexts through a combination of physical and social interactions in the environment. For rural acute care nurses in British Columbia and Alberta, being professional means experiencing interactions in the community and the workplace that foster professionalism, professional practice environments, and job satisfaction. In the community
context, visibility emerged as the predominant theme, and in the workplace, nurses related the importance of embracing reality as integral to their experience of being a professional. One of the most significant findings of this study was discovering that community members play a very active and important role in rural nurses' experiences of being a professional, and further study toward understanding the nature of this phenomenon is absolutely warranted. Though the findings of this qualitative study cannot be generalized to the rural nursing population as a whole, this study has enhanced the current understanding of professionalism, and provided a number of suggestions for future research as well as implications for nursing practice and education.
References


Appendix A

The Nature of Nursing Practice in Rural and Remote Canada

NARRATIVE COMPONENT

Interview Questions and Probes

Begin by introducing yourself – as a registered nurse… NOTE: It is not as important to get through all of the questions. Try to get to a few situations.

1. What is it like to be a (type of role) ______ nurse, in (setting) ______ in (town/village) ______?

2. What kind of agency/organization do you work in?

3. Can you tell me about the community(ies) in which you work? (size, economic base, geographic location, cultural makeup)

[NOTE: These first 3 questions could be covered by: Tell me how you came to be a ........ nurse in ........]

4. Could you describe what a typical day/week is like for you?

5. *Could you tell me about:
   A situation in which you feel your nursing care really made a difference in patient/client outcome, either directly or indirectly?
   A situation that went unusually well
   A situation that is very ordinary and typical
   A situation in which there was a breakdown (i.e. things did not go as planned)
   A situation that you think captures the quintessence of what nursing is all about
   A situation that was particularly demanding

   Probes:
   Could you tell me more about what was going on at the time?
   Why is the situation significant?
   What were your concerns at the time?
   What were you thinking about as it was taking place?
   What were you feeling during and after the situation?
   What, if anything, you found most demanding about the situation?
   What helped you deal with the situation?
6. Can you think of patients/clients in the last few weeks, who have been memorable? 
- compare to earlier in your career
7. What is most challenging to you now in your practice? 
- compare to earlier in your career
8. What sustains you in your practice?
9. Can you tell me about a situation that will illustrate what it means to be a nurse and a member of the community?
10. What does learning through experience mean to you?
11. What advice would you have for:
- New nurses coming into your situation?
- Planners of educational, practice and administrative supports?
12. Do you have any final message you would like to give the researchers?

Demographics:
Position: former, chronology

Education:

Professional Qualifications:

Doctors/other colleagues: Organization/Length of time working with

Physical set-up: office location/clinic/unit layout, equipment, environment – effects on nursing care.

NOTE: You do not need to ask for all of the situations, but ask for at least 2 or 3 of them. The goal is to get nurses to talk about their experiences fully with as many particulars as possible. Please make sure you ask all people question 10.


August 24, 2000

Martha MacLeod  
c/o Nursing

Proposal: EP20000704.51

Dear Prof. MacLeod:

Thank you for responding to the comments about your proposal entitled, "The Nature of Nursing Practice in Rural and Remote Canada."

Your proposal has been approved and you may proceed with your research.

If you have any questions, please feel free to contact me.

Sincerely,

Alex Michalos  
Chair, UNBC Ethics Review Committee