



The nature and scope of rural nursing : distinctive characteristics
by Jane Ellis Scharff

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Nursing
Montana State University
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Abstract:

Currently most professional nurses who enter . employment in rural hospitals have little understanding of what nursing practice in such facilities is really like. Working in a small rural hospital after being educated in a large urban hospital can be an overwhelming experience. Until the nature and scope of rural hospital nursing are described and defined and parameters identified, it is likely that professional nursing will continue to ignore the distinctiveness of practice in rural settings. The task of improving their image will ultimately fall to rural nurses themselves. Rural hospital nurses must describe and define their practice and must describe how the nature and scope of their practice is distinctive.

The scientific nursing community must work with rural nurses to interpret, evaluate, and translate the descriptive information. The objective would be increased understanding of the true nature and scope of rural nursing practice.

This is a descriptive study of rural hospital nursing in which the nature and scope of rural nursing are described within the framework of the Social Policy Statement of the American Nurses' Association. Using that framework the distinctive characteristics which appear in the intersections, dimensions, and boundaries of rural nursing practice are explored. Ethnographic methods, specifically those techniques described by Spradley (1979), were used to gather data from informants who are rural hospital nurses in the Inland Northwest. The pilot phase (N=8) provided information from which tools were developed to study a larger sample of rural nurses in the second phase (N=26).

The practice of nursing in the rural hospital setting was found to be identifiably distinctive in regard to the intersections, dimension, and boundary of rural nursing practice. The core of rural nursing practice, with one exception, was found to be similar to the core of nursing practice in any other setting.

Implications of this study includes the need for education to be tailored to the specific need of the rural nurse, the need to address issues related to safe practice and legal responsibilities of rural nurses, and recognition that nurses who practice in the rural setting identify and seek recognition for the distinctiveness of their practice.

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DISTINCTIVE CHARACTERISTICS

by

Jane Ellis Scharff

A thesis submitted in partial fulfillment
of the requirements for the degree

of

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APPROVAL

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Jane Ellis Scharff

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7/13/87
Date

Blair W. Weir
Chairperson, Graduate Committee

Approved for the Major Department

July 13, 1987
Date

Anna M. Shannon
Head, Major Department

Approved for the College of Graduate Studies

7-29-87
Date

W. P. Malone
Graduate Dean

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Date

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ABSTRACT

Currently most professional nurses who enter employment in rural hospitals have little understanding of what nursing practice in such facilities is really like. Working in a small rural hospital after being educated in a large urban hospital can be an overwhelming experience. Until the nature and scope of rural hospital nursing are described and defined and parameters identified, it is likely that professional nursing will continue to ignore the distinctiveness of practice in rural settings. The task of improving their image will ultimately fall to rural nurses themselves. Rural hospital nurses must describe and define their practice and must describe how the nature and scope of their practice is distinctive. The scientific nursing community must work with rural nurses to interpret, evaluate, and translate the descriptive information. The objective would be increased understanding of the true nature and scope of rural nursing practice.

This is a descriptive study of rural hospital nursing in which the nature and scope of rural nursing are described within the framework of the Social Policy Statement of the American Nurses' Association. Using that framework the distinctive characteristics which appear in the intersections, dimensions, and boundaries of rural nursing practice are explored. Ethnographic methods, specifically those techniques described by Spradley (1979), were used to gather data from informants who are rural hospital nurses in the Inland Northwest. The pilot phase (N=8) provided information from which tools were developed to study a larger sample of rural nurses in the second phase (N=26).

The practice of nursing in the rural hospital setting was found to be identifiably distinctive in regard to the intersections, dimension, and boundary of rural nursing practice. The core of rural nursing practice, with one exception, was found to be similar to the core of nursing practice in any other setting.

Implications of this study include: the need for education to be tailored to the specific need of the rural nurse, the need to address issues related to safe practice and legal responsibilities of rural nurses, and recognition that nurses who practice in the rural setting identify and seek recognition for the distinctiveness of their practice.

CHAPTER 1

INTRODUCTION

The largest number of general hospitals in Montana and in many areas of the western United States are small rural hospitals. In Montana, 73 percent of the hospitals have fewer than 50 beds. Sixty-two percent of the hospitals in Idaho and 39 percent in Washington are in this category (American Hospital Association, 1985). These hospitals and the nurses who work in them are significant factors in the rural health care delivery system. In the published literature, except for anecdotal reports, there is limited information regarding rural nursing. Most of what is written about rural nursing does not address the special practice of the rural hospital nurse.

There is a lack of agreement as to whether rural hospitals are a necessary and important component of this country's health care delivery system. Rural hospitals exist essentially because rural society requires attention to its health just as other segments of society do. The fact that small rural hospitals have a population of consumers actively using services is some validation of

the hospitals' role (Moscovice & Rosenblatt, 1982). However, most of the rural hospitals located in the northwest United States were constructed 20 to 30 years ago during a very different economic climate than exists today (American Hospital Association, 1985). According to Mullner and McNeil (1986) 79.6 percent of the community hospitals which suffered closure during 1985 had less than 100 beds.

Those rural hospitals which continue to survive are doing so in part through diversification of services (Friedman, 1986; Van Hook, 1986). The pressure is on rural hospital administrators to see that their facilities survive the present economic strain (Anthony, 1983). As a result, rural nursing practice is being influenced by external forces as never before. The message to the rural nurse is to prepare to assume even more roles, or prepare for unemployment. Of issue is the obligation which rural nursing faces in the delivery of safe care. Nurses must balance their obligation for ethical and legal practice against the requirement to play many roles.

It was recognized by the author that nursing in rural hospitals can be a powerful experience which differs in some respects from urban nursing. Differences are not based on the argument that nursing care requirements of rural people are special. The medical sociology

literature indicates that the health care requirements of rural people are statistically very similar to those of urban people (Childs & Melton, 1983; Mutel & Donham, 1983). It is hypothesized that rural hospital nursing differs from nursing in large urban hospitals in the method by which nursing services are delivered, and the distinctive manner in which nursing practice is impacted by external forces.

Problem

Rural hospital nursing practice is an important segment of professional nursing. However, this is difficult to substantiate based on the available literature. There is a paucity of sources which adequately describe this group of health care professionals and their practice. Moreover, there are subtle but pervasive omissions in attention to the subgroup of rural hospital nurses. For example, data forms designed to compile statistics regarding clinical areas in which nurses practice or divisions of practice are frequently included in nursing license application and renewal forms, in nursing association membership forms, and even on reader service cards in nursing journals. These data forms usually list a number of specialty clinical areas common to nursing practice. The

instructions most often ask the respondent to check only one area of practice. Rural hospital nursing is never one of the areas listed, nor is the category of generalist nurse listed.

Along the same line, another example of the lack of identity which rural nurses experience is in regard to nursing specialty certification. There is a definite trend in the profession to become certified in one's specialty as a measure of demonstrated expertise. Specialty certification is offered and encouraged by a number of professional nursing organizations, most notably the American Nurses' Association. If rural hospital nurses consistently work three or four different clinical areas, in which should they certify? There is no rural nursing certification offered.

In 1983 it was recognized by the Montana Nurses' Association that rural nurses are required to practice nursing proficiently in many clinical areas. At its annual convention the House of Delegates unanimously passed a resolution requesting that the American Nurses' Association develop a certification examination for rural nursing (Montana Nurses' Association, 1983). To date there is no such examination available. As a comparison in the field of medicine Family Practice physicians, who

are generalists, are recognized for their generalist specialty and can become certified as such.

One of the most significant examples of the lack of importance attributed to rural hospital nursing has been the lack of inclusion of rural nursing in nursing education programs. In the past decade the opportunity to participate in rural practicums has been established at several schools of nursing. However, in most cases the rural practicum is an elective for nursing students, and participation requires that the students spend an additional term in school. In some cases the rural clinical option is reserved for only those students having high grade point averages (Predhomme, 1985).

Currently most professional nurses who enter employment in rural hospitals have little understanding of what nursing practice in such facilities is really like. Working in a small rural hospital after being educated in a large urban hospital can be an overwhelming experience.

Until the nature and scope of rural hospital nursing are described and defined and parameters identified, it is likely that professional nursing will continue to ignore the distinctiveness of practice in rural settings. The task of improving their image will ultimately fall to rural nurses themselves. Rural hospital nurses must describe and define their practice and describe how the

nature and scope of their practice is distinctive. The scientific nursing community must work with rural nurses to interpret, evaluate, and translate the descriptive information.

Purpose

The purpose of this study is to describe the nature and scope of rural nursing practice in the setting of the small rural hospital. Distinctive characteristics of rural nursing practice as perceived and reported by rural hospital nurses will be identified and described.

Definition of Terms

In the nursing literature as well as other literature relative to this study a variety of terms essential to this study's purpose emerge having slightly or grossly different meanings. For example, the term "rural" is defined very differently from one source to another. In order to increase the clarity and understanding of the key elements related to this study, the following terms and definitions will be used.

Nursing. The diagnosis and treatment of human responses to actual or potential health problems (American Nurses' Association, 1980).

Distinctiveness of Rural Nursing. Those characteristics which are perceptibly and identifiably separate or different from nursing in other settings as perceived by rural nurses who have prior urban experience.

Rural Community. A community with a population of less than 5,000 according to the 1980 census and located at least 50 ground miles from an urban center with a population of 50,000 or more.

Rural Hospital. A general hospital having fewer than 50 acute care beds and located in a rural community.

Rural Nurse. A registered professional nurse employed as a nurse in a rural hospital.

CHAPTER 2

REVIEW OF THE LITERATURE AND CONCEPTUAL FRAMEWORK

In the first section of this chapter a review of the literature related to the study is presented. The applicable literature includes research of varying designs. Formal studies using survey and ex post facto designs address issues related to several forms of nursing in rural settings, including a few specific to rural hospital nursing. The literature also includes evaluative projects of rural hospital nursing. In addition, there are anecdotal reports by those who have personal experiences involving rural nursing. The literature is organized and discussed within these three general categories. In the second section of this chapter the conceptual framework for this study is presented.

Surveys and Ex Post Facto Reports of Rural Nursing

The literature contains reports about nurse practitioners, nursing administrators, community health nurses, nurses in the Frontier Nursing Service, and rural hospital nurses. The methods of data collection varied and included mailed surveys, interviews, combinations of

surveys and interviews, and case studies. No studies were found which investigated the nature, scope, and distinctiveness of rural nursing, although one study attempted to assess the unique aspects of rural nursing (Thobaden & Weingard, 1983).

Nurse Practitioner Studies

Draye and Pesznecker (1979), and Repicky, Mendenhall, and Neville (1980) employed similar methods of collecting data on the functions of nurse practitioners in ambulatory practice. In these studies hundreds of nurse practitioners kept logs of their activities and treatment of patients. A large sub-set of nurse practitioners from each study was reported to be from rural or non-metropolitan areas, but differences between rural and urban practice were not the focus of the studies. The authors provided no conclusions which demonstrated that rural practice was different from urban practice.

Through the use of an ex post facto case study Cummings (1978) reported health problems and disposition of cases during a 21-month period in her practice as a rural family nurse practitioner. Cummings reported that there was a depth to rural practice which provided great challenge as well as rich reward to professionals. She suggested that rural nursing included a holistic approach

in which nurses worked not only with individuals, but with whole families to resolve both core and peripheral problems.

Moscovice and Nestegard (1980) studied the factors which influenced the choice of location of practice for 91 family nurse practitioners. The authors noted a positive relationship between rural educational experience and choice of rural practice location.

One hundred forty-two families in rural areas were surveyed to determine their use of a rural nurse practitioner clinic (Weinstein & Demers, 1974). It was found that consumers were loyal to their local clinic and that residents had a desire to obtain health care locally.

Long (1982) investigated the emergency care practices of rural nurse practitioners in Alaska, Idaho, Montana, Oregon, and Washington and found a wide variation in their practice, influenced in part by particular characteristics of each setting. Long's study demonstrated the effects of the demands of rural society on rural nursing practice. For example, some nurse practitioners who worked with physicians reported less need to be familiar with and to use emergency care procedures in their practice than nurse practitioners who worked alone. Those nurse practitioners who worked alone reported a strong need to be familiar with and to use

emergency care procedures in their practice. Presumably, the emergency care requirement of people in various locations is similar. When a physician is not available to deliver such care, the demand of society is felt by nursing, and in the case of Long's study, nurse practitioners responded to this need.

Bennett (1984) studied eight family nurse practitioners in New Mexico to explore the nature of their role. A combined methodology of written questionnaires, interviews, and participant observation was used to gather data on factors which influenced the role identity of rural nurse practitioners. Interpersonal relations were delineated as having a major influence on role identity.

Nursing Administrator Studies

McMillan (1983) studied aspects of rural nursing management by surveying 26 hospital directors of nursing in Montana. McMillan reported that characteristics of the practice of the respondents included isolation, staffing difficulties, poor wage and benefits packages, and low incentive for professional growth. While her narrative report focused strongly on the negative aspects of her findings, closer inspection of her data revealed that 84 percent of the respondents actually stated they were quite

or very satisfied with their situation as rural nursing managers.

Peterson (1984) investigated 36 Montana nursing administrators' sources of influence and mentor-networking relationships. She reported a link between rural setting and isolation of nursing administrators as well as a link between rural setting and health care delivery problems in rural hospitals. Peterson compared her findings to those of McMillan's (1983) and reported an increase from previous study in the professionalism and authority of nurse administrators. In addition, Peterson identified the importance of mentors and professional networks and found that nursing service administrators valued the experience of having a mentor and that they valued professional networks for the purpose of meeting their professional needs.

Another recent study of nursing administrators in small rural hospitals was undertaken by Henry and Moody (1986) who surveyed 10 directors of nursing in rural Florida. The average hospital size in this study was 52 beds and the authors found that these nursing directors, like the staff nurses they directed, had to be flexible and prepared to function throughout the hospital. The authors stated that, "Where few specialists exist, directors must be excellent generalists. They must be

able to practice and demonstrate clinically sound nursing, be well informed in several specialties, and perform well as managers" (p.38).

Community Health Nurses

Winninghoff (1984) interviewed seven rural community health nurses in Montana about their perceptions of their roles as well as what they perceive as optimal community nursing care. The author explored the question of whether Montana community health nurses perceived their role differently than community health nurses in other states. Winninghoff found that responses varied, with some of the informants reporting that their rural roles were very different from urban community health nursing roles and others reporting that their roles were very similar.

Frontier Nursing Studies

A study which does not focus on rural hospital nursing but which does examine the influence of the rural setting on nursing practice was reported by Moscovice (1978). The author examined the patterns of primary care provided to ambulatory patients by family nurse practitioners and by registered nurses. The intent of the study was to address the issue of how much education a nurse requires to function in the expanded role of providing primary care. It was determined that the rural

setting was more influential on the pattern of care provided by nurses than their educational level. The care rendered in the more rural setting was distinctly different and of a more autonomous nature than the care rendered at the less rural setting, regardless of the nurses' educational level.

Hospital Nursing Studies

Job stressors and coping strategies of 24 rural hospital nurses in Montana were studied using an ethnoscience method (Bunde, 1981). Many characteristics which may be distinctive to rural nursing practice were found to be stress evoking to rural nurses. For example, nurses were stressed by the responsibility of being the only registered nurse on duty and by the fluid boundary between nursing practice and medical practice. They experienced physical exhaustion due to the "on call" requirements and felt stressed about their level of competence when dealing with infrequent occurrence of critical patients and specialized procedures.

Rural hospital emergency room nurses' knowledge of Advanced Cardiac Life Support was examined by Ellis (1980). A written survey was combined with an interview method to study 36 rural hospital nurses in Montana. The study revealed that respondents had a general need for

increased knowledge of Advanced Cardiac Life Support measures. Ellis also determined that there were no nurses who worked exclusively in emergency departments and that the nurses reported themselves to be generalists who worked in all areas of the hospitals. In several cases his respondents were nursing directors who worked in clinical areas during times of need.

Canadian investigators, Leatt and Schneck (1982) studied similarities and differences in the work environment of nine different nursing practice areas. Rural nursing practice areas were surveyed as well as intensive care, medical, surgical, psychiatric, auxiliary, rehabilitative, pediatric, and obstetrical units at hospitals in Alberta, Canada. While findings can not be generalized to the present study for a number of reasons including differences in definition of terms, the Canadian study presents an interesting perspective. These authors reported that rural nurse respondents did not have greater autonomy than other nurses and that the complexity of rural nursing was not greater than that of other nursing areas. While these findings may be influenced by the climate of the socialized medical system in Canada, they are in direct contrast to the other reports in the literature review.

Investigators in northern California conducted a study of rural and urban nurses which had a purpose similar to the present study. Thobaden and Weingard (1983) were interested in describing rural nursing and identifying unique aspects of rural nursing. A combined methodology used a modified Bevis Job Activity Scale, an interview guide developed by the authors, and the Schwirian Six Dimension Scale of Nursing Performance. The job activities scale yielded data on the activities most often performed by rural nurses. The interviews contributed ethnographic data about rural nurses' perceptions of rural versus urban nursing. The nursing performance scale contributed data regarding differences between urban and rural nurses. The definition of rural used in the Thobaden and Weingard study was similar to that used in the present study. The framework alluded to was a combination of general systems theory and humanistic psychology. Because the authors did not keep within the definition of terms when the study was conducted, their results must be questioned. The results did not demonstrate that rural nursing was unique based on the two scales used, although the ethnographic data revealed some uniqueness. Activities of rural nurses and performance of rural nurses were found to be similar to those of urban nurses but rural nurses reported their practice to be

unique. The authors did recognize that the validity of the tools used for study was questionable in light of the study's purpose and that the uniqueness of rural nursing might need to be measured by some other method.

Evaluative Studies

The following are reports of studies which were undertaken to assess particular needs for development of specific programs. As a result of these studies, actions were taken to implement or change educational programs to meet needs identified by the studies.

Development of Rural Nursing Practicums

Two studies gathered data which identified characteristics of rural hospital nurses (Benson, Sweeney, & Nicolls, 1982; Shankar & Quiring, 1980). The characteristics were identified in order to shape nursing curricula and could be defined as activities or functions of rural nurses. The characteristic difference between rural nursing and urban nursing which these studies demonstrated was that rural nurses had multiple specialty practices. Other characteristics which both studies identified as attributes in the rural setting were flexibility, need for assessment skills, organization and

management skills, and the ability to make decisions using good judgment.

A project designed to educate nursing students about rural nursing in Colorado was reported by faculty at two different schools of nursing (Arlton, 1984; Predhomme, 1985). In each project senior nursing students were given an opportunity to work in small rural hospitals, and in both cases the faculty witnessed a trend of more graduate nurses choosing to work in the rural setting. These programs had been implemented in the attempt to decrease nursing shortages in rural areas of Colorado. The studies demonstrated that the programs were successful in their purpose of encouraging nurses to choose a rural setting for practice. In the authors' opinion the programs were playing an important role in decreasing Colorado's rural nursing shortage. These projects did not attempt to identify distinctive characteristics of rural nursing.

Rural Nursing Continuing Education

Rural nurses are faced with the difficulty of gaining and maintaining proficiency in multiple areas of nursing practice. A report from Minnesota (Koenig & Dachelet, 1980), and one from Texas (Pickard & Burns, 1979) described how the challenge of a continuing education program for rural nursing staff was met. Each study

emphasized the dilemma faced when a small staff must cover a broad spectrum of nursing demands. In each case, once educational needs were identified, programs designed to meet those needs were implemented.

The perceptions of rural nurses at 13 hospitals in Texas were assessed in order to gain information about university administered continued education programs (St. Clair, 1984). The findings were consistent with adult learning theory which holds that learning must be meaningful to the learner. It was found that because rural nurses function in multiple roles and practice areas, educators must be creative to meet the broad educational needs of rural hospital nurses.

Summary: Studies of Rural Nursing

The empirical literature reviewed indicated that investigation of rural nursing varies widely in approach and focus. Most studies did not address the nature and scope of rural nursing practice and the frameworks for the studies were not always discussed. The predominant framework reported was one of role theory. Several studies noted the influence of the rural setting on the role of nurses. A consistent finding was that rural educational experiences favorably influenced the decision of nurses to choose a rural location for practice.

Experiential Reports

A number of reports made by those who have had personal experiences related to rural nursing were identified in the literature. These reports are rich in the description of the nature of rural nursing practice. However, they do not attempt to discuss a framework for the nature of rural nursing. In the following review of the anecdotal literature the authors will be quoted heavily for the purpose of illustrating for the reader a picture of their perceptions of rural nursing. The reports consistently focused on the phenomena of multiple roles, multiple specialty practice, and various influences of the rural setting on the practice of rural nursing.

Fields (1982) described rural nursing as a special kind of challenge, and the rural nurse as "a generalist who must perform a variety of nursing functions with consistency and a high standard of quality" (p. 5). Fields stressed the importance and value of rural nurses in rural hospitals and noted that "it comes as no surprise that the backbone of patient care is that of the nursing service" (p. 5). She contended that continuity of care was special in the rural setting due to increased visibility and noted:

There is little professional detachment as a rural nurse. The patient who walks through the door may well be family, neighbor, or friend. We know how patients are doing after discharge because we often get to visit with them out in the community. (p. 6)

Fields, a nursing service director, discussed the difficulties of recruitment and retention of nurses in the rural setting and said, "It is my belief that just as any specialty is not to everyone's liking, to be a rural nurse will not be everyone's choice," (p. 6) and she encouraged nursing directors to take that factor into consideration during the recruitment process.

The fact that rural nurses need good assessment skills as well as knowledge of treatment procedures in order to function until physicians can be reached was pointed out by Ross (1979). He indicated some differences of rural nursing from urban nursing such as the variety of specialty areas which may be worked in one day, the lack of availability of medical experts, and the rural nurse's need for autonomous decision making ability. Ross described the rural nurse as "a generalist with sophisticated assessment skills and special technical skills to provide a broad spectrum of medical support" (p. 27), and "a special nurse with the intellectual ability to grasp knowledge in many areas" (p. 27).

The influence of setting on practice was discussed by Zungolo (1979) who said that in Idaho the rural nature of

the state effects the practice of many nurses. The majority of the hospitals are small and rurally located and the author stressed the significance of nurses needing to function independently throughout the facility without the benefit of collaboration with other health care providers. The premise of Zungolo's article was to support the baccalaureate degree as the educational entry level for nursing, especially in the rural setting where nurses "require far more preparation than we are currently providing, perhaps more than nurses require who work in large medical centers with 24-hour coverage from interns, residents, and staff physicians" (p. 59).

In personal accounts by Pakiesar (1978) and by Worcester (1980) the dichotomy of nursing staff limitations versus high expectations was emphasized. Pakiesar offered her observations of the result of a rural hospital practicum. The experience of students in a rural hospital led to an increase in how they valued the role rural nurses assume in that setting. Worcester presented a situation she experienced as a rural hospital nurse which led her to report on the need for nurses with specialized knowledge in rural hospitals. Both of these reports infer that rural nurses place higher expectations on themselves than they are realistically able to meet based on the nature and demands of the setting.

A strong supporter of the concept of rural specialty, Stuart-Burchardt (1982) believed that because of its uniqueness rural nursing practice should be considered a specialty area like pediatrics or medical-surgical nursing.

Rural nurses have a more diversified role and function more independently in this role than nurses in urban settings. A nurse in most rural areas practices to the full extent allowed by the nurse practice act. (p. 618)

Stuart-Burchardt contended that the only real preparation for working in rural hospitals is to offer nursing students a rural clinical experience. She believed that by experiencing first hand days in which a nurse must deliver obstetrical care, cardiac care, psychosocial care, and emergency care, a nursing student gains appreciation of the nature of rural nursing, and only in this way learns decision making and prioritizing skills necessary to function in that setting. Stuart-Burchardt reported that having had a rural hospital practicum, a nurse is more likely to choose a rural setting for practice following graduation.

Faculty and graduate students at the University of Michigan are in agreement that offering a rural practicum is a way to help alleviate the health care deficits which exist in rural areas (Bond, Bailey, Dommer, Hanson, & Wierda, 1984). These authors shared experiential accounts

of their rural experiences connected with the maternal-child graduate program at the University of Michigan. Graduate students' accounts demonstrated a favorable response to having had a rural clinical experience.

Stuart-Siddall (1984) blamed some health care institutions for taking advantage of many rural nurses. She explained that a number of rural nurses are in rural areas for reasons other than choice. In some cases these nurses feel powerless to change their situation of poor pay and benefits because there is no other place for them to work. Stuart-Siddall identified this as exploitation and encouraged rural nurses to work toward a united effort in order to improve their welfare.

Twenty-four hour responsibility was experienced by one nurse practitioner who worked in a rural clinic. Vigesaa (1974) emphasized that having standard clinic hours did not prevent 24-hour accountability. The rural setting influenced her practice by increasing her visibility and decreasing her anonymity. If patients did not find her at the clinic, they simply came to her home.

Summary: Experiential Literature

In summary, there is a form of nursing reported in the literature which is identified as rural hospital

nursing. Rural hospital nursing is claimed by many authors to be special, and even unique by some reports. The phenomena of multiple specialty practice, high visibility and low anonymity, and the necessity for rural nurses to be well educated and highly competent individuals with personal flexibility is frequently reported. These reports give one a sense of the special variety of nursing which is found in the rural setting.

Conclusion

Studies of rural nursing vary in approach, focus, and methods. There is limited empirical information on the nature and scope of rural nursing practice. Conceptual frameworks, rarely reported, were most frequently role theory. Research reports and anecdotal reports were in agreement that rural setting influenced nursing practice and that rural educational experiences favorably influenced the decision of nurses to practice in a rural setting. The experiential literature consistently reported certain phenomena which may be distinctive characteristics of rural nursing practice such as multiple specialty practice and lack of anonymity. However, the empirical literature does not confirm that there are a set of distinctive characteristics which can be shown to fall within the nature and scope of rural nursing practice.

Conceptual Framework

A framework for the study of the nature and scope of rural nursing practice is necessary in order to identify and describe the distinctive characteristics of the practice of nursing in rural settings. In this section such a framework is presented. It allows for a logical sequence of investigation into the details of rural hospital nursing practice. Appropriate rural sociological literature is addressed because of its importance in establishing a framework for rural nursing.

A Social Policy Statement

The Social Policy Statement of the American Nurses' Association [ANA] (1980) represents the extensive work of a task force charged with defining the nature and scope of nursing practice and characteristics of specialization of nursing practice. The policy statement provides a framework for an organized and systematic approach to studying nursing, as it defines nursing and delineates the nature and scope of nursing. The use of the social policy statement as a framework for study has been suggested in the literature. Steel (1984) supported its use as a framework and as a means of generating new information about special areas of nursing practice.

The Nature of Nursing

The American Nurses' Association Social Policy Statement (1980) describes the relationship between the nursing profession and society as mutually beneficial and states:

Nursing, like other professions is an essential part of the society out of which it grew and with which it has been evolving. Nursing can be said to be owned by society, in the sense that nursing's professional interest must be and must be perceived as serving the interests of the larger whole of which it is a part. (p. 3)

If nursing belongs to society, then rural nursing belongs to rural society. If there are differences in rural nursing from the whole of nursing, then it is in the interest of rural society that the differences exist. Nursing does not dictate to society, and although it may be instrumental in initiating change, the profession of nursing exists as a response to the needs of society.

It is important to note that the people living in rural communities indicate a desire to remain close to home for needed hospital care. This has been substantiated by a number of authors (Stuart-Burchardt, 1982; Weinstein & Demers, 1974; Moscovice & Rosenblatt, 1982). Consumers report a sense of loyalty to their local hospitals, physicians, and nurses, and desire to be near their families and support systems when they require

health care. They often boast proudly about the local hospital and nurses (Sullivan, 1985).

Delivering health care to rural consumers is a challenge for nursing. There are a large number of rural hospitals with a limited number of nurses in each hospital providing a broad range of services. The demands on rural nurses are intense, because the rural health care facility attempts to provide quality comprehensive services.

Nurses, as health care providers, play an essential role in this system for they are ultimately seen by the patient as the major caregivers. If patients receive poor nursing care during a hospital admission, they are less likely to want to return to that facility for future hospitalization needs (Rosenblatt & Moscovice, 1982). Inversely, if patients receive quality nursing care, they are likely to return to a facility they know and trust.

As was noted earlier, rural society does not have health care needs which are significantly different in nature from the needs of urban society. In general, rural people experience patterns of health and life expectancy similar to those of urban people (Childs & Melton, 1983; Mutel & Donham, 1983). However, there are a few particular health problems related to lifestyle and livelihood in rural areas. Rural communities are often those with economic and industrial bases of farming,

logging, and mining. These industries are known to have high accident and injury rates so that the degree of trauma seen in rural hospitals may be high.

With respect to help seeking behavior patterns, there are some differences between rural and urban people. Rural people wait longer when ill before they obtain care, are sicker when they do seek help, and require hospitalization more frequently by the time they do seek help than do their urban counterparts (Mutel & Donham, 1983). Rural nursing, in its role and relationship to rural society may be influenced by the distinctiveness of rural health seeking behavior. Nursing has a health oriented mission which means that rural nurses need to know how rural people perceive health.

The Scope of Nursing

The scope of nursing includes four definitive characteristics which are intersections, dimensions, core, and boundary (ANA, 1980). These four characteristics of the scope of nursing practice are the foundation for the framework of this study. Each characteristic has specific meaning and each will be discussed in relationship to rural nursing.

Intersections: Nursing intersects with other professions involved in health care. These intersections

are points at which nursing meets and interfaces with other professions as well as expands its practice into the domain of the other professions as necessary. It is common knowledge within the nursing profession that many of the present domains of other health professions were formerly owned by nursing. With the evolution of the nursing profession it has been necessary for nursing to delegate many of its roles and functions, creating new groups of professionals such as respiratory therapists, dieticians, social workers, and the like. The lines are not static, and in the rural setting where availability of other health care professionals may be limited, the intersections of rural nursing may be dramatically and significantly fluid and distinctive from the intersections of nursing in urban settings. The interpersonal nature of nursing's intersections is basic.

Dimension. Characteristics such as philosophy, ethics, roles, responsibilities, skills, and authority are part of nursing's dimension. These are qualities which give a depth to the scope of nursing practice. They are characteristics which are underscored and influenced by interpersonal relationships and intimacy as well as the intrapersonal quality of nursing. If these dimensions are

distinctively affected by the rural setting, then rural nursing can be described as dimensionally distinctive.

Core. The concept of the core of nursing is complex and somewhat more difficult to discuss than the preceding concepts. The needs of people form the basis or core for nursing. Nursing is defined as "the diagnosis and treatment of human response to actual or potential health problems" (ANA, 1980, p. 9). Nursing exists to deal with human response and the core of nursing is the human response. This can be more clearly explained using examples of the nomenclature which has come to be called nursing diagnosis. For example, the human response of "anxiety related to chestpain" would be at the core of nursing care. The human response of "self-care deficit related to post-surgical state" or the response of "mobility impairment related to traumatic amputation" are other core nursing concerns. It is not anticipated that human response to actual or potential health problems will be found to be different from one person to another. The "anxiety" or "self-care deficit" or "mobility impairment" response will occur similarly for all people. It is not anticipated that the core of rural nursing will be distinctive. All nurses attempt to meet emotional needs,

self-care deficits, and mobility impairments of the people for whom they care.

The concept of nursing core will be briefly discussed when appropriate throughout this study, but due to the complexity of the concept there will be no attempt to test it. The research design will be limited to explaining the concepts of intersection, dimension, and boundary.

Boundary. Nursing's boundary is external and expands as nursing responds to the demands and needs of the society it serves (ANA, 1980). As society changes, so does nursing. As nursing's intersections and dimensions change, so does its boundary. If there are needs, demands, and capacities of rural society which are distinctive and different from the rest of society, then the response of rural nursing requires distinctively different boundaries. Factors which influence nursing's boundary may include setting and environment.

Summary

The framework for this study is the Social Policy Statement of the American Nurses' Association (1980). Nursing has a definable nature and scope that includes descriptive characteristics of that nature and scope. Nursing is part of society, is owned by society, and serves society. The scope of nursing includes

intersections, dimensions, core, and boundaries, which are affected by the demands or requirements of the society which nursing serves.

Figure 1 is a model of the social policy statement which illustrates that the intersection, dimension, core, and boundary, are characteristics of the nature and scope of nursing, which is in turn a part of society. Figure 2 illustrates the conceptual framework for rural nursing used in this study.

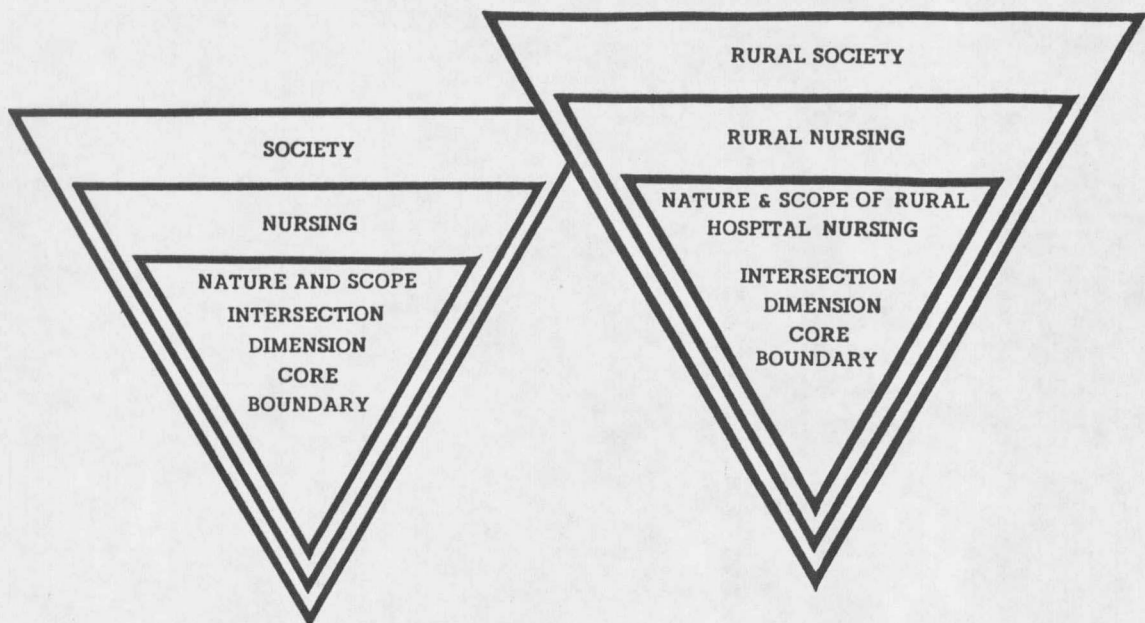


Figure 1.
The relationship of
nursing to society.

Figure 2.
The relationship of rural
nursing to rural society.

CHAPTER 3

METHODOLOGY

The research design and methodology, and the development of the tools for study are described in this chapter. A discussion of the selection of informants, data collection during the pilot and second phases, and data analysis are also included.

Design and Method

In an effort to describe the nature and scope of rural nursing, it was determined that the ethnographic method would yield the most useful data for qualitative analysis. The method used in this study is based on ethnographic techniques developed by Spradley (1979), which were suitable for describing and explaining phenomena connected with rural nursing.

The Spradley Technique

Spradley has written extensively on ethnographic methodology (1979), and explained that ethnoscience is appropriately used in order to gain empirical data from people about their lives. Using an ethnographic method,

the researcher is able to investigate phenomena such as human diversity, cultural differences, societal complexities, and human behavior. The Spradley technique is therefore ideally suited to this study and is consistent with the study purpose of describing the nature and scope of rural nursing, as well as identifying the distinctiveness of rural nursing. There are twelve steps to Spradley's technique. The essential elements of the twelve steps were followed in the present study method with only minor modifications as necessary to suit the study purpose. A brief overview of the twelve steps of Spradley's technique is presented. Thereafter, an explanation is presented of the adaptation of each step for this study.

Step 1. Locating an Informant. Spradley (1979) suggested that informants should be thoroughly enculturated and currently involved in the culture of potential study. They must have time to participate and ideally will respond without analyzing their own responses.

Step 2. Interviewing an Informant. The ethnographic interview includes three important elements which are: an explicit purpose, ethnographic explanations, and ethnographic questions. During interviews informants are

encouraged to respond freely and to expand on their responses. The ethnographer or interviewer attempts to elicit as much detailed information as possible while providing whatever explanations an informant requires to respond.

Step 3. Making an Ethnographic Record. The ethnographic record is simply recording research data by any means. It may include the impressions of the researcher as well as pictures or artifacts. Spradley stressed that ethnographers should make verbatim records of their informants' responses. This is most easily done by audio taping, but may be done by taking field notes.

Step 4. Asking Descriptive Questions. Descriptive questions are broad and general questions designed to elicit a great deal of information from an informant. Spradley (1979) compares the use of descriptive questions to asking informants to paint a picture with words which illustrate their experience.

Step 5. Analyzing Ethnographic Interviews. Cultural meaning is discovered through ethnographic analysis. Spradley explains that unlike some more rigid research techniques of science, ethnography "requires constant feedback from one stage to another" (p. 93). Therefore,

the steps explained thus far may occur concurrently and the researcher begins immediately to determine if there is a necessity to modify questions and techniques in upcoming interviews.

Step 6. Making a Domain Analysis. When people communicate, they generally use semantic relationships to express themselves; that is, they talk about one thing in relation to another. Spradley (1979) categorizes these relationships into semantic domains and claims that nine semantic relationships essentially cover all of those he encountered as an ethnographer. For purpose of illustration, the following are the semantic relationships used by Spradley to conduct domain analyses:

- | | |
|---------------------|--------------------------|
| 1. strict inclusion | x is a kind of y |
| 2. spacial | x is a part of y |
| 3. cause-effect | x is a cause/result of y |
| 4. rationale | x is a reason for y |
| 5. location | x is a place for y |
| 6. function | x is used for y |
| 7. means-end | x is a way to do y |
| 8. sequence | x is a step in y |
| 9. attribution | x is characteristic of y |

(p. 111)

For each domain there is a cover term which would be placed in the "y" position in the above relationships. For example, in the statement "working in a small hospital is part of rural nursing," rural nursing is the cover term in an attribution type semantic relationship. The ethnographic record should be analyzed for cover terms and semantic relationships, and the process is called domain analysis.

Step 7. Asking Structural Questions. Following domain analysis, structural questions are developed to further test the ethnographer's assumptions or further clarify the information so far gathered. In this step an informant may be asked to verify that information and assumptions are correct. For example, "Is working in a small hospital a part of rural nursing?"

Step 8. Making Taxonomic Analyses. Essentially, taxonomic analysis means a comprehensive analysis of a limited number of domains (Spradley, 1979) and needs to be done to keep research manageable and to accomplish the purpose of the research. Taxonomies are inclusive of a number of domains and relationships.

Step 9. Asking Contrast Questions. Contrast questions are simply those asked in a different and

sometimes negative manner in order to clarify meaning or validate interpretations. It is one more way of eliciting meaningful information from informants.

Step 10. Making a Componential Analysis. The process of looking for contrasts in the data which has been gathered is what Spradley calls making a componential analysis. The process includes sorting and grouping contrasts and entering the information onto a graphic display which Spradley calls a "paradigm." (p. 179). Verifying information with informants to fill in any missing data is essential.

Step 11. Discovering Cultural Themes. Any concept or principle which is either implied or stated repeatedly by informants, or which is simply noticed by the researcher is a cultural theme. This means that when the ethnographer begins to notice that informants are saying the same thing as other informants, or are using terms or ideas repeatedly, or that certain activities are repeatedly observed, a cultural theme has been discovered.

Step 12. Writing an Ethnography. Spradley emphasizes that the ethnographic report should be done carefully, often using the language of the informants so that the meaning of the informants' responses is not lost.

The report can be started before the study is completed and revised as the study progresses.

Application of Ethnographic Technique
to Study Rural Nursing

In order to accomplish the purpose of the study which was to describe the nature and scope of rural nursing practice and to identify distinctive characteristics of that practice, the study was approached in two phases. The pilot phase was conducted to elicit a broad range of information and to identify cultural themes. From that information an interview schedule was refined and used in the second phase. Use of the refined interview guide in the second phase meant that greater numbers of informants could be involved to contribute to the results of this study.

Because ethnographic methodology is a continual process which involves interviewing, reinterviewing, and observing in an effort to understand the full meaning of the culture of study, the steps do not necessarily take place in a set order. While Spradley identifies twelve steps and assigns them an ordinal position, he explains that the ethnographer is likely to move back and forth between steps. In the case of the present study, many of

the ethnographic steps were accomplished in both the pilot phase and the second phase of study.

Geographic Location of the Study

The Inland Northwest was chosen as the region of study due to the researcher's familiarity and experience within the region. The Inland Northwest is a geographic region surrounding Spokane, Washington. The radius of approximately 150 miles includes portions of eastern Washington, northern Idaho, and western Montana (see Figure 3). This region is an established health care referral area, especially between Spokane Deaconess Medical Center, Sacred Heart of Spokane Medical Center, and the many small rural hospitals within the region.

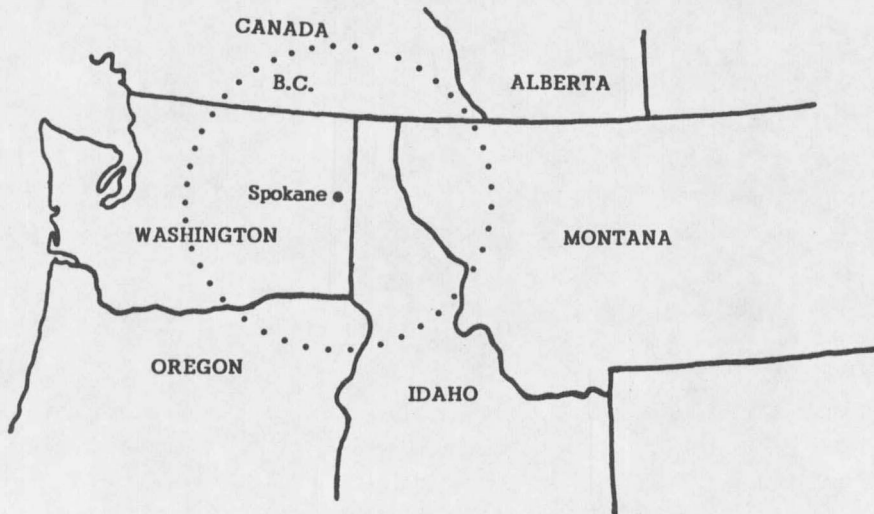


Figure 3. The Inland Northwest.

Pilot Phase

Choice of Informants. Informants who participated in the pilot phase worked in Libby, Montana, which lies within the geographic area known as the Inland Northwest. They were a convenience sample of eight rural nurses who indicated an interest in participating.

Interviewing, Making the Ethnographic Record, and Asking Descriptive Questions. The pilot phase began with four informants who were interviewed using a broad and open-ended guide for questioning (see Appendix A). All interviews were conducted by the researcher and followed the same format. Interviews were recorded on audio tape with informants' permission and were then transcribed verbatim. In addition, each participant completed a self-administered demographic questionnaire (see Appendix B).

The taped interviews were between 60 and 90 minutes in length and the transcriptions revealed a wealth of descriptive data. The informants responded candidly and enthusiastically to the questions. The interviewing guide used in the pilot phase had been developed by incorporating the ideas found in the literature with the ideas expressed by rural nurses during prior informal discussions with the researcher. As discussed earlier,

previous studies tended to focus on activities of the rural nurse and role of the rural nurse which did not prove to be significantly different from activities and roles of other nurses. The questions in the pilot phase of this study were designed to elicit information specifically regarding the nature and scope of rural nursing which were believed to be distinctive.

Analyzing Interviews and Making Domain Analyses. A content analysis was conducted on the transcriptions of the initial four interviews from the pilot phase. It became apparent at this early point that the line of questioning was useful and appropriate because the informants' responses were immediately revealing similar descriptive statements about rural nursing nature and scope. The responses were organized into domains, each domain including a cover term and items within the domain bearing a semantic relationship to the cover term. For example, "things that are a part of rural nursing" is one domain.

Structural Questions, Taxonomic Analysis, and Contrast Questions. Following the identification of domains and items within domains, a verification process was undertaken, the process known as asking structural questions. In the pilot project three of the four

original informants were reinterviewed using a direct line of questioning based on the domain analysis. This second interview was designed to elicit data which would verify or refute their initial descriptions, to verify the accuracy of the investigator's interpretation of data, and to verify the characteristics emerging as distinctive.

After the repeat interviews of the three original informants, three new informants were interviewed. These new informants were asked the structural questions described above. In all cases the responses were nearly identical to one another and to the original informants' responses, which validated the usefulness to the study of the structural questioning.

Finally, the emerging distinctive characteristics were discussed with one informant who had no previous exposure to the study. At this exchange taxonomic relationships were explained and contrast questions were asked in order to validate the meaning and strength of the previous informants' responses. The characteristics which had emerged as distinctive were discussed and validated. These distinctive characteristics were then included in the interview guide for validation with a larger population.

Second Phase

Choice of Informants. A convenience sample of 26 second phase informants was chosen. Access to these informants was gained through a network of professional nurses. Participants for the second phase of study were from four facilities located in the Inland Northwest. The facilities were located in Libby, Montana; Ritzville and Omak, Washington; and St. Maries, Idaho (see Figure 4).

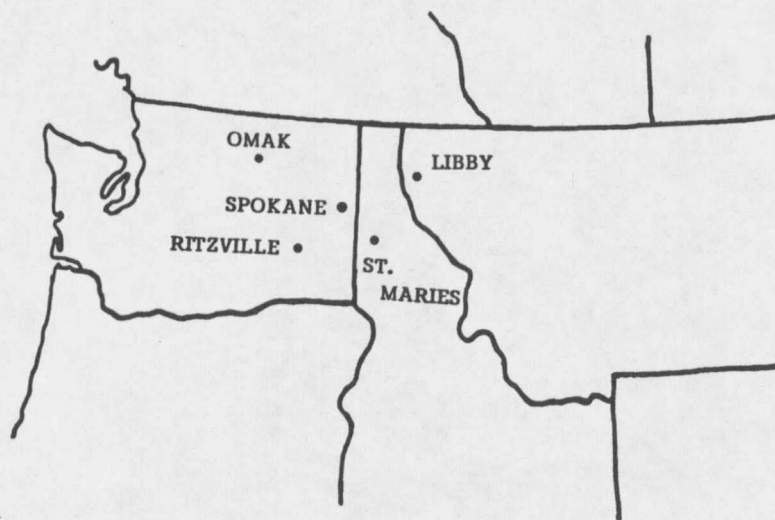


Figure 4. Interview sites

While the facility at Libby, Montana was used for both the pilot project and for the study, informants in the pilot phase did not participate in the second phase of data collection. The pilot phase was conducted approximately one year before the second phase of study.

Interviewing, Making the Ethnographic Record, and Asking Descriptive Questions. Two phases of study were required to refine the line of questioning to meet the purpose of this study. The information gathered during the pilot phase served as the basis for the interview guide used in the second phase of study. This refined interview guide (see Appendix C) was used to interview 26 study participants, as was the background questionnaire (see Appendix B). The interviews during the second phase required 30 to 60 minutes to complete. While the questioning was primarily very structured, requiring a yes or no response, there were opportunities given the informants to elaborate on any question. The interviews were audio-taped, and verbatim transcriptions were made.

Analyzing Interviews and Making Domain Analyses. In the second phase of study all questions were concretely organized by identified domains. In this way, the second group of subjects served to validate the information elicited from the pilot study.

Structural Questions, Taxonomic Analysis, and Contrast Questions. Using the interview guide in the second phase of study, it was possible to discuss distinctive characteristics in depth with the 26 study participants. In discussing the issues of distinctiveness, it was found

that the responses of these participants confirmed the notions of the pilot project informants.

Componential Analysis and Cultural Themes. Apparent distinctive characteristics were identified and organized into a componential grid using the terms from the conceptual framework for this study. In the researcher's opinion certain characteristics seemed to be related to the intersections, dimensions, core or boundaries of rural nursing. Out of this process a line of questioning was developed specific to eliciting a measure of validation regarding the distinctiveness of the nature and scope of rural nursing.

The Ethnographic Report. Following the second phase of study an analysis of the nature and scope of rural nursing was made. The analysis includes extensive discussion regarding the distinctiveness of rural nursing. This final step is known as the ethnographic report and is included in Chapter 5.

CHAPTER 4

FINDINGS, PART I

Demographics

This was a descriptive study in which the ethnographic method was used. Ethnographic methodology was particularly suitable for accomplishing the study purposes which were to describe the nature and scope of rural hospital nursing practice and to identify the distinctive characteristics of that practice. In conjunction with standard ethnographic techniques of data collection, demographic information was obtained by two methods. Participants completed a self-administered background questionnaire and other demographic data was collected by the researcher through observation as well as through questioning of administrative personnel at each facility. The data were gathered over a three week period during the month of November, 1986. The researcher personally collected all of the data.

This chapter presents the demographic information about the study sample which is provided to give the reader an understanding of the background of the

participants and the facilities in which they practiced. The ethnography in Chapter 5 will describe in some detail the findings regarding distinctive characteristics in the nature and scope of rural hospital nursing practice as reported by the participants.

Participants

Twenty-six participants completed both a self administered background questionnaire and a face-to-face tape-recorded interview with the researcher. This was a convenience sample of self-identified professional nurses from Libby, Montana, (N=7); Omak, Washington, (N=5); Ritzville, Washington, (N=8); and St. Maries, Idaho, (N=6). Each rural community had a population of less than 5,000 (1980 census) and was located at least 50 ground miles from an urban center with a population of 50,000 or more.

All of the participants were women and ranged in age from 25 to 61 years with an average age of 40 years. The average number of years a participant was licensed as a registered nurse was 18.4, with a range of three to 40 years of licensure. The number of years actively employed as a registered nurse was slightly lower with a mean of 15.9 years and a range of three to 35 years. The number of years spent working in rural hospitals was about half

of the total active years, with the mean being 7.9 years and a range of two and a half months to 25 years.

Of the 26 participants, 15 had basic diploma nursing preparation. Four participants entered nursing with associate degrees, and seven entered with baccalaureate degrees. The highest degree earned ranged from 14 nurses with a diploma preparation to two with masters degrees in nursing. One participant held a bachelor of science degree in bacteriology as well as her nursing baccalaureate.

One participant indicated she was a parent/child clinical nurse specialist, one a medical/surgical clinical nurse specialist, and one a womens' health care Nurse Practitioner. Four participants reported they were certified in their specialty areas, e.g., emergency nursing, womens' health care, nursing administration, and public health. Current certificates for Advanced Cardiac Life Support were held by 10 of the participants. Ten participants indicated that they had at some point completed a class for physical assessment and two had completed an emergency medical technicians' course.

An intent to pursue additional education was indicated by five of the nurses. Three said they planned to obtain a bachelor of science in nursing, one planned to obtain both a bachelor and master of nursing, and one

respondent planned to obtain her bachelor of science in health care management.

Forty-two percent of the respondents (N=11) held membership in at least one professional organization such as the American Nurses' Association, the Organization of Nurse Executives, the Emergency Department Nursing Association, and the American Association of Critical Care Nurses. Three nurses were members of two professional organizations. The nursing staff at two facilities were organized for collective bargaining and were represented by their state nurses' association.

Seventeen of the participants were employed full time, while the other nine worked an average of 23 hours per week. In addition, 15 were occasionally placed "on call", although the call status was for a variety of reasons. At one facility nurses primarily took call during periods of low census, while the opposite was true at another facility where nurses were placed on call for backup during periods of high census. At one of the facilities, three of the nurses interviewed took call 12 to 15 days a month for the operating room. Most participants reported usually working overtime two days a month. All respondents were reimbursed for their overtime.

Exactly one half of the participants indicated that they carried professional nursing liability insurance. Several of those who answered that they do not carry insurance at the present time said that they had done so in the past. Several of the nurses mentioned during the interview process that they used to carry liability insurance, but were informed by their hospital administrator that they do not need to carry a personal policy because the hospital carries a policy which protects them.

Participants were asked to indicate the number of continuing education events they attended in a year. Four nurses indicated that they attended more than ten continuing education events per year. Eight attended between seven and 10 per year, ten attended between three and six a year, three went to one or two a year, and one nurse indicated she went to about one continuing education event every other year. In only one case did a nurse say that the hospital did not offer continuing education, and in one case another nurse said her hospital did not sponsor employees to out of town workshops. They indicated that their greatest educational needs were in the areas of cardiac care, trauma, obstetrical, and critical care (non-cardiac).

Participants were asked to indicate which professional journals they read on a regular basis. Three nurses read four or more journals on a regular basis and 24 read at least one journal regularly. Nursing was the most frequently cited, with 17 of these nurses reporting it to be a journal of their choice. The American Journal of Nursing was the next most frequently cited with RN, The Journal of Nursing Administration, Nursing Management, Pediatric Nursing, Focus, Heart & Lung, Nursing Life, Emergency Nurse, Hospital MD, Journal of the Emergency Medical System, Critical Care, Nursing Administration Quarterly, and Emergency Medicine being the other journals cited. Some of the reasons that participants indicated they chose to read journals regularly were: to obtain new information, to read about what others are doing, to read about trends and get new ideas, to look for answers to questions, to solve problems, to obtain research results, to read about current legislation, and to read about nursing theory.

As one of the criteria for participating, nurses were to have practiced nursing in a hospital of 100 beds or more prior to becoming a rural nurse. All participants had worked in a hospital with at least 100 beds, and 19 participants had worked in a hospital of at least 300 beds. Some of these hospitals were tertiary care centers

and teaching hospitals. Of the 26 participants, six had worked in another rural hospital at some point in their nursing careers.

Participants were familiar with a variety of nursing care delivery systems. Because of the nature of these small hospitals, it was not unusual for a nurse to use one nursing delivery system on one unit and a different system on another unit during the same shift. The delivery systems' reportedly used were team nursing, functional care, total care, and primary nursing. There was some confusion among participants regarding definition of delivery systems. Nurses from more than one facility stated that they delivered primary care, however, only one facility had a bonafide primary nursing delivery system in effect.

Participants also used a variety of nursing documentation modes. All 26 participants reported that they performed a nursing history, while 23 reported that a nursing physical exam was done. Eighteen reported they used nursing diagnosis, but only 16 used problem lists. Twenty-four reported that a nursing care plan was used, but only half of the respondents used problem oriented charting (SOAP notes) while the other half used source oriented, or narrative charting.

The Rural Hospitals

Information about the hospitals was obtained through interviews with nursing, fiscal, administrative, or other personnel, as well as through the participant observation process. This was an informal process and the information was recorded by field notations.

The hospital buildings were between three and 35 years old. However, the organizations were between 20 and 60 years old. Only one facility was accredited by the Joint Commission on Accreditation of Hospitals (JCAH). Administrative personnel explained that there is little to be gained by small rural hospitals as a result of JCAH accreditation. On the other hand, the expense of JCAH accreditation is sizeable, and a rural hospital can not offset the cost.

The ownership of the four hospitals was stated as: "non-proprietary," "public district," or "community". All of the hospitals were governed by a Board of Directors who held the authority for decision-making and to whom the administration was accountable. These governing boards were comprised of between three and ten directors, and were either self-perpetuating, or elected by the community. At each of the facilities there was an attitude held by the staff nurses toward the Board of Directors that they don't understand the real issues of

nursing and health care, and that all they care about is the "bottom line."

All of the facilities were listed as being in the black financially, although there was a universal problem of limited cash flow, and two were experiencing a negative trend. Apparently community support was perceived as good for two hospitals and not good for the other two. In the nurses' station or nurses' lounge at each facility there were "Thank You" notes posted which had been sent by recent patients. There were also public "Thank You" notices in the local newspapers.

The average tenure of the directors of nursing was 2.9 years with a range of one to four years. The average tenure of the administrators was 11 years and the range was from two months to 25 years. The turnover rate for registered nurses was low at all facilities with the most senior RN having been on staff from 16 to 25 years.

Because the nature and scope of rural nursing is dependent on numerous variables and forces, it is important that the reader have an understanding of each hospital setting. There were some similarities and many differences between the facilities.

Hospital A. The first facility was licensed for 26 acute care beds, three intensive or coronary care beds,

five bassinets, and three swing beds. The average daily census on the medical-surgical floor at this facility was eleven. The intensive or coronary care unit (ICU/CCU) was occupied more often than not, with the utilization for the previous fiscal year being 264 patient days. Usually there was only one patient in the ICU/CCU at a time, although it was not uncommon for two of the three beds to be occupied. The ICU/CCU was staffed by floating a qualified registered nurse (RN) from the medical-surgical floor, but once an RN floated to the ICU/CCU she was no longer responsible to provide care in any other area of the hospital.

The obstetrical (OB) department at Hospital A was usually occupied. The number of births for the previous fiscal year was 183 and considered a slow year. It was not unusual to have several days go by with no deliveries, then to have three or four deliveries within 24 hours. During the observed period, there were four deliveries within 10 hours at this facility. It was most common to have only one or two mothers and newborns at any given time. Most newly delivered mothers elected to stay at least one night after delivering. The OB department was staffed by floating a qualified RN in from the medical-surgical floor. If there was only one mother and one newborn to care for, that RN would also be assigned one or

two medical or surgical patients or else the emergency department. If there was a woman in active labor, an RN was assigned on a one-to-one basis to the labor and delivery department.

The surgery and recovery departments were staffed separately. Nurses were not expected to cross-train for that department. However, there were surgical nurses who also worked in other clinical areas of the hospital. During some weeks these nurses were on call to surgery while working regular shifts in the medical-surgical department. The number of surgical cases for the previous fiscal year was 389, an average of 1.5 surgeries per weekday.

The emergency department was staffed by floating an RN in from the medical-surgical department. Emergency department utilization was greater during the evening shift and the nurses who worked that shift were highly skillful at floating from one clinical area to another in order to provide coverage for the emergency department. There were 3,305 emergency cases recorded in the previous fiscal year, an average of nine emergency cases every day. Each of these emergency cases had an average length of 56 minutes, which means that on the average, there was a nurse needed in the ER for nine hours a day.

The nursing department at Hospital A was 83 percent RNs. It was the philosophy of the nursing department that a high RN ratio was required to deliver safe care in all clinical areas. There were few aides and licensed practical nurses (LPNs), and only RNs were actively recruited for positions. Six new RNs had been hired in the previous year for a total of 26 on staff at that time. Daily staffing at this facility was done according to acuity levels and if census was low, nurses were required to be on call rather than come in to work.

There were 12 physicians with staff privileges. Their specialties were family practice, general surgery, internal medicine, pediatrics, radiology, obstetrics and gynecology, ear, nose, and throat, urology, and podiatry. There were no physician residents.

Hospital B. This facility was licensed for 20 acute care beds, and ran an average daily census of 3.5. There was no license held for intensive or coronary care unit beds although there was a special care room with cardiac monitoring equipment available. There were five swing beds, and much of their medical-surgical occupancy was attributed swing status. They were licensed for six bassinets, but there had been only 16 deliveries there in the previous fiscal year. They had recorded 974 emergency

room visits in the past year, with an average length of one hour. There had been 31 surgeries in the past year.

All clinical areas were staffed by having a nurse float from the medical-surgical department, although not all nurses floated to all areas. There were two registered nurses qualified to float to surgery and two qualified to float to the obstetrical department. All nurses floated to the emergency department.

This facility had nine registered nurses and four licensed practical nurses on staff. They staffed two 12 hour shifts with one RN and one LPN or two RNs per shift. During times of high census another RN was placed on call for each shift.

There was virtually no turnover in nursing staff at this hospital. In the previous year one RN had been hired for an on call position. She hoped to get her "foot in the door" by accepting the position and that in the event one of the tenured nurses moved, retired, or quit to have a baby she could have the job.

Hospital B had a small physician staff with one internist and two family practice physicians having staff privileges. There was no house physician.

Hospital C. This hospital had a medical-surgical licensure for 44 beds, two intensive or coronary care

beds, and six bassinets. The average daily census of the medical-surgical department was 14. The number of patient days in the ICU/CCU for the previous year was 248, and there had been 262 newborn deliveries. Surgical cases for the previous year numbered 1,082 which averages to four surgical cases per weekday. The emergency department had recorded 4,572 visits in the previous year with an average of 12.5 emergency department visits a day. The length of time that each visit took was not available.

The intensive or coronary care unit was staffed by a registered nurse floating from the medical-surgical department. Once a nurse was assigned to the ICU/CCU she was no longer responsible for patient care in another clinical area. The same rule held true for the obstetrical department. Not all RNs were cross-trained for all clinical areas. The emergency room was generally staffed by a supervisor who would float from the medical-surgical department. There was an emergency room physician in the facility from 5:00 p.m. until 7:00 a.m. on weekdays, and 24 hours a day on weekends and holidays.

The surgical department was staffed separately at this facility and surgical nurses did not work in other clinical areas of the hospital. There were a total of 33 registered nurses, 11 licensed practical nurses, six nurses' aides, and two ward clerks on the nursing

department staff.

A total of 17 physicians had staff privileges. Included in that figure were 10 family practice physicians, three radiologists, a urologist, ophthalmologist, anesthesiologist, and surgeon.

Hospital D. The fourth hospital had 30 medical-surgical beds, three intensive or coronary care beds, and seven bassinets. The average daily census of the medical-surgical department was 10.9, and there was no figure available for the ICU/CCU utilization. There had been 90 births at Hospital C in the previous fiscal year, and 163 surgical cases. The average number of emergency cases was 5.7 per day for the previous year, or a total of 2,068. Each emergency case averaged 45 minutes in length.

There were 13 registered nurses, eight licensed practical nurses, and 12 nurses' aides or ward clerks at this hospital. In the previous year only two RNs had been hired.

The emergency department, obstetrical department, and intensive or coronary care unit were all staffed by floating an RN from the medical-surgical department. Surgery was staffed separately, but the surgical nurses also worked in other clinical areas of the hospital. Not all nurses were expected to float to OB, but all were

expected to rotate through ICU/CCU and ER.

There were six physicians with staff privileges at this facility. They were four family practice physicians, a surgeon, and one radiologist. There was no house physician.

Cultural Themes

Preparing Nurses for Intensive or Coronary Care Unit

In only one case was there a credentialing procedure for RNs who worked the ICU/CCU. At one facility there was an informal but universally understood method of preparing nurses to work the ICU/CCU. In many cases nurses expressed anxiety about working in the ICU/CCU. Even many who were qualified according to the standards of their facility were anxious about it. At one point during the interview the question was asked, "What is the worst situation you can imagine having to deal with?", and more often than not the informants expressed their distress in having to deal with unstable cardiac patients, fresh myocardial infarctions, and cardiac arrests.

Nurse Physician Relationships

At each facility the researcher observed a number of nurse-physician relationships which ranged from congenial and collegial to inimical and antagonistic. It was easy

to discern a difference in the way certain nurses behaved in the presence of certain physicians. At two facilities there was obvious animosity between some nurses and a physician. By and large there was a favorable rapport demonstrated between nursing and medical staffs. In a few cases nurses called physicians by their first names. In general the appearance at each facility was of a team working toward shared goals.

In several cases physicians approached the researcher and questioned her objective, and most were content to move on after a simple explanation of her presence and a statement of the purpose of the study. However, in two cases physicians attempted to offer the researcher their perception of rural nursing, which in both cases were lists and descriptions of the medical diagnoses the physicians were most accustomed to managing. There was not sufficient opportunity to question physicians regarding their attitudes or opinions toward the nursing staffs. Although it might have been interesting to do so, it was not within the purpose of the present study.

Ancillary Departments

At most of the facilities the ancillary departments (laboratory, x-ray, respiratory therapy, physical therapy) were not staffed during the evening or night. In one case

laboratory personnel stayed from 7:00 a.m. to 11:00 p.m., and in another case respiratory therapy personnel did the same. Otherwise, those departments were closed by 5:00 or 6:00 p.m. each day.

Tenure of the Nursing Staff and Group Acceptance

The most senior nurse at these facilities had been there for a period of from 16 to 25 years. At all facilities nurses were heard to use the terms "new" and "old" in reference to a given nurse's tenure on the staff. There was no particular time limit identified as to when a nurse makes the transition from new to old, nor how one arrives at a level of acceptance. However, it was apparent that tenure less than two years was definitely considered new, tenure of three to five years generally constituted acceptance, and tenure beyond ten years was definitely considered seasoned. When informants talked about a seasoned nurse who they really considered to be one of the old-timers, they were usually talking about a nurse who had 20 years tenure. The area in between was somewhat gray depending on the nurse's level of proficiency and how well she fit into the group. At any point of tenure a nurse's acceptance was influenced by her level of competency and personality.

Summary

Twenty-six rural nurses agreed to participate in this study. Each participant completed a background questionnaire. The data from all questionnaires were usable and indicate a homogeneity of participants.

Further data were collected through conversations with numerous personnel in each facility and through the process of participant observation. These findings demonstrate many of the distinctive characteristics of the nature and scope of rural nursing practice.

In the following chapter the "story" of rural nursing is told. It is the ethnographic report on the nature and scope of rural nursing.

CHAPTER 5

FINDINGS, PART II

The Ethnographic Report

According to Spradley, (1979) an ethnography describes a culture and "aims to understand another way of life from the native point of view" (p. 3). The ethnographer must "enter the cultural scene you hope to understand.... get inside the language and thinking of your informants" (p. 205). In the following ethnographic report the culture of rural hospital nursing is explored. In the process, the distinctive characteristics of the nature and scope of rural nursing practice are described.

The Rural Communities

During a three week period in November, 1986 the researcher traveled to four separate rural communities in the states of Montana, Idaho, and Washington for the purposes of gathering information regarding the nature and scope of rural nursing. Upon arrival in each community, time was taken to drive about, observe the local terrain, the indicators of economic basis, inspect a few of the local businesses, walk about town to observe the pace and

lifestyle, discretely eavesdrop on the casual conversations at the drugstores or post offices, and purchase and read each community's local weekly newspaper.

There were many similarities and a few differences between the communities in terms of how they appeared to the outsider. Each town was located near railroad tracks, all of which were currently used. Three of the four towns were located on a river in a forested mountain terrain and were logging and lumbermill towns. The fourth town was located on an expansive plain and was a wheat growing community. This farming community was located near an interstate highway while the three logging communities were located some distance from interstate highways.

Each of the communities appeared to be primarily inhabited by caucasian peoples. There were several minority people observed, some being Black, Hispanic, Asian and Native American. The only true groups of minorities seen were Hispanic and Native American.

Each of the towns was laid out in similar fashion with one main street and several auxiliary streets on which the "downtown" businesses were located. There was hardly a difference from one town to the next in regard to the appearance of these business districts. Each town boasted the typical hardware stores, grocery stores, clothing stores, restaurants, post office, drug stores,

employment office, farm or logging machinery shops, ice cream stands (most of which were closed in the off season), beauty shops, feed stores, junk shops, several small motels, numerous bars and churches. Most of the towns were large enough to have a franchise type business or two such as J.C. Penney or True Value Hardware, but the majority of the stores appeared to be privately owned local business ventures.

None of the towns could be described as "bustling," although one was certainly "lazier" than the rest. Each community had a well-kept appearance, although none were especially bright against the early winter gloom. All of the towns bore the scars of economic hard times and unsuccessful businesses, such as empty storefronts bearing "for rent" signs and buildings boarded up.

Walking or driving around each community, the residents were found to be friendly and helpful. These people had a very conservative appearance in their dress and their hairstyles. On rare occasion a young adult or adolescent was observed sporting such "new wave" fashions as studded leather clothing, multiply pierced ears, and multi-colored hair. But the majority of the people would not stand out in any crowd.

Many of the business proprietors recognized the researcher as an outsider and were curious to know the

reason for her visit. Upon explanation of the reason for the visit all of these residents expressed pleasure that their community had been targeted for this study and eagerly conveyed their high regard for nurses in general and "their nurses" specifically. In no case did these residents express animosity toward the community of nurses, although a few shared an unfavorable experience from their past involving some physician. Most had a specific story to share about the time "Doc X" and "Nurse Y" saved their aunt or their cousin's friend or something similar. Many of the residents were confused by the author's status as "graduate student in nursing," and heartily reassured her that becoming a nurse was a fine thing to do, and wished her a lot of luck.

The Referral Area

All of these towns lay within the boundaries of the "Inland Northwest", a regional term which describes an area including part of western Montana, northern Idaho, and eastern Washington (see Figure 5). The focal urban center of the Inland Northwest is Spokane, Washington. There are two tertiary medical centers and several other large hospitals located in Spokane and it is considered the major center for referral of health care for the Inland Northwest.

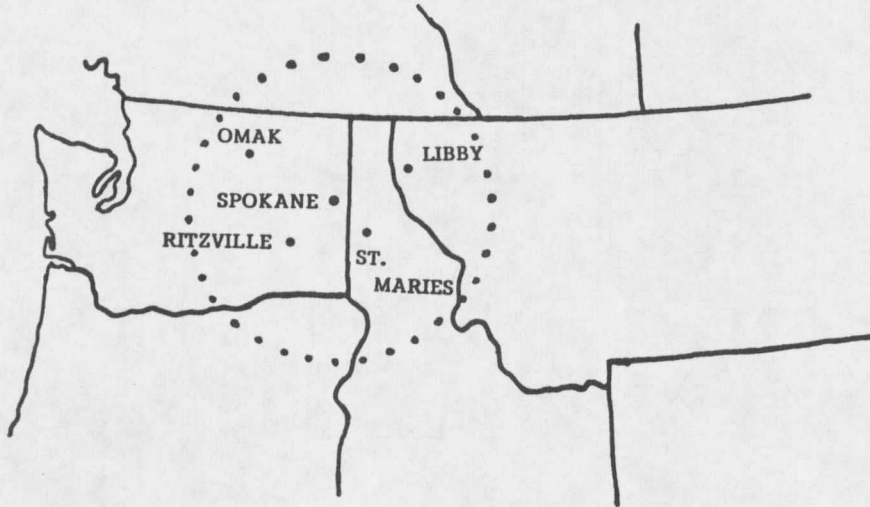


Figure 5. The Inland Northwest and research sites.

Near the time of the study it was reported by a source from the Spokane Deaconess Medical Center that approximately 40 percent of their referred patients came from the "outlying areas of the Inland Northwest" (A. M. Ericksen, personal communication, March, 1985). The rural communities in this study were located between 60 and 160 miles from Spokane. Ericksen indicated that each of the visited communities is considered an important component of the Deaconess Medical Center's global community.

The Guided Interview

Based on a pilot project with eight rural nurses an interview guide was developed to elicit information from rural hospital nurses regarding the nature and scope of their practice. This interview guide (see Appendix C) was used to interview 26 rural nurses. The interviews were tape recorded with the informants' permission. Informants were asked whether they agreed or disagreed with specific statements, and were then asked to share their own ideas about the statements. Informants responded in an open and candid manner and at no time did any informant request that the tape recorder be turned off or that the interview be discontinued.

The questions in the interview guide were organized to validate various themes which had become evident about rural nursing. The responses to this line of questioning were very consistent among the 26 informants and strongly supported the themes. The additional comments made by informants were very valuable and added a great deal to the descriptive data on rural nursing practice. Each of the topic areas is discussed in detail in the following section with an emphasis on what the informants actually said.

The Rural Hospital

As evidenced by the literature there is a difference of opinion about the definition of rural. This study deals with a fraction of rural health care which might be referred to by some as "very rural". Informants confirmed that a rural hospital has less than 50 beds, is located in a geographically isolated area which is sparsely populated, and that the bed size, location, and population which it serves are factors which influence rural nursing practice in a distinctive way.

The Rural Hospital Nurse

A rural nurse is a "jack of all trades" and "wears many hats." Most rural nurses have a great deal of knowledge regarding a variety of nursing practice areas, although "someone just coming to the rural hospital for the first time may not be so knowledgeable." When a nurse first begins to work in a rural setting she suffers a reality shock because of the variety of demands which are placed on her. One nurse commented on this by saying, "Although you might start and you don't have that wide knowledge, you better get it quickly." A nurse who had been in the rural setting for less than two years spoke of her colleagues' knowledge level saying, "The amount they have in different fields is impressive." Almost all rural

nurses work in three or four different specialty areas of nursing practice every week or even every day. One nurse said, "The ones who are experienced in rural nursing seem to be very comfortable in switching back and forth between specialties and do seem to have a lot of knowledge."

Rural nurses are challenged by the pace and demands of the constant change.

Personal Characteristics

There is no such thing as a typical rural nurse, and there are various personality types and personal characteristics wherever one goes. However, a number of traits assist a nurse in making it in rural nursing, such as good common sense, good judgement ability, the ability to prioritize, good physical assessment skills, physical, and emotional strength. The reason why these traits, which would be desirable in any nurse, are distinctively important to rural nursing is that rural nurses are so alone in their practice.

There are times when a registered nurse is the only professional nurse in the rural hospital. But even when there are two or three RNs in the house, they may be in separate clinical areas, far from each other and far from a phone when a crisis occurs which requires their immediate attention. The nurses explained, "You have to

make all your own decisions. There's no one to do that for you." "You have to be able to be autonomous." "You can't go to somebody else for concurrence with decision-making." "Because at any time during your shift your assignment may change drastically." "You are ultimately the sole responsible person." "You can make the difference between life or death ... the judgement calls are yours."

All informants were adamant that the feeling of aloneness and serious responsibility which prevails in the rural setting was distinctive to the rural setting. None of the informants perceived that such a feeling existed in their urban experiences. There is a very real and pervasive burden of responsibility which rural nurses bear to their patients. These nurses are making life and death decisions on a consistent basis. The ones who don't have the ability to do so are the ones who don't make it in the rural setting.

Old-timers claim that they can often tell right off who will make it as a rural nurse and who will not. Sometimes a nurse comes to work in the rural hospital "and she catches on in six weeks. And some of them never get it." A relative newcomer talked about this phenomenon and said, "I don't know if I ever will make it as a rural nurse."

Factors Related to Continuing Education

Most rural nurses assume a great deal of responsibility for their own education. The burden of responsibility for seeing to one's own education is greater in the rural than in the urban setting. There are a variety of sources from which rural nurses receive their continuing education, specifically, out of town workshops, inservice at the hospital, physicians, other nurses, journals, textbooks, and practice sessions at urban hospitals.

Rural nurses see each other as more important sources of information and education than any other single source. In several instances they explained this by saying that exchanges of information with other nurses most often occurred during a moment of high need, so that they were learning while doing, which tended to heighten the memory in their minds. They said, "The new girls ... they teach us a lot and I think it's a real sharing." "We try to share everything we can with each other." "Sometimes the new girls expect you to know things, and I don't, and it can be embarrassing. So we look it up together." "When you've been around for awhile you develop a comraderie. We know each other and we know what we can expect from each other."

Out of town workshops are the next most important source of continuing education. Many informants qualified their response by saying that the importance only held if the topic was applicable to the rural setting. "It's got to be meaningful. You know, you go up to the city and they tell you how to do something, and they don't realize how different the setup is." "But it's good to go out of town and hear somebody talk and get all fired up."

Interpersonal Relationships and Nursing Practice

Rural nurses know everyone who works at the hospital, they know all the physicians and the physicians know them, and most of them know all of their patients. Rural nurses say that knowing everyone they work with has a positive influence on their practice. On rare occasion knowing coworkers could have a negative effect on their practice, but in general the interpersonal closeness is a very positive thing. Knowing the physicians and having the physicians know them is usually a positive influence on rural nurses' practice, and knowing patients personally usually has a positive effect on rural nurses' practice.

The intensity of interpersonal relationships is distinctive to the rural setting. It is likely that all nurses develop some close relationships in their work setting. However, the rural nurse is a unique situation

of being personally acquainted with every hospital employee, every physician, possibly their families, and every patient. Rural nurses explain the impact on their practice in a number of ways. One said, "It's nice to know the people you're working with. You work more together, you try harder, and you work closer." Another said, "You get a good idea of the limitations and abilities of the people you work with." An oldtimer explained, "I don't have to explain when I say something. They believe me and they do it without wasting time." In terms of knowing patients personally a nurse commented, "It makes me more in tune with patients' needs." A nurse who's matter of fact manner and physical size gave every indication that she could back up her statement said, "You really get involved as an advocate. Sometimes I feel like I am really protecting a patient ... from whatever."

Nursing and Other Departments

The nursing department carries the burden of responsibility for coordinating patient care for all the hospital departments in any setting. The nursing department is more influential in this process in the rural setting. Communication is easier to attain in the rural setting, and nursing is more directly involved in facilitating the activities of the other departments, even

to the point of practicing within the realm of other disciplines. Rural nurses recognize that this may not necessarily always be a safe practice.

Respiratory Therapy. Rural nurses must perform some respiratory therapy activities on a regular basis. The type of activities they do are primarily respiratory therapeutic treatments and the setup and administration of oxygen. Sometimes rural nurses must monitor the respirator in the intensive care unit, and some have to draw and run arterial blood gasses. Sometimes nurses perform percussion and postural drainage maneuvers. The necessity for nurses to manage respiratory therapy is most common during the evening and night shifts, and weekends. There is not 24 hour coverage by a respiratory therapist at all facilities. One nurse said, "If the therapist is off and you get somebody bad, you just have to take care of it."

Radiology. Rural nurses can frequently be found in the radiology department where they are most likely assisting with positioning. This is frequently related to an emergency patient. The nurses also might be attending a patient who requires constant nursing attention, even during x-ray. Rural nurses are occasionally asked to administer a medication integral to a specific x-ray, such

as contrast media, or may be asked to monitor patients' status during the injection of contrast media.

Laboratory. Laboratory functions frequently performed by rural nurses are related to drawing blood specimens. The specimens may be for blood chemistries, microscopic studies, blood cultures, alcohol levels, or other laboratory analyses, so that nurses must be familiar with the variety of test tubes and their uses. Also, the nurse must be mindful of specific procedures related to obtaining specimens. Other laboratory functions which rural nurses perform are urine specimen collection, urine specific gravity testing, newborn infant blood glucose testing, fern tests, and occasionally setting up a culture plate.

Pharmacy. Pharmacy was clearly a domain in which rural nurses are required to function frequently and extensively. Only a few rural nurses escape performing pharmacy related procedures. Many rural nurses lament that they are required to spend too much of every working day performing the activities of a pharmacist. The activities include such things as stocking medications, calling the local drugstore to order medications, dispensing medications from the pharmacy to the patient by more than one dose at a time, dispensing emergency

medications from the pharmacy to patients in the emergency room, checking on drug compatibilities, and mixing intravenous medications and adding them to IV fluids. The nurses said, "We pour meds from one big bottle into a little bottle for the patient." "We mix all our own IVs." "At night you are the pharmacist." "I know we're not supposed to do what we do."

Dietary. Rural nurses are required to do dietary department activities such as providing nourishments, dietary teaching and counseling. Rural nurses are occasionally asked to prepare whole meals, and wash the dishes. One nurse said, "If the cook gets snowed in, we do breakfast." Another commented, "I don't think most nurses can do the teaching as well as the dietician could ... I know I don't have the background for it." A third said, "when somebody gets admitted after hours you go in the kitchen and fix them up a tray if they're hungry."

Social Services. With the advent of discharge coordinators rural nurses are no longer required to do as many activities related to coordinating social services for their patients as they did in the past. Discharge planning is clearly a function within the practice of nursing, however, the total coordination of social services is not. Nevertheless, rural nurses often make

arrangements for their patients, including the orchestration of nursing home beds or home health care for the elderly, a referral to the county welfare agency for victims of child abuse, or arranging for a safe shelter for a victim of battering. These are time consuming activities which nurses take on in addition to their regular clinical responsibilities.

It was pointed out that the need to perform social work activities was increased during the evening, night, weekend, and holiday hours, when the discharge coordinator was off. Naturally, those are the hours when other community social services are closed. The result is that for rural nurses, social work is a frequent activity. The informants made such comments as: "I often help patients figure out their bill." "Sometimes we have to round up transportation." "I've taken people home with me and let them sleep at my place overnight because they needed a place to stay."

Medical Practice. The rural hospitals nurses in this study were for the most part very reluctant to say they practiced medicine. In spite of that reluctance, a number admitted that they thought many of the activities they were required to do might constitute medical practice. For the most part the nurses described situations which

were clearly those required by necessity, by emergent situations, dictated by the needs of their patients and influenced by the peculiar relationship between rural nurses and rural physicians.

For example, these rural nurses frequently administer intravenous fluids and medications to patients in the emergency room whether or not there is a protocol or standing order to cover that action. They often order laboratory tests prior to obtaining a physician's order. They may call ancillary people into the hospital to perform certain tests before a physician is contacted. "You take it upon yourself and do what has to be done to make sure the patient's stable before you can call the doctor."

Rural nurses may order certain medications on inpatients without calling the physician, usually at a late hour such as at three o'clock in the morning. One nurse said, "I certainly would not call a doctor for Tylenol at three o'clock in the morning, but I'd give it." Another nurse stated that she will sometimes administer a sedative to a patient who complains of insomnia, and in the morning asks the physician to write an order for it.

Rural nurses may also direct physicians in the sense that they will tell a doctor what to order when the doctor does not know a patient as well as the nurse does. Some

nurses also learn to manipulate certain physicians on the patients' behalf. One nurse said, "There have been times with a couple physicians where I felt like I had to direct them." Another commented, "The new docs don't know the patients like we do, so we tell them what to order."

Finally, on rare occasion, the rural nurse may function as the physician's right hand or assistant, beyond the scope of professional nursing practice, in the absence of another physician during an emergency situation and at the direction of the physician in attendance. One nurse described a situation with a newborn in respiratory distress that she managed while the physician continued to tend to the hemorrhaging mother. Another nurse recounted a story about delivering general anesthesia to a mother who's fetus was critically distressed. The attending physician talked the nurse through the experience of administering the anesthesia while he began a cesarean section on the mother. The anesthetist, who lived many miles away arrived in the middle of the procedure and relieved the nurse. In reflecting on the experience, the nurse said:

I was scared shitless, but the patient really needed that surgery and we had to get that baby out.... If I had refused to do it? We would have had at least one death, and maybe two. I suppose I would do it again. I don't think I could stand there and refuse to do it--for the patient's sake.

Another nurse said that one physician used to

expected her to inject local anesthesia prior to his suturing in the emergency department. While she used to comply, she no longer does so.

Other situations which describe the type of practice which rural nurses believe may be beyond the boundary of nursing and into that of medicine are situations such as asthmatics in the emergency room who may receive oxygen, an intravenous line, medication, or a respiratory treatment before the physician has evaluated them, or before the physician can be consulted. Sometimes emergency room patients are only evaluated and treated by a nurse because the physician chooses not to come in to the hospital to see the patient based on what the nurse says over the phone.

On occasion inpatients may have an observed status change so that the rural nurse performs blood cultures, or starts an intravenous line, or moves the patient into the intensive care unit before she has a chance to talk to the physician. Almost every rural nurse who has been in a rural setting for any length of time has had an obstetrical patient deliver her baby precipitously into the nurse's hands. Frequently in these situations the physician arrives just in time to deliver the placenta, and usually the nurse gets a pat on the back and a round

of applause from the physician, the patient, and the nursing staff alike.

These nurses sounded confident that they tried to act in a cautious, thoughtful, and prudent manner when there was a question of the action being beyond the scope of nursing practice. They were also adamant that they had a responsibility to the patient to do whatever was required during an emergency, and that while actions sometimes felt somewhat uncomfortable, inaction would have constituted neglect. Another important point that was made is that these nurses informed the physician of their actions as soon as they were able. Most of the activities that were performed that might be construed as practicing medicine were done "in emergency situations to save time until definitive treatment can be given." The words of one nurse summarize the situation, "We do it because we have to, because it would be wrong if we didn't."

Rural nurses are frequently faced with performing business office functions. Those nurses who work during the evening and night shifts are very likely to spend some time every shift filling out admission forms for outpatients and inpatients, answering the switchboard, collecting insurance information, and collecting money, as well as explaining bills to patients. At more than one facility there was some noticeable animosity between

nursing and business office personnel which appeared as a difference in values, nurses valued a patient's clinical information and business personnel valued a patient's economic information. While each group recognized the importance of the other group's priority, neither would concede to it.

A majority of rural nurses frequently function within the realm of psychiatric nursing, and many do not feel comfortable doing so. A number of examples were described, such as caring for patients who were acutely psychotic and delusional, caring for those who were acutely depressed, (often in conjunction with a suicide attempt), or caring for patients who were being treated for alcohol or drug detoxification. Not only were rural nurses concerned about their own limitations in dealing with psychiatric patients, but they also felt that not enough medical intervention was available in the rural setting for the acutely mentally ill. Many nurses felt that physicians admitted patients who needed the benefits of an intensive psychiatric facility.

Many rural nurses do not feel comfortable with other psychosocial situations which require counseling skills. These are situations which require little medical intervention, so are likely to be dealt with in the emergency room. Victims of rape or sexual assault require

advocacy and emotional support which not all rural nurses feel they can provide. The surviving family members of suicide victims often need more than rural nurses feel they are prepared to offer. Not all rural communities have a volunteer crisis intervention program. Rural nurses feel very strongly that this is an underemphasized area and that physicians do not take patients mental health needs seriously enough.

There are a number of functions from other disciplines which rural nurses are called upon to perform. Some nurses do pastoral counseling or nurturing, especially for dying or grief stricken people. Almost all do housekeeping and maintenance activities, and virtually all rural nurses need to be well oriented to their hospitals' medical records department, especially to be able to retrieve documentation of patients' past hospitalization.

Nursing Expertise

Rural hospital nurses generally believe that no one can be an expert in every area of rural nursing practice. However, there are a few rural nurses who are extremely proficient in all clinical areas and these nurses become role models and mentors to the other nurses with whom they

work. At two of the facilities a number of nurses identified a colleague or two who fit this category. Those who were identified by others as "aces" did not identify themselves as such. Each nurse was very humble about her own capability, but there was obvious pride among many of the nurses who were interviewed, and they were eager for the researcher to be aware that there was an especially proficient clinician amidst their ranks.

All of the rural nurses interviewed agreed that they must be competent in more than one clinical area. There was some difference of opinion as to the most important areas of competency, but the responses varied only between four basic areas. In rank order the clinical areas which the nurses deemed important were emergency department, obstetrics, intensive or coronary care, and medical-surgical department. One supervisory nurse said, "There's a difference between competent and expert. I think everybody who works in this hospital should be able to walk into any specialty area and function." Another nurse commented on the competency issue by saying, "You've got to have good common sense and good judgement. That is more important than anything else." But there was an expectation by each nurse for herself and for others that she be very strong clinically in at least two of the above

named departments and also be able to float to the other departments in a pinch or to assist another nurse more expert than herself.

The Physician-Nurse Double Standard

One of the questions in the interview guide focused around the issue of a supposed double standard which was identified in the pilot project. Explained very simply, the double standard in question is that when physicians are not in the hospital they expect nurses to handle any medical emergency until the physician can arrive. Part of that expectation is that the nurse should make sound medical decisions, that is, "Do the right thing" for the patient. Once on the scene the physician then expects the nurse to assume a subordinate position. In this study the nurses were questioned regarding that double standard. In general, the existence of the double standard was not strongly agreed to. Most of the nurses did agree that when physicians are not on the scene, they expect nurses to handle medical emergencies. But few agreed that once physicians are on the scene they expect nurses to keep their ideas to themselves. Several agreed conditionally and said that the double standard was sometimes true.

It is apparently true that when a physician is unavailable and the nurse takes matters into her own

hands, she is likely to be praised, or at least not chastised for doing what she did as long as what she did helped the patient. Most nurses said that given the above situation, if what they do does not help the patient they are likely to be confronted with the physician's anger, if not disciplinary action. One nurse commented, "I can do something and it's OK, but I caution the young ones not to do that until they get to know the doctors." Another nurse explained, "Some doctors will be glad you do things and others will not be. One physician gets very upset when we follow the protocol for chest pain and start the IV and do the EKG." One nurse was both excited and perturbed by this issue and said, "They expect you to tell them on the phone exactly what's going on, but then you're not supposed to do anything ... you have to wait 'til they get here." A nurse who agreed that the double standard did occur sighed and shook her head saying, "I've always been lucky enough that they backed me up."

The Routine of Rural Nursing

Nurses do not expect the routine of rural nursing to be easy, know they must be prepared to deal with anything, and have to tolerate a constant variety of demands. There is not much boredom, although there are times when it can

be boring, specifically during periods of low census. It is important to take periods of low census in stride, because "you never know what's coming next." Rural nurses often become frustrated trying to stay current to handle the variety of their practice.

In conjunction with the topic of the routine, of rural hospital nursing, the nurses described situations which they had experienced which typified rural nursing to them. For example, one said:

One day there were two in labor who delivered at the same time, there was one in the unit, and someone came in with chest pain.... plus there were med-surg people. The potential was there for patient safety to be a problem, but it turned out okay.

A second nurse said:

Just yesterday evening there were seven patients in the house with nothing going on. Within an hour there was one admitted with a depression state, an OB came in, and there were four or five cases in the ER, one being a child with rectal bleeding, which makes you wonder about child abuse.

The evening turned out all right, but that nurse admitted that she was worried for a while. At the same hospital another nurse explained:

Not long ago we had an OB with a bad baby ... small for gestational age ... and at the same time we got two ambulances five minutes apart and they were both cardiacs with chest pain. While that was happening there was surgery going on, and there was somebody in the unit. I don't know if God is watching over you or what, but for the most part things seem to come out okay in the end.

Knowing Patients Personally

Most rural hospital nurses subscribe to the belief that when they know a patient personally, they can give them better care. However, having to care for family or friends can be a frightening experience. In other situations, caring for friends and family can be richly rewarding. There is little or no anonymity for rural nurses who have been in a small community for many years. A gradual loss of anonymity occurs as a nurse becomes enculturated over a period of time.

The loss of anonymity is sometimes reassuring, and sometimes constricting to these nurses. While one nurse explained simply, "I can be more supportive emotionally when I know them," another elaborated, "Let's say in the ER with 'chronic lungers'... you know them and they feel secure because they know we remember them and that we're going to take care of them." One nurse explained that she had seen a patient at home just prior to his emergency hospitalization:

A diabetic comes in out of control and says he's been on his diet, but I'd just been to their house and saw stacks and stacks of fried chicken boxes and I knew they hadn't had company. I knew why he was out of control!

Another nurse believed that her relationship to a patient made a difference on the patient's outcome. She explained:

I recovered my little neighbor girl after her surgery, and most little kids are scared when they wake up, but when she woke up she knew me and wasn't afraid and recovered really fast. Because fear generates pain, but she wasn't afraid, she recovered faster than usual.

The argument could be made that patients perceive that their care is better based on the close personal contact that is often made in the rural setting.

"Patients are reassured because they know you and they know you care and that you're gonna go to bat for them," one nurse said, and another added, "People have told me they were glad I was on when they were here ... that if I said it was going to be okay, then it was going to be okay." The importance of this trusting relationship was the focus of another nurse who said:

It's a real emotional drain, but you're ahead of the game because the trust is there. I know of several situations where knowing my OB patients who had poor outcomes made a difference to them ... where I was really able to help them get through the experience.

Needs of Rural People

It is a cultural expectation of rural people to be taken care of by someone they know. This differs from the expectation in an urban setting where patients do not expect to know the nursing staff. Rural people have the same basic needs as others do, although one nurse pointed out that due to the extreme isolation, rural people have

more educational needs because they wait until they are "half dead" before they present for medical intervention. One nurse thought that rural people do not expect to have their medical needs met when they live far from a major medical center. This informant said that rural people are "grateful for what they get." However, the other nurses thought that rural people expected to have all their needs met, even if it meant being sent to the major medical center.

Patients often tell rural nurses that they get better care in the rural hospital than in the urban hospital. Some of the things that people say to these nurses are that the care is more personal, that the nurses take more time to listen, and that things get done more quickly. Patients in rural hospitals feel more like a person and less like a number than they do in the urban hospital. There were several "thank you" notes hanging on the bulletin boards at each of the facilities visited. These notes expressed gratitude to the nursing staffs for "special" and "quality" nursing care rendered during the individuals' period of hospitalization.

Rewards and Attachment in Rural Nursing

The nurses in this study receive more personal rewards from their jobs now than they did from urban

nursing, and are more attached to their jobs than to urban nursing. They want to remain in their rural nursing practice situation and would choose to do rural nursing again. These nurses believe that they can make more of a difference in patient outcome in the rural setting. They like to follow whole families throughout the life process, and to have a patient stop them on the street to reminisce about prior care. One nurse shared, "The co-operation of the other nurses and the cohesiveness of the group is probably the biggest reward." Another nurse remembered, "There was one situation eight years ago where I made the right decision with this guy ... and for eight years every time I see his mother she says, 'Oh, you saved my son's life!' I'll never forget that." A nurse who was reflecting on how much more she enjoyed her rural nursing position than when she worked in the urban setting said, "It's been a long time since I worked in an urban hospital, but I don't ever want to go back."

Politics

The political climate and related hassles seem somewhat more intense in the rural hospital than in the urban hospital, and most rural nurses notice that the political strife of the institution influences their practice more in the rural setting than it did in the

urban setting. Most rural nurses find themselves more personally involved in the events of the institution in the rural setting than they did in the urban setting. A single individual can have a bigger impact on the system in the rural setting than in the urban setting, which can be either a positive or a negative effect. Nurses are ambassadors of the hospital where they work regardless of the setting, but rural nurses are more acutely aware of that role than are their urban colleagues.

Advantages and Disadvantages

Living in a rural setting may mean coping with a limited social life. However, many rural nurses believe that a social life is whatever one makes of it, and to some a social life revolves around religious and church activities. Several nurses with families actually enjoy a more complete social life in the rural setting than they did in the urban setting. But single nurses in the rural setting generally agree that their social lives are a major disadvantage of living in a rural environment. There are few places to go to meet other single people. Bars are not seen as a suitable place to meet people, although in many rural communities they are the primary socialization territory.

A limitation of cultural events is a disadvantage of the rural setting. While many rural communities offer community concert series events, local school concerts, and community choirs or bands, most rural nurses feel some cultural deprivation. Some perceive the city as accessible for cultural events if they wish to make the journey.

An advantage to living in their rural setting is the great natural beauty of many rural areas. Most nurses who lived in a flat plains setting did not describe their setting as beautiful, as did those who lived in mountainous regions. These nurses point out that recreational activities abound and that the area is "a great place to bring up children."

There is little chance to obtain a Bachelor of Science degree in Nursing in most rural settings. However, several informants believe that there are methods and opportunities to pursue one's B.S.N. if there was enough desire. It may be easier for a nurse to advance in her job position in the rural setting, although there are only so many positions available, and one might have to wait a long time for a career ladder move.

One nurse pointed out that an advantage for her in rural nursing included the opportunity to "learn about a

wider variety" of nursing practice. Another said that "there's a lot more leeway and not so much red tape" as in the urban setting. Conversely, a nurse described a disadvantage saying, "I don't feel that rural nurses are compensated the way they should be" and another remarked, "You're taking a lot more risk because there's more autonomy." One nurse who had been in the rural setting for many years had seen many newcomers weather the transition period said, "It doesn't matter what kind of degree you have ... when you get here you just feel so stupid."

Rural Hospital Nursing as a Specialty Area

There is strong sentiment among rural nurses that a specialty certification examination should be developed to recognize the proficiency of the rural nurse. This is a frequent topic of discussion among rural hospital nurses. Many rural nurses believe that discussion about the development of such an examination represents an important evolution of their practice. One nurse said:

I used to feel I was just a country nurse, but I've changed my attitude about that. I feel I know a heck of a lot more than a lot of nurses in cities, and I feel we should be recognized as a specialty.

Most rural nurses say they would be likely to take such a certification examination, especially if it was affordable. Many said they would consider \$50.00 to

\$100.00 a reasonable fee for such an examination. One nurse laughingly said, "I'd probably flunk and then I'd have to go be an urban nurse!"

Rural nurses speculate that there might be some difficulty in the development of such an examination, but many believed that it could be accomplished. One nurse adamantly commented, "I don't think anybody should be making up that test unless they've worked out here." Another pointed out some of the difficulties of examination development by saying, "You would need questions that deal with staffing and management, budgeting, and personnel because rural nurses do these things." A nurse who reflected on the general trend within nursing to emphasize recognition of clinical experts said, "I think as certification becomes of general importance I would really like to see the rural nurse become certified. There are experts out here." Some Directors of Nursing in rural hospitals admitted that if they were hiring a new nurse and learned that she was a certified rural nurse, they would be more likely to hire her than a non-certified nurse.

Defining Rural Hospital Nursing

Most of the nurses interviewed have difficulty defining their practice, although they can describe it.

Their descriptions are a variety of rich, thoughtful, colorful, and sometimes exceptionally articulate responses. Rather than individual descriptions, a composite definition is offered here.

Rural hospital nursing is a special variety of nursing in which the nurse must have clinical skills, knowledge and ability to practice proficiently in three or four different clinical areas at once, and the desire to do so. It is the practice of adapting at any moment to a different clinical area, knowing what to do and believing in one's self. This requires professional and personal maturity to enjoy the demanding pace of constantly switching gears. Rural hospital nursing is a comprehensive, holistic practice of responding to the needs of patients throughout their lifespans in a multitude of circumstances. Showing initiative, taking risks, and being willing to commit to a community are important facets of this practice. Rural nursing could be well defined by using a definition of general nursing offered by theorist, Delores Krieger, who has said that "Nursing is 'tending the flow of life'" (Krieger, 1985). Surely the essence of the rural nurse's practice is "tending the flow of life."

Summary

Rural hospital nursing is generalist nursing, but the intensity of this kind of nursing practice is what makes it distinctive. It is conceivable that on any given day the practice of a rural nurse might include: caring for a newborn as well as for its mother during the labor and post-partum phases; caring for an injured child as well as the anxious parents; helping an adolescent diabetic cope with the psychological and physical demands of his disease while trying to determine a way to discuss with his alcoholic father the meaning of optimal health; preparing a well adult for elective surgery and monitoring an unexpectedly poor recovery afterward; or nurturing an old person through the process of anticipated death. It is just as conceivable that a rural nurse could have a smooth, quiet day with a few stable medical or surgical patients, no crises, no upsets, and plenty of time to discuss with those patients their plans for future healthcare management.

Many rural hospital nurses feel misunderstood and poorly recognized for their particular variety of practice, but they are a proud lot. They yearn for greater recognition and in some cases identify a new wave of interest in what they consider their "specialty".

Rural nurses express frustration with the complexity of their practice, yet most are steadfast and would choose to remain in the rural setting. "It is," they say, "really real nursing."

CHAPTER 6

DISCUSSION

The Distinctiveness of the Intersections, Dimensions,
Core, and Boundary of Rural Hospital Nursing

Distinctive characteristics in the nature and scope of rural hospital nursing practice were demonstrated in this study. To interpret the findings, it is most helpful to discuss them in light of the major concepts of the conceptual framework. The concepts are taken from the Social Policy Statement of the American Nurses' Association (1980) which states that the nature and scope of nursing include the characteristics of intersection, dimension, core, and boundary. In this chapter each concept is discussed in detail as it pertains to the findings of this study.

Intersections

Intersections are "meeting points at which nursing extends its practice into the domains of other professions," and "are not hard and fast lines separating nursing from another profession" (ANA, 1980, p. 16). It was discussed earlier that many health care domains were

at one time nursing functions or activities. As nursing has evolved, nurses have experienced increased levels of responsibility and have been forced to delegate many responsibilities to other health care providers.

Analysis of the perceptions of rural nurses clearly indicate that the intersections of rural hospital nursing are distinctively marked and fluid. Rural nurses consistently and necessarily practice well within what is now the realm of other health care disciplines including: respiratory therapy, laboratory technology, dietary, pharmacy, social work, and medicine. The most remarkable intersections as identified by this study are those between nursing and respiratory therapy, pharmacy, and medicine. Clearly, the intersection of nursing practice and the practice of medicine in the rural arena has the most far-reaching implications. At this point of intersection many of the decisive actions of rural nursing are identified.

Also of note are the distinctive "intraprofessional intersections" seen in rural nursing practice. The Social Policy Statement (ANA, 1980) states that "individual nurses ... limit the scope of their practice in light of their education, knowledge, competence, and interest," (p. 16) and that these self-identified differences constitute intraprofessional intersections. This concept

can easily apply to urban nursing practice where nurses routinely specialize in their knowledge and skills. However, in light of the practice of rural nursing, it could be said that the intraprofessional intersections are distinctively influenced by the environment so that rural nurses, rather than limiting their scope, must have the capacity to expand the scope of their practice by expanding their education, knowledge, competence, and interests. This is necessitated by the demands of their work and the needs of the people they serve.

Examples of the intersections between rural nursing and respiratory therapy include: performing treatments on inpatients as well as emergency room patients, doing electrocardiograms, monitoring the function of croup tents, monitoring the respirator, performing percussion and postural drainage maneuvers, performing arterial punctures, running the blood gas machine, and managing the respiratory therapy component during resuscitative procedures when no therapist is available. While some of these activities fall within the scope of nursing practice, it was generally agreed that in most urban hospital settings, few, if any of these activities would be performed by the nurse.

Examples of intersections between nursing and radiology were primarily in the area of assistance.

However, there were reported cases of having to administer the medication for nuclear medicine, and having to be present during intravenous pyelogram procedures. While these activities are not outside the scope of nursing practice, in an urban situation it is less likely that the nurse would be called upon to do them.

Laboratory procedures which the nurses reported carrying out included: drawing babies' blood if lab personnel could not successfully do so, drawing blood on any person in a variety of circumstances to facilitate the timeliness of the procedure, setting up cultures, performing fern tests, drawing blood cultures, performing specific gravity tests, and "scrounging for results", that is, finding results of laboratory tests when they have not been communicated by laboratory personnel. Again, the scope of nursing practice is not in question, but the intersections occurring here would not be likely in the urban hospital setting.

By all indications, rural nursing practice frequently intersects with pharmacy at complex levels. When asked what kinds of activities were required, informants gave a number of examples, such as: setting up all intravenous medications, pouring medications from large stock bottles into small bottles for the patient, ordering drugs from the drugstore, going to the drugstore to get medications,

stocking medicines, including narcotics which are delivered in large boxes, dispensing emergency room medications, calling in prescriptions for the doctors, filling the medicine cart, getting their own drugs from the pharmacy, and dispensing medications when there is a new admission. Nurses were asked how they felt about these activities and whether there may be an issue of safe practice at this point of intersection. One nurse did not feel there was a problem and said, "Nurses are no less safe than the pharmacist." Another nurse was hesitant, but stated, "We're not supposed to do what we do." A third admitted, "I don't think there's a problem, but I don't know the legal implications of what I do." It would seem that some of these intersections constitute a departure from the scope of nursing. Undoubtedly some of the situations which were described are of questionable legality. These intersections are distinctive of rural hospital nursing and would hardly occur in an urban hospital setting.

Nurses frequently intersect with dietary, even to the point of "cooking meals when the cook gets snowed in." One nurse recalled, "I've had to wash dishes before." Many respondents indicated that they spent time teaching or counseling patients about diets. Although it seems incredible that a nurse might have to cook or do dishes,

none of the activities actually fall outside the scope of nursing practice. However, the likelihood that a registered nurse has the extensive nutritional science background that a registered dietician does is remote. It is doubtful that these intersections would occur in an urban setting to the same extent.

There were frequent indications that rural nurses intersect with social work, although these intersections would probably be considered within the scope of nursing practice. However, nurses are not necessarily educated about the intricacies of social service networks, and rural nurses are sometimes not aware of how to make referrals for such social crises as child abuse, domestic violence, sexual assault, or medical indigence.

Discharge planning is certainly a role of nursing, although coordinating discharge is a time consuming activity which has recently become a discipline in its own right. Rural nurses did not indicate that they felt personally uncomfortable with the intersections between their practice and that of discharge coordinators. However, the time which this service required was universally recognized, and rural nurses are glad for the advent of discharge coordinators. Unfortunately, rural nurses who work evening, night, and weekend shifts

continue to carry the responsibility for coordinating discharges which occur during these times.

The intersection between rural nursing practice and the practice of medicine is obvious. In general this intersection is considered a gray area based on the individuals involved and the circumstances. Some rural hospital nurses are willing to intersect more extensively than others, but none do it casually. The most complex intersections generally occur during emergent situations. The words of one nurse stood out in the analysis. She emphasized, "We do it because we have to ... because it would be wrong if we didn't."

There were non-emergent points at which nursing intersected with medicine. Some rural nurses who work night shift order medications for patients without having a doctor's order. Nurses do this when they feel the physician requires sleep and that the physician will "cover them," or concur with the nurse's decision. In these cases the nurse writes an order in the patient's chart as if it was a "verbal order," and informs the physician at the next convenient opportunity of her action. In general, the nurses who do this meet with a high rate of physician approval. This represents a phenomenon of mutual understanding between certain nurses and certain physicians. While this phenomenon may occur

in urban settings, it is distinctive that in the rural hospital setting the extent of the understanding is great.

Another non-emergent condition where rural nurses intersect with their medical colleague's practice is when a patient who a nurse knows is admitted by a physician who does not know the patient. In such a situation it is common for rural nurses to advise the physician about the course of medical treatment for the patient. It is not uncommon for physicians at some rural hospitals to rely heavily on nursing documentation of a patient's history and physical to institute a therapeutic plan.

Some other examples of how rural nurses intersect with medical practice are: anticipating and ordering laboratory tests and medicines; beginning procedures which require a physician's order; describing the findings of a physical assessment over the phone to a physician, which may influence his decision to come to the hospital or not; delivering a baby; and ordering x-rays. At some rural hospitals nurses give medical advice over the phone to people who call with questions.

Rural nurses were very thoughtful about the issue of safe practice surrounding the intersection of nursing and medicine. Many had strong concerns about the scope of their practice and acceptable boundaries. Their concerns are reflected in the following statements related to their

need to work within the domain of medicine. One nurse said, "It sometimes feels uncomfortable, but it's part of my responsibility to the patient." Another concurred, "It means putting your neck out there on the line, but you have to make the judgement that it's safe practice and go on." Several nurses admitted to feeling apprehensive about their actions in the emergency department. One said, "In the ER it doesn't always feel okay to do the things we have to do until the doctor gets there, but you go ahead and do it and take the consequences if it's wrong."

Dimension

The dimensions of nursing practice are certain concepts or characteristics which lend further description to the scope of nursing (ANA, 1980). These include, but are not limited to such characteristics as: "philosophy and ethics ... responsibilities, functions, roles, and skills" (p. 18). There are other elements which mold the dimension of nursing as well. For example, the concept of "caring" is central to nursing practice. After the data collected from rural nurses were examined for relevance to the dimension of rural hospital nursing practice, it became evident that the practice of nursing in the rural hospital setting is dimensionally distinctive.

Rural nurses bear testimony regarding their ability to care for the people they know. One such example was, "With known diabetics ... you know that they're having a reaction and you automatically put the IV in and get the lab there ... you know what's going to happen." A nurse who frequently works in obstetrics said:

People have told me they were glad I was on when they were here ... that if I said it was going to be OK, then it was going to be OK. Like when they get into real hard labor and they want something for pain and I say, 'No, it's better if you can just hang in a little longer. You're just about there and it will be better for you and the baby, and I know you can do it,' They trust me and they believe me, and they do it ... and then it's over and it is better.

Another nurse simply stated, "Knowing my patients personally makes me more in tune with their needs."

Another explained that "It puts you in the position of doing primary nursing even if that's not the kind of nursing you're supposed to be doing."

Nurses are characterized as having a "profound regard for humanity" (ANA, 1980, p. 18), which applies to themselves, the people with whom they work, and those for whom they care. Rural hospital nurses certainly exemplify this dimensional characteristic. For example, rural nurses described the impact which is made on their nursing practice as a result of the phenomenon of knowing everyone with whom they work including all the physicians. One

nurse said, "It makes it easier to work together. Its easier when I know them and understand their problems." This mutual concern and regard for one another was repeatedly expressed. "You try to understand what everybody is feeling," and "You can go to them when they're having a bad day and cheer them up," were common themes. Also, rural nurses believe that the closeness of co-workers improves patient care. A nurse explained, "Things get done better. You're more conscientious, and we can perform better." A further point was made by one nurse who said, "When you know how a certain person is going to react in a given situation, you may try to defuse that before the situation comes to him."

Nursing is described functionally by the American Nurses' Association (1980) as "an interpersonal relationship process" with patients, families, or groups which is conceptualized as "privileged intimacy" (p. 18). The functional components listed are physical care, anticipatory guidance, health teaching, and counseling. In many instances rural hospital nurses begin their relationships with their patients at an intimate level, and the intimacy then intensifies. Rural nurses talked about being able to accomplish goals quickly with their patients because groundwork is already done, or because

baseline information is already available. It is as if a dimension of practice includes guidance, teaching, and counseling behaviors which are automatic and holistic to the rural nurse's caring behavior. Patients often tell rural nurses that they feel like they get better care in the rural hospital than they do in the urban hospital. One such example was given by a nurse who said, "I got a letter from a lady who said she'd been in all these hospitals in California, and never did she receive the type of care she got here." Another nurse reflected, "Especially the moms who have babies here...they all say that this is the best experience they've had and they're so glad they didn't go to the city." Many nurses expressed the fact that patients comment on the personal nature of the care they receive. One such comment was, "They can't believe how much more personal and flexible we are. They feel they have a better relationship with their nurse and that there's better communication."

The American Nurses' Association Social Policy Statement (1980) presents a discussion of nursing skills and knowledge in terms of the generalist nurse versus the specialist nurse. It is stated that while all nurses are expected to practice according to prescribed standards, each nurse is accountable for the quality of her or his

own practice and that it must be based on the individuals' level of education and skill. Further, it is explained that most nurses are generalists and that this requires a comprehensive approach from nurses to meet the various health needs of individuals and whole communities. Some of these concepts are reflected in the words of rural nurses as they reflected on the knowledge requirement for their practice. One nurse explained, "You need to be competent in every area and more than competent in at least one area." Another said, "You have to be independent and make decisions on your own." An important point was made when one nurse expressed, "You have to know when you don't know, and you have to know where to go to find out."

No discussion about nursing practice would be complete without considering the dimension of legal accountability. Rural nurses were asked to think about these issues in reference to the issue of safe practice and safety of patient care. It is an issue that they do not take lightly. An old-timer mused:

It's a concern for our new graduates especially. They're much more suit conscious than we ever were. They don't want to be stressed to the point where they would ever be in trouble. They want to continue at a nice leisurely pace.

An experienced nurse, but relative newcomer to the rural setting said:

I think there are instances where nurses do things without protocols and I don't think that's safe. Not that it isn't safe for the patient...but when you're overstepping that line I think we're taking risks we shouldn't be.

Another nurse reflected, "From what I've seen here the likelihood of patient safety really being a problem is remote. There is good support between staff and from supervisors." A seasoned rural nurse thought a long time before she added, "I think we're lucky that something doesn't go wrong, because I think if it did--you wonder--could you come back to it?"

While there are many points about rural hospital nursing practice which may cause outsiders to raise their eyebrows in amazement or shake their heads in wonder from a legal point of view, it appears that these nurses have a strong sense about what they believe is ethical. When liberties are taken which have legal ramifications, it is not because these nurses desire to break regulations or laws. Their decisions are ultimately made based on what they perceive as the sake of the patient. Rural hospital nurses are mindful, if not well informed, of the legal perspective of their practice.

Core

In the conceptual framework for this study it was discussed that the needs of people form the basis or the core of nursing. Human responses, which nurses diagnose and treat, are the core of nursing. It was anticipated at the outset of this study that no significant discoveries would be made in relation to the core of rural hospital nursing and its distinctiveness from urban hospital nursing. Core was a category that was designed to be only minimally investigated. The basis for this decision was the ample information available in the medical sociology literature which explained that the patterns of health of rural people are not significantly different from those of urban people (Childs & Melton, 1983; Mutel & Donham, 1983). In reviewing the data it can be determined that the core of rural hospital nursing is very much the same as the core of nursing in the urban hospital setting. That is to say, that the kinds and types of "human responses" seen and dealt with by rural nurses were found to be similar to those in any other nursing arena.

The Social Policy Statement of the American Nurses' Association (1980) lists "dysfunctional perceptual orientations to health" (p. 10) as one of the potential phenomena at the core of nursing. While the intent of the study was not to analyze the concept of nursing's core,

one interesting point did come though in the comments of rural nurses regarding the society they serve. The needs of rural people are not unique or different than those of people living in urban situations, with one possible exception. Some sources (Childs & Melton, 1983; Mutel & Donham, 1983; Ross, 1982) suggested and some informants in this study agreed that rural people equate health with the ability to work or even the ability to get out of bed, so that they tend to wait until they are very ill before they seek medical intervention. Veign (1982) identified that rural peoples' help-seeking behavior is influenced by their contact with others. In the case of very isolated individuals, they may postpone seeking health care because they feel they have no one to call. As a result of these phenomena rural people are more frequently hospitalized at the point of seeking care, and may require longer term care when they finally break down than urban people do. This phenomenon could be referred to as a "dysfunctional perceptual orientation to health," which would represent a distinctive characteristic of the core of rural nursing.

Boundary

The characteristic of nursing's boundary is dependent on the three characteristics already discussed. Nursing's boundary is external, and constantly expanding as nursing

responds to new and growing needs and demands from society. When "new needs and demands impinge upon nursing ... the other three defining characteristics of scope begin to change, resulting in the expansion of the boundary" (ANA, 1980, p. 16). If the dimension of nursing changes, the boundary expands to accommodate. If intersections increase, the boundary expands to accommodate.

The intersections and dimensions of rural nursing have been demonstrated to be very distinctive. As a result of those findings, it becomes clear that the boundary of rural nursing practice is distinctive in its own right. Rural hospital nursing practice has expanded its boundary to include the complex intersections and dimensional intricacies which are distinctive and different from those of nursing practice in other hospital settings.

When the comments of the study informants are inspected for statements pertaining to the boundary of their practice, it is evident that rural nurses have boundaries that are entirely different than they would have in an urban setting. These boundaries are neither regular, even, nor smooth and they vary day to day and even by situation.

Consider the following "stories" which include factors of dimension and intersection in situations where rural nurses try to deal with the core of their nursing practice. These stories paint a picture of the boundary of rural nursing practice.

A relative newcomer shared:

One time I was the only RN on and an OB came in. We had 12 patients on the floor, fresh post-ops among them. I had to go with the OB. Then in came a car accident with four victims, not badly hurt, but shaken. The aid did the vitals, I left the OB to come out and do the neuros. When I realized they were stable I went back with the OB. It worked out OK, but it is definitely scary.

A nurse who was no longer a newcomer, but not truly an old-timer said:

I think anytime I have a crisis I am always amazed that I came through it. I can remember code situations when I first came here that would just overwhelm me. I had never been in a code. To see all the different people function and know I was supposed to help ... that really stressed me. It still overwhelms me sometimes. You try to learn everything you can, but you can't always keep up with your skills, and when it's been a year since you've done something ... well, all you can do is try your best.

An old-timer offered this example:

You come on shift and there's an OB, and she ends up needing a C-section and you go with her to the OR and do the section, and you come out and recover her, and then there's a code in the ER and you're the charge nurse and you haven't even seen the ward patients yet. It's typical.

When nurses come to the rural setting they are very aware that the boundaries of their practice change. The

transition period for nurses who enter rural hospital nursing is not always easy. The expansion of the boundary of their practice is often accompanied by ambivalence, discomfort, and frustration. It is a stressful period of professional growth. Many informants commented about their feelings of "I can't believe this is happening" when they first entered the rural hospital setting. Just as the boundary of rural nursing has expanded gradually, the boundary of each rural nurse's practice requires time to expand. All rural nurses must become enculturated to the distinctiveness of the intersections and dimensions of their practice setting. However, not all nurses are willing to accept the boundary of rural hospital nursing. Some are able to survive within the setting by self-imposing boundary limitations which the other nurses also accept, but some choose to leave the rural setting.

Summary

Using the conceptual framework for this study to focus the discussion about the findings, it is apparent that there are many distinctions in the nature and scope of rural hospital nursing practice. The intersections with other health care professionals' practice are typical and are often taken for granted by all of the parties involved. They are frequent and accepted, but they are

distinctive to the rural hospital setting. The dimension of rural hospital nursing is likewise distinctive. There is a magnitude and intensity of caring, a willingness of rural hospital nurses to "go out on a limb" for coworkers, physicians, and patients alike which exemplifies the dimensional distinctiveness of rural hospital nursing practice. The core of rural hospital nursing, as expected, is very similar to the core of other nursing practice settings. The boundary of rural hospital nursing is remarkably distinctive. Boundary is a composite of and is influenced by intersections, dimensions, and core. The boundary of practice fluctuates continually as the rural hospital nurse moves from one clinical area to the next, from one circumstance to the next.

CHAPTER 7

SUMMARY AND CONCLUSIONS

This study was conducted to describe the nature and scope of rural hospital nursing. It was felt that there were distinctive characteristics about this form of nursing practice, and it was the intent of the study to identify and describe those distinctions. The existing literature included insufficient information to draw conclusions about the nature and scope of rural hospital nursing. Many authors claimed that rural nursing was unique, but there was no discernable measure or definition of uniqueness. There were numerous anecdotes about rural nursing, but none were presented within a conceptual framework. The American Nurses' Association Social Policy Statement (1980) on nursing which defines nursing and delineates the nature and scope of nursing practice was utilized as the comprehensive framework for this study.

This ethnographic study, using Spradley's (1979) technique, was conducted in two phases. First, the pilot phase of the study included collecting descriptive data from eight rural nurses about the nature and scope of their hospital practice. Based on these findings an

interview guide was developed and used in the second phase of the study to gather specific information about the nature and scope of practice from 26 rural hospital nurses. In the tradition of ethnography, data were collected through various techniques of participant observation as well.

This study demonstrated that there are distinctive characteristics in the nature and scope of rural hospital nursing practice. As indicated in the conceptual framework, the scope of nursing includes four definitive constructs: intersections, dimensions, core, and boundary. The results of the study indicate that rural nursing practice includes distinctive intersections and dimensions, that there may be a distinctive aspect of its core, and that rural nursing practice has a distinctive boundary.

Intersection

The scope of rural hospital nursing practice includes distinctive intersections. Rural nurses not only work in all areas of nursing practice, their practice crosses over into almost all departments of the hospital, including clinical and non-clinical departments. In any given day they may perform activities which would be classified in an urban hospital as being the function of respiratory

therapy, laboratory, radiology, pharmacy, medicine, dietary, physical therapy, business office, maintenance, or housekeeping. Rural hospital nurses perceive these intersections as a necessary and unavoidable part of their practice. However, they do not feel comfortable with all intersections which occur. The intersections which rural hospital nurses most often object to are between nursing and pharmacy or nursing and medicine.

Dimension

There are many dimensional distinctions about rural hospital nursing practice. There is an expectation that all rural nurses have the competence to function autonomously in every clinical area of practice, and proficiently in one or more areas. They must be prepared to work in three or four clinical specialty areas during one day if necessary. Rural nurses "look out for each other" and "work together as a team" in a very distinctive way. They feel a special sense of responsibility to one another as colleagues because, as one nurse said, "We're friends, and we don't want to let each other down."

In isolated settings where continuing education is limited, rural hospital nursing practice includes the increased responsibility for seeking experiences specific to rural nurses needs. It is important to emphasize that

rural nurses value the expertise of one another more than any other single source of education. At any rural hospital there is an identifiable resource pool of nursing knowledge. That is, nurses know who to turn to for help with a nursing problem. There is a strong sense of community between these nurses and they are committed to teaching and supporting each other through clinically demanding times in the work setting. Many old-timers become mentors for newcomers in the rural setting. That in itself is not distinctive, however the mentoring phenomenon appears to be an essential component in the process of grooming nurses to become rural nursing experts. The characteristics of decision-making ability, sound judgement, and the ability to see the grand picture and prioritize are paramount for the rural hospital nurse. Such qualities require practice and maturity for optimal development.

The dimensions of legal and safe practice for nurses in the rural setting is distinctive. Rural nurses are not always well educated about some of the procedures they must do, especially those in other health care domains. They may not fully understand the laws which govern either their practice or the practice of the health care domains into which they cross. Rural nurses are divided about carrying liability insurance coverage.

Rural hospital nurses value the interpersonal depth they attain with their patients and believe that they are able to give better nursing care than they could in an urban hospital setting because of the intensity of the relationship. Urban hospital nurses may also have the opportunity to develop special relationships with their patients, however, it is dimensionally distinctive that rural nurses achieve intense nurse-patient relationships with almost every patient. Because nurses in the rural hospital setting almost always have a comprehensive perspective of their patients, they are able to deliver holistic care. Equipment and resources may be limited, yet they have a strong sense of what they can accomplish for their patients, to whom they feel personally committed. Rural people frequently say that they get better nursing care in rural hospitals than they do in urban hospitals.

Core

It is not clear whether the scope of rural hospital nursing practice includes distinctiveness of its core. Testing the concept of core was intentionally avoided due to its complexity. However, some discussion of the concept of core could not be avoided because a theme in the findings appears to fall within the realm of core. It

appears that rural people may perceive health differently than urban people do, and if that is true, the scope of rural hospital nursing includes a core distinction.

Boundary

A clear distinction of rural hospital nursing practice is its boundary. The need to act autonomously in a majority of situations is an aspect of that boundary. While physicians are often only a telephone call away, nurses frequently must make life-or-death decisions before they have an opportunity to call for help. This is especially true on evening and night shifts where there are few personnel to share in the decision-making process. This can leave a rural nurse feeling isolated and alone, particularly when she is criticized after the fact for her decision.

Rural nurses think of themselves as specialists of a generalistic nursing practice. They believe that this kind of nursing is not for everyone and that greater recognition should accompany rural nursing so that potential recruits can make an informed choice to work in rural hospital settings. Rural hospital nurses value the concept of certification and would like to have the opportunity to become a certified rural nurse if it were available.

Implications

The discipline of nursing includes the components of theory, research, and practice. The implications of this study fall within these categories. Nursing science bears a commitment to conducting research which will "clarify aspects of a delimited part of the field of nursing," for the purpose of specialization in nursing practice (ANA, 1980, p. 21). This process also involves application of various theories in order to advance nursing practice. This study offers descriptive information related to the nature and scope of rural hospital nursing practice which could be integrated into the work of other nursing researchers who are focusing their efforts on rural nursing theory development.

Continued systematic investigation of rural nursing practice and refinement of the descriptions of the distinctiveness of practice are needed. A primary goal would be to improve educational programs for rural nurses. This study has clearly identified areas of educational need expressed by rural nurses as well as needs identified through observation. The community of nursing educators has a responsibility to provide rural nurses with education that meets their needs. One of the findings of

this study was that 38 percent of rural nurses were certified in Advanced Cardiac Life Support (ACLS) by the American Heart Association, and numerous others had previously held such certification. Nevertheless, these nurses expressed high anxiety regarding dealing with cardiac arrest cases, and working in the intensive or coronary care unit. The question is raised as to whether there is some method of providing cardiac related education to rural nurses which enables them to feel more confident about their knowledge and abilities?

Of equal importance to clinical information is the rural nurse's need for education regarding statutes which govern nursing practice. The issues of liability and accountability connected with nursing practice are often gray in any setting. They may be grayer still for rural hospital nursing where the boundary of practice is so fluid. Not all rural nurses are aware of the legal implications of some of the activities they perform. In many cases, even when nurses feel uncomfortable doing certain jobs, they feel powerless to refuse or to change the situation. The factor of isolation influences their practice because rural nurses so often feel the vulnerability of standing alone.

Limitations

It is possible that a regional bias has influenced these data. Rural hospital nursing in other regions of the country may differ from that within the Inland Northwest. Therefore, these results should not be generalized to rural hospital nursing in any other region.

The study definitions could have been more clear and should be refined for future study. While hospitals are classified according to number of beds, that is not an indicator of census or acuity at a given facility. The definition might be improved by basing it on average daily census and utilization figures. The definition for urban hospital was not given. Participants were required to have worked in a hospital of at least 100 beds, but the consent form failed to stipulate that the hospital must have been located in an urban area. It is not felt that the oversight disrupted the purpose of the study.

Recommendations

The study should be replicated in other rural areas of this country to determine if the findings are consistent with those demonstrated in the Inland Northwest. The study should be conducted in an urban setting, interviewing urban nurses who were once rural

nurses, to determine if those findings uphold what was found in this study.

Empowerment of rural hospital nurses should be addressed. The pervasive attitude of physicians being more important than nurses in the rural setting is real. Rural physicians are frequently aware of how essential rural hospital nurses are to the physician's work, yet the fact is not emphasized. Rural nurses do not recognize that they have power to control their practice boundaries.

The issue of rural nursing specialty certification is one which requires further investigation. There is a lack of agreement within the academic nursing community regarding the validity of rural nursing as a specialty. However, there is a movement among clinicians to recognize it as such. A formal request has been made to the American Nurses' Association from their Montana delegation to designate rural nursing as a specialty and offer a certification examination. For that to occur, the clinical, academic, and research communities must work in a collaborative and systematic manner.

A study of the transition of rural nurses from newcomer to old-timer status would be helpful to strategize recruitment and retention procedures in the rural setting. During the observation periods of this study it became apparent that the development of nursing

expertise is accomplished in a complex way. Benner (1982) has studied the phenomenon of nursing expertise acquisition, but not in a rural setting where each nurse may have different levels of expertise in each clinical area. A nurse who is expert in a given clinical area prior to entering the rural setting may not accomplish transition successfully if she can not adjust to the demands on her knowledge in other clinical areas. She will need to find mentors in those other areas, even though she may act as a mentor in her own area of expertise.

A study which focuses on the core of rural nursing is needed. The concept of core should be closely examined to determine if there is distinctiveness within this component of the scope of rural hospital nursing.

Continued investigation will demonstrate that rural hospital nursing, as a distinctive segment of professional nursing, makes a special contribution to health care. Rural nursing distinctively responds to the needs of the society it serves by blending the evolution of technical aspects of practice with the permanence of generalist practice. The distinctive nature of rural hospital nursing's scope enhances professional nursing as a whole.

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APPENDICES

APPENDIX A

Pilot Phase Interview Guide

1. Tell me about rural nursing. What is rural nursing?
What is distinctive, if anything, about rural nursing?
How would you describe rural nursing to someone?

Please elaborate on how rural nursing is distinctive from other nursing which you have done. What effect does the rural setting have on your practice?

Do you think other nurses share your views on rural nursing? Other rural nurses. Other urban nurses. Do you think patients share your views on rural nursing? Do you think physicians share your views on rural nursing?

2. Can you describe a typical rural nurse? Is there a typical rural nurse? Are there traits which might be distinctive to rural nurses? Are there traits which might be distinctively unlikely to be found in rural nurses? Who survives in rural nursing?

Can you think of distinctive advantages for you in rural nursing? Disadvantages?

Where would you be practicing nursing if you had your choice and could make a change today? Why?

3. Tell me how the people you work with effect your practice. How do the other nurses effect your practice? How do the physicians effect your practice?

4. How do you interact with the following departments personnel, and how does that interaction effect your practice?

Respiratory Therapy

Physical Therapy

Dietary/Nutritional Therapy

Radiology

Laboratory

Administration

Business office

Support services (laundry, housekeeping, maintenance)

5. Talk to me about your patients. Tell me about the people you care for. How would you describe the major needs of the people you care for? What thoughts do you have regarding your responsibility and accountability to the people you care for?

6. Explain, if you can, why do rural hospitals exist? In whose interest do rural hospitals exist?

Would you say that rural hospitals have viability in the present climate of health care delivery systems? What are the reasons that you think rural hospitals will or will not survive?

Can you describe ways in which rural hospitals are distinctive?

What part does nursing play in the survival of rural hospitals?

APPENDIX B

Background Information Questionnaire

1. In what year were you born? _____
2. Your gender. _____ WOMAN _____ MAN
3. In what year were you first licensed as a Registered Nurse?

_____ YEAR LICENSED

4. How many years have you actively worked as an RN?

_____ YEARS IN PRACTICE AS RN

How many years have you worked in rural hospitals?

_____ YEARS IN PRACTICE IN RURAL HOSPITALS

5. What type of basic nursing education did you complete?

_____ DIPLOMA

_____ A.D.N.

_____ B.S.N.

6. What is your highest nursing degree?

_____ DIPLOMA

_____ A.D.N.

_____ B.S.N.

_____ M.N./M.S.N.

_____ Ph.D./D.N.S.

7. Do you hold a non-nursing degree?

YES

NO

If YES, explain what nonnursing degree you hold.

(example: B.A. English)

8. Please list all professional organizations of which you are a member.

9. Are you a nurse practitioner or clinical specialist?

YES

NO

If YES, explain your credential, where and when you received it.

(example: Adult N.P., Univ. of Colorado, 1979)

10. Are you presently certified by the American Nurses' Association or any other certifying body?

YES

NO

If YES, by whom are you certified, in what field, and when did you become certified?

(example: AORN, Surgical Nursing, 1985)

11. Have you completed a comprehensive physical assessment course?

YES

NO

If YES, describe the course length, who taught it, and when you completed it.

(example: 20 hour course taught by the inservice educator, 1984)

12. Have you any specific intentions regarding further formal nursing education?

YES

NO

If YES, what are your intentions?

(example: Intend to get B.S.N. in next five years.)

13. What is your employment status?

FULL TIME

PART TIME

If PART TIME, how many hours a week do you work?

Hours a week

14. Are you ever "on call" due to low census?

YES

NO

If YES, about how many days a month are you "on call"?

Days per month "on call".

Are you paid while "on call"?

YES \$ per hour

NO

15. Do you ever work overtime due to inadequate staffing?

YES

NO

If YES, about how many days a month?

16. What is your present base hourly wage?

\$_____ per hour

17. Check each of the following approaches to providing nursing care which is used at the hospital where you work.

- _____ TEAM NURSING
- _____ TOTAL NURSING CARE
- _____ PRIMARY NURSING
- _____ FUNCTIONAL NURSING

18. Check each of the following components of documentation of the nursing process which is used at the hospital where you work.

- _____ NURSING HISTORY
- _____ NURSING PHYSICAL ASSESSMENT
- _____ NURSING DIAGNOSIS
- _____ PROBLEM LIST
- _____ NURSING CARE PLAN
- _____ PROBLEM ORIENTED RECORDING (SOAP CHARTING)
- _____ SOURCE ORIENTED RECORDING (NARRATIVE CHARTING)

19. Is continuing education offered for the nursing staff at the hospital where you work?

_____ YES

_____ NO

20. Does this hospital sponsor nurses to continuing education out of town?

_____ YES

_____ NO

21. How often do you attend continuing education events?

_____ NEVER

_____ ONE OR TWO TIMES A YEAR

_____ THREE TO SIX TIMES A YEAR

_____ SEVEN TO TEN TIMES A YEAR

_____ MORE THAN TEN TIMES A YEAR

22. What are your greatest needs for continuing education?

23. Please list any professional journal that you read regularly (monthly or nearly every month).

24. Please attempt to explain your rationale for reading any professional nursing journals, that is, what do you get out of reading them?

25. Please describe your previous nursing positions and the length of time you spent in those positions. I am interested in the type of nursing you did before, not where you worked. SEE EXAMPLE.

TYPE OF POSITION AND LENGTH OF TIME WORKED

(example)

staff nurse, med/surg, 400 bed hospital, 2 years

Thank you. Now we will proceed with the interview.

APPENDIX C

Second Phase Interviewing Guide

(read to each participant)

The nurses with whom I have talked have told me a great deal about rural nursing. I have also read much of the literature about rural nursing. In this phase of my study I want to share some of that information with you to get your reaction and comment. I'd like to know if you agree or disagree with these ideas, and I would like for you to share your own ideas. Please feel free to be candid. Remember that your responses are confidential.

1. While there are many characteristics which play a part in what makes a hospital a rural hospital, in general, they usually have less than 50 beds (agree/disagree) and are located in a geographically isolated area (agree/disagree) which is sparsely populated (agree/disagree). The bed size, location, and population seem to be factors which impact rural nursing practice in a distinctive way (agree/disagree). What other thoughts do you have?

2. Two expressions rural nurses often use to describe their practice to me are "Jack of all trades" and "wearer of many hats." Would you say that these are apt descriptions? (agree/disagree). Also, I am told that most rural nurses have a great deal of knowledge regarding a variety of nursing practice areas (agree/disagree) and that most rural nurses work in three or four different specialty areas of nursing practice every week or even every day (agree/disagree). Does this hold true for you? (yes/no). Tell me what your work situation is typically like.

3. When I have tried to determine who the typical rural nurse is, I have been told that there really is no such thing. There are various personality types and personal characteristics no matter where you go (agree/disagree). However, when I ask about what sort of characteristics might assist a nurse in making it in rural nursing, I am told that these traits help - and I'll list them:

Good common sense (agree/disagree)
 Good judgement ability (agree/disagree)
 The ability to prioritize (agree/disagree)
 Good physical assessment skills (agree/disagree)
 Physical strength (agree/disagree)
 Emotional strength (agree/disagree)

It would seem that these characteristics would be desirable for any nurse, so can you comment on why they may be distinctively important to rural nursing?

4. I am told that in order to keep current with everything one needs to know in rural nursing, individuals assume a great deal of responsibility for their own education (agree/disagree). The burden of responsibility is greater than it was in urban settings (agree/disagree). And you obtain the information you need from a variety of sources such as:

Out of town workshops (agree/disagree)	(Imp	not)
Inservice at your hospital (agree/disagree)	(Imp	not)
Physicians on staff (agree/disagree)	(Imp	not)
Other nurses (agree/disagree)	(Imp	not)
Journals (agree/disagree)	(Imp	not)
Textbooks (agree/disagree)	(Imp	not)
Practice sessions at urban hospitals (agree/disagree)	(Imp	not)

Now let's go back over that list so you can tell me which of those methods you would consider very important and which you would consider not very important.

5. One of the things that seems to be distinctive about rural nursing is that everyone knows everyone else. For example, you probably know everyone who works at your hospital (agree/disagree). You know all of the physicians and they know you (agree/disagree). You know most, if not all of your patients (agree/disagree). Now, can you tell me how knowing everyone who works at your hospital impacts your practice? Is it sometimes positive? (agree/disagree). Sometimes negative? (agree/disagree). How does knowing all the physicians impact your practice? Sometimes positive? (agree/disagree). Sometimes negative? (agree/disagree). How does knowing your patients impact your practice? Sometimes positive? (agree/disagree). Sometimes negative? (agree/disagree).

6. It can probably be said that in most any hospital setting the nursing department carries the burden of responsibility for coordinating patient care for all departments (agree/disagree). However, in rural nursing the interdepartmental management of patient care seems to be more directly under the influence of the nursing department (agree/disagree). Communication between nursing and other departments is probably easier to attain (agree/disagree). And nursing is more directly involved in facilitating the activities of other departments (agree/disagree). In addition, as a rural nurse you are consistently required to have knowledge in other disciplines, because often you must practice in the realm of that discipline (agree/disagree). This may not always be safe (agree/disagree). For example, do you ever function within the realm of:

Respiratory therapy (yes/no)	How often?	In what way?
Radiology (yes/no)		
Laboratory (yes/no)		
Pharmacy (yes/no)		
Dietary (yes/no)		
Social work (yes/no)		
Medicine (yes/no)		
Business office (yes/no)		
Psychology (yes/no)		
Other _____		

Now let's go back over that list so you can tell me in which, if any of those areas you think safe care or safe practice may be an issue.

7. I've been told that you can't be an ace in every area of rural nursing practice (agree/disagree). But you really need to be competent in more than one area (agree/disagree). What would you say the two most important areas of competency are?

8. I have been told a double standard exists between nurses and physicians in the rural setting. When physicians are not on the scene they expect nurses to handle medical emergencies (agree/disagree). When physicians are on the scene they expect nurses to keep their ideas to themselves (agree/disagree). When you are forced to handle an emergency situation on your own because the physician is ten or thirty minutes away you are likely to be praised, or at least not chastised as long as what you do helps the patient (agree/disagree). But if what you do does not help the patient, you are likely to face the physician's anger, if not disciplinary action (agree/disagree). Can you give me an example of this?

9. I am told that in rural nursing you can not expect an easy routine (agree/disagree). You must be prepared to deal with anything (agree/disagree). To survive in rural nursing you must be able to tolerate a constant variety of demands (agree/disagree). And there is little chance for boredom in rural nursing (agree/disagree). But staying current to handle such a variety can be frustrating (agree/disagree). Can you tell me about something which happened to you in rural nursing...something which seemed too incredible to be true...but you just had to deal with it? What is the worst thing you can imagine right now that you'd have to deal with? In the real experience you described, would you say that patient safety was compromised? And in the imaginary situation you described...would you call that safe practice?

10. I am told that when you know a patient personally you are often able to give them better, more quality care (agree/disagree). Giving nursing care to friends and family members can be a frightening experience (agree/disagree), but it can also be rewarding (agree/disagree). Anonymity is virtually absent (agree/disagree). This can be reassuring (agree/disagree), but can also be constricting (agree/disagree). Can you tell me about a situation when knowing your patient made a significant difference in the care you were able to give them?

11. Do you think there are more personal rewards in rural nursing than in urban nursing? (agree/disagree). Do you think that you become more attached to rural nursing than to urban nursing? (agree/disagree). Providing circumstances allowed you to choose, would you remain in rural nursing or choose a rural setting again? (agree/disagree). Can you tell me about a particularly rewarding experience you have had in rural nursing?

12. Would you say that it is important to rural people to be taken care of by someone they know? (agree/disagree). More important than for urban people? (agree/disagree) Would you say rural people have the same basic needs as anyone else does? (agree/disagree). If not, what is different? Do you believe that rural people expect to have their medical needs met even if they are far from major medical centers? (agree/disagree). And do people ever tell you they get better care in the rural hospital than they do in the urban hospital? (agree/disagree) Can you tell me a little more about some of these things?

13. Are the politics and hassles in a rural hospital more intense than in an urban hospital? (agree/disagree). Do they influence your practice more in the rural setting? (yes/no). Do you become more involved emotionally or otherwise in the events of the institution in the rural setting? (yes/no). Do you think one person can have a bigger impact on the system in the rural setting? (yes/no). And do you feel like you are an ambassador of the hospital more in the rural setting than in the urban setting? (yes/no). Can you give me some examples?

14. There are advantages and disadvantages to being in any situation. Living in a rural setting means you must cope with a limited social life (agree/disagree). Cultural events are also limited (agree/disagree). The setting has great natural beauty (agree/disagree). There is little chance to obtain a BSN (agree/disagree). It is easier to advance in your job position in the rural setting (agree/disagree). Can you share some of your own thoughts about the advantages and disadvantages?

15. Many rural nurses would like to see a specialty certification exam developed to recognize the proficient rural nurse. Do you think this is a good idea? (yes/no). Would you be likely to take the exam? (yes/no). Do you see any difficulty in developing such an exam? If so, what? What do you think would be the most important things to include on such an exam?

16. We have covered a lot of territory. Now I would like you to reflect for a minute on what we have said and then tell me: What is rural nursing?

What do you want me to know that hasn't been said?

What questions do you have that you want to ask me?

Thank you very much for participating in this study.

APPENDIX D

Letter of Introduction to Directors of Nursing

Autumn, 1986

Dear Director of Nursing and Administrator:

This correspondence is to follow up on our previous contact regarding my study. As you know, I am a graduate student at Montana State University College of Nursing and am conducting a study about rural nursing.

The purpose of my research is to describe the nature and scope of rural nursing, and to identify distinctive characteristics found in rural nursing. You are probably aware of the focus on rural health care which is being made by organizations such as the American Hospital Association and the American Nurses' Association. This is an exciting time to be involved in rural health care delivery.

It is my understanding that several nurses who work at your facility are interested in participating in my study. I will be meeting with them during off-duty time at their choice of location. Their participation is voluntary and their responses are strictly confidential.

I am looking forward to visiting your hospital and expect to be there on _____, 1986. If you have any questions or comments about this study I would be happy to discuss them with you at that time.

Thank you for your support of this project.

Sincerely,

Jane Ellis Scharff, RN
Graduate Student
College of Nursing
Montana State University
Bozeman, MT 59717

APPENDIX E

Consent Form

Autumn, 1986

Dear Study Participant:

Thank you for your interest in this study of rural nursing. Your participation is important in the development of a description of the nature and scope of rural nursing.

To participate in this study you must be a registered nurse currently employed in a rural hospital. You must also have had some prior employment as an RN in a hospital of 100 beds or more.

Your responses will be confidential and your name will not be published. Your name will at no time be associated with your responses. Responses will be coded under a reference number for the sole purpose that the researcher can contact you following the interview if it is necessary to clarify any response. It is believed that this study presents no risk to you as a participant.

There are two parts to the study. You are asked to complete a questionnaire of background information as well as to participate in an audio-taped interview. You may refuse to answer any questions on the questionnaire or during the interview. You may discontinue the interview at any point.

If you want to participate in this study of rural nursing, please read and sign the statement below. Please feel free to ask me any question or voice any concern you might have about this study.

Sincerely,

Jane Ellis Scharff, RN
Graduate Student
College of Nursing
Montana State University
Bozeman, MT 59717

I have read the above explanation of the purpose and procedure of this study. Based on the above information I choose to participate in the study.

NAME (print) _____ DATE _____

SIGNATURE _____

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