"(This book) continues to be the first line resource toward understanding rural health nursing and the interface with cultural, health, health beliefs, and healthcare in rural populations... Highlights the realities of rural nursing from bedside to advanced practice... This book and the chapters within are some of the most often cited in the rural nursing literature."

Pamela Stewart Fahs, RN, PhD
Associate Dean and Dr. G. Clifford and Florence B. Decker Chair in Rural Nursing
Decker School of Nursing, Binghamton University
Editor in Chief, Online Journal of Rural Nursing and Health Care

The newly revised fifth edition of this authoritative classic continues to be the only text to focus specifically on rural nursing concepts, theory, research, practice, education, public health, and healthcare delivery from a national and international perspective. Updated with 22 new chapters, these additions expand upon the rural nursing theory base and research. Content delves into the life of rural nurses, addressing their unique day-to-day challenges of living without anonymity, often acting as the sole healthcare provider, and establishing self-reliance as a nurse generalist. New chapters provide information on unique populations, such as veterans and Native Americans, as well as specific types of care, such as palliative nursing, bereavement support, substance abuse treatment, and much more. Free, searchable, digital access to the entire contents of the book and PowerPoint slides accompany the text.

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Charlene A. Winters, PhD, RN
Helen J. Lee, PhD, RN
EDITORS

CONCEPTS, THEORY, AND PRACTICE
Rural Nursing
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Rural Nursing
Concepts, Theory, and Practice

Fifth Edition

Charlene A. Winters, PhD, RN
Helen J. Lee, PhD, RN
Editors

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Winters and Lee continue to be the first-line resource toward understanding rural nursing and the interface with culture, health, health beliefs, and healthcare in rural populations. Whether you are developing and disseminating knowledge about rural health and nursing, or learning about rural dwellers or practicing rural nursing, there is much to gain from reading this latest edition of *Rural Nursing: Concepts, Theory, and Practice* (5th ed.). Multiple new chapters are presented in each section. This book highlights the realities of rural nursing from bedside to advanced practice. Community and acute care settings for rural healthcare are examined. Theoretical perspectives, as well as new models of practice and research, are found in this edition. Winters and Lee support rural nurses not only by identifying the challenges, but also by highlighting opportunities in rural healthcare and innovative practice.

The relevance of this text on the development of rural nursing over the past few decades is apparent from the perspective of a nursing educator, researcher, and editor of a journal focusing on rural nursing and healthcare. This text is a staple in graduate nursing education in the rural nursing PhD program at Binghamton University. As an editor, I feel confident that this book and the chapters within are some of the most often cited in the rural nursing literature. Winters and Lee have been, and I am sure will continue to be, in the lexicon of rural nursing.

*Pamela Stewart Fahs, PhD, RN*  
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*Editor-in-Chief, Online Journal of Rural Nursing and Health Care*
The fifth edition of Rural Nursing: Concepts, Theory, and Practice, like the editions before it, focuses on the health of rural dwellers, the provision of healthcare in rural settings, and the skills and knowledge required for effective nursing practice, education, and research required within this context.

The genesis of the rural text originated from a vision of Dr. Anna Shannon, dean of the College of Nursing at Montana State University. She was well aware of the early work on nursing theories and noted that little emphasis was placed on environment, and when examining the literature, she found an absence of rural nursing articles. Shortly thereafter, a master’s degree program focused on rural nursing was established at Montana State University College of Nursing with a strong emphasis on rural nursing theory. The theory development process grew through the efforts of College of Nursing graduate students, faculty, administrators, and help from consultants. Interviews of rural persons throughout the state of Montana were examined for concepts that frequently emerged from the data. This qualitative material, linked with quantitative studies, led to the theory article published in 1989 by Dr. Kathleen Long and Dr. Clarann Weinert (see Chapter 2). The first edition of the rural text was titled Conceptual Basis for Rural Nursing and consisted of chapters written by faculty and students of Montana State University College of Nursing. Subsequent editions were retitled, Rural Nursing: Concepts, Theory, and Practice. Each new edition continued to include material written by faculty and students, and then expanded to include authors from across the United States, Canada, and Australia. More than four decades have passed since the College of Nursing developed a master’s program that focused on the care of individuals living in a rural/remote environment. Since that time, a doctor of nursing practice (DNP) program with family nurse practitioner and psychiatric/mental health nurse practitioner options has been added to the curriculum at Montana State University College of Nursing to prepare nurses to care for rural and frontier populations.

The four published editions have recorded the progress of our work and the expansion of content beyond Montana to the United States and beyond our borders. The extension of the content areas and the countries represented demonstrate the book’s importance to nurse educators, researchers, clinicians, and policymakers. The fifth edition of Rural Nursing: Concepts, Theory, and Practice expands our understanding of the rural healthcare environment. As
with the first four editions, the quest continues to provide an evidence base and theory structure to help nurses and other providers address the health needs of persons living in rural communities. New chapters have been added on topics important to rural providers, educators, and researchers including a chapter on the history of rural nursing theory development; lack of anonymity; a program of research in rural communities; the lived experience of rural nurses; the rural nurse practitioner; the synergy model for rural nursing; telehealth nursing; trauma care; palliative care; bereavement; workforce issues; public health issues; care for American Indians; complementary therapy; development of a Rural Knowledge Scale; collaborative education models; substance abuse; and community-based participatory research. The fifth edition continues the tradition of including seminal chapters and updated chapters retained from the previous edition.

The text is divided into five sections. Each section includes new chapters as well as updated chapters from previous editions. The first focuses on rural nursing theory and includes the seminal work by Long and Weinert. The focus of Section II is rural nursing practice. In this section is Jane Scharff’s chapter on the nature and scope of rural nursing practice that has been so widely quoted since its publication nearly 20 years ago. Section III focuses on healthcare delivery in rural settings. Section IV addresses nursing education for rural populations and Section V focuses on public health. Qualified instructors may obtain access to ancillary instructor’s PowerPoints by emailing textbook@springerpub.com.

We hope readers will find the latest edition thought provoking and useful in their clinical practice, teaching efforts, and research activities. We look forward to the comments and critiques of our rural colleagues.

Charlene A. Winters
Helen J. Lee
We wish to acknowledge the work of our many colleagues, students, consultants, and research participants whose contributions made this text possible.
Chapter 4

Updating the Rural Nursing Theory Base

Helen J. Lee and Meg K. McDonagh

DISCUSSION TOPICS

● Select one of the relational statements from the rural nursing theory statements and diagram it. Include additional concepts that might be related to the statement.
● Lack of anonymity has changed over the years since it was first identified as a concept in rural nursing theory. Identify if there are other concepts that have changed over time? In what way?
● Identify a concept and select the fields of study from which you could analyze it.

Many disciplines exist to generate, test, and apply theories that will improve the quality of people’s lives.

(Fawcett, 1999, p. 1)

“Sparsely Populated Areas: Toward Nursing Theory” was the title of a symposium presented by Montana State University (MSU) College of Nursing at the Western Council on Higher Education for Nursing (now Western Institute of Nursing). It was introduced by Dean Anna Shannon who stated that it would demonstrate how the school could “maximize its resources, provide opportunities for faculty and student research and contribute . . . to the development of an empirically based theory of nursing” (1982, pp. 70–71). This chapter includes a summary of the rural nursing theory structure subsequently published in 1989 by Long and Weinert. It is followed by a review of the literature supporting or refuting the viability of the theoretical statements and concepts. Based on the review, we propose a revised rural nursing theory structure and make suggestions for future work.
THE ORIGINAL RURAL NURSING THEORY STRUCTURE

The quality of the lives of rural persons and the lack of empirical studies about their healthcare was of concern to MSU College of Nursing researchers. A middle-range theory emerged from a recognized need for a framework that acknowledges the unique perceptions of rural persons and the generalist experience of nurses who practice in rural settings. Prior to the development of the theory, it was assumed that nursing care of rural persons was similar to the care of persons living in urban environments.

The resulting descriptive theory is the “most basic type of middle-range theory” (Fawcett, 1999, p. 15). Middle-range theory focuses “on a limited dimension of the reality of nursing” and grows at the “intersection of practice and research to provide guidance for everyday practice and scholarly research rooted in the discipline of nursing” (Smith & Liehr, 2003, p. xi). The theory emerged from observations gathered through qualitative and quantitative descriptive studies conducted in the sparsely populated rural setting of Montana. It describes specific characteristics and observations made of rural persons seeking healthcare and their healthcare providers. The published theory contains three theoretical statements and several key concepts (Long & Weinert, 1989).

The first statement is descriptive and states that “rural dwellers define health primarily as the ability to work, to be productive, to do usual tasks” (Long & Weinert, 1989, p. 120). Key concepts associated with this statement are work beliefs and health beliefs. The second statement is relational and proposes that “rural dwellers are self-reliant and resist accepting help or services from those seen as ‘outsiders’ or from agencies seen as national or regional ‘welfare’ programs” (Long & Weinert, 1989, p. 120). Rural persons preferred to seek healthcare from insiders, persons with whom they were familiar. Additional key concepts pertaining to this statement are “old-timer” and “newcomer.” A corollary to the second statement is that “help, including needed medical care, is usually sought through an informal rather than a formal system” (p. 120). The third statement is relational and focuses on healthcare providers; it indicates that lack of anonymity and role diffusion are experienced more acutely among rural providers than among providers in urban or suburban settings. Lack of anonymity also applies to the recipients of healthcare in rural areas, as all persons in that environment have a “limited ability . . . to have private areas of their lives” (Long & Weinert, 1989, p. 119).

In addition to the abovementioned three statements, an understanding of the concepts “isolation” and “distance” is important in the healthcare-seeking behavior of rural residents. Isolation refers to separation from or being placed alone (Lee, Hollis, & McClain, 1998). Distance is measurable time, physical space between places, and personal perception of that space (Henson, Sadler, & Walton, 1998). Qualitative data upon which the theoretical work was based indicated that rural residents did not feel isolated, despite the fact that they averaged 23 miles of travel to their nearest emergency department (ED) and over 50 miles to their primary healthcare source (Long & Weinert, 1989, p. 119).
The content of Long and Weinert’s (1989) rural nursing theory article was and is widely quoted in nursing literature, including community health and rural nursing texts, and in presentations given about rural nursing. However, periodic rural nursing literature reviews contain few citations specifically focusing on health perceptions and needs of rural persons. We located three qualitative studies through conference proceedings, the contents of which were subsequently published (Bales, Winters, & Lee, 2006; Lee & Winters, 2004; Thomlinson, McDonagh, Reimer, Crooks, & Lees, 2004). Other sources included two nursing master’s theses (Bales, 2006; Moran, 2005), a study that focused on the healthcare meanings, values, and practices of Anglo-American male population in the rural American Midwest (Sellers, Poduska, Propp, & White, 1999), a study exploring rurality and health in midlife women (Thurston & Meadows, 2003), and a study examining the health-information-seeking experiences of rural women in Ontario, Canada (Wathen & Harris, 2006, 2007). We also located several journal articles, mostly qualitative rural research, that included rural concepts found in Long and Weinert’s article. In the following sections, each theoretical statement is followed by findings from the literature supporting or refuting the statement.

**Theoretical Statement 1 (Descriptive)**

. . . [R]ural dwellers define health primarily as the ability to work, to be productive, to do usual tasks. (Long & Weinert, 1989, p. 120)

Four qualitative studies conducted in the United States examined health perceptions; one with rural men aged 25 to 49, one with rural men and women aged 28 to 63, and two with older rural persons aged 60 to 85. Three provided support for the abovementioned descriptive statement that defines health as the ability to carry out important functions (Niemoller, Ide, & Nichols, 2000; Pierce, 2001; Sellers et al., 1999). In the fourth study, Averill (2002) found that definitions of health varied across her southwest United States sample that included older retirees, more recent retirees, and Hispanic elders. The older retirees from mining and ranching communities viewed health in a similar manner to the original qualitative theory development samples, whereas more recent retirees focused on strategies to remain healthy—proper diet, regular exercise, and regular health exams. The Hispanic elders in Averill’s sample frequently mentioned incorporating home remedies and herbal preparations into their health maintenance practices.

Participants in the several health perceptions and needs studies (Bales, 2006; Bales et al., 2006; Lee & Winters, 2004; Moran, 2005; Thomlinson et al., 2004; Winters, Thomlinson, et al., 2006) conducted in the United States and Canada
were more likely to define health holistically. Lee and Winters (2004) found that for rural persons working in service occupations, being able to function included being physically, mentally, and emotionally fit. Participants in a study conducted by Bales et al. (2006) thought that being healthy meant being mentally and physically active, eating well, and having an overall sense of well-being. Thomlinson et al. (2004) interpreted their participants’ responses by saying that health was a “holistic relationship between the physical, mental, social and spiritual aspects of their lives” (p. 261). This same view of health was echoed by Canadian middle-aged women in Thurston and Meadows’s (2003) study and by the older adults residing in Appalachia who completed surveys and participated in focus groups (Goins, Spencer, & Williams, 2011).

Australian women in de la Rue and Coulson’s (2003) study, aged 73 to 87, equated health with not being ill. They knew maintenance of their health was influenced by their geographical location and their desire to remain living on the land.

**SUMMARY**

The literature both supports and refutes the first theoretical statement. Support appears in studies of rural male adults and of older persons and retirees from the extractive industries (mining, farming). Lack of support for the functional definition of health emerges from a variety of settings and from differing rural samples. It may be that age, the rural environmental setting, the influence of the work ethic, and the culture are factors in defining health (de la Rue & Coulson, 2003). Potentially, younger rural participants may be influenced by increased media exposure and its emphasis on health promotion and the use of preventive health practices. In addition, healthcare providers may be expanding their view of health beyond the illness care model and may be sharing this with their clients.

**Theoretical Statement 2 (Relational)**

... [R]ural dwellers are self-reliant and resist accepting help or services from those seen as ‘outsiders’ or from agencies seen as national or regional welfare programs. (Long & Weinert, 1989, p. 120)

The attribute of self-reliance dominates the literature about rural persons and their health-seeking behaviors (Davis & Magilvy, 2000; Jirojwong & MacLennan, 2002; Lee & Winters, 2004; Niemoller et al., 2000; Sellers et al., 1999; Thomlinson et al., 2004; Wathen & Harris, 2006, 2007; Winters, Thomlinson, et al., 2006). Care was sought by rural residents after first “consulting books” (Jirojwong & MacLennan, 2002, p. 251) and trying “to deal with an illness themselves” (Thomlinson et al., 2004, p. 10). Because of the presence of chronic illnesses,
older adults were knowledgeable about nearby medical care resources, including physicians, physician’s assistants, and nurse practitioners (Niemoller et al., 2000; Pierce, 2001; Roberto & Reynolds, 2001), and if available, would use them “to achieve their desired level of independence” (Niemoller et al., 2000, p. 39). However, if the desired resources were not available, these same older adults stated they would “manage” (Niemoller et al., 2000, p. 39).

Canadian women (aged 20–82) in the study conducted by Wathen and Harris (2006) shared differing strategies when faced with an urgent health situation. Some would visit a hospital ED while others would self-medicate and wait until the next morning to contact their family doctor. Decision making was influenced by perception of the knowledge and skills of available professional practitioners and, in some situations, by the results of previous interactions about managing their chronic illnesses. In addition, decisions were affected by the distances they needed to travel, particularly in winter.

**Corollary to Relational Statement 2 (Descriptive)**

[H]elp, including needed healthcare, is usually sought through an informal rather than a formal system. (Long & Weinert, 1989, p. 120)

The literature revealed a variety of findings related to the relational statement corollary. Bales (2006) found that mothers with children living in U.S. frontier settings would seek advice from family, friends, and neighbors and would initiate self-care activities if healthcare situations were not considered serious. However, if the illness or injury was gauged as serious, professional healthcare was immediately accessed no matter the distance involved. Bypassing the informal for the formal system because of the seriousness of the illness or injury also was found in studies conducted by Buehler, Malone, and Majerus (1998) and Thomlinson et al. (2004).

Participants in two Canadian studies (Thomlinson et al., 2004; Wathen & Harris, 2006, 2007) indicated that family, friends, and neighbors were cited as a major source of support, particularly during the information-gathering phase (Wathen & Harris, 2006). Those particularly valued were persons who held a healthcare professional role or had experienced a disease or illness firsthand (Wathen & Harris, 2006). Although older rural women in the U.S. study conducted by Pierce (2001) stated that they were eager to help neighbors and the less fortunate, they also shared their reluctance to tell family and neighbors about their own needs unless really necessary.

Help gained through accessing informal knowledge via the media, popular magazines, books, libraries, and the Internet was cited in three studies (Roberto & Reynolds, 2001; Thomlinson et al., 2004; Wathen & Harris, 2007). A sample of older women living in the United States actively sought information about living with their osteoporosis (Roberto & Reynolds, 2001): Members of
a Canadian sample stated that they frequently made use of formal information sources through libraries, books, and computers (Thomlinson et al., 2004; Wathen & Harris, 2007).

**Summary**

The second theoretical statement and its corollary are both sustained and refuted by the findings in the literature. Self-reliance continues to be a characteristic attribute of rural persons and influences the way they respond to illness or injury and their subsequent care-seeking behaviors. The informal system (family, friends, and neighbors) is still frequently used as a resource. However, the rural cultural barrier to accessing care through formal resources appears to be changing. The increased knowledge and the need to have information about health and the chronic illnesses they are experiencing may be removing the cultural barrier of approaching “outsiders” for health and medical care. In part, this may be occurring because desired health information can now be obtained through use of the Internet while maintaining anonymity. Prior to the current age of information technology, maintaining anonymity while seeking health information was not an option.

**Theoretical Statement 3 (Relational)**

... [H]ealth care providers in rural areas must deal with a lack of anonymity and much greater role diffusion than providers in urban or suburban settings. (Long & Weinert, 1989, p. 120)

The findings for the two concepts forming this relational statement—lack of anonymity and role diffusion—are sustained in the literature about healthcare providers from Australia, New Zealand, and the United States. In relation to the lack of anonymity, authors stated that “in close knit communities ... news travels fast” (Lau, Kumar, & Thomas, 2002, Results and Discussion, paragraph 7) and that “social life realities in small communities frequently blur professional boundaries” (Blue & Fitzgerald, 2002, pp. 319–320). Social factors pertaining to practice in rural communities include privacy issues for both the professional and the clients for whom they give care (Lau et al., 2002). Healthcare practitioners in rural environments who are known by their clients may find that older women prefer receiving professional care from a familiar person (Courtney, Tong, & Walsh, 2000; Pierce, 2001), whereas middle-aged women prefer to go elsewhere for care because of that familiarity (Brown, Young, & Byles, 1999; Lee & Winters, 2004). Lee and Winters found this is particularly true for women’s healthcare and mental health.

According to the work by Swan and Hobbs (2017), the meaning of the concept, “lack of anonymity,” has also undergone change since the earlier work of
Long and Weinert (1989). With the advent of widespread access to the Internet and the use of social media, maintaining any sense of anonymity has become increasingly difficult for everyone, including rural nurses. And while Lee (1998) found that personal and professional boundaries may be diminished, Swan and Hobbs and Chipp et al. (2011) found that the issue may be related to how one establishes boundaries for one’s personal and professional self. Another key factor related to the current meaning of lack of anonymity is the environmental context of those involved, specifically rural nurses. Previously this was thought to be a physical, geographic, and relational context and now it would seem that “environment” also includes digital and temporal.

Role diffusion was found in studies conducted with psychiatrists and nurses in Australia (Lau et al., 2002) and by Rosenthal (1996) in her study of rural nursing in America. Hegney (1997) described role diffusion in both generalist and extended roles in her study of Australian rural nursing practice. Role diffusion was evident in the practice of hospice nurses in New Zealand (McConigley, Kristjanson, & Morgan, 2000). The reality in sparsely populated areas is that with fewer persons available to perform multiple tasks, more tasks must be undertaken by the individuals who practice in these areas.

SUMMARY

The third theoretical statement about lack of anonymity and role diffusion is well supported in the literature. Familiarity, the opposite of anonymity, can be a facilitator or a barrier to seeking health and illness care from local healthcare practitioners. Familiarity is a distinguishing feature of rural nursing that allows rural nurses a special knowledge of those for whom they provide care within their communities (Hegney, 1997).

The lack of anonymity that healthcare providers experience in rural communities is in itself a paradox. On the one hand, it is often the familiarity and knowing of community members and the lack of anonymity that draws healthcare professionals to rural areas. Yet, it is often these same attributes that can later drive them away.

CONCLUSION

The review of the literature pertaining to the descriptive middle-range rural nursing theory base revealed a variety of findings. The rural residents’ definition of health in the first descriptive statement is changing from that of a functional nature to a more holistic view that includes physical, mental, social, and spiritual aspects. The self-reliance of rural residents in the second relational statement is broadly supported; however, the resistance to seeking help from those seen as “outsiders” is changing. The third relational statement pertaining to healthcare providers and their lack of anonymity and role diffusion is
supported. The findings for the concept of distance in the original rural theory development work are not supported. This literature appraisal of the rural nursing theory base structure supports a need for change.

THE REVISED RURAL NURSING THEORY

Based on this review of the literature, we recommended the following revisions to the first two theoretical statements originally proposed by Long and Weinert in 1989.

Theoretical Statement 1 (Descriptive)

Rural residents define health as being able to do what they want to do; it is a way of life and a state of mind; there is a goal of maintaining balance in all aspects of their lives. (Lee & McDonagh, 2006, p. 314)

Older rural residents and those with ties to extractive industries are more likely to define health in a functional manner—to work, to be productive, and to do usual tasks. (Lee & McDonagh, 2006, p. 314)

Essential to understanding rural persons’ motivation for illness treatment, health maintenance, and health promotion is knowledge of their health perceptions (Long, 1993). The abovementioned replacement statements provide a broader view of the health perceptions that have been found with more recent research among rural individuals, families, and communities. They reflect both the earlier emphasis on role performance evident among older residents and among those employed in extractive industries and the expanded view of health perception definitions elicited from other individuals living in rural communities.

Theoretical Statement 2 (Relational)

Rural residents are self-reliant and make decisions to seek care for illness, sickness, or injury depending on their self-assessment of the severity of their present health condition and of the resources needed and available. (Lee & McDonagh, 2006, p. 315)

Rural residents with infants and children experiencing illness, sickness, or injury will seek care more quickly than for themselves. (Lee & McDonagh, 2006, p. 315)

These theoretical statements refer to the health-seeking behaviors of rural residents. Key concepts from the 1989 model included self-reliance, seeking care from insiders, and the use of the informal system. Research findings continue
to assert that self-reliance is a key characteristic identified in the management of healthcare situations by rural persons. However, changes were seen in the health-seeking behaviors of these residents as they seek advice and care from insiders and outsiders and also make use of both informal and formal systems of care.

Additional concepts emerged from the comparative research about rural persons’ health behaviors: health-seeking behaviors and choice (Winters, Thomlinson, et al., 2006). Health-seeking behaviors, defined as “conscious behaviors designed to promote healthy relationships among physical, mental, social and spiritual aspects of one’s life so that life balance is maintained” (Winters, Thomlinson, et al., 2006), include three subthemes: symptom–action–timeline process (SATL; Buehler et al., 1998), resources, and self-reliance.

Conscious choice is made in at least two domains of rural persons’ lives. The first is the choice to live in a rural environment; the second is in accessing healthcare resources. Choosing to live in a rural environment is closely associated with the concept of place (see discussion later in this chapter).

Theoretical Statement 3 (Relational)

Healthcare providers in rural areas continue to experience lack of anonymity and role diffusion. Although the literature review demonstrates that the meaning of “lack of anonymity” has been expanded, the concept is still well supported. Therefore, the original statement was well supported in the literature review; no changes are recommended.

FUTURE DIRECTIONS

Exploration of the literature regarding rural health perceptions and needs revealed many new avenues for future exploration. Themes of distance and resources were identified repeatedly in the literature reviewed. Newly proposed concepts emerging from the literature review included health-seeking behaviors, choice, environmental context, and social capital. Each of these concepts is addressed in the following sections.

Distance

Although distance was not part of the three theoretical statements making up the rural nursing theory base, the content of the rural literature we accessed for this review frequently touched on the concept. In the seminal article by Long and Weinert (1989), the participants included in the multiple studies tended to see health services as accessible and did not view themselves as isolated. Canadian authors MacLeod, Browne, and Leipert (1998) stated that distance may not be a problem but said the concept exerts a strong influence in providing healthcare
in rural areas. This view affirms Johnson, Ratner, and Bottorff’s (1995) assertion that one’s geographic location may influence or even determine the form of health-seeking behaviors rural residents demonstrate. Pierce (2001) found that the older women described distance and geographical barriers with concern; yet, they seemed to take problems with accessibility “in stride” (p. 52). In addition, the study participants did express concern about the quality of nearby health services.

The remainder of the research all refuted the initial findings about distance and access to healthcare in Long and Weinert’s (1989) theory-based article. Fitzgerald, Pearson, and McCutcheon (2001), Moran (2005), Pieh-Holder, Callahan, and Young (2012), and Racher and Vollman (2002) stated that access to healthcare services is a major concern for rural and remote residents and for the health professionals serving them in Australia, Canada, and the United States. In a quantitative study examining the relationship between distance to the nearest mammography facilities in Kentucky, researchers found a significant relationship between the presence of advanced diagnoses and longer average travel distances (Huang, Digan, Han, & Johnson, 2009).

Australian rural healthcare experts were asked how rural and remote areas are different; Wakerman, Bourke, Humphreys, and Taylor (2017) found “geographic distance” and “access to healthcare” to be the chief characteristics of that difference.

Access to care is particularly a concern for rural individuals with chronic illness; an expressed problem was finding the “best” doctor (Fitzgerald et al., 2001). Distance to emergency care was an expressed concern of service providers in rural areas (Lee & Winters, 2004) and of mothers of children living in frontier areas (Bales, 2006; Pieh-Holder et al., 2012). Wong and Regan’s (2009) study participants averaged at least two chronic illnesses each; they made tradeoffs between their safety because of poor winter driving conditions and meeting their health needs. In a survey of middle-aged women, Brown et al. (1999) concluded that experiencing difficulties with accessing healthcare results in greater reliance on self-treatment and self-care, thereby leading to development of “attitudes of independence and self-reliance [sic]” (p. 151).

**Resources**

In addition to distance, the concept of resources directly impacts access to healthcare services. Gulzar (1999) and Racher and Vollman (2002) discuss the complexity of accessing health services. The rurality or remoteness of a given place affects access to health services. Within the rural environment, factors such as geography, politics, and economics, as well as the acceptability and the education of healthcare providers, all influence the residents’ access to and choice of health resources. Studying patterns of healthcare use and feedback loops among residents may add to the understanding of the complexity of accessing healthcare services in rural and remote areas (Racher & Vollman, 2002).
Delivery of health services across sparsely populated areas presents unique challenges because of the vast distances involved and the scarcity of health professionals. For example, the greater the nurse-to-patient or physician-to-patient ratio and the more rural or remote the community, the more limited the health resources are for rural and remote community members.

**Health-Seeking Behaviors**

Health-seeking behaviors were defined as “conscious behaviors designed to promote healthy relationships among physical, mental, social and spiritual aspects of one’s life so that life balance is maintained” (Winters, Thomlinson, et al., 2006, p. 34). The authors included three subthemes, SATL process, resources, and self-reliance, as part of health-seeking behaviors. The SATL process (Buehler et al., 1998) is used to describe the social process and to identify symptoms of sickness, illness, or injury and then seek the appropriate level of requisite care. The level of care sought may be self, lay, or professional, depending upon the perceived seriousness and type of symptom. Accessing resources is a part of the SATL process (see Chapter 16). Self-reliance, defined as behaviors to promote or maintain health without seeking assistance from others, was prevalent in the data from Montana and the Canadian provinces of Alberta and Manitoba. Winters, Thomlinson, et al. (2006, p. 35) considered self-reliance a subtheme of health-seeking behavior because of its paramount influence on a person’s seeking healthcare in sparsely populated rural areas.

**Choice**

Choice, the making of conscious decisions to live in a rural environment and access healthcare resources, was a new theme that emerged from the comparison study (Winters, Thomlinson, et al., 2006). Explicitly evident in the Montana data and implicitly identified in the Canadian study through the participants’ expressions of the benefits of living in rural environments, the theme of choice is associated with the concept of “place.” Although we think of place in a geographical context, it is a broader entity that shapes one’s political, economic, spatial, geographic, and cultural views of the world (Kelly, 2003). De la Rue and Colson (2003) found that rural participants’ well-being and health were influenced by the “geographical location of living on the land” (p. 5). “Place” provided these rural residents with a kind of emotional or spiritual connectedness that affected the outcomes of their health experiences.

Wathen and Harris (2007) stated that rural living affected the choice of resources that members of their Canadian study would consult about a chronic health concern or an acute medical problem. If the available rural doctor “might not be the best or too up-to date” (p. 643), they preferred their informal system (colleagues, friends, family), medical books, pharmacists, and/or the veterinarian.
Choice in making decisions related to accessing healthcare can be affected by several factors. Questions often asked to aid in determining a course of action are: Where is the closest facility that will provide the healthcare needed? What are the qualifications of the persons who staff that facility? What level of confidence is there in the local facility’s healthcare providers? Does familiarity with the professionals who staff the facility make a difference in making the choice of where to go? Is anonymity an important factor in this situation? Does the healthcare facility accept the insurance (true in the U.S. healthcare system) carried by the individual or family seeking care (Moran, 2005)? What hours does the facility stay open? What are the weather conditions? During stormy conditions, what roads are better maintained (freezing rain, snow, and ice; summer rain, wind, and flooding). In an acute emergency, can a fixed-wing aircraft or helicopter land nearby? These represent only a fraction of the factors and questions that play a role in the decision making for accessing healthcare.

Environmental Context

Appearing repeatedly throughout the literature reviewed were terms like place, geographical location, context, or environmental context. According to Jones and Ross (2003, p. 16), nursing practice is “shaped by its situatedness” (p. 16). Authors speak of the context of a place and the resources needed that are particular to a context or place (Andrews, 2002, 2003; Andrews & Moon, 2005; MacLeod et al., 2008; Poland, Leboux, Holmes, & Andrews, 2005; Thurston & Meadows, 2004; Winters, Cudney, Sullivan, & Thuesen, 2006). According to Lauder, Reel, Farmer, and Griggs (2006), “‘Context’ is an important unit of analysis . . . A rural health context is both physical and relational and aspects of rural environments . . . may enhance or impede health” (p. 75). According to Swan and Hobbs’s (2017) work on lack of anonymity, with the prevalence of Internet use and social media, “environmental context” should now also include the cyber or digital realm.

Health perceptions, needs, and actions of rural persons are also influenced by the environmental context. This was particularly evident in the research reported by de la Rue and Coulson (2003), Thomlinson et al. (2004), and Winters, Cudney, et al. (2006). In their intervention study of rural women with chronic illnesses, Winters and her colleagues found that four themes emerged through the “overarching theme of distance: (a) physical setting, (b) social/cultural/economic environment, (c) nature of women’s work, and (d) accessibility/quality of health care” (pp. 284–285).

Social Capital

Social capital is a concept that comes from sociology and has come into increasing importance over the last 25 years (Shookner, Scott, & Vollman, 2008). Rankin (2002, as cited in Lauder et al., 2006) defines social capital as “forms of association that express trust and norms of reciprocity” (p. 75). The Policy Research
Initiative for the government of Canada (PRI; 2005 as cited in Shookner et al., 2008) further clarifies social capital as the “networks of social relations that may provide individuals and groups with access to resources and supports” (p. 87). “Creating supportive environments is about building social capital” (p. 87) and is similar to the notion of building “rural health services research capacity” (Hartley, 2005, p. 12).

Nurses practicing in rural settings tend to be more actively engaged professionally and personally in the rural communities in which they live and work (Bushy, 2000; Scharff, 1998). However, the present role of nurses in creating supportive healthcare environments is not well understood; recognition, conceptualization, and measurement are needed “to more fully appreciate the impact nurses have on rural health access and services” (Lauder et al., 2006, p. 74).

Three qualitative studies about nurses spoke to the necessity of developing social capital within rural communities (Conger & Plager, 2008; Gibb, Livesey, & Zyle, 2003; MacKinnon, 2008). APRN graduates realized the importance of “rural connectedness” through development of support networks with other healthcare providers, relationships with urban healthcare centers, connections with local communities, and support through electronic means (Conger & Plager, 2008). Nurses providing maternity care realized that they needed to know “their community—who lives in their community, what their skills are, and whether they are available to address local health needs or respond to emergency situations” (MacKinnon, 2008, p. 6). Nurses in solo mental health practice recognized the necessity of assisting rural and remote clients “to achieve a level of social functioning to integrate the person back into their community network” (Gibb, 2003, p. 248). To do this, they found that they needed to work more closely with the potential support structures identified within the clients’ community. This was best achieved by fostering a caring home environment, trying to keep people with their families and in their place of employment (Gibb et al., 2003). By having such a support structure, rural mental practitioners can avoid sending the mental health client to a psychiatric institution when a crisis occurs.

Summary

Theories are developed for the purposes of describing, explaining, and predicting phenomena (Fawcett, 2000). The intent of the early theory development work at the College of Nursing at MSU was to use the descriptive research data collected in sparsely populated rural areas to develop a middle-range theory, one that would provide a framework for nurses providing care to rural dwellers (Shannon, 1982). What evolved was a descriptive theory, the most basic type of middle-range theory (Fawcett, 1999).

Although controversy exists about the placement and abstraction level of middle-range theories within the hierarchical structure of nursing theories (Peterson & Bredow, 2004), the basic theory structure, regardless of level, is
similar—theoretical statements that describe or link key concepts (Fawcett, 1999). The interweaving of those concepts and statements provides a pattern of ideas, which provide a new perspective on phenomena (Smith & Liehr, 2003). The pattern, once published and subjected to testing, should remain open to scrutiny, debate, and if necessary, to change and the incorporation of new ideas.

By subjecting the middle-range rural nursing theory to testing in several studies (Bales, 2006; Bales et al., 2006; Lee & Winters, 2004; Moran, 2005; Thomlinson et al., 2004; Winters, Thomlinson, et al., 2006) and in the findings from several related studies, it was evident that change had occurred over the past 30 years that had altered the applicability of the original published rural nursing theory base by Weinert and Long (1989). This change is demonstrated by the revisions to theoretical statements and the new emerging concepts.

VISION FOR THE FUTURE

Because of the descriptive nature of the middle-range rural nursing theory, additional descriptive research is needed (Fawcett, 1999). Concept analysis methods can take several approaches, including the Wilson method (Walker & Avant, 1995), the evolutionary method (Rogers, 1993), the empirical or inductive approach (Morse, 1995), or a combination thereof. Testing of the proposed changes to the rural nursing theory relational statements through qualitative studies (ethnography, grounded theory, phenomenology, narrative inquiry, historical inquiry, and photovoice) and participatory action research needs to take place in other sparsely populated areas. Development and testing of instruments to measure the concepts are also needed. Conducting surveys to measure attributes, attitudes, knowledge, and opinions using open-ended and semistructured interviews and questionnaires is required (Fawcett, 1999). With a compilation of these focused research efforts can emerge a model, a schema, or a list of logically ordered statements that, when present, will provide guidance for the care of rural dwellers (Smith & Liehr, 2003).

Moving the Work Forward

A core group of nurse researchers from Montana and Alberta periodically met to review and critique theoretical material and models. Members of this North American Study (NAS) group discussed and planned projects to further rural nursing theory development while offering research and educational opportunities to graduate students within their courses or independent studies. A rural nursing and theory listserv group, initiated several years ago, provided a mechanism for online discussion for furthering rural nursing research and theory development. While this listserv is now dormant, a resource is potentially available for reestablishment of communication: The International Council of Nurses (ICN) Rural and Remote Nursing Network, www.icn.ch/rrn_network.htm, and...
Improving Health Among Rural and Vulnerable Populations, www.facebook.com/#!/groups/395662340465359.

The NAS and listserv members did identify the following questions for continued exploration of rural healthcare behaviors: (a) Are these health-seeking behaviors unique to rural residents? (b) Will health-seeking behavior activities of the Health-Needs–Action Process (HNAP; Chapter 16) process fit under the same middle-range theory framework as those for health promotion? (c) How do illness variables affect rural persons’ health-seeking behaviors? (d) How do illness variables affect rural people’s choices of healthcare providers? (e) Are rural dwellers more accepting of “outsiders” if they are healthcare professionals working in partnerships with the rural community and local health professionals?

CONCLUSION

The revised statements for the middle-range rural nursing theory as published by Lee and McDonagh (2010) are ready for testing. The emerging concepts identified in the review of the rural nursing literature are also ready for exploration, testing, and tool development. Continued research and theoretical development efforts will increase the potential for a middle-range theory that can provide a structure for acceptable, adaptable, and evidence-based nursing care interventions for rural persons.

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Chapter 8

The Distinctive Nature and Scope of Rural Nursing Practice: Philosophical Bases

Jane Ellis Scharff

DISCUSSION QUESTIONS

- Describe from your perspective what it means to “be a rural nurse.” Compare and contrast your meaning of being rural with your colleagues’ meaning of being an urban nurse. How are they similar? How are they different?
- Design a project to explore rural nursing. How does rural nursing today compare with rural nursing described by Scharff?

Plenty and little have changed in 10 years. Rural nursing practice seemed a dichotomous set of the routine and the extraordinary to me back then, as it does now. I was an insider, if not an old-timer, and my findings, although remarkable to some, seemed simply confirmatory to me. Already a budding pragmatist and not yet fully a scientist, I thought, at the time, it was enough to have empiric validation for the practice that I had known and in which my former workplace colleagues continued. For that reason and so many others, I did not publish the findings of my master’s thesis in 1987. Subsequently, I have been cited frequently, misrepresented occasionally, and poached a time or two when it comes to references about the world of rural nursing. It is time to uphold my responsibility to nursing science and to set the record straight. The nature and scope of rural nursing is distinctive. I am now willing to be quoted on that. Furthermore, rural nursing can now be given a definition based on that distinctiveness.

Rural nursing practice, be it hospital practice, private practice, or community health practice, is distinctive in its nature and scope from the practice of nursing in urban settings. It is distinctive in its boundaries, intersections, dimensions, and even in its core. Ten years ago, I was loath to claim distinctiveness within
rural nursing’s core. It seemed too bold to proclaim that at the very level of essence, and not attributable to setting alone, rural nursing could be so different. Today, I am determined to claim it: The core of all nursing is care, and care is the substance of the relationship between nurse and patient; consequently, what happens at the core of rural nursing is something apart from what happens at the core of nursing anywhere else.

I am still a pragmatist; my job is to get readers as close to the experience as I can. Thankfully, my growth as a scientist makes the job easier than it was some years back. Although no longer in the practice, I understand rural nursing better today than I did then. The importance of rural nursing has not decreased as my worldview has expanded. On the contrary, the more I dissect and reconstruct my thoughts about life and truth and nursing science, the more clearly I see the beauty emanating from the nature and scope of rural nursing, and the more clearly I appreciate its relevance to all of nursing science.

From an ontological viewpoint, I will share some information about what it means to “be” a rural nurse, and from an epistemological viewpoint, I will express a little of what it means to “know” rural nursing practice. What came as primary expression to me, because I lived it, breathed it, and studied it, is secondary expression as I write it; I will do my best to translate the experience through common language. However, the story I tell will require imagination to transcend time and space and to gain a sense of the reality of rural nursing practice. The information for this chapter comes from my ethnographic study of rural hospital nurses in the Inland Northwest, completed in 1987, from dialogue with key informants before then and up until today, and from my personal experiences within rural healthcare systems over the past 20 years.

In the past 10 or 15 years, I have made some presentations about portions of this work to nurse clinicians, nurse researchers, and nonnurse healthcare audiences. Inevitably, following such presentations, I was approached by one or two individuals who had been rural nurses who wanted to tell me that the presentation struck a chord. I understood their need, which stemmed from the human desire to be recognized and understood. It stems from the frequent, albeit unintended, distortion of truth about rural nursing communicated by those who do not fully understand what it means to walk a mile in a rural nurse’s duty shoes. I may not be able to change that, but I offer my perspective nonetheless.

CONCEPTUALIZING RURAL NURSING PRACTICE

Being Rural

There was a wonderful line in the 1984 science fiction film The Adventures of Buckaroo Banzai: Across the Eighth Dimension (Rausch, 1984). The line was delivered by the main character, Buckaroo, a multiskilled neurosurgeon, particle physicist, rock musician, and Zen warrior who, in the midst of chaos

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matter-of-factly declared, “No matter where you go, there you are.” If this sounds simple, I would caution that it is hardly simple. Buckaroo was talking about being in the moment, so imagine for a moment what it means to have “gone rural.” What of rural nursing identity? While the imagery may seem silly or surreal, the truth is real, authentic, important, credible, respectable, and as serious as any nursing practice anywhere. However, as indicated earlier, rural nursing practice is also distinctive from nursing anywhere else. Although I use the analogy of Buckaroo Banzai, hoping it will bring a smile, rural nurses will recognize the script of playing a cool and noble professional, simultaneously enacting multiple roles, and managing the continual transition from one part to another with the frankness of Buckaroo.

Being rural means being a long way from anywhere and pretty close to nowhere. Being rural means being independent or perhaps just being alone. Being a rural nurse means that when a nurse saves a life, everyone in town recognizes that she or he was there; and when a nurse loses a life, everyone in town recognizes that she or he was there. Being rural means turning inward for answers, because there may be nobody to turn to outward. Being rural means that when a nurse walks into the emergency department (ED), it may be her or his spouse or child who needs a nurse, and at that moment, being a nurse takes priority over being anyone else. Being a rural nurse means being able to deal with what she or he has got, where she or he is, and being able to live with the consequences.

**Knowing Rural**

Certainly, every reader has heard that a little knowledge can be a dangerous thing. The adage was probably modified from what Alexander Pope (1711, as cited in Evans, 1978) said in the 17th century: “A little learning is a dangerous thing.” I dispute it now and say that a little knowledge can be a lifesaving thing. The demarcation between danger and safety is the difference between having knowledge and using knowledge. From time to time, I have had conversations with academic colleagues about dangerous nurses. In these conversations, we have agreed that dangerous nurses are not those who know they do not know what they are doing—although there is certainly an element of danger in that scenario, which ultimately must be addressed. The greater danger, however, emerges with those nurses who think they do know, but actually do not know, what they are doing. Although I have no statistics on the prevalence of such nurses, it is my belief that they hide more easily in urban settings than they do in rural settings.

Knowing rural means knowing that what one knows may be all one has. Knowing rural means personally knowing everyone with whom one works and having knowledge about nearly everyone for whom one cares. As a rural nurse, knowing means sharing knowledge in an informal yet crucially important exchange with other professionals, where the addition of one mind can mean expanding the knowledge base by 100%. Although whom one knows can
be important in any setting, the distinction between rural and urban dynamics of whom one knows is that in the urban setting whom one knows is more likely to be related to competitive advantage, whereas in the rural setting whom one knows is more likely to be related to cooperative advantage. Knowing rural means that knowledge can mean the difference between perishing, surviving, and thriving, and therefore knowing is inextricably connected to being when one is rural.

THE NATURE AND SCOPE OF NURSING

For practicality, a framework for the study of the nature and scope of rural nursing practice was sought to identify and describe the distinctive characteristics of practice in rural settings. The American Nurses Association (ANA) Social Policy Statement (1980) provided the framework for a logical sequence of investigation into details of rural nursing practice. The policy statement includes an organized and systematic approach to studying nursing nature and scope.

- Nursing’s Nature. Within the policy statement, the nature of nursing is characterized as a relationship between the nursing profession and the society that is mutually beneficial, and nursing itself is deemed an essential outgrowth of the society that it serves. Nursing is described as existing in response to society’s needs. From that standpoint, my study of rural nursing was based on assumptions that rural nursing emerges from and is essential to rural society, and distinctions of rural nursing are due, in part, to distinctive interests and needs of rural society.

- Nursing’s Scope. The scope of nursing includes four definitive characteristics: intersections, dimensions, core, and boundary (ANA, 1980). These four characteristics became conceptual foundation blocks for my study of rural nursing.
  - Intersections. Nursing intersects with other professions involved in healthcare. These intersections are points at which nursing meets and interfaces with other professions and expands its practice into the domain of other professions as necessary.
  - Dimensions. Characteristics such as philosophy, ethics, roles, responsibilities, skills, and authority are examples of nursing dimensions. These are qualities that add depth to nursing practice. They are characteristics underscored and influenced by interpersonal relationships and intimacy as well as the intrapersonal quality of nursing.
  - Core. The concept of the core of nursing is complex and somewhat more difficult to discuss than are the other concepts. It is oversimplification to say that the needs of people are the core of nursing, although such is true. Nursing exists to deal with human response to health issues, and
human response can be equated to human need with respect to health. The patients’ needs and their responses are outgrowths of who they are as human beings. The nursing care we provide is an outgrowth of who we are as human beings. The core of nursing is the dynamic of nursing care juxtaposed with human response.

- **Boundaries.** Nursing’s boundaries change and expand in direct reflection of the intersections, dimensions, and core of practice. Boundaries are nebulous, unseen, intangible lines of demarcation between what is clearly within the nature and scope of nursing and what is questionably within nursing’s scope. Unlike physical boundaries, nursing’s boundaries are metaphysical, are relationally and contextually based, and sometimes have origins outside the control of nursing.

**METHODS**

In an effort to describe the nature and scope of rural nursing, it was determined that an ethnographic method, using participant observation and interviewing techniques, would yield the most pertinent data for analysis. Data were gathered throughout several stages of conceptualization concerning rural nursing phenomena. Field notations, printed news media, and taped interviews were employed. The study of rural hospital nurses included an exploratory phase in which eight rural nurses from northwest Montana were interviewed. These interviews were audiotaped, and from initial open-ended questions, a more refined interview guide was developed that contained both closed and open-ended questions. Twenty-six rural hospital nurses in one of four rural towns in eastern Washington, northern Idaho, or western Montana were interviewed. All interviews were audiotaped and then transcribed verbatim. The findings reported in this chapter are related to many aspects of rural nursing practice and are based on the responses of all 34 rural nurses, as well as several other key rural informants and my own observations. All samples were convenience, and all informants elected to be included in the studies.

**FINDINGS**

**Informant Demographics**

All of the informants were women ranging in age from 25 to 61 years with an average age of 40 years. The number of years actively employed as a RN was 3 to 35 years. The mean number of years spent working in rural hospitals was 8 years and, for most informants, was roughly half the total of their active nursing years. Most informants were originally diploma-prepared, seven
were baccalaureate graduates, and four were associate graduates. Two informants had achieved a master’s degree in nursing. Although informants were not asked about marital or parental status, nearly all said during the interview that they were married and were parents.

Most of the informants worked full time, and those who worked part time averaged 23 hr/wk. In addition, many were placed “on call” if they were not working. On-call status could be attributed to low census, high census, operating room call, cardiac care call, or emergency department call. Most informants reported 1 or 2 days of overtime per month. In almost every case, informants indicated a need to be flexible about their working schedules with regard to the events of the rural practice setting. Turnover rates were low at all facilities, and the most senior nurses had been on staff from 16 to 25 years.

**Hospital Demographics**

Information about the hospitals was obtained through interviews with nursing, fiscal, administrative, or other personnel, as well as from public records and the participant observation process. The hospital organizations were between 20 and 60 years in existence, the present structures were between 3 and 35 years old, and all had undergone some renovation over time. Ownership of the hospitals was stated as nonproprietary, public district, or community. Each hospital was governed by a board of directors of three to 10 individuals who held fiduciary and decision-making authorities and to whom the administration was accountable. Board membership was either self-perpetuating or community elected. One facility was accredited by what was then the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Administrative personnel said that there was little to be gained by small rural hospitals having JCAHO accreditation, especially in light of what the JCAHO charged for the process.

The hospitals had licensure ranging from 20 to 44 acute care beds, zero to three intensive or cardiac beds, five to seven newborn bassinets, and three to five swing beds for extended care. In every case, occupancy was at a fraction of licensure, and occupancy figures averaged to be about 20% to 40% for acute care beds. There was some variability in the use of the other services at each facility. Two had fairly active use of the cardiac or intensive care beds. Two had fairly active obstetrical departments. Three had active surgical departments. Emergency cases at these hospitals ranged from three to 13 per 24-hour day during the previous fiscal year. One relied on the constant occupancy of swing beds to maintain financial solvency. The number of physicians on medical staff ranged from three to 17. Typically, physicians who held admitting privilege at a given facility did not necessarily live within the community. Undoubtedly, the variety of medical practitioners on staff impacted the occupancy of each facility. Usually, nurses were expected to be able to float from medical–surgical areas to emergency, obstetrical, and intensive care areas, but not to the operating room, which seemed to be the one sacrosanct specialty area.
The Rural Communities

At the time of the study, I spent several weeks traveling to and about four separate communities in western Montana, northern Idaho, and eastern Washington to gather information regarding the nature and scope of rural nursing. Each of these towns fits the operational definition of being geographically isolated and of having less than 5,000 residents. Upon arrival in each community, time was taken to drive about, observe the local terrain, look for indicators of economy, walk around town to observe the pace and lifestyle, note the casual conversations taking place in public areas, and read each community’s local weekly newspaper.

There were many similarities and 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 towns were on a river in forested mountain terrain and were logging or lumber mill towns. The fourth town was on an expansive plain and was an agricultural community. Each town was inhabited mostly by White residents, and each was laid out in typical western fashion with one main street and several auxiliary streets at which the center of the business district was found. Each town boasted the typical hardware stores, grocery stores, restaurants, farm or logging machinery shops, tool shops, post office, drug store, beauty shops, ice-cream stands, feed stores, junk shops, small motels, bars, and churches. Each town had a well-kept appearance, although each had a few empty buildings or storefronts in the business district.

Residents in these communities were friendly and helpful. They recognized me as an outsider, and, although willing to answer my questions, were curious and wanted to know the purpose of my presence in their town. When I explained myself, the residents registered sincere interest and pleasure that their community had been targeted for this study. They acted like they felt privileged and eagerly conveyed their high regard for nurses in general and their nurses specifically. Never did these residents express animosity toward the community of nurses. Most of them had a story to tell about how a friend or relative’s life was saved at the local hospital.

Rural Hospital Nurses

The rural nurses I observed and interviewed were a dynamic group of women who could certainly be called “expert generalists.” They moved quickly, and for the most part easily, from one role to another as circumstances required. They explained that most rural nurses have a great deal of knowledge regarding a variety of nursing practice areas. When beginning work in a rural hospital, many nurses suffer reality shock due to the variety of demands placed on them. One seasoned nurse told me, “Although you might start out and you don’t have that wide knowledge, you better get it quickly.” A relative newcomer nurse..
expressed admiration about the knowledge level of her rural colleagues, calling them “impressive.” The nurses I interviewed routinely worked in three or four different specialty areas of nursing practice every week, and sometimes every day. When talking with one respondent about this phenomenon and how easy certain nurses made it look, she said, “The ones who are experienced in rural nursing seem to be very comfortable in switching back and forth between specialties.”

**Nursing Staff Tenure and Group Acceptance**

At all facilities, nurses were heard to use the terms “new” or “newcomer” and “old” or “old-timer” in reference to a given nurse’s tenure on the staff. There was no particular time limit identified when a nurse makes the transition from new to old, nor how one arrives at a level of acceptance. However, tenure of less than 2 years was apparently definitely considered “new,” and tenure of 3 to 5 years in combination with competence generally constituted acceptance. Tenure beyond 10 years was considered “seasoned,” and in special cases of achieving high proficiency or social acceptance, one of these nurses might be called an “old-timer,” but usually this term was reserved for someone who had been around for 20 or more years. What I discerned was some gray area depending on a nurse’s tenure, level of proficiency, and sociability related to group fit. It seemed that a nurse who was very skillful, flexible, and likeable might reach old-timer status sooner than a nurse who was lacking one of those characteristics.

Although I cannot pinpoint a “typical” rural nurse, certain characteristics were confirmed as traits of distinctive advantage for a rural nurse’s success. For example, good common sense, good judgment ability, the ability to set priorities, good physical assessment skills, and physical and emotional strengths were considered of survival significance to these nurses, due, in part, to the aloneness of their practices. They made comments such as, “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 for concurrence with decision making.” “At any time during your shift, your assignment may change drastically.” “You can make the difference between life or death—the judgment calls are yours.” All informants were adamant that the prevalent feeling of aloneness and serious responsibility were distinctive to the rural setting. None would concede that the feeling was anything like that experienced in an urban setting. These nurses expressed a very real and pervasive sense of responsibility that rural nurses bear for their patients. The nurses who do not have the ability consistently to carry the burden of such decisional responsibility are the ones who do not survive as rural nurses. Old-timers claimed they could often tell right away, or within a few weeks, if a newcomer was going to catch on or not. Old-timers based such predictions on their assessments of a newcomer’s characteristics as mentioned earlier, combined with evidence of adaptation to the new environment.
**Education and Professional Development**

The burden for self-responsibility of education is greater in the rural setting than in the urban setting, and most rural nurses accept this burden. There is a wide variety of sources from which rural nurses receive their continuing education, such as out-of-town workshops or conferences, in-service education, journals, textbooks, practice sessions, physicians, and other nurses. The greatest educational needs voiced were in cardiac, trauma, maternal/child, and complex medical nursing.

Informants indicated a thirst for knowledge in accredited professional continuing education. Several respondents reported attending more than 10 continuing education events in a year. Most attended between three and 10 events annually. These events were developed and held locally, developed elsewhere but held locally, or developed and held in urban settings. Although expenses were a factor, they were not the central factor in respondents’ attending continuing education events.

Nearly all informants also relied on journals for new information, read journals regularly, and reported the most popular journals to be *Nursing, American Journal of Nursing, RN, Journal of Nursing Administration*, and *Nursing Management*, in that order. Current journals were visible in each facility, and notations were seen hanging on bulletin boards in nursing report rooms or locker rooms with a suggestion from one nurse to others that everyone review a given recent journal article germane to a given current case.

Rural nurses, in fact, identify one another as their most important single source of information and education. This was often explained as information being imparted from a peer when it was needed most, so that learning occurred while doing, which tended to heighten the memory. Comments that supported these phenomena included, “We try to share everything we can with each other.” “New nurses sometimes come in with great new information or real current ideas. It helps a lot.” “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 a while, you develop camaraderie. We know what we can expect from each other.”

Out-of-town workshops were identified as the next most important source of continuing education to rural nurses. Informants qualified this by stressing that the topic or presentation needed to be relevant to the rural environment. One informant said, “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.”

**Interpersonal Relationships and Nursing Practice**

Rural nurses know everyone who works at the hospital, all of the physicians, and most of their patients. Rural nurses say that the interpersonal closeness of
knowing everyone with whom they work and for whom they care generally has a positive influence on their practice. The intensity of this interpersonal dynamic is unique to the rural setting. Although it is likely that nurses in any setting develop close relationships, rural nurses are in the distinctive situation of being personally acquainted with all of those around them, so that the depth of interaction is potentially greater, and the accountability for interpersonal exchange is a constant that is simply not present in other settings. An informant explained the bond she felt with coworkers by saying, “It’s nice to know the people you’re working with. You work more together, you try harder, and you work closer.” Another nurse shared that among many rewarding qualities of rural nursing, “The cooperation of the other nurses and the cohesiveness of the group is probably the biggest.”

An old-timer at one hospital said, “I don’t have to explain when I say something. They believe me, and they do it without wasting time.” It was easy to verify this through observation. Certain old-timers could communicate a virtual reassignment of responsibilities through the tone of their voices as they disappeared momentarily to deal with a risen crisis, such as the admission of trauma victims in the ED. On occasions, it was like watching a dance, the motions of which were so well understood, each dancer so valued and respected, that without missing a step, workers would change places based on available expertise and would back each other up without visible cues. Even physicians were seen deferring to old-timer nurses at such times. Yet, the choreography depended heavily on the direction of the one in charge; and on other occasions, with an inexperienced newcomer directing, the dance was frantic and the flow chaotic.

**Practicing Medicine**

Rural nurses are understandably reluctant to admit that they practice medicine, but they know their boundaries are sometimes stretched by circumstance. “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,” said one nurse to me. When patient crises occur, calling the physician is considered important, but it simply does not rank at the top of the list. The nurses I interviewed and watched used a standard A-B-C (airway, breathing, circulation) order of setting priorities to respond to patient needs. Thus, they often began written or unwritten medical protocols while the aide would be sent to summon the physician. Physician response times varied from 5 to 30 minutes at the rural hospitals, resulting in nurses being responsible for considerable decision making during the time lapse. At each site, I heard or saw variations on the themes of nurses stabilizing cardiac or trauma victims and nurses managing precipitous births without the benefit of physicians present. In interviews, nurses were adamant that they had a responsibility to the patients to do whatever was required during an emergency, and although it sometimes felt uncomfortable, inaction would have constituted neglect.
The words of one nurse summarize the collective opinion, “We do it because we have to, because it would be wrong if we didn’t.”

There were also circumstances of newcomer physicians relying on seasoned nurses for insight into or even direction regarding a given patient case. Per physician request, the nurse would literally advise what medications and treatments to order in cases where the doctor did not have the familiarity with a patient’s history that the nurse did. This was especially true in after-hours situations of physicians covering for another’s patients. My assessment of these circumstances is that each party acted within unseen lines of mutual trust and understanding with the dynamic of trust specific to a given relationship.

Another observation I made at these facilities, which struck me then and which I have informally reconfirmed on multiple occasions since, is that rural physicians seem more likely to read and respond to nurses’ notes about patients than do urban physicians. Doubtless there is great individual variability, yet it is tempting to hypothesize that rural professionals have a better grasp than do their urban counterparts of pertinent information that is necessary to communicate to the healthcare team. Certainly, further study would be required to confirm the probability.

**Rural Expertise: Aces and Pinch Hitters**

Rural nurses generally believe that no one can be an expert in every area of rural nursing practice. However, a few nurses 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 study sites, many informants identified a colleague or two who fit this category. Interestingly, those who were identified by others as “aces” did not identify themselves as such. Each nurse was very modest about her own capability, but the pride toward aces among the staff was obvious. I was aware that talking to or watching these aces in action was as much an honor for the locals as it was for me as an investigating outsider.

All rural nurses interviewed agreed that they must be competent in more than one clinical area to be considered an acceptable staff member. The top four clinical areas deemed to be most important for competency were emergency nursing, obstetrical nursing, intensive or coronary nursing, and medical-surgical nursing. A supervisory nurse told me, “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.” But there was an expectation held by all informants that they be clinically strong, if not expert, in at least two of the above-named areas and be able to float to any other department and still function well in a pinch.

With regard to functioning in a pinch, in the early 1980s two rural Montana nurse executives who are admitted baseball fans coined the Pinch Hitter Theory of Rural Nursing. One of those persons, Jean Shreffler, now an academic, is author of other chapters in this book. The second person, Maura Fields, was
then and remains today the nurse executive at a rural hospital in Montana and is arguably one of the most innovative and masterful nurse leaders I have ever had the good fortune to know. Her rendition of the theory went like this:

In rural nursing, you have to be like a pinch hitter. You may not perform a task or procedure or work on a very specialized case but once a year. But when you go to do it, you have to do it like you do it every day. In baseball, a batting average of 300 is good. But the pinch hitter, well, you want them to be better than that, really, you want them to bat a thousand. That’s what it’s like for a rural nurse, when they go to work, you want them to bat a thousand. (Maura Fields, 1983, personal conversation)

For those readers who are doubting that there can be that many instances in which the aforementioned theory becomes important, rest assured that it happens all the time. Industrial and recreational traumas are frequent in these communities. Rural citizens experience their share of severe burns, drug overdoses, cardiac arrests, head injuries, freak accidents, and critical illness. Although transfer to larger medical centers is sometimes preferred, stabilization is necessary first, and transfer is sometimes not possible. One hospital in this study is 90 road miles from the nearest medical center of any size and 150 road miles from a trauma center. Rotary blade or fixed wing aircraft are often used to transport cases that require more care than can be delivered locally, but northwest mountain weather conditions can be a significant factor in keeping aircraft grounded.

Although rural nurses do not expect an easy routine, frustration is common surrounding the conflict of trying to achieve expertise in such a complex practice. Boredom is rare as they face the constant variety of demands. One informant related the example of the prior day’s evening shift. The informant was one of two RNs on duty at the time, assisted by one aide. The scenario she described began after change of shift report and went like this:

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.

Although two nurses and an aide would have no difficulty caring for seven stable medical–surgical patients, the admission of the depressed patient was a wrench in the works. Mental health diagnoses are among those for which rural nurses feel least appropriately prepared, and they lack confidence in rural physicians’ ability to treat mental health patients appropriately, as well. The depressed patient required suicide precautions for a period of time, which meant that the aide was assigned to remain with the patient at all times. The pediatric patient in the ED required careful documentation, delicate interaction,
and a social services consultation. The obstetrical patient admission required nurse assessment and individual care until it was determined that the patient was in early labor. One nurse moved back and forth between the ED and the general care unit; the other moved back and forth between the labor room, the depressed patient, and the general care unit.

Here is an account from another informant about another evening shift where three RNs were on duty but without assistance from an aide:

Not long ago we had an OB with a bad baby, small for gestational age; and at the same time, we got two ambulances 5 minutes apart, and they were both cardinals 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 you or what, but, for the most part, things seem to come out okay in the end.

In this case, one nurse was already assigned to the intensive care unit, and one was required to remain with the obstetrical patient to do monitoring and other procedures. When the first ambulance arrived, the third nurse was dispatched to the ED. Fortunately, some ambulance crew members were emergency medical technicians and could help with continued patient monitoring and calling in the physician, laboratory, and respiratory personnel. Also, fortunately, the physician arrived within 10 minutes and was designated to care for both patients. The final good fortune is that nothing went wrong on the general care unit while hell was breaking loose elsewhere.

**Knowing Patients Personally**

Most rural nurses subscribe to the belief that when they know patients personally, they can give better care. The possibility of experiencing fear when caring for family members or best friends notwithstanding, the rewards are considered rich. A gradual loss of anonymity occurs to rural nurses as they become immersed in and assimilated into rural society, making anonymity nonexistent for old-timers. “I can be more supportive emotionally when I know them,” one said, and another elaborated, “Let’s say in the ER, with chronic lungers, you know them, and they feel secure because they know we remember them.” I saw instances of rural nurses informally calling to check on patients after discharge. As far as I know, patients were always glad to have these calls. The loss of anonymity is generally considered reassuring for those professionals who are comfortable with rural life, but it can be constricting as well. It should not be assumed, however, that negative aspects of anonymity loss are necessarily related to poor patient outcomes. On the contrary, one informant told me,

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. It’s a real emotional drain, but you’re ahead of the game because the trust is there.

The argument could be made that patients perceive their care to be better based on the close personal contact that is often made in the rural setting. A nurse who believes that her relationship to a patient made a difference in the patient’s outcome said,

I recovered my little neighbor girl after her surgery. 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.

It is a cultural expectation of many rural people to be taken care of by someone they know. This differs from the expectation in urban settings. For the most part, informants agreed that rural people do expect to have their medical needs met, even though they live far from a major medical center. However, one informant said that rural patients often wait until they are “half dead” before they seek intervention and are “grateful for what they get.” Another nurse said, “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.”

Nearly all rural nurses could confirm that sometimes they had patients from out of town who had previously experienced urban hospital admissions. These patients, whether vacationing in the rural setting or passing through the rural area, ended up in rural hospitals for reasons not important to this story. Their comments about the care they received in rural hospitals are important. The nurses were told by these patients that the care was of better quality, that they felt more cared for, that the rural nurses took more time to listen, that care was accomplished more quickly and smoothly, and that they felt more like people and less like numbers in the rural hospital than they did in any urban hospital. The outsider patients often expressed surprise at the high level of competence they encountered in the rural setting.

**DISCUSSION**

*Rural Nursing’s Distinctive Nature and Scope*

Analyses of the reports of rural nurses show that the nature and scope of rural nursing are clearly distinctive. Using a framework to focus the discussion, the distinctions can apparently be categorized as those pertaining to rural nursing’s nature, as well as the four components of rural nursing’s scope, those being intersections, dimensions, core, and boundary.
The Nature of Rural Nursing

Most rural nurses have difficulty in defining their practice, although they can describe it. Their descriptions are a variety of rich, thoughtful, colorful, and articulate responses. Rural nursing is generalist nursing, not to be mistaken for mundane, and includes an intensity of purpose that makes it distinctive. Rural nurses may feel misunderstood and poorly recognized by the larger nursing community, but they are nonetheless a proud lot.

The Scope of Rural Nursing

The intersections of rural nursing are distinctively marked and fluid. Rural nurses consistently and necessarily practice well within the realm of other healthcare disciplines, the most notable being respiratory therapy, pharmacy, and medicine. The intersection between nursing and medicine has the most extensive implications. It is a gray area that hinges on circumstances and relationships, and the most complex intersections occur during emergent situations, “until the doctor gets there.” Some rural nurses embrace this intersection more willingly than others, but none do it casually. Reflective concern is apparent in comments related to this intersection. One informant said, “It means putting your neck out there on the line, but you have to make the judgment and go on.” Another told me, “It sometimes feels uncomfortable, but it’s part of my responsibility to the patient.”

It is evident that the practice of rural nursing is dimensionally distinctive. Rural nurses embrace an ethic of openness and honesty that is pervasive. The dimension of interpersonal knowing is viewed as a positive feature of rural practice, and it exists between nurses and patients as well as among coworkers. A nurse administrator shared with me that, “in terms of practice outcomes, your accountability is right in front of your face.” Rural nurses talked about being able to accomplish goals more quickly with their patients and said that guidance, teaching, and counseling behaviors are automatic to their practice in the rural environment. Communication patterns in the rural setting are more direct and suffer less obfuscation than do those in urban settings. There are fewer barriers to go through when imparting messages from one to another. As a result, there are probably fewer errors of omission and commission related to practice in the rural setting than there are in the urban setting. Confronting and managing conflict is more common in the rural setting, avoidance being an unacceptable dynamic for group cohesiveness that stems from mutual concern and regard for one another. Independent decision making is given in rural practice, but rural nurses are aware of their limitations. One said, “You have to know when you don’t know, and you have to know where to go to find out.” Rural nurses are mindful, if not fully informed, about the legal dimensions of their practice. However, with respect to questions of patient safety and survival, rural nurses sometimes decide that their ethical obligation to do what is right for their patients carries more
weight than their legal responsibility to uphold the law. These cases generally become lessons of learning, are scrutinized and discussed by the group, and are entered into memory for future reference.

Human responses, which nurses diagnose and treat, are the core of nursing. Some sources have suggested, and informants in this study agreed, that rural dwellers are known to delay health seeking and tend to define health as the ability to get out of bed and go to work. Thinking in terms of nursing diagnosis, one might call this behavior “dysfunctional perceptual orientation to health,” which requires distinctive intervention at nursing’s core. Rural nurses are faced with determining an appropriate line of demarcation between a rural dweller’s rugged individualism and stubborn disregard for health. Inextricable from rural nursing’s core are the relational issues of what it means to be rural. As noted earlier in this chapter, from an ontological standpoint, rural nursing is distinctive at its very core.

Boundary being dependent on the intersections, dimensions, and core of nursing, there can be no question as to rural nursing’s distinctive boundary. Rural nursing is constantly changing in response to complex intersections and dimensional intricacies distinctive to rural society. The boundary is therefore neither smooth nor even static. When nurses come to a rural setting from an urban setting, they are very aware that the boundary of their practice changes. The transitional period for these nurses is not always easy, and boundary expansion can be accompanied by ambivalence, anxiety, and frustration. Newcomers must become adjusted to the rural culture to function effectively, and not all survive. Rural experts can play a key role in the success of newcomer transition, and those aces who invest themselves in the orientation and mentoring of newcomers know the importance of the payoff.

**Defining Rural Nursing**

Rural nursing is a special variety of nursing in which the nurse must have a wide range of advanced knowledge and ability, in combination with commitment, to practice proficiently in multiple clinical areas simultaneously along the career trajectory. The practice requires constant and continual personal and professional adaptation in developing identity. A rural nurse has both an ontological sense of being and an epistemological sense of knowing that connect the nurse with the surrounding community, and through which the rural nurse creates a reality of rural professional nursing practice. In no other setting is a nurse’s practice so thoroughly and integrally a constant factor in a nurse’s life. In a society where separating one’s private life from one’s professional life is considered obligatory, rural nurses are singularly challenged, stripped of their own anonymity while simultaneously charged with protecting their patients’ privacy.
CLOSING THOUGHT

The newcomer practices nursing in a rural setting, unlike the old-timer who practices rural nursing. Somewhere between these spectral extremes lies the transitional period of events and conditions through which each nurse passes at her or his own pace. It is within this temporal zone that nurses experience rural reality and move toward becoming professionals who understand that having gone rural they are not less than they were, but rather they are more than they expected to be. Some may be conscious of the transition and others may not, but in the end, a few will say, “I am a rural nurse.”

REFERENCES