

It Takes a Village:
Rural Nursing Preceptorships as Cultural Mediation

by

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Abstract

In-depth interviews with five nursing students and five rural preceptors in the southern interior region of British Columbia were used to develop an ethnographically informed, multi-dimensional account of the nature and educational value of rural hospital-based preceptorships. Rather than a straightforward teacher-student or mentor-novice relationship, the reciprocity between preceptor and student was situated within a process of cultural mediation in which relationships with the healthcare team, community members, and place itself all played important roles. Specific issues or dimensions highlighted in this study included: the role of the rural preceptor as cultural mediator; the significance of the healthcare team in rural preceptorships; the unique importance of rural relational continuity for student learning and healthcare practices; the challenges of living the professional ethic of confidentiality in a rural context; and the interplay between independence and dependence in rural nursing practice, given the distribution of resources within and beyond the rural context. The preceptorship experience provided students with diverse learning opportunities, including learning to expect and prepare for the unexpected, that facilitated the development of technical skills and clinical decision-making skills. Recommendations are outlined for the redesign of rural practice-education in order to maximize educational opportunities and benefits and to develop a scholarship of place-based engagement in nursing education.

Keywords: Place; Culture; Rural; Preceptorship; Dissonance; Mediation; Continuity; Reciprocity; Gemeinschaft

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1. Landscape of Inquiry

1.1. Setting the Context

A growing and projected shortage of nurses in Canada has prompted national emphasis on the preparation, recruitment, and retention of nursing professionals. At the same time, concerns have been raised over the disparate effects of such shortages in a rural context. Rural healthcare in Canada poses distinctive challenges and rewards for practitioners, yet relatively little is known about the process of becoming a rural nurse, or of the factors that may support or hinder this form of professional education.

Preceptorships are a frequently used nursing practice-education strategy, wherein students are paired with practicing nurses to promote the development of student competence and confidence in particular contexts. Faced with increased demand for practice spaces, nurse educators are asking nursing students to take up rural undergraduate preceptorship experiences to relieve some of the demand on traditional clinical spaces. In the absence of a deeper educational understanding of such preceptorships, however, such decisions are primarily guided by instrumental rather than educational reasoning.

This ethnographically informed study explores the nature and educational value of the rural hospital-based preceptorship experience. By identifying some of the key educational and cultural dimensions of the process, it seeks to enhance the planning and implementation of undergraduate practice-education in rural contexts, both in British Columbia and elsewhere. It is situated within the substantial scholarship about preceptorships in general, the limited

scholarship on rural preceptorships in hospital-based acute care in particular, and the growing research and educational literature on rural nursing in Canada.

Specific issues or dimensions of the rural preceptorship experience identified by this study include: the role of the rural preceptor as cultural mediator; the significance of the healthcare team in rural preceptorships; the unique importance of rural relational continuity for student learning and healthcare practices; the challenges of living the professional ethic of confidentiality in a rural context; and the interplay between independence and dependence in rural nursing practice, given the distribution of resources within and beyond the rural context. In addition, the study documents how guided rural practice provides students with diverse learning opportunities, including learning to expect and prepare for the unexpected, that facilitate the development of technical skills and clinical decision-making skills.

The central recommendation from this study is that rural preceptorships be conceptualized as a process that extends well beyond the preceptor-preceptee relationship. In this expanded conception of practice-education, relationships are central: relationships with the healthcare team; relationships with community members shaped, in part, by time, geography, and people; and relationships across healthcare agencies and between the university and the rural practice setting. Through such relationships, students learn to navigate between the culture of rural practice, on the one hand, and academic traditions and expectations and professional standards based outside the rural context, on the other.

Chapter 1 lays the groundwork for understanding the history and current state of undergraduate rural hospital-based preceptorships and the importance of this study. Introduced is the context for the study, including my professional background, the general field of preceptorship research, Canadian rural nursing research, policy context, and practice-education initiatives. In addition, the questions and methods that guided this study are introduced. The

practice-education model of preceptorships is described and contrasted to apprenticeships and mentorships. The various ways in which urban preceptorship experiences have been studied are reviewed, primarily to illustrate the extensiveness of the urban-based preceptorship literature.

Chapter 2 outlines the theoretical perspectives that inform the study, as well as the research literature more directly concerned with rural nursing preceptorships. The main concepts of culture, place, relationships and social learning are highlighted, and the intellectual tradition of ethnography informing my research approach is introduced.

Chapter 3 provides a description of the research strategy, including the sites for the research, the recruitment of participants, the instruments and procedures used to gather data, and the data analysis method.

Chapter 4 consists of an interpretative analysis of the interview data. Participants' descriptions of the qualities and processes that shape rural preceptored practice are analyzed for themes that connect to the theoretical perspectives informing the study. Numerous extracts from the data are used to illustrate and contextualize these themes.

Chapter 5 compares the results of this study with rural related research and provincial rural education initiatives, and makes recommendations concerning future research, policy, and educational practice.

1.1.1. Personal Context

Since 1986, I have had several opportunities to be the faculty-of-record during preceptored practicum experiences for students at or near the completion of a nurse preparation program. I have participated in recruiting nurses to be preceptors; linked preceptors to students (preceptees); oriented preceptors and preceptees; acted as a liaison between healthcare agencies, preceptors and preceptees; coached preceptors and preceptees; and interviewed preceptors

about preceptee practice in order to establish the preceptee's readiness for graduation and entry-level nursing practice.

I have had the opportunity to hear stories of rural and urban nurses (preceptors) as they spoke about the challenges and rewards of preceptoring undergraduate nursing students (preceptees). I have also listened to many stories from students about being a novice in a variety of settings. As students came to be aware of these differences and commonalities through their experiences and by observing nurses' practice in various settings they expressed these perceptions in journal format and in conversation of which I was a reader, listener, and responder. Over the years, it became increasingly apparent to me that, while there were some common assumptions, beliefs, and values about nursing generally, there were also somewhat different qualities to nursing practice in different settings. The differences and similarities in the perspectives of nurses and students, and between urban and rural settings, were interesting and complex. However, it was my observation that stories of rural nursing become marginalized or invisible in many nursing education settings and in the research literature. From my perspective this hiddenness was mainly due to the greater number of urban nurse voices and by an urban shaped view of nursing. Through an ethnographically informed exploration of the rural hospital-based preceptorship experience, I intended to provide a forum for the stories of students and nurses about the meaning they make of this form of practice-education, and to argue for greater emphasis on rural practice-education from a program development, policy and research perspective.

In my educational leadership roles, the 'value and challenges' of the preceptorship experience in a rural setting was occasionally the topic of discussion by nurse educators and practice leaders. Listening and participating in deliberations about the design of nursing education programs, I encountered instrumental arguments for and against the use of rural

settings. I recall hearing from urban healthcare nurse leaders that more practice experience in an urban context better prepares nurses for practice in rural settings. It was also suggested that rural settings were unsuitable for beginners or novices to initiate their career or start nursing practice. Little consideration was given to the particular educational value of rural experience.

As a nurse educator, I also recall stories from nurses in rural settings about how they enjoyed having students in practice because they brought with them new ideas or made them rethink their practice. Preceptees often commented about the receptiveness of rural preceptors to students and compared this favourably with previous experiences. Still, the possible lessons from such practice stories were generally neglected. In part, this was due to the absence of a forum for faculty interested in rural practice, in an institutional context and time that seemed increasingly to put emphasis on getting placements rather than on what students were getting from placements. Many of the rural preceptored practicum decisions I witnessed or participated in were driven by relatively uninformed faculty opinion, and by the need for more placements to accommodate the growing number of students. Discussion about the quality of rural preceptored practice-education took a back seat to the concern that students be placed within available, readily accessible settings. I also participated in practicum placement decisions denying students rural practice experiences because the student was an insufficiently strong and independent learner, a quality thought by many colleagues to be essential to a successful rural practicum.

Because of these experiences, along with being a faculty-of-record for rural preceptorships, I became deeply committed to exploring the meaning of rural preceptored practice experiences for preceptors and preceptees, with the hope of enhancing decision-making in this area. From my perspective and experience, in a school of nursing that is generally more urban-centric yet surprisingly rich with rural learning opportunities, few students considered

rural learning locations as career relevant, while those who might be interested in a rural experience were hard pressed to cover the possible additional expense associated with a rural placement, or were unwilling to absorb the other personal costs of a placement outside their community of origin. Greater awareness of the educational value of rural placements may lead to improvements in policy and practice that help to lower these barriers.

1.1.2. Professional Education Context

Nursing education has a societal obligation to prepare nurses to assist all people to meet their highest possible level of health. At the Alma-Ata Conference in 1978, the World Health Organization (WHO; 1978) declared that:

health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and [that] the attainment of the highest possible level of health is a most important world-wide social goal. (p. 1)

Nurse educators assume responsibility to prepare nurses

with the competencies necessary to provide safe, competent and ethical nursing care in a variety of settings with a wide range of clients⁴ through a curriculum that responds to the current and evolving needs of the health care system. [⁴patients, individuals, families, groups, populations, communities] (Canadian Association of Schools of Nursing [CASN] & Canadian Nurses Association, 2004, p. 1)

Nursing education offers “the foundation for critical and creative thinking including professional reflection, self-evaluation, moral/ethical decision-making and clinical judgment” (CASN, 2004, p. 1).

The Collaboration for Academic Education in Nursing (CAEN) is a consortium of nine of the 19 post-secondary institutions offering nursing education in British Columbia (BC). The CAEN Consortium offers a common curriculum among the partner institutions. I work as a

nurse educator in a BC based university nursing program that is a member of the CAEN consortium. The CAEN philosophy of nursing signals a professional intent and process:

[Nursing is an] art and a science . . . a practice profession centrally concerned with health and healing. Nurses work with people (individuals, families, groups, communities, populations)—ill and well—in diverse settings. . . . Nursing is a relational practice that incorporates empirical, practical, ethical and political knowledge, including unique nursing knowledge as well as knowledge integrated from other disciplines. In collaboration with clients, nurses use knowledge in making decisions and implementing interventions that support the health and healing of clients. Nurses assume responsibility for their decisions, their professional growth, and for maintaining professional standards and ethics. (CAEN, 2005, pp. 1-3)

The CASN (2004) position statement echoes the ideals that undergird nursing education and advances the notion of regional responsibility.

Although baccalaureate nursing programs provide general nursing education, they may also respond to particular regional health needs. This approach permits programs to assess and meet the nursing needs of society in general, while respecting and responding to particular demographic, socio-economic, cultural and geographic characteristics of the community in which the program is located. (CASN, 2004, p. 1)

It follows that nurse educators' responsibility includes preparing nurses to practice in rural settings with rural residents and their unique health issues, particularly when programs are situated near rural areas. Experiential learning through practice placement in rural settings affords students an opportunity to learn to care for the health of rural residents; to promote the highest possible health for rural residents; and for nursing education to live up to its societal obligations.

Today, in contradiction to these professional objectives, a discourse of clinical placement availability or access and instrumental or technical rationality tends to dominate nursing education, particularly within urban situated areas and an urban oriented academy. Broader philosophical and social perspectives held by nurses become "overshadowed and undermined by

more dominant views which define what nurses are and what nurses are for, a situation which places nurses in the uncomfortable position of trying to render their perspectives believable or credible” (Ceci & McIntyre, 2001, p. 126). From my perspective, this discourse promotes global, technological, generalizable, object-directed, value-free knowledge, while disregarding local, personal, contextual, human-directed, value-embedded knowledge. It is a discourse guided by urban perspectives and issues, as is evident from the volume of nursing research that samples urban nurses, the absence of rural-relevant nursing policies in education and practice, and the predominantly urban location of nursing schools, clinical placements, and preceptorships. In addition, in an effort to reduce the impact of the current and anticipated nursing shortage, many institutions are exploring ways to prepare nurses faster and with fewer financial resources in a context of healthcare reform and restructuring (MacFarlane et al., 2007). Such an emphasis on efficiency tends to favour standardized programming that may be unsuitable for rural practice-education.

The current tendency to describe rural nursing as a specialized practice contributes to a perception that rural practice is less suited for a novice nurse generalist. Many educational institutions, for economic, geographic, and sometimes pedagogical reasons, offer most undergraduate experience in urban centres and only a few students engage in practice experience in rural settings. This can result in rural healthcare facilities hiring nurses without rural practice experience, and in urban nurses having little understanding of the particular challenges and conditions of rural nursing. Nursing faculty who articulate and defend the core values of nursing education must therefore reassert a value for rural practice and seek to influence policy in “ways that will increase access to care for underserved populations” (Edwards, 2002).

1.1.3. Rural Context

In a pioneering pan-Canadian report from the Canadian Institute for Health Information, the authors report that “generally, rural residents of Canada are more likely to be in poorer socio-economic conditions, to have lower educational attainment, to exhibit less healthy behaviours and to have higher overall mortality rates than urban residents” (DesMeules & Pong, 2006, p. v). In addition, as “is the case in many small towns, **a graying population relies less on resource-dependence and becomes increasingly oriented towards personal services, especially health care**” (Nolin, McCallum, & Zehtab-Martin, 2009, p. 30). These shifting demographics of the rural population coincide with a significant drop in access to rural healthcare providers. Between 1991 and 2006 rural in-migration was 26,816 persons across Canada (Pitblado, Jacobs, Papkov, & Léger, 2010). Canadian rural physicians and nurses aides out-migrated over the same 15-year span, with physicians’ rural out-migration at approximately 9%. Registered nurses (RNs) were identified as one of the healthcare providers that saw a net rural in-migration over the same period at a little over 3% (Pitblado et al., 2010).

The current trend, then, is towards greater reliance on RNs for the delivery of rural healthcare. Rural, remote and northern areas are experiencing the Canadian nursing shortage more acutely, since recruiting, retaining and educating nurses is more challenging in these areas (Med-Emerg Inc, 2006). In the Interior Health Authority (IHA) of BC, for example, “projections indicate that IH will increasingly face health human resource shortages driven by growing demand, tightening of supply, aging of the workforce, and a concentration of the workforce . . . in urban centres. Human resource shortages may be felt most markedly in rural communities” (IHA, 2009, p. 8).

These trends pose significant challenges for healthcare education. Maintaining an adequate supply of RNs who are willing to practice in a rural context becomes an urgent and

ongoing concern. The need is particularly acute in small communities where the absence, through retirement, resignation or migration, of one rural nurse may constitute a substantial loss of healthcare resources and potentially limit access to healthcare for rural citizens and practice-education opportunities. Yet there is no consensus on the best way to ensure that adequate replacements can be found. “Clinical education is a critical component in nursing education and yet it is difficult to identify ‘best practices’ that will prepare nurses to work in all sectors in both rural and urban settings” (Med-Emerg Inc., 2005, p. 30). Nor is there adequate leadership on the status of rural nursing education in the context of policies that support rural health and education.

In Canada, much attention is given to the recruitment, retention and practice issues associated with physicians in rural and remote areas (Kulig et al., 2003) and less to the practice of rural nurses and the education of nurses for rural practice. Little Canadian literature exists concerning undergraduate nursing education or rural nursing practice, and policy makers gave little attention to these important rural health issues (MacLeod, Kulig, Stewart, Pitblado, & Knock, 2004). Playford, Larson, and Wheatland’s (2006) Australian based longitudinal survey of 429 allied health professionals about rural student placement and future rural employment suggests there is value in a rural placement experience for professional development. These authors indicate that “more qualitative research to understand what constitutes an excellent experience would be valuable” (p. 18). It is this lack of research to guide or help evaluate decisions concerning nursing student experience in rural settings that provides the immediate context for the present study.

1.1.4. Focus of Inquiry

Informed by the foregoing considerations, the guiding question for this inquiry was the following: What is the nature and educational value of the hospital-based rural preceptorship experience for nurses and students?

Several focusing questions emanated from this guiding question:

1. Is there a culture of rural nursing practice and how is this culture expressed in rural nursing preceptorships?
2. How do participants experience the particular qualities of a rural context and how, if at all, do these qualities shape the rural preceptorship experience?
3. What are the key relational aspects of the rural undergraduate nursing experience?
4. What do participants consider to be the educational value of a rural preceptorship?

The approach taken was to examine the experiences of five rural nurse preceptors and five rural nursing preceptees through semi-structured ethnographically informed interviews. An interpretation of the meaning of the individual accounts and perspectives of study participants was set within personal, political, historical and scholarly contexts. By providing a clearer picture of the rural preceptorship experience, it was hoped that the study would inform the perspectives and practices of nurse educators, administrators and researchers regarding undergraduate rural nursing education.

1.2. The Preceptorship Model

Collaboration between educational institutions and healthcare agencies and providers in the form of a preceptorship model is a long-standing means of engaging students in nursing practice (Kaviani & Stillwell, 2000). Preceptorship experiences are unlike the apprenticeship models commonly used in nurse preparation programs up to the 1970s, which tied nurse 'training' to the service needs of healthcare institutions (Rawmsley, 1999). Nor is the

preceptorship model exclusively a nursing concept, being used by other health professionals such as medicine, dentistry, and pharmacology (Backenstose, 1983). The use of preceptors (clinical nurses employed by a health agency), as one form of practice-education, has gained popularity since the 1970s and is currently commonly used in nursing education programs (Budgen & Gamroth, 2008).

The preceptorship generally marks a transition from student nursing practice, guided by an educational institution such as a university, to professional practice under the mandate of health institutions and professional regulating bodies. Preceptorships involve RNs facilitating this transitional learning experience for students by guiding them through the responsibilities of a beginning nurse. There are several preceptorship models, but most are non-remunerated, time-limited practice experiences near the end of the undergraduate program. The responsibility for student development rests substantially with the preceptor and student with varying degrees of university educator involvement.

The Council of University Teaching Hospitals (COUTH, 2001) defined preceptorship experiences as:

an instructional or supervisory role whereby a health sciences professional (the preceptor) is paired for a specific time period with one of the following categories of preceptees: (1) a student at a specific points of their education program, to help him/her learn the roles and responsibilities in a particular are of practice, (2) a new graduate, to help him/her adjust to and develop roles as beginning practitioners, and (3) a new staff who has transferred to a different or more specialized area of practice. (pp. 1-2)

Unlike preceptorships, the term mentorship is normally reserved for relationships between professional nurses wherein nurses agree to support the development of other nurses over an extended period, as opposed to the intense one-to-one short-term relationship generally associated with preceptorships. Preceptorships differ in character from mentorships in several ways: context, time, relationship reporting, expected outcomes and commitment (Mills, Francis,

& Bonner, 2005). Despite these differences, however, there may be some value in studying mentorships as a related rural nursing professional development model (McCoy, 2009), given the limited research in rural nursing practice-education and the professional isolation some rural nurses experience. It seems plausible that novice nurses beginning their practice in a rural context and senior nursing students experiencing rural nursing practice might encounter similar issues.

1.2.1. Introduction to Preceptorship Research

There is a significant research literature on nursing preceptorships which is dominated by the use of convenient samples from urban health centers. Some of the main themes in research prior to the year 2000 are reviewed below, along with references to a thematic integrative literature review by Billay and Myrick (2008). Since the year 2000 a research focus on rural practice-education has been growing; that literature is reviewed in Chapter 2 under the thematic headings of intention/motivation, learning outcomes, culture, place and relationships, which form the primary domains of inquiry of this study.

So what does the urban preceptorship literature tell us? Preceptors' perceptions of rewards/advantages, supports, challenges and motivation have been explored (Dibert & Goldenberg, 1995; Hill, Wolf, Bosetti, & Saddam, 1999; Usher, Nolan, Reser, Owens, & Tollefson, 1999) and general characteristics of preceptors described (Yonge, Krahn, Trojan, & Reid, 1997). Nurses' commitment to the role of preceptoring increased with the perception of perceived rewards, which included being able to "assist preceptees to integrate into the nursing unit, to teach, to improve their teaching skills, share knowledge, and gain personal satisfaction from preceptoring" (Dibert & Goldenberg, 1995, p. 1149). Yonge et al. (1997) also noted that preceptorship experiences encouraged nurses to examine their knowledge about nursing practice

and cited this as an advantage of preceptoring. Similarly, Usher et al. (1999) found a positive correlation between preceptor commitment and perception of personal and professional benefits, including assisting staff to integrate into the unit, sharing knowledge, developing teaching skills, keeping own knowledge base current and contributing to the profession.

Preceptors had a more positive view of preceptoring when the educational unit and coworkers valued their involvement, although greater educational and administrative support was perceived as vital for preceptor well-being. Hill et al. (1999) reported preceptor appreciation for contributing to student development and preceptor frustration when preceptoring students with low motivation and professionalism. Yonge et al. (1997) also spoke to preceptor frustration when preceptees had poorly developed nursing skills. Preceptoring offered nurses an opportunity to increase their self-reflection; sometimes considered a burden of preceptoring, this was also seen by preceptors as positive given the new insights they developed into their professional identity (Öhrling & Hallberg, 2000). These authors noted that preceptors felt positive about facilitating a student to learn, and at the same time obliged to prepare them for the demands of professional practice.

Oermann (1996), after a review of nursing programs, noted two significant preceptor responsibilities: selecting appropriate clients or clinical assignments, and teaching. Shared responsibilities between preceptors and faculty included assessing student learning needs and evaluating student performance in the clinical context. Using factor analysis to analyze a survey of nurses and nursing students, Byrd, Hood, and Youtsey (1997) concluded that knowledge of the preceptoring process, ability to give and receive feedback, clinical competence and compatibility promote positive learning partnerships. They suggested that preceptors and preceptees approach the preceptorship with various perspectives, and this may cause some friction as a result of different values, unclear expectations or unique communication styles.

Preceptors identified clinical competence of the student as extremely important in the development of a successful partnership, whereas students identified compatibility as a key aspect of preceptor-preceptee relationships. Communication skills were ranked equally important to the preceptorship relationship by both students and preceptors. However, preceptors emphasized giving and receiving feedback, while students saw this as less important. Both students and preceptors ranked perspectives on teaching and learning as an important factor in the relationship (Byrd et al., 1997).

Qualities of nurse preceptors that promoted critical thinking in novice nurses were the focus of a study by Myrick and Yonge (2001). These authors concluded:

when preceptors genuinely value, support, and work with students in the practice setting, and when staff accept them as part of the team, together they set the stage for a climate that is conducive to learning, a climate which promotes critical thinking by making students feel safe enough to question, to challenge and be challenged, and to problem-solve creatively. (Myrick & Yonge, 2001, p. 467)

The same authors explored further aspects of the question in subsequent papers. In a study of the importance of questioning to critical thinking (Myrick & Yonge, 2002b), they concluded that preceptors' supportive questioning challenges preceptee thinking, promotes clarity of student thinking, fosters justification of reasoning, spurs creativity when addressing patient issues, and promotes the development of student abilities to address dilemmas and make judgements about their practice and learning. Another study (Myrick & Yonge, 2002a) further elucidated preceptor behaviours that promote critical thinking in preceptees, including "role modeling, facilitation, guidance, and prioritization" (Abstract, para. 1).

Another focal area in preceptorship research is the role of faculty in the development of a preceptorship relationship. A content analysis of themes in a study of preceptor-student relationships and the role of the educator in the development of this relationship highlighted the importance of trust (Hsieh & Knowles, 1990). Other themes included sharing of self,

encouragement, mutual respect, honest communication, well articulated expectations, support systems including peer and educator support for preceptors and students, and administrative support for preceptors (Hsieh & Knowles, 1990). Preceptor orientation is considered important in developing preceptor knowledge and skills for clinical teaching and evaluation (Kaviani & Stillwell, 2000; Oermann, 1996; Yonge et al., 1997). From the preceptor's perspective, more faculty support in the development of preceptoring skills, beyond the usual visits that involved discussion of student progression, would be desirable (Öhrling & Hallberg, 2000).

Preceptor and preceptee lived experience was explored by Nehls, Rather, and Guyette (1997) and Öhrling and Hallberg (2000). Students in the study highlighted the notion that:

it was instructive and personally satisfying to learn nursing thinking alongside practicing nurses. They perceive nurse preceptors as thoughtful teachers, that is, nurses who were committed to understanding what individual students needed to learn in particular in particular situations. Moreover, the preceptors communicated a belief in the student's future as a nurse. (Nehls et al., 1997, p. 223)

Presencing, or being available to the student, was a key aspect of preceptoring and facilitating a student's learning to think like a nurse (Nehls et al., 1997). Remaining near or physically close to the student, taking time to come to know the student's skills and knowledge, adjusting to the student's pace, and learning when to offer support and plan new learning opportunities was all part of preceptoring skills (Öhrling & Hallberg, 2000).

In 2008, Billay and Myrick published an integrative review of the preceptorship model literature between 1995 and 2004 from a sample of 313 articles. The authors concluded:

- (1) clinical preceptorship remains a common teaching and learning method used by the practice professions of nursing, medicine, pharmacy and dentistry in teaching students,
- (2) the profession of nursing continues to use clinical preceptorship as the main teaching and learning method for socializing nursing students to the profession,
- (3) findings from this integrative review reveal the need for partnership and collaboration between education and service providers,
- (4) a major asset to student learning is the preceptor's knowledge and experience,

(5) for a preceptorship model to succeed, a well developed and thoughtful curriculum is essential to accommodate clinical practice, (6) there are identifiable preceptor attitudes and approaches integral to successful student learning. These include: early and meaningful preceptor involvement, attentive listening, facilitation of learning opportunities, constructive performance feedback, and appropriate professional socialization. (p. 265)

Preceptorship is an established form of practice-education that supports the practice development of primarily, but not exclusively, senior students in a clinical context. Much of the research on preceptorships focuses on the relationship between preceptor and preceptee, which is viewed as the principal educational relationship involved. External educational faculty generally play a much smaller supportive role. One implication of the present study is that the assumption of the primacy of the preceptor-preceptee relationship should be reviewed in the context of rural hospital-based preceptorships, for reasons explored in the following chapters.

1.3. Rural Nursing in Canada

The purpose of this section is to situate my research within the context of rural nursing, in particular as it understood in Canada. Following an introduction to the nature of rural nursing, I offer a brief review of Canadian policy initiatives regarding rural nursing and undergraduate rural nursing education.

1.3.1. Nature of Rural Nursing: A Canadian Perspective

Bushy (2002), using published sources, explored rural and urban characteristics of nursing practice in Australia, Canada and the USA. Despite the diverse locations, diverse models of healthcare, and varying populations of small communities, Bushy concluded that the rural lifestyle has some common qualities. Rural residents tended to be more familiar with each other than residents in a more populated area were, and the social dynamics differed from those in urban areas. Frequently, fewer formal healthcare services were available in rural communities,

leaving rural inhabitants less likely to rely on formal networks and structures. Rural nurses, highly visible members of the community, occupied a more generalist role in the provision of healthcare than their urban counterparts did, while having greater autonomy. Rural nurses tended to be more familiar with rural residents and were more likely than urban nurses to integrate informal and family care services with formal healthcare services. Rural nurses often assumed multiple roles and had diffuse involvement in the healthcare facility and in community activities beyond employment. Bushy's (2002) review was limited by imprecise definitions of remote, rural, suburban and urban, making it challenging to compare rural policies and practice issues in similar settings. Despite these limitations, this inquiry highlighted unique characteristics associated with rural nursing across international contexts.

A Canadian initiative, between 2001 and 2004, to explore and describe the nature of rural and remote nursing practice (Kulig et al., 2003) was a foundational inquiry that served, among other ends, to highlight the lack of political and academic focus on rural nursing and education. Within this initiative, a narrative analysis of 152 interviews of Canadian nurses was designed to capture small-town, rural and remote nurses' perceptions of the meaning of nursing practice (MacLeod, Kulig, Stewart, & Pitblado, 2004). These authors indicated that interconnectedness between rural context and rural nursing was paramount in influencing work life and everyday practice across multiple places where nursing occurs. They found that the features of a rural community (such as size, distance from other places, demographics and climate) influenced the focus of nurses' attention, the form of work nurses were engaged in, the resources available to them, and the people for whom they provided care services. These unique features of a rural community also served to shape rural nurses' knowledge and skill set. The close relationship of rural nurses to the community in which they practiced helped them to be informed and responsive to people's healthcare needs (MacLeod, Kulig, Stewart, & Pitblado, 2004). A key

element was the degree to which trusting relationships developed between community members and nurses. Nurses experienced unique challenges when practicing in Aboriginal communities, particularly when there was a rapid nurse turnover in combination with existing cultural differences.

1.3.2. Rural Nursing Policy Document Review

In 2001 the Commission on the Future of Health Care in Canada was struck by the Prime Minister with a mandate for the Commissioner, Roy Romanow, to inquire into Canadians' perspectives on publicly funded healthcare and make recommendations to promote the system's sustainability (Romanow, 2002). The Commissioner found that Canadians generally uphold the values of the healthcare system as expressed in the Canada Health Act: sustainability, public administration, comprehensiveness, universality, portability, accessibility, and medical necessity. Several policy recommendations sought to address the health inequities that arise from living and working in rural and remote regions of Canada. One key paragraph addressed the need for skilled healthcare providers in rural settings:

Take steps to ensure that rural and remote communities have an appropriate mix of skilled health care providers to meet their health care needs. A portion of the funds from the proposed new Rural and Remote Access Fund, as well as those from the Diagnostic Services Fund, the Primary Health Care Transfer and the Home Care Transfer, should be used to ensure that people in smaller communities across the country have access to an appropriate mix of skilled providers. (Romanow, 2002, p. xxvii)

In addition, two recommendations provided direction for national and provincial policy actions to improve rural health:

1): Establish a new Rural and Remote Access Fund to support new approaches for delivering health care services and improve the health of people in rural and remote communities . . . [; and] 2) Use a portion of the Fund to address the demand for health care providers in these communities. (Romanow, 2002, p. xxx)

In the subsequent 2003 federal budget the recommendation for an immediate 1.5 billion dollars for a Rural and Remote Access Fund was not adopted (Nagarajan, 2004). Instead, at the September, 2004 meeting on the Canadian First Ministers Health Care Accord, a 10-year plan was outlined to: (a) reduce wait times and improve access to the healthcare system; (b) develop and implement health and human resources strategies; (c) develop home care services; (d) reform primary healthcare with emphasis on electronic health records and telehealth; (e) create a Territorial access healthcare fund; (f) build a national pharmaceutical plan; (g) strengthen Canada's public health care system focusing on prevention, health promotion, and public health; and (h) stimulate health innovation through research, science, and technology (Health Canada, 2004).

Despite the lack of a dedicated fund to improve the health of rural Canadians, several of the rural health policy directions were taken up, in part, by provincial health authorities and academic institutions. Since the Romanow (2002) report several rural related nursing initiatives have emerged across Canada. Some of these educational initiatives are briefly reviewed here, in order to give a picture of the policy environment in which rural nursing preceptorships are situated, with an emphasis on initiatives in British Columbia where this study was located.

In the context of MacLeod, Kulig, Stewart, and Pitblado (2004) seminal research on the nature of rural and remote nursing in Canada, the team produced a documentary analysis of the policy environment at the time (Kulig et al., 2003). They found that many government documents on health and education focused on urban issues, while most rural and remote healthcare reports focused on the recruitment and retention of physicians to the exclusion of other categories of health professional. These authors suggested that the educational preparation for rural nursing practice in Canada had been given only cursory attention and, while there were a few nursing programs that formally prepared nurses for such settings, there were no available

program evaluation reports focused on rural nursing. This lack of focus on rural nursing education was further complicated by a “lack of analysis regarding the theoretical and practical meaning of rural” (Kulig et al., 2003, p. 7).

In the year following this report, the Nursing Directorate of the Ministry of Health Services published a 1-page article in the journal of the College of Registered Nurses of British Columbia (CRNBC), *NursingBC*TM. Authored by two Chief Nursing Officers, who oversaw rural nursing practice in two health authorities with substantial rural regions, and the scholar who led the MacLeod et al. study, the article cautioned against the uncritical application of urban-oriented policies to rural practice:

B.C.’s Chief Nursing Officers (CNOs) recognize that excellence in rural nursing practice supports rural and remote communities to maintain and improve the health of their residents. Yet, the complexities of nursing in rural communities and the challenges and opportunities that are part of the everyday experience of rural nurses are often ‘taken for granted’ and are not well understood . . . Therefore, before they are adopted in the rural setting, they need to be reviewed in light of the growing understanding of the rural practice context. (Ulrich, Fulton, & MacLeod, 2004, p. 27)

In response to both provincial and federal directives to focus on the health determinants and healthcare delivery issues of rural and remote communities, the BC IHA released a document in 2004 called the “Interior Health Rural Health Services Planning Framework” (IHA, 2004a). While the IHA was not responsible for the education of RNs for entry into practice, it did employ newly graduated nurses throughout the health region and demonstrated interest in access to education for its citizens and health professionals. Within this framework, several possibilities were outlined for nurses to work with government to increase the number of available rural nurses. Funded by the Ministry of Health, the framework focused primarily on revitalizing a rural nursing workforce population, rather than on strategies to prepare

undergraduate nurses for practice (an area that fell under the jurisdiction of the Ministry of Advanced Education).

Parallel developments can be seen in the concept and practice of interprofessional education, adopted in 2003 by Health Canada as a policy instrument to promote collaboration for patient-centered practice among healthcare providers (Health Canada, 2006). Since 2003 the Interprofessional Rural Program of BC (IRPBC) has funded students from various health disciplines to experience rural practice and lifestyles (British Columbia Academic Health Council [BCAHC], 2004). The general purpose of this initiative was to improve “the health of rural communities, the specific goals of the program are to model and evaluate interprofessional learning, expand the capacity for educating health professionals in BC, and contribute to the recruitment and retention of health professionals in rural communities” (Charles, Bainbridge, Copeman-Stewart, Art, & Kassam, 2006, p. 41). The main interprofessional learning goals of IPRBC were to develop participant understanding of health professional roles, boundaries and opportunities for collaboration and to advance understanding and practice of teamwork. A formative evaluation of this project claimed students met these learning goals (BCAHC, 2004). A review of this report is provided in Chapter 5.

There have also been moves in British Columbia to establish formal programs at the undergraduate level designed to prepare nurses for rural practice. In 2007 the University of Northern British Columbia (UNBC) announced a Rural Nursing Certificate Program. This distance education program was initially designed to support the practice of nurses employed in rural community hospitals. The program included 30 credits of online courses, and clinical experiences and/or occasional onsite workshops (UNBC, 2009). Diploma prepared nurses, those nurses with a 2- to 3-year college preparation common to nursing education prior to 2000, could credit this program towards an undergraduate degree in nursing.

Several Canadian provincial governments, such as BC, Ontario, and Newfoundland and Labrador, offered tuition support, travel, and accommodation stipends or loan forgiveness programs for undergraduate nursing students and recently graduated nurses who opt for rural practice, particularly in underserved communities (Government of Newfoundland and Labrador, n.d.; Health Force Ontario, 2007; StudentAid BC, n.d.). Little is reported about the effectiveness of these incentives in promoting choice of rural practice upon graduation.

Despite a decade of growing interest by federal and provincial stakeholders and some promising initiatives in British Columbia, the financial assistance offered to support rural education, recruitment and retention of nursing students or nurses continues to pale in comparison to that offered to medical students and physicians. In particular, the support of rurally based nursing education programs remains constrained. The recent emphasis on restructuring the British Columbia healthcare system in the context of battered global and local economies may further spur competition for urban and rural education funding. “It is quite likely that rural regions of developed nations such as Canada, will be disproportionately affected by the current recession, relative to urban places” (Ostry, 2009, p. 1).

Despite incremental progress, therefore, ongoing funding, innovation, and research is required to support the development of rural nursing education in order to achieve Romanow’s (2002) goal of an appropriate mix of skilled healthcare providers in rural settings. Within this policy context, there is value in learning more about how the rural nursing preceptorship experience works and how it can be structured and supported more effectively.

1.4. Summary

Preceptorships are a predominant practice-education model in nursing that replaced the apprenticeship model in the 1970s, when most nursing training in hospitals moved to nursing

education in post-secondary institutions. Much of the preceptorship research of the past 20 years has focused on urban versions of this practice-education model. Rural nursing has garnered more attention recently, particularly given the increasing emphasis on healthcare delivery for all Canadians, and the potential for a pan-Canadian nursing shortage to place greater pressures on rural healthcare delivery and deepen the health inequities between rural and urban citizens. While research and policy in this area are still relatively underdeveloped, there is clearly a more receptive environment for studies and initiatives in rural nursing than there were a decade ago.

There are three principal challenges in rural nursing education: it must inspire new professionals to take up rural nursing, it must provide them with a foundation for entering rural practice, and it should ideally increase all students' understanding of rural nursing in order to promote understanding of the diverse contexts of nursing practice across the healthcare system. The practice-education strategy of the rural nursing preceptorship, which has so far been inadequately studied or understood, may play an important role in meeting these challenges. By undertaking an ethnographically informed study of the rural preceptorship, I hope to contribute to inspiring the next generation of rural nurses and building greater awareness of the importance of rural nursing. This in turn will contribute to the promotion of rural health by enhancing citizen access to rural healthcare.

2. Intellectual Traditions

2.1. Introduction

The purpose of Chapter 2 is to explicate the foundational theoretical perspectives and research that informed this study. This chapter begins with an overview of the research on rural undergraduate nursing education (and related professions). Following this, I focus on four theoretical notions of particular importance in this research literature: culture, place, relationships and learning communities. These concepts underpin this study as a whole. Finally, ethnographically informed inquiry is introduced as one way of coming to know about ‘the other’ in his or her social and cultural context (employment, profession, community). The study is situated in this intellectual tradition.

I began participant interviews in 2007. The literature discussed in this chapter is limited to studies published up to 2008, in order to provide the reader with a view of the body of scholarship about rural undergraduate preceptorships prior to my engagement in the interviews. Research reported from 2008 onwards is used primarily in Chapter 5, when I compare other research findings with the findings from this study.

2.2. Rural Preceptorship Research

In my review of the literature, particularly up to the mid 2000s, I noticed that much of the research focused on both the instrumental and educational value of rural placements. Mixed opinions and varied research outcomes abound concerning the recruitment potential of an undergraduate rural experience. Much of the literature speaks to the importance of exposing

students to rural nursing as a strategy to interest students in taking up rural nursing practice upon graduation. More recently, the educational value of rural placements has become a focus of inquiry. The organization of this section reflects these two orientations.

2.2.1. Intentions, Motivations and Recruitment Outcomes

Much of the research about undergraduate rural preceptorship has focused on the effect of rural placements on recruitment and retention. Researchers have reported mixed results in terms of the potential for rural practice placements to serve as a recruitment strategy (Courtney, Edwards, Smith, & Finlayson, 2002). Neill and Taylor (2002) claimed that rural and remote clinical experience for undergraduate nursing students, particularly those from urban backgrounds, was an overlooked recruitment strategy for rural healthcare facilities. These authors suggested that given the absence of rural or remote opportunities for nursing experience, many undergraduate nursing students were likely to plan careers in large urban settings. Hegney, McCarthy, Rogers-Clark, and Gorman (2002) countered that undergraduate exposure to rural practice was unlikely to influence career decisions about practice in rural areas. Armitage and McMaster (2000) and Courtney et al. (2002) claimed undergraduate student rural practice experiences were personally and professionally rewarding and contributed to future interest. Charleston and Goodwin (2004), based on an impact evaluation of rural preceptorships in Australia, concluded that improving the preparation of preceptors for rural students enhanced rural recruitment. Playford et al. (2006) identified a positive association between rural employment and rural background, voluntary rural placement, and a placement of 4 weeks or less duration.

Bushy and Leipert (2005), following a focus group of students attending a conference, reported on personal, professional, and financial factors that influenced post-graduation

employment decisions in support of rural practice. The personal factors centred on having had previous experiences and connections with a rural lifestyle. The professional factors focused on a desire to attend to perceived inequities in healthcare delivery between rural and urban settings and a sense of familiarity with rural healthcare delivery. The financial factors that promoted post-graduation employment in rural practice included attending a nursing school with a scholarship or bursary from a local or rural organization that eased the financial strain of a rural practice-education experience and financial incentives that drew advanced practice nurses to a rural context.

The motivations of rural preceptors were an element of a recent Australian based study that used mixed method questionnaires of 255 preceptors from medicine, nursing and allied health. Shannon et al. (2006) highlighted three primary reasons rural nurses opt to act as preceptors. These reasons included enjoying teaching, valuing participation in student knowledge-skill development, and perceiving preceptorship as an opportunity to promote rural health as a career path. Other enjoyable aspects for nurses included raising preceptors' interest in current health developments and journal articles, promoting preceptor review of clinical knowledge basics, and instilling preceptor confidence in professional ability. Opportunity to have more contact with academic faculty ranked low on reasons cited to act as a preceptor (Shannon et al., 2006).

Differences between what rural preceptors and students or novice nurses identified as valuable were reported by Floyd, Kretschmann, and Young (2005) in an evaluation study of an orientation program for new graduate RNs in a semi-rural healthcare setting in southern Oregon. Practicing rural preceptors (expert nurses) ranked professional and personal topics and advocacy for patients and families as most useful for preceptees, whereas preceptees (novice nurses) identified clinical skills as most useful, followed by organizational orientation.

Despite the additional workload involved, Floyd et al. (2005) reported that practicing nurses agreed to act as preceptors because of staffing shortages and the need to recruit new colleagues. Arlton (1984) reported that rural hospital administrators thought nursing students were a general asset to the agency, insofar as they had an opportunity to observe students before offering employment and students served as a source of knowledge for staff. More broadly, Fauchald (2004) argued that preceptorship experiences can serve academic and rural community partnerships' interests, but also contribute to educational and healthcare service objectives by enhancing the quality of cost-effective services to underserved populations through service learning.

Australian based researchers Adams, Dollard, Hollins, and Petkov (2005) reviewed the literature on student perceptions of living and working in rural settings and developed, tested, and refined a questionnaire called "Student Attitudes to Rural Practice and Life," using a sample of 182 pre-rural placement and 122 post-rural placement allied health students (medicine, nursing, physiotherapy, pharmacy and others). Four factors made up the questionnaire and included friendliness and support, isolation and socialization, enjoyable aspects of rural life, and work opportunities. Friendliness and support encompassed professional, community and social issues such as supportive staff, friendly people, welcoming people, friendly practice environments, and a sense of community. Factor 2, isolation and socialization, tended to be associated with somewhat negative aspects of rural life and practice such as professional isolation, limited socialization, isolation from family and friends, and inadequate recreation. Factor 3 emerged as the enjoyable elements of rural life, and included a positive attitude towards the possibility of making friends and things to do that are often associated with a rural lifestyle. The fourth factor covered the professional-employment opportunities afforded by a rural setting which included diversity of skills, potential for career advancement, opportunity for autonomous

practice and desirable employment. The four factors were not to be considered mutually exclusive (Adams et al., 2005).

As previously noted, much of the research literature with respect to rural practice-education emphasized the notion of health and human resource planning by recruiting students to rural practice upon graduation. Several factors supported the recruitment of rural nurses such as a welcoming community, rural lifestyle, financial incentives, diverse and autonomous practice. Isolation stood out as a substantial challenge when recruiting nurses for rural practice. Students and nurses tended to differ on what the key areas of focus for learning in the rural context. Research indicated that preceptors were motivated to preceptor for purposes of recruiting new staff and for the preceptor's professional development.

The focus on the literature on motivations of students and nurses prompted me to include this dimension within the topics explored in the interview process. In Chapter 4, I summarize what I heard from preceptors and preceptees, and this research informs later recommendations on improving pre-practicum orientation for nurses and students alike.

2.2.2. Learning Outcomes

Most research in this review regarding the rural preceptored practice experience came from program evaluation studies. The next several paragraphs provide an overview of program evaluation findings from 1984 to 2005 that address the value of a rural educational experience both for undergraduate students and nurses. Subsequently, more recent research is reviewed that both echoes and expands the earlier understandings of rural practice-education experiences for undergraduate students. It should be noted that while most of the literature affirms the value of rural practice experience for students, some publications demonstrate the general lack of awareness of rural nursing and its potential as a site for quality learning experiences. Given the

limited research on undergraduate nursing preceptorships in rural settings, literature about preceptorships in other disciplines or beyond undergraduate education was included to inform and situate this study in the broader scholarship.

Senior nursing students reported that a rural practice experience contributed to a growing sense of competency, a growing perspective of holistic care by coming to know the patients “as a whole person within a social framework” (Arlton, 1984, p. 206), an appreciation for healthcare staff relationships, and an appreciation for being welcomed into the community.

Rural preceptors generally found the experience of preceptoring buoyed their self-confidence as they became increasingly cognizant of the knowledge supporting their practice and that students acted as a motivator to refer to textual and other reference sources (Arlton, 1984). In a study by Koehler, Broom, Clayton, and Morse (1988), preceptors noted that the most satisfying aspects of the preceptor’s experience were sharing their knowledge, observing preceptee development and appreciating preceptees’ willingness to learn. Nurses, in a program evaluation research study in southern Alberta, “identified that the presence of a student in their institution stimulated critical thinking among employees and that this thinking stemmed from questions related to practice and procedures, especially if these differed from what was taught in nursing school” (Baird-Crooks, Graham, & Bushy, 1998, p. 37).

Preceptorship in rural settings has been used for other purposes beyond the education of undergraduate students, including the continuing education of practicing nurses. One such example was the use of preceptorship as a staff development method to advance rural RNs capacity to identify their learning needs and employ empowering continuing education strategies rather than teacher delivered content driven strategies (Dusmohamed & Guscott, 1998). L’Esperance, Digregorio, and Wellerstedt (1996) offered another example of continuing education of rural nurses by learning about high risk perinatal nursing care from preceptorships

with experienced nurses in urban settings. Preceptorships have also been used to facilitate post-registration role transition to rural practice and to promote rural employment for recently graduated Australian nurses (Smith, 1997). Not unlike the value of undergraduate preceptorships, the post-registration preceptorship model studied by Smith was reported to facilitate the development of confidence, self-esteem, interpersonal skills, time-management skills and competence to practice in various settings (Smith, 1997).

The literature on educational outcomes in rural settings using a preceptor model up until the late 2000s was sparse yet promising. Baird-Crooks et al. (1998) identified several short-term outcomes from an evaluation of a southern Alberta rural hospital-based practicum for undergraduate nursing students that highlighted the importance of the process of acceptance and the development of professional competence.

Students consistently reported they found rural communities to be warm, friendly, and welcoming. They commented on their increased level of professional confidence and development of assertiveness skills that evolved from opportunities to use assessment skills with more independence than in previous clinical situations. (Baird-Crooks et al., 1998, p. 36)

Van Hofwegen, Kirkham, and Harwood (2005), in a small scale qualitative inquiry into a community health nursing practice experience in rural BC, identified similar themes to Baird-Crooks et al. (1998). These researchers identified the nature of the experience as different from urban nursing practice: the quality of relationships developed in rural settings was unique and the interdisciplinary nature of a rural setting was evident, as was the more generalist-nursing role in the community. These characteristics remained constant even when the practice focus (such as acute or community) for rural nurses differed (Van Hofwegen et al., 2005).

Edwards, Smith, Courtney, Finlayson, and Chapman (2004) reported on an Australian quasi-experimental pre- and post-test design study of the influence of rural or urban practice placement on the confidence, competence, organizational skills and general satisfaction of 137

senior student nurses. On all pre-clinical and post-clinical self-rated measures, rurally based student nurses rated themselves as more confident, competent and organized than urban-based student nurses. The four most frequently cited elements contributing to a positive learning environment for both rural and urban students included learning supports, being part of a team, feeling valued for their part in patient care, and the opportunity to obtain diverse clinical experience (Edwards et al., 2004). These authors suggested that faculty should be mindful of the culture of practice of particular places and whether or not this culture supports student learning. Orpin and Gabriel (2005) also concluded, following Australian based quantitative longitudinal survey research, that better patient relationships are afforded in rural practice and that in most cases rural practice offers a diversity of clinical experiences. The inclination to select a rural practicum was strongest among students from self-described rural origins (Orpin & Gabriel, 2005). Such an inclination raised the possibility that self-selection into practice locations by students from a rural background may predispose them towards greater competence, confidence and organization, making it difficult to account for the influence of location on learning outcomes (Edwards et al., 2004; Thomas, Olivares, Kim, & Beilke, 2003).

It is noteworthy that, contrary to these positive perceptions of rural practice experience, half of the 66 senior nursing students surveyed in a United States based program evaluation designed to understand student choice of rural or urban practice-education experience by McDonough, Lambert, and Billue (1992) perceived rural nursing settings as offering a superficial and generalized experience with insufficient opportunity to gain practice experience to prepare them to be ready for the workplace after graduation.

Rural life is often perceived as a Spartan existence that is devoid of luxuries, and marked by simplicity, frugality and a slow pace. Nursing, in the rural setting, tends to be seen as generalized, out-of-date, not “high-tech,” lacking anonymity, and being autonomous. In contrast, urban life is often perceived as exciting, fast-paced, and convenient. Nursing in the urban setting, is perceived as specialized,

modern, high-tech, impersonal, and interdisciplinary. (McDonough et al., 1992, p. 32)

Many healthcare students continue to hold traditional or inaccurate views of rural life and rural practice (Deaville et al., 2009) that are inconsistent with the diversity of rural communities. Likewise, rural health and rural healthcare practice tend to be regarded by the public and students as a deficit or a problem rather than associating them with positive assets and creative problem solving (Bourke, Humphreys, Wakerman, & Taylor, 2010). In the long run, such representations do not serve the recruitment of rural practitioners or the delivery of rural healthcare.

From an educational perspective, Erkel, Nivens, and Kennedy (1995) advocated for nursing student practice in rural communities to promote the development of health professionals who are culturally aware and able to practice with diverse populations from an interdisciplinary perspective in a rural context. Many nursing educators have noted the potential of rural nursing practice placements to help build intercultural awareness and competence. I was interested in exploring this dimension of the rural preceptorship with my participants; as described in Chapters 4 and 5, however, I found little evidence to suggest that this potential is currently being realized. The benefits for clinical practice were much more consistently affirmed by nurses and students alike.

2.3. Culture and Practice

Culture has a wide range of meanings in relation to nursing practice-education. At the macro level, culture exists as a confluence of history, politics, people, economics, education, and traditions that contribute to the uniqueness of each practice setting. On a micro scale, culture consists of the beliefs, values and norms individuals hold, influenced by the larger contextual culture, and observed in people's actions and words. In this section, perspectives on culture

along with a few research examples of preceptorships explored through a cultural lens provide evidence as to the utility of the concept for the present study.

Schein (1992) defined culture, in relation to groups and organizations, as “(a) pattern of shared basic assumptions that the group learned as it solved its problems of external adaptation and internal integration, that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems” (p. 12). Adapting to such a particular, local professional culture, such as exists in an hospital-based health agency in a rural setting or serving a rural population, is part of the challenge of learning to practice nursing within the traditions of rural nursing, particularly when the student has been schooled primarily in urban traditions. “To understand a group’s culture, one must attempt to get at its shared basic assumptions and one must understand the learning process by which such basic assumptions come to be” (Schein, 1992, p. 26). Because “the function of cognitive structures such as concepts, beliefs, attitudes, values and assumptions is to organize the mass of environmental stimuli, to make sense of them, and to provide, thereby, a sense of predictability and meaning to the individual” (p. 299), one can expect cultural dissonance, or a sense of discomfort or confusion, as urban educated students come to take on the role of a rural nurse.

Myrick and Yonge (2005) suggested that students and preceptors “originate from disparate workplace cultures” (p. 5). Moreover students, and by extension new graduates, tend to learn a culture of nursing practice that represents a combination of urban academic, professional and healthcare organizational culture wherein values, beliefs, behaviours and practices are uniquely recreated in ‘new nurses’ that may be different from other health professionals (Hall, 2005). Shaw and Degazon (2008) highlighted the idea that students come with their unique backgrounds and cultures and this difference, referred to as a cultural chasm, is bridged by the

education and socialization of nursing students to professional values. According to them, it is this diversity of cultures (individual student, academic culture, rural nursing practice culture, professional culture, unique place setting) that challenges students to recognize and reconcile multiple values, perspectives and behaviors in the context of a meaningful learning experience. Mellows (2005) posited that the potential for cultural dissonance stems primarily from the modification of urban developed standards within a rural context.

Mills, Francis, and Bonner (2007), in an Australian based grounded theory study of rural nursing perspectives, used the lens of culture, politics and practice to examine the notion of mentoring. They reported evidence of rural nurses negotiating norms and practices in their relationships with community members and professional colleagues. For example, the urban norms associated with professional boundaries between nurses and the people they provide care for are more challenging to maintain when the nurse is caring for a neighbor. The study explored intrapersonal, interpersonal, intraprofessional, and interprofessional conflict as a way to identify some of the cultural norms associated with rural healthcare settings and actors. In my own interviews I sought evidence of such conflict, but as I describe later, this met with only limited success as a research strategy. There were, however, many indications of cultural dissonance as a central dimension of the student experience.

The literature on rural nursing consistently emphasised the influence of rural culture on professional practice. Arlton's (1984) early scholarship, for example, described rural nursing as "shaped by individual and community attitudes, values and beliefs. The cultural system integrates the effects of such factors as sparse population, geographic barriers, and availability of water, social traditions and interpersonal relationships" (p. 204). Arlton suggested that rural nurse isolation led to the "development of strong inner resources along with strong family and community ties" (p. 204). More than 2 decades later, Lea and Cruikshank (2007), on the basis of

a hermeneutical-phenomenological framed study of new graduates in rural practice settings in New South Wales, emphasized that socialization to nursing in rural practice is the major task required of new graduates in a rural practice setting. They reported that new graduates experienced difficulty in developing friendships and becoming socially accepted within particular rural settings. Within a rural community, there might be individuals who have worked together for years, perhaps even obtained nursing education together, who may have spouses or partners who have economic and social ties with one another and possibly have children who are also friends that create their social network (Lea & Cruickshank, 2007). Such close-knit networks are a unique component of rural nursing and serve as an additional challenge for newcomers.

The effect of a rural workplace on learning and career decisions is a growing area of nursing research. The complexity of multiple factors that come into play, on a micro and macro scale, when graduates choose initial nursing employment is highlighted by Brodie et al. (2005), who undertook mixed method research in the British context to explore the impact of location on the decisions of nursing students and nurses at the beginning of their careers. Participants were asked to rate the importance of 21 employment location qualities. Several of the top 'workplace' qualities were feeling valued, quality of patient care, clinical opportunities, team atmosphere and morale, attitude towards students, educational opportunities, and ease of travel. The researchers noted that "perceptions of workplaces relate to complex mixes of cultural, managed, economic and physical features" (Brodie et al., 2005, p. 1878).

Of particular note is the authors' call for further place-related research, on both a micro and macro scale, as part of ongoing attempts to describe and "account for the messy and contingent nature of place" (Brodie et al., 2005, p. 1878). Macro-scale research would focus on the culture within a particular healthcare agency, locating it within a provincial, national, or international context. Micro-scale research would focus on the cultural experience of

practitioners within a unit in a healthcare agency. While my own research was not focused specifically on career decisions, examining the beliefs, values, and norms embedded in rural practice-education can evidently contribute to our understanding of the factors affecting those decisions.

The interplay between social and professional norms and relationships within a rural context can be challenging. Warner et al. (2005), in research designed to explore ethical issues in rural healthcare, surveyed healthcare providers (physicians, nurses, counsellors, psychologists, physician assistants) in New Mexico and Alaska. Stigma, dual patient-provider relationships, and confidentiality were among the issues they explored. They reported that across sites healthcare providers valued confidentiality highly, noting that the smaller was the community, the greater was the perception that patients were less willing to share their health issues because of confidentiality concerns. The researchers noted that healthcare providers in smaller communities reported more frequently having dual (personal and professional) relationships with patients/community members, yet feeling less awkward than did healthcare providers in larger regions. “Overall, it appears that overlapping personal and professional roles are perceived and handled differently and perhaps more adaptively in rural than non-rural areas” (Warner et al., 2005, p. 31).

As described in Chapter 4, the interview process gave me valuable insights into the cultural values and norms of rural nursing, including the key value of relational continuity that emerged unlooked-for from the data. Many of these norms were shaped by the nature of rural place—a concept that is important enough to warrant separate examination.

2.4. Place

The significance of place for healthcare practice is a neglected area of research. In this study, the notion of place includes the historical, physical, social, pedagogical, and occupational aspects of a rural hospital. Its importance in this study arises from the tendency, in modern conceptions of nursing practice, to reduce issues of place to the purely spatial and measurable (see below). I wanted to explore whether a personal, multidimensional, lived sense of rural place played an important role in the preceptorship experience for nurses or students.

According to Casey (1993), place, as a positive enduring concept, “belongs to the very concept of existence. To be is to be bounded by place, limited by it” (p. 15). Time, too, he argued, can be thought of as a particular form or aspect of place, with more than objective meaning; discussions about the passage of time often refer more to the psychological, social or historical sense rather than to time as a physical dimension. However, the modern era is erasing the notion of place, and modern science, with its quantitative conceptions of time and space, is contributing to that negation (Casey, 1993). Escobar (2001) echoes this lament of the neglect of place. He argues:

that place continues to be important in the lives of many people, perhaps most, if we understand by place the experience of a particular location with some measure of groundedness (however, unstable), sense of boundaries (however permeable), and connection to everyday life, even if its identity is constructed, traversed by power, and never fixed. (p. 140)

The modern prioritizing of global and generalizable knowledge has contributed to the neglect of place in general, and of rural places in particular.

Applying these ideas in the context of healthcare delivery, Malpas (2003) spoke of conversations underpinned by “‘spatial’ rhetoric, ways of thinking and modes of organization. This ‘dominance of space’ . . . is to be seen in a range of forms, but is perhaps most often

expressed in an emphasis on quantitative calculation over qualitative ‘judgement’, on formal processes over concrete practice, on the global and international over the local and proximate” (p. 2343). People are said to interact according to particular formulas and patterns that betray the influence of atomistic thinking and associated conceptions of space (Malpas, 2003). This modern view of predictability and standardization contrasts with a place view of healthcare delivery that embodies fluidity through changes in time, people, technology, and relationships. By emphasizing human decision-making and actions in a complex particular context, this view resists the homogenization of people’s experience of place and rural nursing practice (Malpas, 2003). Similarly, I sought in my research to resist conceptualizing rural nursing practice from a quantitative or spatial perspective by conveying the unique experiences of nurses and students through personal narrative and insights. As described in Chapters 4 and 5, this leads to a conception of the rural preceptorship in which culture, place and relationships are of central significance.

Malone (2003) considered how ‘proximity’ influenced nursing relationships and how structural-spatial practices can serve to disrupt the fundamental therapeutic relationship between nurses and patients. He suggested that on the basis of physical proximity, narrative and moral proximity can develop: that is, the conversations that allow the nurse and patient to come to know each other, and the sense of ‘being there’ for the other person. Increasing physical distance between nurses and patients, in a “spatial” mode of organization, disrupts the nurse-patient relationship through its effects on narrative and moral proximity (Malone, 2003).

Other researchers have argued for richer conceptions of place, space and time when considering the effects of geography on healthcare. Kelly (2003) wrote of place as “the local, lived articulation of sense, body, identity, environment, and culture, a person is always in and of place. Place is captured in the intersubjectivity of sharing of experience and social practice” (p.

2280). Gesler and Kearns (2002) offered the perspective that place can be constituted by “two related experiences: that of actual, literal places, and that of ‘place in the world’” (p. 5). Casey (2003) claimed that if perspectives on healthcare were considered in terms of a ‘place world’ attention would become focused on uniqueness and heterogeneity, the local stories and customs of particular places, rather than on pessimistic conversations about the limitations of space, time, and resources.

Based on this assumption of heterogeneity, a search for diversity or explorations of difference is an important aspect of understanding place. Common characteristics of communities can be described in standard ways such as lifestyle, ages, and distances from other communities, numbers of people, economic trends, and other qualities. These give a general and distant idea of what a community might be like, but in the process, they minimize the influence of diversity and the insights that come from observing and valuing difference. Diversity among people, recognized primarily as distinctness associated with ethnicity, occupations and associated economics/industry, the seasons, and people’s personal health, was taken up as an idea that permeated this inquiry; it was also reflected in the decision to have the text be multivocal and representative of students and nurses as participants and myself as researcher.

This research orientation resembles that recommended by Bryant and Joseph (2001), who asserted that the heterogeneity of rural Canada ought to be explored through local commentary that could shed light on factors such as migration, aging, and economics that contribute to reshaping local cultures. The complexity and diversity of rural places significantly shaped the processes of cultural mediation that I saw underlying my data, giving rise to powerful statements of individuals that were unique, informative, and worthy of future inquiry.

2.5. Relationship

This inquiry began with the assumption of the primacy of the preceptor-student relationship. The assumption was based, in part, on the voluminous literature focusing on preceptorship relationships (see Chapter 1); it also reflected my personal perspective. Other relationships, such as those with other healthcare professionals, with rural community members, and with nursing educators were considered necessary but secondary elements of the rural nursing practice-education experience. However, as the study developed, it became apparent that a broader view was necessary.

As alluded to in the previous section, many of the effects of place are mediated through its effect on relationships, making the latter a primary consideration for practitioners and researchers (McGarry, 2004; Williams & Cutchin, 2002). Some of the place-related dimensions of rural relationships include relational conflict or strength of agreement among individuals or groups, differences in relational forms, the quality of stability or temporariness, and in the case of health occupational relationships, the degree of autonomy or reliance on others. As depicted in Chapter 4, all of these proved to be significant for the preceptorship experience.

2.5.1. Gemeinschaft and Gesellschaft

Tönnies' (1887/2002) notion of the social world hinges on two primary concepts: *Gemeinschaft* and *Gesellschaft*, ideal forms of community representing social relationships arising from natural and rational will. *Gemeinschaft* tends to represent the traditional community, such as a rural community, as made up of people with common life-ways and beliefs, close ties and regular interactions, small numbers of people removed from power centers, the sense of familiar and continuity, and an emotional connection to the community (Brint, 2001). Relationships are built on mutual advantage, appreciation, and unity among unequal beings. "Gemeinschaft refers

to the concept and experience of ‘community,’ . . . in which people are primarily involved with people-family and neighbors-and everyone works for survival, but work is otherwise secondary to personal interactions and social pleasures” (Hartog & Hartog, 1983, p. 911). “Relationships are seen as personal and enduring; unlimited and unspecified in their demands and imbued with a strong sense of loyalty not only to friends and relatives, but to the community and its members” (Strasser, 2003, p. 458). Communications is personal and direct (Fredericks & Mundy, 1978).

Gesellschaft, on the other hand, represents a community that includes diverse ways of life, beliefs, diffuse ties and irregular interactions, large populations, proximity to centers of power, regulations to promote trust, provisional arrangements, and regulated competition—qualities more commonly associated with urban living (Brint, 2001). “The ideological basis of Gesellschaft can be found in values such as freedom, material success, conspicuous consumption, rationality, and individualism” (Christenson, 1984, p. 162). In a healthcare delivery context, “*Gesellschaft* denotes that official, impersonal web of organizational structures, hierarchies, departmental divisions, policies and procedures which govern human interactions and relationship in big, complex bureaucracies, such as modern hospitals and health care systems” (Braithwaite & Westbrook, 2009, p. 1). While these concepts tend to be polarizing and primarily descriptive, they are intended to demonstrate differences in philosophical perspectives arising from rural and urban places. However, these concepts are not exclusively urban or rural but exist to varying degrees in all social contexts.

Rural communities, Tönnies’ (1887/2002) argued, tend to be characterized by Gemeinschaft-like relationships in three forms: fellowship, authoritative relationship, and mixed relationship. The fellowship form of relationship is the simplest, existing among those who live in similar communities, share similar sentiments and engage in similar activities or are united by

common beliefs. The authoritative form of relationship is based on one partner having greater power to protect the other member, such as in the parent-child relationship. Mixed forms of relationship exist when both fellowship and authoritative elements are present, such as in some spousal relationships in particular cultures and eras.

In *Gesellschaft*-like relationships these same forms exist; however, the relationships are not assumed but rather constructed through social contracts. Examples are the authoritative relationships between police-citizens, employers-employees, or nurses-patients; the fellowship role may be found in relationships between professional peers, students, condominium residents, contracted companions and the like.

Mellows (2005), in a BC study of the professional predicament of rural clergy, contended that codes of conduct or standards of practice have generally been developed on the basis of urban perspectives and must usually be “adapted” in a rural setting. Of particular interest in the present context, he interpreted the contrast between urban and rural norms in terms of a tension between *Gesellschaft*- and *Gemeinschaft*-like relationships, yielding “multiple dilemmas to be worked out in professional practice” (p. 66). These dilemmas included the challenges of dual relationship (professional *Gesellschaft*-like role and being members of a *Gemeinschaft* community), the need to modify *Gesellschaft*-based standards of practice developed from an urban perspective, and the need to be a generalist within a rural context despite their previous specialized expertise.

As my analysis of the data progressed, I was struck by the relevance of the concept of *Gemeinschaft* to understanding many of the values and norms of rural nursing. As suggested by Mellows’ (2005) study, the cultural dissonance experienced by students could likewise be interpreted as a conflict between *Gemeinschaft* and *Gesellschaft* cultural norms. The meaningful

relationships experienced by students and nurses in rural settings bore witness to these differences.

2.5.2. Relations with Rural Preceptors

The literature on rural preceptorships tends to emphasize the need for shared values and similar expectations in the preceptor-preceptee relationship, as in a descriptive exploratory study of baccalaureate students in Prince Edward Island (Crawford, Dresen, & Tschikota, 2000).

Should values and expectations differ between students and preceptors, the potential for conflict exists.

Mills et al. (2007) posited that local culture, that is, the accepted norms and practices of rural communities, is foundational to the development of mentorship relationships with new or novice rural nurses. They described nurses as negotiating their interactions with others based on multiple perspectives of themselves: as members of a community, members of a profession, and individuals. In a mentorship role, nurses described their ‘cultivation’ of the new nurse in ways that were protective and interpretive. “Demystifying local practice or ways of communication” (Mills et al., 2007, p. 587) was an important task to minimize a novice’s sense of personal threat in unfamiliar situations. In a way, the mentors became cultural interpreters assisting novices to understand what would be normative practice in a rural setting. Although preceptorships are different from mentorships, this role as a cultural interpreter is still likely to be an important component of the relationship.

2.5.3. Rural Interprofessional Relations

Over the past several decades, there has been growing interest in research focused on the development of interprofessional appreciation, teamwork, and competencies. In an expert opinion article, Vinal (1987) suggested that rural practice, in communities culturally and

economically different from a professional's urban community of origin, promotes mutual reliance and a collaborative pooling of resources and capacities to meet healthcare needs. Other researchers likewise noted that "interdisciplinary experiences . . . result in significant change in perception of professional competence and autonomy and actual cooperation and resource sharing within and across professions" (Hayward, Powell, & McRoberts, 1996, p. 325).

Bourke et al. (2004) concurred that team practice develops more readily in a rural healthcare context than in larger healthcare agencies, given the interdependence that comes with living in a small community with fewer health resources. Likewise, United States researchers Mu, Chao, Jensen, and Royeen (2004) reported that interprofessional rural education enhanced student regard for the interprofessional team approach, their appreciation for other health professionals and the other cultures within the community, and their commitment to collaboration with rural practice. These research findings support the notion that interprofessional collaboration is an essential component of rural practice, and hence the development of relationships with the healthcare team is an important aspect of the preceptorship experience.

2.5.4. Relations with Rural Community

Fundamentally, despite their location of practice on a day-to-day basis, nurses serve the community as a whole. Relationships between the community and the hospital-based nurses are therefore worth paying attention to in this inquiry. Rural nursing occurs in various places: hospitals, homes, communities, clinics, and on the street. "The importance of place, and consequent relationships development within overall care provision, should be a matter for serious consideration by practitioners and researchers alike" (McGarry, 2004, p. 304). Despite this observation, the relationships between the hospital-based nursing student and the

community at large have garnered little research, especially in comparison to community-based practices such as public health or home care nursing, where community relationships are a central research focus.

Neill and Taylor (2002) noted students' appreciation for rural nursing and attributed this appreciation, at least in part, to the qualities of the community in which the experience was gained, and to the development not only of interprofessional relationships but also of nurse-patient-family relationships over time. One student narrative example from their study highlighted the educational importance of such relationships:

. . . was every good thing I've heard about rural communities and the friendliness and open acceptance of people was amazing. The highlight of my placement was nursing one elderly man who was not expected to leave hospital. As his primary nurse for 3 weeks, I worked with him consistently, and as he improved, his wife and I planned his discharge home. It was rewarding to participate in his progress, knowing that in a city hospital I could not have given him so much attention, time and professional continuity. (Neill & Taylor, 2002, p. 242)

Vukic and Keddy (2002), in an institutional ethnography designed to explore the nature of northern nursing work in Aboriginal communities in Canada, described nurses in remote northern contexts as 'outsiders,' as most nurses generally did not originate from the community and were likely not to stay there in the long term. Their informants believed that being involved with the community helped to establish trust and was a paramount task of the nurse in northern remote settings. This contrasted with the situation of the rural nurse, who usually, but not always, lived and worked within the community and was an 'insider'. Vukic and Keddy highlighted the significance of trust building between nurses and communities in remote settings, but noted the lack of data and analysis on how this took place. Further to this observation, MacLeod, Kulig, Stewart, and Pitblado (2004) noted that quality rural nursing practice is predicated on trusting relationships between nurses and community members. Rural nurses have local knowledge and commitment, making them responsive to community

healthcare needs (MacLeod, Kulig, Stewart, & Pitblado, 2004). However, the process of gaining acceptance and trust within a rural network complicates the nurse's ability to glean and share contextual knowledge (Sivamalai, 2008).

Lauder, Reel, Farmer, and Griggs (2006) proposed that "rural nurses may directly and indirectly contribute to the growth, development, and cohesion of a rural healthcare system through multiple professional and social interactions" (p. 74). Theorizing from a social capital framework wherein trust, networks, community participation, and reciprocity are central, these authors support the notion that the local circumstances and the unique characteristics of each rural community must be considered when attempting to understand the transactions that occur between nurses and the community in the provision of healthcare. They suggested that strong interpersonal relationships, trust, and reciprocity between healthcare providers and receivers reduce health transaction costs and ought to be considered when evaluating nurses' contribution to rural health.

While familiarity with rural residents creates unique relationships, allowing nurses to integrate family and informal healthcare with formal healthcare services (Bushy, 2002), it also challenges nurses' professional boundaries (Bourke et al., 2004). Scharff (2006) likewise reported that knowing most people rural nurses care for and work with had a positive impact on nurses' practice. However, this distinctive aspect of rural nursing practice also contributed to a loss of anonymity not normally experienced by urban nurses.

Dalton (2004), in a United States based ethnographic hermeneutic study, noted that students tended to take the relationships between rural nurse and rural residents for granted early in their practice experience. However, as their experience with rural practice deepened, so did their appreciation of the ways in which nurses' work is inextricably linked to the community conversations and information exchanges of a rural network. Engagement with rural residents

informed the way in which students thought about rural nursing practice beyond that required by organizational timelines and tasks; ideally, it could help them achieve greater intimate understanding of patients' health needs based on humanistic relationships (Dalton, 2004, 2005). Yonge, Ferguson, and Myrick (2006), in a research report about rural preceptorships in Alberta and Saskatchewan, cautioned however that the short-term nature of the preceptorship influences the degree to which preceptors share patient information beyond that which is needed to provide care at a particular time. They speculated that limited information sharing about a patient protects the rural resident's privacy and promotes the trust between rural nurse and rural resident.

This interplay between the *Gesellschaft*- and *Gemeinschaft*-like relationships associated with nurses, as professionals and as citizens of a rural community, proved central to this inquiry. Of course, *Gemeinschaft*, as an ideal type, is not fully realized in any community, and the concept is not intended to stereotype rural life, rural practice, and the rural educational experience. Nonetheless the concept shed useful light on features common to practice settings in this study.

2.6. Learning Communities and Ethnographic Inquiry

Nursing education employs multiple approaches to learning, including knowledge-based and situational/contextual based forms. The practice-education preceptorship model assumes primarily a relational and contextual form of learning. There are significant differences and tensions between this approach and knowledge or cognitive based approaches, such as tend to dominate in classroom settings. The latter:

have been criticized for their basic belief that knowledge and expertise are located in the heads of individual subjects. The situated and social learning approach, which has challenged the assumptions of cognitive and knowledge-

based approaches, suggests that knowledge and expertise are primarily present in the discursive interactions of practical communities. (Eteläpelto & Collin, 2004, p. 231)

While such an analysis of educational approaches is not central to the study, it is highly congruent with the ethnographically informed approach employed and with its interpretative themes of culture, place, and relationships. A focus on ‘discursive interactions of practical communities’ in the context of rural preceptorships is congruent with the perspective that learning and change come from the interaction between culture and personal agency (Polkinghorne, 2004).

Wenger (1998) outlined a social theory of learning as a form of learning that does not replace, but rather augments, other forms. Social theory of learning is based on several assumptions: people are social beings, “knowledge is a matter of competence with respect to valued enterprises” (p. 4), knowing comes from actively engaging in the pursuit of the enterprise, and learning consists in enhancing our ability to experience the world through meaningful engagement. Preceptorship can be viewed as a form of social learning, as it incorporates the interconnected and mutually defining components essential to the process: meaning, practice, community and identity.

Meaning, in the context of social learning theory (Wenger, 1998), is the conversation about how our experiences of our world change our capacities. Practice is the dialogue about shared social and historical resources, perspectives and frameworks that sustain focus and engagement on particular actions. This echoes the previous emphasis on the shared culture of nursing as a practice that focuses on the health of people, with a history and some common perspectives that unite the discipline. Community is “a way of talking about the social configurations in which our enterprises are defined as worth pursuing and our participation is recognizable as competence” (Wenger, 1998, p. 5). Identity is the manner of talk about how learning shapes people and

“creates personal histories of becoming in the context of our communities” (p. 5). These conversations serve to form the identities of nurse educator, student, and practicing nurse.

Social learning theory thus supports the idea that one can learn from the stories of nurses and students about preceptored practice experience within a rural community. Such conversations became the ethnographically informed method through which data was collected for this inquiry. Entry into research conversations within a community of practice is a way to develop and share knowledge.

“Ethnography is a scientific approach to discovering and investigating social and cultural patterns and meaning in communities, institutions, and other social settings” (Schensul, Schensul, & LeCompte, 1999, p. 1). Normally ethnographic inquiry starts with some preliminary yet connected ideas that undergo revision throughout the research process and can come from one’s personal experience, secondary sources such as media, public information about the research community of interest or practice, research and conceptual literature. Ethnographic inquiry can include the integration of both qualitative and quantitative forms of data. Ethnography requires face to face communication with participants of particular communities to collect data and thus “by definition, all ethnography is local. Ethnography effectively builds local theory—theories that explain events, beliefs, and behavior in the special site an ethnographer is studying” (Schensul et al., 1999, p. 7).

Ethnographically informed research tries to understand and advance the state of affairs experienced by participants (Schensul et al., 1999). The present qualitative study, emerging from an ethnographic tradition, is focused on a particular kind of community of practice and motivated by interest in the pedagogical value of a traditional form of practice-education. What I set out to understand and advance was students’ learning through a cultural and social lens: how

the rural nursing practice environment contributed to student learning, and how students influenced the learning of others in the context of a rural nursing preceptored practice experience. This ethnographic research stance would inform my search for culturally or socially meaningful strategies to promote student learning. If necessary, changes to the preceptorship model could be advocated, or the research could lead to recommendations for broader changes in the approaches to rural undergraduate practice-education.

2.7. Summary

Chapter 2 has provided an overview of the practical and theoretical perspectives that informed this study. These included a review of rural undergraduate nursing research over several decades up until 2008, with a focus on rural preceptorship purpose, relationship building, and the development of student nurse practice. These themes are taken up again in Chapter 5 and compared with the most recent literature and the findings of this study. Subsequently, the concepts of culture, place, relationships, and social learning/learning communities were outlined, to serve as the conceptual basis for the collection and analysis of data in the ethnographic tradition. The people who inhabit places create culture; the uniqueness of a place and the relationships therein shape both culture and people. Rural hospital-based practice-education is a rich environment for learning about the interaction of these four factors and their impact on the learning experience.

3. Methodological Approach

3.1. Ethnographic Inquiry as a Research Tradition

This qualitative interpretive study, guided by an ethnographic tradition and methodological orientation, was intended to document and make meaning of rural undergraduate preceptored experiences from three perspectives: students', nurses' and my own. Classic ethnographies provide an overview of a cultural context, norms and values within a neighbourhood, ethnic group or village (Rubin & Rubin, 2005). However, ethnographic methods can also focus on specific issues within specific contexts among small groups (Roper & Shapiro, 2000, p. 7), as was the case in this study.

An ethnographer's instruments are varied; they include self and fieldwork that relies on relationship development, observation skills, interviews, surveys, reviews of archival materials and secondary data, plus analytical and writing skills. "The field is a physical setting, the boundaries of which are defined by the researcher in terms of institutions and people of interest, as well as their associated activities in geographic space" (Schensul et al., 1999, p. 70). Entry into the field can be complex, particularly when the language and culture may be substantially different from those of the researcher. Such conditions may require locating appropriate individuals and creating relationships with them so they can provide relevant information, reconsideration of the methods of collecting data in an efficient and unobtrusive manner, and sorting through information (Schensul et al., 1999).

Unlike a classic ethnographic inquiry, my research context provided relatively easy access to the field. I was part insider, having had previous experience as the faculty-of-record for rural

preceptorships and sharing a common nursing language with the participants. At the same time, I also considered myself to be partly an outsider as I was not a rural nurse or student and had never practiced rural nursing. Unlike a conventional ethnography, I opted not to observe nurses and students in practice but rather interview them only. I wanted to gather participant perspectives and not observe behaviours that might involve my presence around patients.

Spradley (1979) noted that witnessing culture directly is not possible. Culture is learned by being part of a group, through observations of actions, listening, and then making inferences based on reasoning from evidence or from assumptions. Cultural knowledge shared in a very direct manner through spoken communication allows the researcher to make inferences with some ease, as this knowledge is particularly explicit (Spradley, 1979). However, some cultural knowledge is so implicit that it becomes challenging to convey this knowledge in a straightforward manner. This tacit knowledge is, in part, what researchers attempt to reveal by listening carefully to what people talk about, observing how they behave, or by studying specific objects (Spradley, 1979). “Because language is the primary means for transmitting culture from one generation to the next, much of culture is encoded in linguistic form” (Spradley, 1979, p. 9).

Previous research has confirmed the relevance of these observations to rural nursing. MacLeod, Kulig, Stewart, and Pitblado (2004) noted the challenges nurses experienced in communicating the character and complexity of rural practice:

[nurses] found that although the words they used were the same as in urban areas (e.g., ‘complex’, ‘distance’), the meanings were different because of the community and practice contexts. They talked of needing to get ‘underneath the words’ so that their meanings could be more clearly understood. (p. 18)

In their research, listening emerged as a way for others, such as learners and stakeholders, to come to understand rural nursing: learning to listen and listening to learn.

Ethnography can include the personal narrative as a form of text, with the purpose of mediating inherent contradictions between the self as objective observer/researcher or as engaged, subjective participant (Pratt, 1986). Personal narratives, in the form of personal notes, stories and observations, can serve the analysis process by deepening interpretations, particularly when explored within larger disciplinary, socio-historical and political contexts. The researcher's text is a complex expression of epistemological and socio-cultural commitments; as such, the researcher must be conscious of being an interpreter of meaning rather than the conveyor of facts or statements (Atkinson, 1990). As one enters the inquiry, engages in interviewing others, and seeks to make meaning of any narrative materials, Davies (1999) advocates engaging in reflexivity. The research process involves coming to pay attention to what is important to others and then making mental notes about these matters, a sense of being willing in the interview process to go where the participants' interests lie (LeCompte & Schensul, 1999) as well as seeking information to address the research question. Reflexivity moves the inquirer to consider the ways in which the researcher and participants influence the research process (Davies, 1999).

The research design was, in part, open and flexible in the place, time, and semi-structured nature of the interview process. The analysis process was primarily inductive, guided by the research questions, interview questions and main concepts of interest: culture, place, relationship, and learning. An ethnographic tradition informed this research in several ways: (a) my personal experience with rural preceptorship that inspired this inquiry; (b) how these experiences shaped my assumptions; (c) a specific definition of culture that required thoughtful consideration of conflict or congruence of assumptions, values and beliefs; and (d) the personal process of thinking, questioning and writing to make meaning for self and others in a way that would authentically represent rural preceptorships.

3.2. Ethical Considerations

Simon Fraser University (SFU), my own employer and the IHA Research Ethics Committee all granted Human Subjects ethics approval; see Appendix A, B, and C. Participants as professional or pre-professional nurses expressed no difficulty in giving informed consent. A research overview provided in writing prior to the interview was part of the recruitment process (see Appendices D and E for letters of invitation). Recipients of the invitation were requested to reply via an addressed pre-paid RSVP Card (see Appendix F). Information about benefits, potential risks, expectations of time, and the voluntary nature of participation was reiterated at the start of the first and second interviews. All participants agreed to sign a consent form (see Appendix G).

A summary of the ethical obligations and steps to maintain confidentiality was part of the written documentation provided to participants. This became part of the pre-interview conversation about commitment to confidentiality and representations in the research product (dissertation, papers, and conferences). Participants were informed, in both writing and verbally, of their rights as a research participant and any methods of recourse they had should they find their rights undermined. As the researcher, I arranged my professional work-life so as not to be in a supervisory position in relation to preceptorship experiences or be the faculty-of-record for any student, so as to limit any potential power-over relationship with a student. Participants never disclosed a serious potential threat to patient safety during the interviews that might legally or professionally necessitate disclosure of a situation and associated persons.

A promise of anonymity was implausible, but a professional promise of confidentiality was possible and obligatory. I did convey verbally to participants that it was their decision about whether or not to share their participation with others. I was aware that some nurses had shared their participation with direct supervisors. A certificate of research participation mailed to the

participants along with a copy of their transcript served as evidence of their having lived up to professional standards of engaging in research. Participants were apprised in writing and verbally that quotes from the interview would be used in the products of research to provide a form of evidence for analytical arguments, and that it remained a possibility that others might claim recognition of participants' words, circumstances or stories despite the absence of attribution. To minimize the risk of participant recognition, personal identifiers (name, gender, position/title, dates, etc.) were not linked to place-related identifiers. Confidentiality, a cornerstone of human subject research, was a foremost consideration and participants seemed confident of my intent to uphold this responsibility.

Participants' right to privacy was a paramount consideration and discussed with participants prior to arranging a place to meet for the interviews. Identifiers were removed from transcripts prior to returning them to individual participants via Canada Post.

3.3. Identifying Participants and Collecting Data

3.3.1. Sampling

The concept of rurality has multiple definitions emerging from multiple disciplines and epistemologies. At present "there is no universally accepted definition of either rural or remote in Canada" (MacLeod, Kulig, Stewart, & Pitblado, 2004, p. 2). Kulig et al. (2003), in an extensive review of policy documents concerning rural and remote nursing practice in Canada, noted that the terms "rural" and "remote" lacked theoretical meaning and were assumed to be implicitly understood by writers and readers. The relative lack of definitions failed to capture "the range of diverse rural and remote communities that exist across Canada" (Kulig et al., 2003, p. 60). A lack of thoughtful reflection about the meaning of rural and how it encompasses a diversity of settings and people results in an oversimplification of rural nursing practice (Kulig et al., 2003).

It was therefore important to be mindful in the ways I went about recruiting participants for the study, since I wished for a sample of rural nursing preceptorship practice that could capture the essence of being a professional serving human health in particular places.

Pitblado (2005) cites two analytical approaches for conceptualizing rural: technical and social. The technical definitions generally involve distances, areas, and density combined to form units of measurement. The efficiency of technical systems tend to form boundaries that have less to do with the subject and more to do with the efficiency of collecting data for provincial or federal statistics (Pitblado, 2005). Social approaches, developed more theoretically than methodologically, are “used with the intention of highlighting the fact that points, lines, and areas are merely locators or containers where lives are lived” (Pitblado, 2005, p. 165). Pitblado (2005) suggests that Canadians have barely begun to explore the implications of using a social representation definition of rural. In setting boundaries for sampling, I opted for a technical definition of rural using the Interior Health system of categorizing hospitals. As participants came forward, however, I took care to characterize their rural setting from a social as well as a technical perspective.

Sixteen community hospitals within four Local Health Areas, categorized as either level 1 or level 2, were identified as serving rural and remote populations by and within the Interior Health Authority (IHA, 2004b) and deemed suitable sites from which to recruit student and nurse participants. A Local Health Area (LHA) is a descriptor used to outline 31 geographic regions within the IHA (Armstrong, 2009a). According to the categorization at the time of the study, Level 1 hospitals provide emergency and ambulatory care services, laboratory and radiology services, beds for patients requiring medical treatment, observation, recovery, palliation, and low risk obstetrics. Level 2 hospitals provide an increased level of service in the

form of obstetrical care, 24-hour RN triage services in emergency, and some medical specialties such as internists, ambulatory care surgery, and low complexity surgical services (IHA, 2004b).

In 2002, the Canadian Institute for Health Information (CIHI) reported the following statistics concerning RN employment in rural Canada:

17.9% of all RNs employed in nursing in Canada work in rural areas, where 21.7% of the Canadian population live. . . . The majority (53.8%) of rural RNs work in hospitals but increasingly higher proportions of rural RNs are employed in long-term care and home care compared with RNs in urban areas of Canada. (pp. 4-6)

Statistics Canada (2009) reported that 6 million people lived in rural areas, or slightly less than 20% of the Canadian population; in 2001, people living in rural areas made up 21.7% (CIHI, 2002). In 2010 CIHI reported only 10.7 % of the RN workforce worked in rural and remote areas and Territories, compared with 17.9% in 2002 (CIHI, 2002). However, the methodology of sampling the workforce had changed between 2002 and 2009 and CIHI cautioned about comparisons between historical data and present representations. This disparity highlights the challenges of defining and comparing rural using diverse technical definitions.

Population workforce statistics from 2001 were used for sampling purposes because at the time of the study design and implementation the 2006 workforce statistics were not reported. The university nursing program in which I taught had approximately 150 undergraduate nursing students in Years 3 and 4 at the time of this study. A potential rural quotient of these nursing students, based on distribution of rural RNs, would be approximately 14 rural hospital-based placements every year ($18\% \times 150/2 = 13.5$). To be able to sample approximately 40% of this potential annual preceptorship population would mean interviewing five students and five nurses. However, had the data analysis failed to reveal ample common themes, the necessity to interview more participants might have become self-evident. Schensul et

al. (1999) identify the “informational saturation point” (p. 262) as being reached when more data does not produce more information. At the time I completed the interviews I was fairly confident that no significant additional themes were forthcoming. Confining the potential participant pool to a particular locale was intentional to allow me to interview participants face-to-face over an anticipated 1-year timeframe. I underestimated the time in which to recruit students from one school of nursing and nurses from one health authority. Recruiting an adequate sample took 2 years using the original criteria.

Potential participants for this study were contacted by letter of invitation. The university Practice Placement Coordinator(s) and the Interior Health Professional Practice Education Coordinator identified potential participants that fit the criteria and were provided with a package to mail to each individual. The package included a letter of invitation, and RSVP card, and a self-addressed envelope. Fifteen invitations were sent to students and 25 invitations were sent to nurses.

My final sample consisted of five nurses who responded to the invitation to be participants, all of them practicing in Level 1 hospitals within the Thompson Cariboo Shuswap Health Service Area (TCSHSA); and five third- or fourth-year undergraduate nursing students, four of whom had preceptored practice experiences in a Level 1 hospital and one of whom had preceptored practice experience in a Level 2 hospital. For the remainder of this text these LHA’s are given fictional names to promote the privacy of participants. Practicing nurses and nursing students were not actively engaged in the preceptorship experience at the time of the interview and there was no attempt to pair student participants with nurse participants. All students in the study had between 200 and 300 hours of experience in rural acute care practice and were interviewed within 6 months of their experience.

3.3.2. Interview as Method

“At the very heart of what it means to be human is the ability of people to symbolize their experience through language” (Seidman, 2006, p. 8). Interpretive researchers “try to elicit the interviewees’ views of their worlds, their work, and the events they have experienced or observed” (Rubin & Rubin, 2005, p. 28). An interpretive constructionist approach to research recognizes that:

researchers do not need to drop their cultural assumptions and assume those of the conversational partners, but researchers do need to be cautious lest they fail to hear the meaning of what the interviewees have said because their own cultural assumptions get in the way. (Rubin & Rubin, 2005, p. 29)

In-depth semi-structured interviewing was the fundamental method chosen for data collection about participants’ experiences, their stories, and the meaning they give to activities or events (Seidman, 2006). I opted for the semi-structured interview method of data collection for its practicality and credibility, and because it allowed me to draw on my proficiency in professional nursing language and my familiarity with this form of practice-education to nurture productive conversations. “Semistructured interviews combine the flexibility of the unstructured, open-ended interview with the directionality and agenda of the survey instrument to produce focused qualitative textual data at the factor level” (Schensul et al., 1999, p. 149). While the questions on a semi-structured interview guide can be predefined, it was the intention of the interview process to allow the participants to provide answers that were open-ended and allowed for greater elaboration with interviewer probes or participant desire to provide a full explanation (Schensul et al., 1999).

Twenty interviews were completed. Participants consented to two semi-structured taped interviews of approximately 1 to 2 hours each with the time and place of the interviews mutually negotiated. Originally I had planned to do the first interview face-to-face and the second

interview via telephone to reduce the time and cost associated with travel. After the first interview, it seemed more appropriate as a gesture of commitment to participants, particularly nurses living and working in different communities, as well as consistent with an ethnographically-informed method of data collection, to travel to the nurse's community to hold the second interview face-to-face as well. Consequently, all interviews occurred face-to-face. The interviews occurred between August 2007 and April 2009 and all but one interview with a student took place at the university. One interview with a student took place off campus in the participant's community of residence. Three nurse participant interviews occurred within the community the rural hospital was located, two of which were conducted in a private room in the hospital and one in a private room at a community library. Two nurse participants opted to meet me at the university. The length of the first interview ranged from 90 to 120 minutes. The length of the second interview ranged from 60 to 90 minutes. A transcriptionist was hired to transcribe the recorded interviews. I reviewed the transcriptions against the recordings for accuracy.

Questions for the first semi-structured interview encouraged nurses and students to share their experiences and understandings of rural preceptorships (see Appendices I and J for samples of preceptor and preceptee questions). I explained to the participants at the outset that other questions might come up during the interview or they might have other thoughts not related directly to a question and should feel free to go in any direction that mattered to them. The second set of interview questions was designed to follow up on this first conversation, by exploring a general line of thinking further or asking for verification, clarification, and elaboration of certain points. The following quote of a second interview with rural nurse participant Ilene illustrates a typical interaction. At that time, I shared my in-the-moment interpretation of the sentiments of the participant in order to establish mutual understanding.

Cheryl: Yeah, actually that was one of my questions, written down. It was about that notion of specialty, here it is on page 3, but you inferred in a way and I have read this in other places, that rural practice is really coming to be a speciality of sorts, right, and other specialty areas are now taking new grads right but how does educational practice enhance new graduate readiness for rural practice?

Ilene: That's a good question. I think with rural practice it solidifies everything that you have learned but the pace is a lot different from the floor you can do it . . . you can do . . . sometimes it's totally crazy rural and sometimes it's very, very calm, quiet and you can solidify all your learning and experience together, whereas, depending on where we are in the cycle, like now the acute here it's more . . . multi illness, it's always multi illness now and it doesn't really give you a chance but on those quiet times you'll be able to sit back and bring it all together. You know, so some are, some are, quicker than others picking up the pieces and fitting the puzzle together. Do you sort of understand what I'm saying?

Cheryl: So, I'm saying, well I'm going to try and restate it so that we can kind of see if we're at the same place.

Ilene: Yep.

Cheryl: So there is busy times and there are quieter times and one of the, although that's a challenge this change in intensity it allows also for some time for reflection and learning, maybe while you're at work

Ilene: Exactly, whereas, here we don't, OK say you're in Springfield you have your med surg you have your ambulatory care you have your 5 North and the routine is so constant, right, whereas in the rural there is the routine but it's not as consistent because you have to.. You can be pulled away in 10,000 directions in 1 day. [rn4 Ilene: 4855-5040]

Listening emerged as a significant activity in the research process. Listening was vital during the interview process and enhanced my ability to pose clarifying questions or to paraphrase sentiments conveyed in order to enhance mutual understanding. Listening to the tape after the first interview provided an opportunity to consider questions for the second interview and to make personal notations. Listening to the spoken word also provided an opportunity to hear the pace and tone of the interview conversation which differed immensely from reading transcripts, allowed me to verify the transcriber's accuracy and offered me the opportunity to re-immense and be transported to the conversational quality and ideas that were important to participants in that moment. Re-listening to the digital recordings also served as inspiration and spurred motivation to continue with the inquiry.

It is noted here that text from participant transcripts are included as somewhat denaturalized quotes (Oliver, Serovich, & Mason, 2005). Some of the grammar has been altered and involuntary vocalizations, speech mannerisms, and response tokens such as ‘um and uh huh’ have been removed to improve readability while still conveying the essential meaning of the transcribed text. In working with the data I was primarily concerned with “the substance of the interview, that is, the meanings and perceptions created and shared during a conversation” (Oliver et al., 2005, p. 1277).

Before describing the process of interpreting the interview data, details of the participants and of their rural practice settings are provided.

3.3.3. Participant and Place Descriptions and Confidentiality

The use of terms such as “participant” to represent individuals, and symbols such as lines within the text to represent unnamed places, undermines the ability of a text to communicate the individuality and particularity of people and settings. In presenting the personal stories of students and nurses while also honouring the confidentiality of individuals, I have therefore chosen to use pseudonyms for participants and places. Student participants are identified by names starting with letters A through E: Abbie, Bobbie, Carla, Daniell, and Estelle. Nurse participants are identified by names starting with letters F through J: Fern, Gayle, Haley, Ilene, and Jaime. The rural communities and sites of rural hospitals were renamed Waterton, Westmount, Windermere and Pleasantville. The rural community population and health related statistics are described later using these fictional names.

Table 1. Preceptorship Place by Student and Registered Nurse

Place	Student Nurse	Registered Nurse
Windermere	Abbie	Haley
Pleasantville	Bobbie Carla	Fern Gayle
Westmount	Daniell	Ilene Jaime
Waterton	Estelle	

Note. The student preceptees and nurse preceptors were not paired.

Participants referred to three additional places. The place of the students' educational program, where they resided for at least the first 3 years of a 4-year nursing program, was renamed Springfield. Springfield had one regional referral hospital that served approximately 110,000 people: the second largest LHA of the 31 in the region (Armstrong, 2009a). A second large urban area, fictionally named Centreville, had a regional referral hospital and several specialized health services. A large metropolitan area with more than 500,000 people, fictionally called Urbania, approximately 350 km from Springfield, was referred to occasionally by participants.

3.3.4. Introducing the Students and Their Context

The student participants were from a 4-year Bachelor of Science in Nursing (BSN) program located in Springfield. Approximately 80 students were in each year of the program in two separate intakes (40 in September and 40 in January). At the end of each year of the program, students chose a practice setting where they would have consolidated practice experiences (clinical course only without theoretical classes). In the second year consolidated practice, students normally remain in Springfield, with the exception of those students who may be returning to a community of origin. For the purposes of this study, I focused on students who had completed a preceptored practice experience at the end of the third or fourth year. In

the third year, students had the choice of hospital-based experience of approximately 200 hours anywhere in BC or they could opt for an international experience, provided their clinical performance was satisfactory. At the end of the fourth year of the program, students could choose a community- or hospital-based 300-hour practice placement anywhere in BC, as sites and preceptors were available and willing.

At the time of the interviews, two of the student participants had recently graduated and the remaining three student participants had completed their third year of the program. The students were all female, under the age of 30, with no children. Four student participants were not married. Two students were engaged to marry within a year of the interview. All but one student had lived in a rural area in BC during their adolescence.

Abbie spent most of her adolescent life in a rural community very close to Pleasantville. At the time of the interviews she had finished a third year consolidated practice experience in a hospital in Windermere.

Carla had grown up in the community of Pleasantville and, at the time of the interviews, had completed her fourth year final practice experience at the Pleasantville hospital and was now working in the Springfield hospital.

Bobbie grew up entirely in the community of Pleasantville. She opted for a preceptored experience at the end of her second and third year in Pleasantville hospital. At the time of the interview, Bobbie had completed the end of third year preceptored practice experience in Pleasantville and was entering her fourth year. Bobbie was working as an Employed Student Nurse (ENS) in Pleasantville hospital at the time of the first interview.

Daniell had lived her entire life in Springfield and opted for an end of third year practice experience in Westmount hospital. At the time of the interview, she had begun her fourth year of the program.

Estelle was raised in a BC rural community north of the IHA. Like most students, she lived in Springfield for most of the nursing program. She relocated in her fourth year of the program to a rural community close to the Waterton hospital and opted to do part of her final fourth year practicum there. Estelle was employed part-time in Waterton public health at the time of the first interview.

3.3.5. Introducing the Preceptors and their Context

One preceptor had graduated with a BSN degree from Springfield several years earlier and was practicing in the hospital where this participant had completed their final preceptorship experience. Two of the preceptors had graduated in the 1970s and 1980s from the same college-based diploma nursing program in the Interior Health region and were nursing at different rural sites. I had known both these nurses while they were nursing students and had worked with one as the faculty-of-record when she preceptored a student. One nurse had moved to BC after graduating with a college-based nursing diploma in Ontario. One nurse graduated from a hospital-based nursing diploma program in BC and went on to obtain a Bachelor of Science degree via a distance delivered program in the 1980s. Four nurses were married with adolescent or young adult children, and lived within in the community in which they nursed. One nurse participant was unmarried and did not live within the rural community.

Fern's community of origin was Pleasantville with an approximate 2-hour commute by car to Springfield. Fern worked in Springfield regional hospital and the Pleasantville rural hospital in the early part of a nursing career as well as out-post nursing. Fern had preceptored

several nursing students from Springfield throughout her career. Gayle, also from Pleasantville, had nursed for 35 years primarily in Pleasantville. Gayle had preceptored several students from Springfield and Urbana.

Haley was a mid-career nurse, married with children, living and working in the Windermere hospital. Throughout this nurses' career, positions in rural settings, emergency rooms, rural community nursing and rural hospitals were the norm. Haley relocated 5 years earlier from what had been Haley's rural community of origin in which Haley practiced in the local rural hospital for several years. Windermere was about a 1.5-hour commute by car from Haley's rural community of origin and 1-hour commute from Springfield. Haley had preceptored several students from different colleges and universities throughout the province while practicing in rural acute care hospitals.

Ilene was a mid-career nurse. After graduation, Ilene moved to Westmount to obtain part-time employment. Ilene noted the move to Westmount came, in part, because there were few employment opportunities for nurses throughout the province at the time of graduation and Ilene generally being attracted to rural settings and rural practice. For the most part Ilene had worked full-time at Westmount and had acted as a preceptor for Springfield nursing students almost every year for 15 years. Westmount was approximately a 2-hour commute by car from Springfield. I had the opportunity on several occasions in the mid 1990's to work with Ilene when preceptoring students and I was the faculty-of-record. I acknowledged this previous relationship with Ilene.

Jaime was an early-career nurse having graduated with a BSN degree from Springfield University several years earlier. Jaime grew up in Springfield and after living in several smaller communities throughout the western provinces opted to live in a rural community between Springfield and Westmount. While in the nursing program, Jaime was interested in rural and

remote nursing and had requested an isolation posting. When an out-post practicum was not available the now graduate nurse agreed to be preceptored in the final practicum in Westmount. Upon graduation Jaime started nursing at the Westmount hospital. At the time of the research interviews Jaime was just finishing a first experience as a preceptor in rural hospital-based practice.

3.3.6. Places of Preceptored Practice

Outlined here are the general population and health characteristics associated with the actual places of preceptored practice. As noted in Chapter 2, technical measures such as population data and health statistics do not adequately define rural; they are only presented here to provide a sense of the range of communities and their general population and health issues. The largest community, Waterton, includes a higher proportion of elderly people than the other communities; it is also the only one to have a Level 2 community hospital offering a greater range of services. Like the other hospitals in the study, though, it serves a substantial rural population (see note to Table 2). There were several First Nation reserves with the youngest populations within Westmount and Windermere regions. All regions had similar leading causes of death, although Windermere and Pleasantville had motor vehicle accidents as a leading cause of death while Westmount and Waterton did not. Table 2 provides an overview of population statistics and leading causes of death for the LHA's; the sites used for this research.

One measure of healthcare needs in BC communities is the Overall Regional Socio-Economic Index, which provides “an overall weighted average of Economic Hardship, Crime, Health Problems, Education Concerns, Children at Risk, and Youth at Risk” (Armstrong, 2009b, p. 13). Using this index the Local Health Areas (LHAs) in BC were ranked from worst off (1) to

best off (78). Windermere and Westmount both ranked among the 10 worst-off areas in the province. Waterton ranked in the low 20s and Pleasantville in the low 30s (BCStats, 2009).

Table 2. Local Health Area Profiles

Community (within a Local Health Area)	Pleasantville (LHA 26)	Westmount (LHA 29)	Windermere (LHA 31)	Waterton (LHA 20)
Level 1 or 2 Hospital	Level 1	Level 1	Level 1	Level 2
Population to nearest 500 (2008)	4500	4500	11,500	35,000
Median Age of Population	45.4	41.1	42	48.1
Population over age of 65	15.8%	14.4%	15.5%	22.2%
Population under age of 20	22.8%	24.5%	24.2%	19.8%
Leading Causes of Death	Malignant Neoplasm, Disease of the Circulatory System, Alcohol-Related Deaths, Motor Vehicle Accidents, and Endocrine & Metabolic Diseases	Malignant Neoplasm, Disease of the Circulatory System, Alcohol-Related Deaths, Disease of the Respiratory System, Disease of the Digestive System	Malignant Neoplasm, Disease of the Circulatory System, Alcohol-Related Deaths, Motor Vehicle Accidents, and Endocrine & Metabolic Diseases	Diseases of the Circulatory System, Malignant Neoplasm, Disease of the Respiratory System, Alcohol-Related Deaths and Disease of the Digestive System
Primary Communities within LHA	2 small towns	3 Indian reserves and a small town	4 Indian reserves and a mid-size town	4 small- to mid-size towns and a small city
# Persons/km ²	0.4	0.6	1.8	10.9

Note. Information compiled from Armstrong (2009a, 2009b, 2009c, 2009d, 2009e). “An urban area has a minimum population concentration of 1,000 persons and a population density of at least 400 persons per square kilometre. All territory outside urban areas is classified as rural. Taken together, urban and rural areas cover all of Canada. Urban areas are defined using population counts and population density data from the current census” (Statistics Canada, 2010, p. 499). “Rural population includes all population living in the rural fringes of . . . census agglomerations (CAs), as well as population living in rural areas outside . . . CAs” (p. 230). While several towns and reserves in a particular local health area may have populations consistent with the definition of a census agglomeration of 1000 persons or more they tend not to meet the standard of population density to be defined solely as an urban area. Level 1 and 2 Community Hospitals as defined by the Health Authority exist within defined Local Health Areas were chosen as sites given these hospitals are situated in lower density areas than tertiary hospitals and serve substantial rural populations. Populations identified in the table represent ‘areas’ and not specific towns or communities.

3.4. Transcript Interpretation

3.4.1. Strategies for Meaning Making

The purpose of ethnographic narrative analysis is to convey the meaning of experience or events in written form to enhance public, professional, and researcher understanding

(Cortazzi, 2001). A feature of ethnographic inquiry is the researchers' propensity to work with unstructured data not coded according to a predetermined set of analytic categories (Denzin & Lincoln, 1998). LeCompte and Schensul (1999) describe a bottom-up analytical framework I chose as a guide for the analysis. This choice was made after I had reviewed several of the verbatim transcripts during the process of checking the accuracy of the transcriptionist's text against the digital recording. During these initial reviews of the transcripts, I found myself thinking about three different ways to represent the text: words that conveyed concepts, descriptors that elaborated on the concepts, and ways in which the concepts relate. The LeCompte and Schensul (1999) method of inductive analysis closely mirrored my original intuitive approach to the data. They describe a bottom-up method that transforms words into three levels of abstraction: item, pattern and constitutive (structural). The inductive process isolated and grouped specific elements in the data because of one or more qualities: frequency of occurrence, rarity or absence despite expectations of presence, and seeming influential or critical to other items.

LeCompte and Schensul (1999) advised that identifying items for purposes of coding required attention to the specific research question(s). I approached the text without a predetermined set of codes; however, it seemed consistent to keep the conceptual lenses from the original design of the research (culture, place, relationship, and learning) at the forefront of my thinking. Coding involved reading and re-reading the interview transcriptions line by line. Words, sentences or paragraphs were selected on the basis of individual words or phrases, and codes assigned to them. As I moved through each text, new codes became infrequent and the majority of the text became coded.

Ethnograph 6 © is the qualitative data analysis software that I chose for its availability, simplicity, and cost effectiveness. The software provided for storage and retrieval of text-based

data, creation and management of a code-book, memoing researcher ideas and reflections, and tabulation functions. Transcribed interviews were reviewed for accuracy by listening to the digital recording and reading the text at the same time. The text was timed and approximately every 3 minutes the time was inserted into the text to facilitate my ability to return to the digital recording to re-listen to particular aspects of the text. The first and second participant interview transcripts were compiled into single files and assigned a file code to reflect the participant group and sequence of interviews: RS1 to RS5 for students and RN1 to RN5 for nurses to reflect the order in which the interviews occurred. Individual electronic text files were then imported into Ethnograph 6 © under one project name.

A code-book was built for analysis by reading through the transcripts and selecting words used by the interviewer and participant that appeared to capture key ideas expressed in common language. These common code words, or item words, were entered into the Ethnograph 6 © code-book along with pattern code words reflective of key connected items and broad-conceptual codes that reflect this study's conceptual orientations (culture, place, relationships, learning), as described in more detail below.

Personal notes made immediately after each interview took the form of identifying new questions for future interviews, initial impressions of the interviews and participants, and reflections upon what themes or ideas were emerging in the interview process. Personal notes helped document the research process and promote auditability, and provided textual sources to facilitate interpretation of process and product.

Memoing took the form of recording emerging thoughts, questions, and personal perspectives during the review of transcripts. Memos were linked electronically to the transcript site or text where the thought occurred. Memoing served to strengthen analysis and deepen

interpretations. Table 3 illustrates a personal memo linked within the qualitative data analysis software directly to a specific portion of participant text.

Table 3. Personal Memo Linked to Participant Text

Transcript	Memo
<i>Cheryl: Right, right so you find students sometimes are surprised</i>	This segments speaks to the cultural dissonance or surprise that students experience around the interpersonal and interprofessional relationships, that the size (density) of the community creates conditions wherein professionals are also friends outside of work, that they do things together whereas in a larger community that interpersonal and interprofessional connectedness may not exist. (Cheryl Zawaduk, 01-05-2009)
<i>Ilene: Mm hmm</i>	
<i>Cheryl: by the nature of the . . .</i>	
<i>Ilene: The culture shock, just overly how small it is and what is available in our fine little community</i>	
<i>Cheryl: Right, right that's interesting, when you say the culture shock and sort of the services, is there anything else they [students] are surprised about or that you notice they are sort of surprised about in the rural community or rural practice</i>	
<i>Ilene: Just the, basically the tight knit working environment here, you know we sort of all do things together and all hang together and it sort of like a little family. We are all very close. [rn4 Ilene: 1490-1540]</i>	

Noticing patterns between items and ways in which they relate was the next level and phase of analysis. LeCompte and Schensul (1999) identify patterns as phenomena that are challenging to operationalize, have no clear beginning or end and vary in meaning. Patterns are complex sets of ideas or behaviours grouped around things such as norms/values, motives, beliefs, interactions, practices, themes, meanings, explanations. The pattern level of analysis required ordering of items into groups of related or associated items, using umbrella terms to identify them. Some patterns were identified by participants themselves, as when they were asked what they had noticed as common features of rural practice over time; others were found by examining relative frequency, similarity or co-relationship among specific items or ideas that

reoccurred within the text. Examples of identified patterns included, but were not limited to, density, dissonance, continuity, time, and autonomy.

The broadest level of examination outlined by LeCompte and Schensul (1999) took the form of structural or domain level analysis, wherein relationships were explored among the emergent patterns in the data. Attempting to categorize codes into these themes or patterns led to more questions about whether or not certain items belonged within a particular pattern and how each pattern related to other patterns. Describing the relationships among patterns led to a developing portrait of the culture of rural preceptorship that helped me to rethink the nature and value of rural preceptorship experiences from the perspective of students and nurses. The tension between identifying common patterns and searching for difference and diversity existed for me throughout the analysis. This tension supported my noticing of participant comments that did not fit the pattern and kept me mindful that human experience differs.

The process of analysis and interpretation of participants' narratives remained within the researcher's domain. Participants had the opportunity to review their interview transcript and provide clarification and elaboration (Forbat & Henderson, 2005; see Appendix K for an example of the letter accompanying of transcripts mailed to participants). No participant reviews were received, however. The thematic overview resulting from this extended inductive analysis of the transcripts is presented in Chapter 4.

As the primary analysis of the narrative data took shape, a secondary analysis began to develop connecting it to the current rural nursing practice-education conversations evident in public documents, such as policy and literature. This process served to place narrative findings in a larger context and so made evident ideas that converged or diverged, possible reasons for common or differing perspectives, areas requiring future research, and recommendations emerging from this inquiry. This second phase of the analysis is presented in Chapter 5.

A growing desire to honour individual participants' time and words became apparent throughout the research process. In addition to providing each participant with a transcribed text as evidence of their contribution, I sent each of them a thank-you letter (see Appendix L). The letter could be used to demonstrate to professional or occupational organizations evidence of participating in research; such written evidence becoming increasingly important, particularly for RNs, when accounting for their professional development and service contributions.

3.4.2. Validity

Schensul et al. (1999) outline three forms of validity (internal, construct and external) and two forms of reliability (internal and external) for which research should be scrutinized. In this section and the next, I discuss strengths and limitations of the research approach in these areas.

“Internal validity refers to the correspondence between measures and the reality of the field situation” (Schensul et al., 1999, p. 275). As previously noted, no direct observations of the field situation were made during this research. However, my previous experience as a faculty-of-record overseeing rural preceptorships provided indirect field experience. The interview method could be expected to ensure high validity, given that nursing was my profession and I shared a common language with participants. The length of time four of the five nurses (preceptors) had worked in a rural hospital-based setting plausibly strengthens internal validity by yielding consistent insights based on a stable professional history. Furthermore, the credibility of my interpretations of participant conversations, particularly in the absence of participant validation, was enhanced by the inclusion of several participant quotes for each theme I identified as meaningful (Ryan-Nicholls & Will, 2009). Several examples of participant text enable readers to form their own interpretations and check them against my own. Finally, a careful comparison of

findings of this research in comparison to other similar forms of research acted as a form of 'interobserver agreement' (Schensul et al., 1999) and is a primary focus of Chapter 5.

“Participants can give false or misleading information in the researcher’s presence. This threat to internal validity is commonly referred to as the impact of observer effects” (Schensul et al., 1999, p. 280). One of my original concerns was about the degree to which the nurses and students would trust me so that they would share information that they would not necessarily share in a public forum. In order to limit the power dynamics in the interviews, I made decisions about my teaching and educational employment that would prevent my being in authority over student outcomes in their educational program in order to promote student participants’ willingness to express their personal perspectives freely without concern about a future relationship with me as an educator. I also communicated to participants my commitment to protecting their individual privacy. Among the practices I employed were arranging secluded interview rooms, describing the transcription of digital recordings and removal of identifiers, outlining how participant information and stories would be represented in the products of the dissertation, and forwarding each participant a copy of their interview transcript. Holding onto a participant’s transcript, it seemed to me, would further a power inequity and undermine participant trust in the research relationship.

“Construct validity refers to whether instruments measure what they are assumed to measure” (Schensul et al., 1999, p. 275). Construct validity is less relevant in exploratory research as this form of inquiry normally does not predefine concepts or behaviours; as noted, the primary method of analysis used was inductive. The semi-structured interview process allowed for a free flow of information exchange between research and participant and did not specifically revolve around certain predefined concepts. The 2 hours allotted for each interview promoted

in-depth discussions. My post-interview reflections included a review of the degree of attention given to the areas of focus and whether or not there were different questions to be posed in the second interview to deepen the discussion or description. Often in the second interview the question, “What, if anything, did you want an opportunity to tell me about the nature and educational value of the rural hospital-based experience that you have not had an opportunity to do?” helped promote the comprehensiveness of the exploration. Regular self-questioning during and after the interviews, after the interviews, and in the stage of data analysis was important in order to remain open to different questions and thoughts that were not preconceived. Such questions came forth through thorough examination of the transcripts, careful coding of all of the transcripts, and willingness to continue to add to the codes and explore additional concepts not initially identified for their fit with what seemed to be essential messages in the data.

“External validity refers to the applicability of representations to other groups” (Schensul et al., 1999, p. 275). External validity is undermined by: (a) a failure to use appropriate research instruments or methods of data analysis, (b) by use of language understandable by a limited audience, (c) through inattention to the historical experiences of participants or the cultures within which they exist, or (d) by inappropriate participant-research relationships that can result in a manipulation of the field or the research outcomes (Schensul et al., 1999). A common professional language shared by participants and myself could potentially limit external validity; hence, terms and contexts were clarified so that others could understand the text. Being self-critical in relation to the ways rural nursing practice and preceptorships are represented in the study was challenging, given that most participants were overwhelmingly positive about their experiences. It must be acknowledged that, largely, my attention in this inquiry focused on the merits rather than the deficits of rural practice-education. I did, however, pay heed to comments that did not fit with the general themes, as they required consideration in the light of others’

comments and could potentially serve as sources of inspiration for further exploration. Diversity of comments also spoke to the heterogeneity of rural places and people.

3.4.3. Reliability

Reliability is the notion that the study results are likely reproducible. In exploratory qualitative research, ensuring duplication of findings by future research is not necessarily a desired goal. Rather, qualitative exploratory research can lead to future research questions, theory formation, development of other research instruments, and shed light on other research (Schensul et al., 1999).

“Delineating clearly all of the steps in conducting an ethnographic study, including data analysis and links to interpretation, is central to ensuring the external reliability of a study” (Schensul et al., 1999. p. 289). Outlined in this chapter are the specifics of sampling, the methods of data collection and analysis based on a specific framework chosen from a reliable source, and the questions that formed part of the semi-structured interview process. Recorded interviews enhanced reliability, as I was not required to rely on memory of the main sentiments of participants. The inclusion of multiple verbatim participant quotes serves to support my interpretations and help the reader follow the interpretive process.

The process of interviewing participants on two separate occasions strengthens reliability (Roper & Shapiro, 2000). It was valuable to have time to reflect on the interviews and to form new questions or repose original questions specifically for participants to reconsider, clarify, or elaborate on their perspectives. The approach was non-confrontational, acknowledging that a participant’s position or perspective could change over time. It became increasingly evident to me throughout the second interview that participant responses were generally consistent with first interview; their perspectives did not change substantially. I experienced a growing sense of

affirmation of the original interview as having accurately reflected the participant's perspective.

This sense was conveyed to a research participant:

Cheryl: Absolutely, there's another part I want to tell you about that you've helped me with while I listen to your tape, you are very consistent in your beliefs. No, no, and actually I found within your text that you validate yourself, so from the beginning to the end there is a level of consistency there because I would ask the question in a different way and that validated sort of your own story in my sense, you didn't come up with a divergent perspective so I just wanted to tell you, it was all, and that was done purposefully, in a way, to see if you would say it again just in a different way. [rn4 Ilene: 8222-8274]

On several occasions participants wanted to hear whether their ideas were similar to others, whether they had talked about ideas that others had talked about or had brought to light new ideas not yet covered in the research, and what themes I was likely going to focus on in my dissertation. In part, I attribute this curiosity to the singleness of the preceptorship experience in a rural context; the lack of rural colleagues means that nurses and students have fewer opportunities than urban students do to compare their experience with others.

3.5. Summary

The ultimate purpose of the research approach outlined in this chapter was to allow me to develop a nuanced portrait of the culture of professional rural nursing and its impact on the rural preceptorship experience. Such a culture was evident in participants' beliefs and values, and the ways in which, within their narratives, individuals and groups of nurses learn to problem solve, to perceive issues, to think about and adapt to the practice setting and associated problems. It is within this culture that certain values, beliefs and patterns of behaviour were deemed valid and taught to novice nurses (Schein, 1992).

Polkinghorne (2004) put forward the notion that 'practice' is dialectic between the individual and culture, wherein culture is not an independent entity but rather a reflection of group norms and expectations. Eliciting accounts of practice can thus foster recognition of how

students and nurses experience a culture of rural nursing, how rural practitioners, community members and students influence each other, and wherein points of conflict or contrast highlight important differences in experience. Both convergent and divergent perspectives are included in the following chapter. Differences between participants, and points where they differed from my own assumptions about rural preceptorships, places, relationships, and practice, served as inspirational points to spur further reflection, analysis, and exploration into the nature and educational value of rural preceptorships.

4. A Cultural View of Rural Preceptored Practice Experiences

4.1. Introduction and Overview of Transcript Analysis

Key cultural and educational themes expressed in participant conversations with nurses and students make-up the content of this chapter. This analysis of the rural preceptorship experience is nested within four inter-related domains: culture, place, relationships, and learning, as outlined in Chapter 2 and guided by interpretive processes outlined in Chapter 3. Participant transcripts were reviewed, noting similarities and differences between participant conversations and my personal perspectives. Salient qualities of the rural undergraduate nursing within a hospital-based preceptorship were identified. The intent of this chapter is to provide a stand-alone narrative in which participant descriptions and perspectives are accompanied by my personal interpretation. Linked to the nature of rural nursing, the three most frequently noted learning outcomes form the later portion of this chapter.

Research participant interview transcripts were reviewed several times by listening to the voice recordings and by reading the transcripts. Key participant words and messages were coded, following the approach outlined in Chapter 3, and notations and memos were made during text review that captured my thoughts about the meaning of the text. Once all transcripts had been read and coded, they were re-read and coding affirmed or modified. Codes were counted by transcript and grouped with the analytical domains. The list of coding terms was refined and condensed throughout the inductive analytical process, wherein participant conversations provided sufficient description to warrant inclusion and commentary in this text. Searching for

student and nurse expressions of difference or conflict as a way to highlight cultural norms was central to uncovering themes. Structural and relational aspects of place and the people who inhabit places came to me by examining the frequency of transcript codes and repetition across participants. Themes within a particular domain were identified by referring to my personal assumptions, theoretical perspectives and relevant literature. It is important to note that the themes associated with particular domain were not exclusive to that domain but intersect within and across domains. For example: the notion of time within a particular place contributed to the experience of continuity of relationships.

Table 3 provides an outline of the analytical domains and related themes. The table also represents an organizing matrix for this chapter. Beginning with a discussion of nurse and student motivation to engage in rural preceptorships, which was not part of the original research questions but proved significant for understanding the context of the preceptorship experience, the chapter explores each domain and theme in the order presented here.

Table 4. *Analytical Domains and Themes*

Domains	Themes
Opting In	Family, Friends and History Distance-Density-Scarcity Renew-Recruit Resources Novel Experiences Information Exchange
Culture	Dissonance Continuity Dependence and Independence: Professional Autonomy and Reliance Confidentiality and Gossip/Private-Public Communication Respect for Urban Rural Differences
Place	Density-Sparseness Time Ethnicity Occupation and Economics Human Resources and Technology Diversity of Health Issues
Relationships	Reciprocity and Information Exchange Preceptor as a Cultural Mediator Interprofessional Engagement/Team as Preceptor Community Educator at a Distance
Common Learning Outcomes	Preparing for Who Knows What Diverse Technical Skill Development Clinical Decision-Making

4.2. Opting for a Rural Preceptorship

I asked about participants' reasons for opting for a rural preceptorship experience in order to gain some insight into their personal histories and expectations. Students cited several interconnected reasons, including their own rural backgrounds, the economic and relationship value of living in their community of origin with family or friends, the intrigue of novel experiences, and various characteristics of rural life including accessibility, population density, and availability of scarce resources.

One source of student motivation came as somewhat of a revelation to me. This was the perception that rural contexts provided opportunity to access both diverse and infrequent

experiences that in an urban context would be limited to only a few students, such as labour and delivery. In the Springfield region, I had observed that the nursing responsibilities surrounding labour and delivery tended to be one of the least favourite aspects of rural nursing for nurses, because of the infrequency of labour and delivery care combined with the potential for labour and delivery to become a complicated and risky event. Although only two students made the observation that they were more likely to engage in obstetrical nursing should they opt for a rural experience, it seemed to play a large role in their decision.

The two most frequently expressed reasons rural nurses cited for opting to act as a preceptor were to recruit potential rural nurses and to further their own professional development. These motivations are in keeping with the preceptorship literature reviewed in Chapter 2. The perceived benefit of mutual exchange of information emerged strongly in the interviews, and is revisited later in the context of preceptor-preceptee relationships.

A key aspect of choosing rural preceptored practice placements was existing or potential connections to family and/or friends. Daniell offered a typical example:

Because in this program, ah, my cousin is also in nursing and her friends are from Westmount . . . And I became really good friends with them. And I have been to Westmount and it is just absolutely beautiful. And it's like "Oh, I've always wanted to live in a small town you know. Maybe I'll check Westmount out. See if I like it. And get the rural nursing experience while I am a student. [rs4 Daniell: 100-129]

Estelle was engaged to be married and her residential choice was informed by this relationship, which in turn influenced her choice of practicum place.

I lived in Springfield for the program for the first 2 to 3 years and then we actually moved and bought a home in this direction and that's when I kind of lived part time in Springfield and part time out here and travelled back and forth and stuff so it was good and practicums I did some in Springfield at the beginning and then I chose Waterton. [rs5 Estelle: 54-65]

Four of the five student participants in this study had once lived in a rural setting. Two students opted to return to their communities of origin for a rural practice experience. Bobbie suggested that personal connections played an important role:

Well before I started nursing . . . I always wanted to be a nurse, always, since I was little. And I think it came from a neighbour . . . I grew up living beside a nurse in the hospital in Pleasantville. And I just . . . she was just like my idol and I always just wanted to be like her and the way she was with people. And she's now a manager in the hospital in Pleasantville so I think that helped my chances of getting in there over other people. [rs3 Bobbie: 15-24]

Practical reasons of economics and quality of life could encourage a return to one's community of origin, as indicated by Carla:

And then I just . . . I did four years of my life in the tiny little dorms up the hill and I, needed to go away, so Pleasantville was definitely an option where I didn't have to look for rent or a place to live right away. [rs2 Carla: 126-135]

Even for a student like Abbie, who opted for a rural practice setting other than her rural community of origin, a personal history of rural living and a positive sense of student and nurse relationships in a rural context factored into her choice:

I grew up in a small town so I figured that someday I might want to go back and work in a small town, but I had also heard that nurses loved to have students come so that would contribute to a good experience if the nurses loved having you there and um picked Windermere. [rs1 Abbie: 152-157]

The desire to gain a broad base of knowledge and skills through new and diverse experiences emerged as an important aspect for most of the students:

A couple of reasons as well, I have a sister-in-law who took the program she's a couple of years ahead of me and she had done a couple of practicums in smaller settings and being the only student in the hospital you get a way better experience. Springfield is overburdened but there are a lot of students and a lot of time you don't get the same opportunities in the hospitals. Being the only student in a smaller hospital you do see a whole lot more different opportunities there as well I knew this was where my future was going to be so I just wanted some experience there as well. [rs5 Estelle: 179-195]

And a big part of it was the labour delivery. I wanted to participate in labour and deliveries so . . . and I knew I wasn't going to get that in Springfield. [rs3 Bobbie: 298-302]

And it was just, it was just a really good chance for me to not be at Springfield and try something new [rs2 Carla: 64-68]

. . . it was just something different from Springfield. A different hospital. [rs4 Daniell: 133-138]

The perceived differences and challenges of the rural preceptorship evoked a mixture of emotions, best expressed by Bobbie:

And it can be pretty overwhelming, but at the same time, it's fun because you get different experience and you get good at everything instead of just one area. Which is why I wanted to go to the rural area to begin with. Because I didn't want to just learn one thing about one kind of illness. I wanted to learn about everything. [rs3 Bobbie: 285-295]

Thus, for the students a mixture of motivations came into play. For some students the novelty of the experience was compelling; for others it was the 'comforts' of home. Some saw the low population density and relative isolation of rural settings as a positive factor, leading to a broader range of practice experience and closer professional relationships; others saw low density and isolation as obstacles to be overcome. Personal background played a strong role in these orientations.

Most of the nurses believed a rural practice experience would encourage the preceptee to consider rural practice sometime in their career, and mentioned recruitment of their successors as a conscious motivation:

And seeing we'll need nurses to work in rural practice for when I'm old and needy so they can take care of me. You think of those things when you are over 55! [rn2 Gayle: 285-291]

You know it's not a power struggle these are the future, they are the ones coming up so that we can retire in 10 years. [rn4 Ilene: 8400-8411]

Why take a student for a rural site anyways, um, one it's advertising for you are always looking for staff, if they come out and like what they see maybe they'll stay, two if they don't want to stay they might tell other people about it and they'll want to come out. [rn5 Jaime: 1558-1584]

Haley, however, was more critical of the preceptorship as a recruitment tool, observing that it rarely led to lasting employment in rural nursing:

I've been the last new nurse that has come to Windermere that has had experience and it's been 5 years for me. Right. All we're getting now is new grads. Young grads that want rural nursing that are young, single and can travel. Nothing to keep them here. So we get them for a year. And then they're gone. And then we do it all again so we're not getting that consistent approach to rural nursing which is why we're losing. Which is a change. And that's quite . . . because usually rural nurses, you know, you're here, you stay. [rn3 Haley: 440-472]

Most rural nurses spoke about transformation as part of their motivation for agreeing to preceptor a student. The transformation was, in part, about facilitating and bearing witness to change in the students. The potential for keeping themselves current and changing by learning from the students was also part of transformational motivation for preceptoring. There was a sense of reciprocal gift giving, the preceptor giving a gift of experiential practice knowledge and receiving a gift of current knowledge and renewed inspiration.

I guess it helps you to stay on your toes. It helps you keep in touch with some of the more current things within practice. Um, it helps . . . I don't know . . . it's fun working with the students too. It's nice to be in touch with people that are keen, that are learning, that are eager. Um, maybe keeps us fresh too. You get as much from it as you give I think. [rn1 Fern: 443-453]

You know you get dragged down by things. You kind of feed off their excitement about getting into the profession. Or their worries or scares about getting into the profession. You know just being eager and um, just asking questions about things that you wouldn't think to question. I'm just trying to think of an example. . . . They do make you think about your practice about things that you kind of take for granted. That they bring to the fact that this is important. This means something versus you kind of get wrapped up with the task about you know . . . [rn2 Gayle: 2394-2428]

I do like students but I am at middle age you know 46-year-old nurse, where I love to share what I've learned I love to share my experience with nurses I love to mentor, these are the nurses that will look after me and just to bring them I like to think I have a hand in their professional development and I know a couple of the nurses in my age bracket feel the same that we are really really we love students. [rn3 Haley: 232-244]

I volunteer because I like to watch the person grow I like to see them when we first get them as a scared little person and I like to see them just take off, spread their wings and fly its just incredible when you see them grow with compassion understanding and them establishing their routines, you know. [rn4 Ilene: 749-768]

Professional development of the rural nurse through preceptoring was part of the message about transformational motivation. I had not anticipated the importance rural nurses

would give to their professional development as a reason to take on the role of preceptor. Rural nurses can experience isolation not only in their daily practice but also in their circumscribed access to traditional onsite forms of professional development, and it occurred to me while reflecting on the data that this isolation was possibly accentuated by infrequent encounters with nursing students. Thus, at the very foundation of the rural preceptorship experience, place-related themes such as density, accessibility, and community appeared as important motivating factors for nurses as well as students.

4.3. Across the Cultural Divide

Student conversation highlighted several ways in which rural nursing practice represented a significant cultural shift for them. From a search through the data for examples of intrapersonal or interpersonal conflict, five principal themes emerged. *Cultural differences and a sense of cultural dissonance* arose primarily in relation to norms students learned in urban hospitals and educational programs. *Continuity as a quality of rural relationships* shaped rural nursing practice and student preceptorships. *Differences in autonomy* between rural and urban nurses often emerged in the student research conversation, focusing on the degree of nurses' reliance or dependence on each other and on other healthcare providers within and beyond the rural community. Reconciling professional standards and expectations of confidentiality with *the nature of public and private (or professional) communication in a rural context* created a particular intrapersonal and professional challenge for nurses and for those students who opted for a practice in their community of origin. *A real or perceived lack of respect for rural nursing* by urban healthcare providers contributed to a sense of interpersonal conflict in rural nurses and underlined the dissonance experienced by students.

In ways to be detailed in later sections, the students' encounters with these various forms of cultural difference were mediated by the qualities of rural place and rural relationships, both in the community and in the professional setting of rural acute healthcare. The nature and educational value of the rural preceptorship hinged on the process of cultural mediation. These five themes thus reappear in various places and guises throughout this chapter, and inform the recommendations presented in Chapter 5.

4.3.1. Dissonance: Discomfort with the Foreign and Unfamiliar

The sense of being lost, scared, or unprepared is not uncommon to the inexperienced student nurse, but it took on unique qualities in the rural context. As Bobbie noted, Springfield students received little preparation for what they might expect in a rural setting:

Our school is preparing us for the ward in Springfield. Not rural ERs. So that's another reason why I was so scared last year to go there because I'm like "I'm going to be lost. [rs3 Bobbie: 2882-2892]

Carla provided a nice summary of some of the key issues when she spoke as if to advise me of what I might encounter in a rural context.

Initially expect to feel kind of scared just because it's a new . . . especially if you have never been rural before. It's a new practice setting. You're used to a big hospital where you're used to having respiratory technicians and everything. You don't have that in a rural setting. So for me at least, I felt kind of anxious, sort of. A low grade anxiety all of the time because if something goes wrong I don't have a code team. I am the code team. Expect to nurse people that you know, or who know you. And expect, like, be open to the fact that this is a hospital and everything is going to be . . . a lot of things are going to be different. Like the supplies that they have are sometimes, were sometimes different. And some of the charting that we did was different from Springfield. [rs2 Carla: 2866-2890]

For Abbie, the absence of written practice protocols among rural nurses contributed to her sense of cultural dissonance and prompted her to question self and others.

Every nurse, I noticed, does things a bit differently because there were no protocols. They went by what their experience was, maybe what they had learned, what they had in critical care and that sort of thing. So there was a bit of variation in nursing care that way. And for me it was hard

because I don't have the experience that a lot of the other nurses there do, to call upon because there was no protocol, guidelines for me to follow. So I was always questioning myself, is this a practice, is this the right way to do it? And if I was asking the nurses for advice I was where are they basing their knowledge from? Is this the right way? So I was always questioning myself. So I found it made me go out and do much research too. So it made me update my knowledge base more instead of just having the protocols. So I guess in a way it had positive and negative things about it. [rs1 Abbie: 4324-4353]

Estelle, with previous experience in the same rural hospital, experienced less cultural dissonance and increased confidence in her preceptored practice. For her, coming to understand the uniqueness of the environment was not as central to her experience as it was for those students without rural hospital experience.

I did my ESN [Employed Student Nurse] on the same floor that I was doing my fourth year practicum so I really got to connect with a lot of the nurses because I was there for a large amount of time so coming back you're recognized. I think it helped dramatically that I knew the ward I knew where everything was what the general procedure was so that makes it a whole lot easier it's a whole different set of stuff that you don't have to learn you can actually just concentrate on the nursing. [rs5 Estelle: 1882-1896]

According to the students, the differences they noted in rural contexts generally served as a cognitive stimulus. This arousal led to activities such as self-questioning, questioning of others, and personal research to reduce cultural dissonance and increase their confidence. Particularly when dissonance was recognized and attended to by the rural preceptor, such activities helped to transform student understandings and enhance their capacity to practice in a rural context.

In the research conversations, preceptors showed their awareness of this aspect of the preceptorship experience:

That you have to make this . . . you have to do all this kind of stuff yourself. You have to go and do that ECG. You have to do up your physician's orders and then you fax it off somewhere because we don't have an in-house pharmacy. And then wait for; well we don't always have the drugs. And you kind of have to make that because you don't have a pharmacy right there. So you have to ask them to send it up and it's going to be a day or two. Just the . . . all the little things that you don't have readily available. I think that's a really kind of amazes them [students] a lot. [rn2 Gayle: 2260-2301]

Those [urban] girls here, they have no idea what I'm talking about. They just can't fathom that we don't have the services in place, or things out there. [rn3 Haley: 624-662]

For some [students] a rural community is just like too small. Where is your nearest mall, where is your Safeway . . . The culture shock, just over how small it is and what is available in our fine little community. [rn4 Ilene: 1458-1509]

Not only did nurses demonstrate awareness of cultural dissonance experienced by students, their role as a preceptor focused substantially on mediating this dissonance. Cultural mediation, as an activity of the rural preceptor, is discussed later in the relationship section.

4.3.2. Continuity

Students and preceptors alluded to the notion of continuity, or the lasting nature of rural relationships among professionals and community members (patients) over time. For the nurses in this study, relational continuity was expressed as closeness to individuals or families within the community. Living and nursing in a community over time contributed to rural nurses knowing people's life and health histories, to having shared histories. Rural nurses came to care for community members not only upon hospitalization but also over time regardless of their location. Rural nurses demonstrated interest in knowing what happened with patients before, during and after discharge; professionally, they sought to know the outcomes of their nursing actions when there was a disruption in nurse-patient relationship, such as when a patient was transferred to a facility outside of the rural community. For students, relational continuity was most often expressed as having time to come to know the rural patient and provide care for individuals over time, from admission through discharge. However, it was also implied in comments about their relationships with the preceptor and the healthcare team.

In several interviews, an association with a community over years or decades was considered a positive asset for preceptors and preceptees alike.

You know even if you know “I kind of know when you were a little girl and now you're having your baby.” And they know me. I think that is a benefit having worked at the clinic. You know people a lot from that aspect. [rn2 Gayle: 1446-1453]

And people even from my CPE2 I remember coming in last year and they came in again this year. And I'm like “I remember you from last year.” And they're like “Really?” And they can't believe that I remembered them, because they ask “are you new here?” “Well sort of but I do remember you. And then that kind of gets them talking and stuff. [rs3 Bobbie: 901-913]

Because a lot of them know who I am through my parents and they're like “ob, you're her daughter.” And sometimes it makes it better instead of uncomfortable because they form a better relationship because they know where I came from and that I'm not some student from the big city and that I actually know about the community and stuff. So that does help a lot sometimes too. . . . I think most of the time it's useful. [rs3 Bobbie: 874-897]

Abbie recalled her preceptor commenting on the value of continuity.

She [preceptor] says your first day that you come on, you'll feel a little lost, but the rest of the shifts just go so smoothly because you know everybody and if you get one or two new ones they will fall into place or whatever. But you know you're routine and you know what needs to get done. So it's just that first bit she said. And also she said it's great working full time because you have that 4 day relationship. She said if you were casual you would come in 1 day then take a day off. She said you have to go through that every day. That whole relationship. [rs1 Abbie: 3092-3110]

Abbie also commented on her personal experiences of relational continuity and patient care delivery in her day-to-day rural practice.

And I got to do everything. You would admit the patient. I would start off with admitting and I would end up with discharging them and everything in between, like doing everything. So that was really neat for me, that whole bit. [rs1 Abbie: 2843-2852]

Carla and Bobbie conveyed a sense of relational continuity when they commented on the number of rural patients, the time available to get to know people and a general desire of people to learn about others.

It was nice that your patients, like there was only 1 set of 8 patients so they weren't changing, like week-to-week, so you really got to follow the ones that were in there for the long term. And so they'd improve or get worse. But no one got worse, everyone got better. So that was really nice. [rs2 Carla: 723-732]

And I don't know if this is just a small town-type thing, but, people are very . . . they want to talk . . . like they want to get to know each other. And I feel like all the staff already knows everyone that comes in, so I'm the one that has to get to know the people. And it's pretty easy.

It sort of just happens. When you don't have a lot of people to care for, you get to spend more time. [rs3 Bobbie: 4775-4786]

This theme of continuity was implicit in the interview transcripts, rather than unambiguously identified by participants. Only when I had most of the research transcript analyzed and was struggling to articulate a ‘missing’ piece did the concept of relational continuity emerge for me as a deeply important and pervasive element of the rural preceptored nursing experience. Continuity emerged as a thread that ran through the domains of culture, place, and relationships within this research during the data analysis phase. The notion of relational continuity was evident in conversations about confidentiality, conflict between urban and rural health professionals, the experience of time and caregiving, and the experience of continuity with preceptors, healthcare team members, and the rural community. The implications of rural relational continuity in rural nursing practice-education are explored in Chapter 5.

4.3.3. Independence and Dependence

The degree of rural nurses’ independence seemed at times to contrast to the rural nurses’ closeness with and reliance upon the rural healthcare team. This simultaneity of independence and dependence of rural nurses was often noted by students, particularly in contrast to urban settings where greater dependence on more professionals and a less harmonious healthcare team culture was the perceived norm.

I think they are really unique in that as a nurse in a rural setting, quite often you're the only nurse on. There might be an LPN. Like in Windermere [hospital] they always have one nurse in the emergency and one nurse on the floor, an LPN on the floor. And you do everything. I got to learn how to do EKG's or whatever they're called. And you do everything, so you're responsible for everything. You just have to have the nurses in there to talk things over. You're the team, yourself and you. Be organized and be able to when more comes on to be able to do that. That's really neat, to have that smaller team as yourself. [rs1 Abbie: 485-502]

I didn't think it would be so independent in our practice. The nurses there have a little bit more autonomy than here [in an urban setting] because their skill level is almost higher because we don't have a respiratory technician and stuff. They have to do that and suctioning or chest

physio or whatever. . . . I wasn't expecting the nurse's role to be different at all. [rs2 Carla: 3010-3035]

They [nurses] certainly may be a little bit more independent just I think based on the years with the doctors maybe. . . . Maybe, maybe the nurses weren't exactly more independent, but I feel like they could probably do something and then get the doctor's cover here maybe. [rs4 Daniell: 1700-1725]

It's definitely a team. There is the x-ray tech and a lab tech and everybody . . . in an emergency situation everybody has been there helping. Nobody is like "ok, well my job is done. I'm out of here!" They will all stay and help until there is nothing else to do. And in a code situation, which I haven't experienced yet in that hospital. It's even from the long term care facility goes, those ladies will come and help. Everybody in the hospital unless its obviously too many people, but, everybody . . . like the code will sound on that side too. [rs3 Bobbie: 1659-1674]

Nurses provided examples of how their rural responsibilities differed from urban nursing responsibilities. The sense of being isolated, alone or feeling like 'you're it' or 'you're everything' captured the sentiment of rural nurses' independence. The notion of dependence was evident in the reliance on others and could account for the limited conflict reported by students and nurses within rural places.

You're on your own there in the middle of the night. Like there is yourself and an LPN. That's about it. [rn1 Fern: 4126-4137]

You know, and just that you're it, you know you have the support of your other partner, of your partner and ___ and _____ and like the place is wonderful for that but you know you have to be very strong in your skills, and just, you have to be strong and not afraid to work alone. [rn4 Ilene: 5056-5082]

In rural nursing you have to do the same sort of thing but I think you also have to take a little more into it because you are isolated you don't have the tools you may not have the resources to do that or the knowledge so you are acting much more independently and you have to figure out am I actually doing this right am I not just doing it correctly but am I doing it ethically am I taking into account everything that needs to be taken care of you know on a surgical floor okay, these two surgeries might be the same you've got everything there you need to deal with it but in a rural site we might have to treat them differently because we don't have the tools and because we don't do them all the time. [rn5 Jaime: 5267-5292]

You don't just start nursing your patient. You have to be the ward clerk. You have to be you know some time the . . . well you have to be the ECG person you know. You have to organize everything else that has to be done. [rn2 Gayle: 526-532]

I used to chuckle when I would go to work in an [urban hospital] or a, a big trauma would come in and I would be assigned to the big trauma bay, you know, you go start at the chest tube

because you know you're going to have to put a chest tube in, or you start with the endotracheal tube, got the IV sets ready or catheters, you get everything ready to open up and you are set to go as soon as that person arrives. Well it's oh wait a minute don't do that the RT [Respiratory Therapist] is coming, oh wait a minute don't do that the intern is coming, oh wait a minute here is the med student or the resident, oh wait a minute here is the third nurse, you don't have to do any order entry the clerk is doing that. I go, well what do I do? chart? you know? And that was you know coming from a rural site where you were expected to get ready to put the chest tube in, get ready to assist the physician with the endotracheal [tube] to you were you had to put those large bore IV into the patient and your IV levels still had to be perfect you had to be prepared to set up a foley, and in between be organized and do your paperwork and you know hand out all those medications and that you're the only person who can do order entry on the computer the medications prep the medications. [rn3 Haley: 375-412]

Westmount is slower it is more laid back, I don't have to run the whole shift but now the difference is I guess, the type of work that I do in a larger facility there's my patient's, there's my pill carts, do my assessments and my paperwork and I'm done, for the most part. Rural site you're everything, I'm the pharmacist the team leader, I'm the front desk clerk, I'm the stock person, and then maybe I'm the RN, ha ha. [rn5 Jaime: 877-893]

Most interesting for me was how this emphasis on rural nurse independence coexisted with a strong sense of reliance on the healthcare team as a whole. This emerged strongly in students' observations about the occurrence and management of conflict:

They always work together and everybody gets along for the most part and it's like they enjoy being there together. Whereas in Springfield my experience has been nobody likes being there and nobody really cares about each other, or wants to help each other. . . . Sort of like a big family-type atmosphere there. And that includes the doctors. . . . The feeling that you can't really do anything wrong there. And if you do, it's ok. Whereas in Springfield you're hung out to dry if you make a mistake. [rs3 Bobbie: 4595-4626]

I guess that whole bit that there are fewer of them than in a bigger hospital so they know each other better. And they're all friends I guess. They all get along that I could see. [rs1 Abbie: 1898-1909]

I was surprised and intrigued by the consistency with which students and nurses spoke both of rural nurse independence and the nurses' sense of dependence or reliance on other rural professionals. Despite the potential for these notions to appear contradictory, both seemed to play a key role in mediating the cultural divide or dissonance experienced by students. This idea is explored further in the later section on relationships and in Chapter 5.

4.3.4. Confidentiality and Gossip: Cultural-Urban-Professional Norms

Public and private communication as a cultural exchange process emerged much more strongly throughout the research than I had originally anticipated. Confidentiality is a cultural and institutional norm in the health professions; the education of novice nurses addresses the concept of confidentiality and students usually encounter and practice the concept within urban context wherein they are primarily caring for strangers. The rural context challenged this notion of confidentiality in a number of ways.

Two student participants, Carla and Bobbie, returned to their community of origin for the preceptored practicum. Their experience of confidentiality became tempered by their past knowledge of community members and their presence within the community. Bobbie, having a personal residence in Springfield, returned to her residence on the days she had no clinical obligations and had fewer opportunities to interact with community members outside of the hospital. Carla returned to live with her parents during the rural practice experience and so was more closely embedded in community life. She found confidentiality to be a relative notion in the rural context:

Well for me especially, it was a little bit harder to deal with because of where my Mom works. She deals with almost every member of the community at some point during the month. It's a department store so if they need stuff that's where they go. So she hears everything. So as much as I would be, you know, confidential, at some point she would figure out who I was caring for and what I was doing. And so that was just harder. Because, you know, I could be as confidential as I wanted to, but the information still got out. Yeah. Even some family members would come and tell her and you know, this is what they are in with even. And she would be like "oh yeah." And they would even say to her "oh, your daughter was nursing her." Oh, ok. . . . It's hard because, like I think it's unspoken that they get . . . like everyone understands that you know, we're not going to go telling their secrets. I think that it's just understood by the people, like the community that there's a confidentiality thing. They get that. [rs2 Carla: 2799-2923]

There's a lot of gossip in that town. And it's really bad. It's really, really bad for gossip. And it would, at least once, someone came in and oh, you know, they'd be in Pleasantville, and they'd sell drugs and just for the staff to be impartial was a lot more difficult than, than to you know, to give them pain killers when they asked for pain killers. I think they had a bit more

trouble with it because they were always in the back of their mind thinking "Well, do you actually want this, like need this, or do you just want it?" So . . . [rs2 Carla: 765-796]

Bobbie found herself in a situation where she deliberately removed herself from immediate care of a patient:

That is probably one of the hardest things about being there. Is that I do know almost every single person that comes in. And actually during my CPE3, a guy that I graduated with came in after his suicide, a suicide . . . he had attempted. But I knew him and I graduated with him and I didn't feel comfortable going in and talking to him or caring for him because I didn't feel like he would want me to. I don't think, I didn't feel like he would want me sitting there looking at him. Knowing me and I didn't want him to think that I was, you know, going to tell everybody about it or judge him. So I chose to not participate in his care at all. And he actually ended up staying for a couple of days on the ward. This was when I was still working ER so I didn't have to actually care for him, but I found that was really uncomfortable for me to know somebody and . . . in that context. And technically, if I had been the RN I would have had to. [rs3 Bobbie: 783-822]

Several preceptors remarked on the complexity and challenges associated with confidentiality. The comments of Fern, Gayle, and Ilene illustrated how continuity of relationship was not limited to nurse-patient relations in the hospital but extended throughout the community.

Well if they're local they need to deal with the confidentiality issue. They need to deal with the fact that some of these locals have known them since they've been this big. . . . I guess talk to them a little bit, the students, about that relationship and how they have to work within that because they have to gain the respect of the patient, as a patient. And that the patient needs to come to some sort of trust in them as a healthcare professional, not as little Johnny that grew up next door. So that's one of the things that you have to talk to them about. [rn1 Fern: 1287-1313]

I'm finding that most of them because some of the girls, most of the girls that I did work with from Springfield [University] were from this area originally so they know that. . . . But you know the confidentiality issue. The fact that so and so could be related to so and so because you know of the small community aspect of it. So everybody has to be you know treated you know with no pre-assumptions about anybody. Just treat them as the patient, not as the relative of so and so. Or you know, just be careful of what you say. Be careful you know of what you say outside the hospital setting at home because you know it is a small community and people know each other so well and it will get around. [rn2 Gayle: 551-572]

And the other aspect of that was the whole confidentiality issue again. Was having dealt with that during the day, . . . when I went home after shift what do you do? So I walk in, my family's there and they know straight off. They know me too. "What's wrong Mom?" So

where do you sit on that whole confidentiality issue? How do you tell them? And those issues. There's no cut and dry answer. There is no right. There is no wrong. You have to . . . and they need to know . . . you know students need to know that those are things that they are going to deal with. You know we have had . . . and that's not unique to rural practice. It's just maybe perhaps a little more common to rural practice. [rn1 Fern: 1859-1886]

Ilene noted the importance of trust between care providers and patients as being enhanced by maintaining confidentiality and recognized that occasionally not all healthcare staff maintain the same degree of confidentiality.

You have people in a small facility that you know they'll see someone come into the ER and you'll hear it on the street by the time you get off work and you know it wasn't you because you are at work and the confidentiality was stressed so greatly when I was a student, even now it's stressed the legalities of it alone. But we have working in a small place we have support staff and . . . [others] that are out there making very derogatory statements you know about the events that have occurred in the emergency situation. [rn4 Ilene: 2064-2108]

I think the trust is there, the trust is there with us nurses. The trust is always there. I mean we are nice, we are polite but we have boundaries. If a person comes up to us and says, "Well hey, is so and so in there?" I don't know, why don't you phone up and see if they are there, why don't you phone one of their family members? You know that because of where I work and because of what I deal with you know, I can't talk about that. But they'll try and I'm like, I'm I not going there or you say, you know, you know better, we're not talking, You know even my Mother, she's 87, says I know you can't talk about it, and then she'll tell me something and I'm thinking, hmm, your grapevine is pretty good! I don't know Mom. But a lot of us maintain the standards and a handful don't. I've been here for long enough and [nurse manager] has been here long enough, that they know what they can and can't get away with, they know our limitations and they know how much to push our . . . you know, we just don't, it's something we don't, a lot of people know that but even your close, close friends the ones that you have you know that you have a closer friendship with, they know. [rn4 Ilene: 2155-2222]

Abbie, Daniell, and Estelle were in preceptorship experiences outside of their communities of origin. Their lack of history and relationships within the community made living the professional standard of confidentiality easier. As Daniell put it, *"Well I'm not going to let anything out, because I don't know anybody . . . Yeah, that's not really an issue for me. As it would [be] for people from there, definitely" [rs4 6132-6135]*). Abbie observed, *"I found especially driving to Windermere, it wasn't a problem to leave it behind. I think for me driving from Springfield that whole physical piece was there so it was easy for me not to think about it" [rs1 2784-2791]*. Confidentiality was thus shaped by both the relational and physical dimension of place.

Both Fern and Gayle observed that the anonymity that came with being a student not from the rural community could be valued by rural patients. The absence of a shared history and relationships between rural nurses and patients could reduce emotional discomfort:

I think it's sometimes is easier for them [community members]. It must be . . . you know because . . . times when someone shows up with an STD [sexually transmitted disease] in emerg. I mean it happens! And so you have to deal with that. And I mean if you've been in the game long enough and someone says "I'm sick and I won't talk to you about it." Well . . . ! Just so you know it. . . . but for a total stranger, it's probably easier for a community member to speak out because there's no baggage. [rn1 Fern: 5018-5046]

I've had them [patients] come in and be uncomfortable with me because they know me. Ah, well that's I guess that's the kind of thing I was thinking about too. Because they might be known and you know how that relationship in a rural setting is? You know you feel comfortable but there has been a situation with people I've known when they come in. But I haven't seen it too much with the students other than "Aren't you little so and so!" You know because they've seen or they know them from school or whatever. But they, no they seem to, you know, a nurse it seems to click and there's kind of a respect thing. I've had people who you know prefer you know . . . I've had a couple of cases when they prefer . . . because not so much that they didn't like me but the fact that they were uncomfortable because I was seeing them in this situation when I know them from other situations. And they feel really embarrassed or . . . [rn2 Gayle: 1349-1381]

Nurses within the rural hospital-based preceptorship experience seemed particularly sensitive to issues of confidentiality and nurse-patient relationships. Some nurses counselled students, particularly those already known in the community, as to the challenges they might anticipate and ways in which to handle public and family questions. Social distance, both in the form of physical distance (living outside of the community) or relational distance (disengaging from general community social activities), served to reduce opportunities for confidentiality conflict. Nonetheless, the data contained several instances in which rural nurses sought information about a rural patient transferred to an urban setting. Estelle provided an example:

Estelle: To other centres there was maybe a few comments I remember just from a nurse calling to talk to another nurse, with say if there had been a patient transfer and if they were inquiring what had been going on and realistically it's confidential so they shouldn't share with it but some of the nurses expected that the other nurse station calling should share with them.

Cheryl: Right, so what do you think was going on there?

Estelle: I think a lot of it is if the nurses had a relationship with each other, like they had been back and forth through the years or what not there was sharing involved if it was someone new that picked up the phone and they had no idea who they were there was no information shared.

Cheryl: So the nurses, I'm thinking about if they called in to the larger centres what would be their reason, you know, why do they call?

Estelle: I think probably personal interest. Well not, I guess patient interest as well right just that follow through of kind of wondering what happened to that patient if they had been sent for a more serious reason or something that a smaller centre couldn't deal with just wanting to know what the outcome was. [rs5 Estelle: 4061-4128]

In this example, it is impossible to know whether the nurses' interest in knowing 'what happened' to a patient if they travelled to another healthcare facility was motivated by a personal interest or a desire to further their professional development. Regardless of the motivation, however, the example illustrated how the continuity of rural relationships, noted earlier, can extend beyond the bounds of the community and local healthcare team.

Confidentiality, as a key aspect of the professional relationship between nurse and patient, proved to be an area of cultural conflict needing mediation in the preceptorship experience. As discussed further in Chapter 5, the challenges of confidentiality in a rural context might provide a valuable teaching focus in a variety of health-related programs.

4.3.5. The Rural-Urban Divide: Technology, Talk and Transfer

Some student and nurse stories addressed cultural conflict as arising from differences between urban and rural agencies and/or personnel, particularly when transferring a patient between agencies. Relationship building between agencies and individuals emerged as important for rural nurses. Nurses perceived a lack of respect for rural nursing practices on the part of urban healthcare personnel, and tended to interpret conflict with urban healthcare personnel as resulting from lack of appreciation for rural-urban differences.

The few examples participants shared underscored rural nurses' interest in getting feedback about a patient they had cared for who had been transferred to another health facility outside of their local health area. Sharing patient information across agencies and between individuals at times was contentious given the interests of maintaining patient confidentiality. The willingness of healthcare staff to share patient information across boundaries differed according to the personal relationships that existed—another way in which rural relationality interacted with the ethic of confidentiality, as noted above.

Abbie noted that rural nurses often went beyond the minimal standard of care in checking on patient transfers.

If they [healthcare team] were transporting somebody out by ambulance. They would always check to make sure that they got there ok and that everything was received. . . . But quite often they will double check to make sure that their care has been passed on, not just leaving it to the ambulance people. [rs1 Abbie: 1651-1672]

Abbie also observed tension that occurred in relation to differing agency regulations and norms. In particular, Abbie's example highlighted how the culture of urban organizations, in this instance the reliance on documentation, dominated rural-urban exchanges.

Then they [urban hospital] called and they were reaming out the hospital here [Windermere] because why didn't they have her [the patient] in this different spot [as opposed to the urban hospital]. They had to help her go to the bathroom and she wasn't their patient and all these things. So things like that. Communication between the hospitals. And then one patient came there [Windermere] and then she . . . they wanted to get medical records from [Urbania] or somewhere and so they called and they had to fill out this whole thing, like you have to send us a request, you can't just [get] information over the phone. And they [Windermere] didn't have proper forms, so they just wrote up something and then sent it off. [rs1 Abbie: 4448-4473]

And the nurses, I also noticed, they tried really hard to have good reputation, not reputation, but a good rapport with bigger hospitals around. If they were sending someone to Centerville and they knew that the last time at the Centerville hospital that it wasn't done properly, so they called the hospital there and got them to fax the forms that they use at that hospital so they could fill them out ahead of time in Windermere. And have everything ready. So that was really neat that they had everything. They were trying to communicate really well with the other hospitals and trying to have that in there. Instead of just sending them there and saying ok you can deal with them now. [rs1 Abbie: 1712-1735]

Haley, Ilene, and Jaime provided more examples of cross-boundary conflict between urban and rural, emphasizing urban healthcare providers' misunderstanding of the rural context and rural nursing. These examples underscored the importance of rural preceptor confidence in their practice in order to accept a nursing student.

So I think it's in that relationship you know, the nurses from Centerville saying 'we're sending back a patient in 48 hours, look after him.' And we're telling them, 'no, no wait a minute, we've got you know 15 patients in an 8-bed hospital.' We have no extra staff. We can't pull from another ward. We physically don't have the stretchers here. You know we have patients lying in the front lobby where we've put chairs together to lie down. And they say, they're telling us they're sending us a patient. So that really strains the relationship and it's the same with Springfield. You know it's Springfield 'We're 30% over census, we're sending you a patient. We can't cope.' The nurses here 'No, you're not listening. I'm 50% over census.' [rn3 Haley: 3617-3650]

Oh, I think it's trying to find . . . like trying to ship . . . the ability to ship a patient out for higher care, higher tertiary care. People at Springfield, people in [regional hospitals], they have no idea what a rural site does. They have no idea they have no idea of our capabilities. . . . It's a very frustrating process because we get, we get . . . terrible treatment we are treated with disdain. It's very frustrating, you know it's like we are at the bottom of the feeding barrel but actually I could go into a large centre and I could run circles around any floor nurse, sort of thing, you know, it's just our experience is different. [rn4 Ilene: 5590-5663]

When rural nurses try to go to large facilities or even transfer patients there I've certainly noticed that we get looked down upon a lot. A friend of mine he just applied for a job with an ICU and I know, this is in Centerville but I know that in Springfield they hired several student nurses right out of school to work in there and within 3 to 4 they are managing up to two intubated patients. My friend he has 4 years as a rural nurse, he's worked on a cardiac floor, he's very much on the ball and he was told, no. . . . So I'm trying to figure out why 4 years of rural nursing doesn't equate to 6 months on an acute care floor. [rn5 Jaime: 955-992]

The cultural power of urban contexts was present in rural settings. Nursing students found themselves positioned between these two worlds and witnessing the sometimes conflictual relationship. This dimension of the rural preceptorship experience, worth acknowledging and exploring, is discussed further in Chapter 5.

4.4. Aspects of Place

Several themes related to the domain of place emerged: density-sparseness, time, ethnicity, economics, technology-resources, and people's health. These features were not predetermined but emerged for me as essential elements required to convey the nature of the rural hospital practice context and to situate an exploration of the influence of these features on the hospital-based rural preceptorship experience. The inter-relatedness of these themes within and across domains cannot be overstated. For example, within the domain of place the associations between the size of the population (density-sparseness) and the number of healthcare professionals and services (technology-resources) available within a community became evident. Likewise, it could be that the fewer people (sparseness-density) there are in a rural community, the more likely it is that a nurse living in the community will become acquainted (time and relationships) with many of the community members. The inter-relatedness of themes, and differences between different rural places and between rural and urban contexts within these themes, became evident in student and nurse descriptions.

4.4.1. Density-Sparseness

For this research, the concept of density and sparseness generally refers to the variations in number of people in a particular context at a particular time. Rural contexts are substantially less dense than urban contexts; indeed, the degree of sparseness relative to other places is a defining feature of rurality. Variance in the number and type of professionals and the number of people they serve shaped the rural practice experience for students in several ways. Terms in the interview data such as few, small size, smaller, fewer, only nurse on, just you and your partner, reflected these themes.

Fern contrasted the relative density of an urban emergency context, where there are multiple people with different expertise and roles, with emergency healthcare delivery in a rural context.

Fern: Stuff like that, . . . that you take for granted. That took me a long time when I went down to work in emerg [in Springfield], was figuring out all these things that I don't have to do. Having so many people around. You know, somebody comes in . . . they're really ill . . . well, hey they came in with a line! My God! That's a novelty. That you have something like three RNs and a doc go down and someone saying "Who's going to take notes. I'll do the lines, you do the . . ." And it's amazing how many people come to the party. And I think that surprises the students sometimes too.

Cheryl: Is how few are here at the [rural] party?

Fern: Exactly! [rn1 Fern: 2619-2649]

Estelle noted how the smallness of a rural hospital and the infrequency of the presence of other nursing students enriched her experience and her relationships with rural nursing staff.

I think I touched on this a little bit before, but just the opportunity of being the only student there. I know sometimes there were a few other students. Waterton [hospital] takes placements from [another university school of nursing program], so there's other students there as well, but just staff so much friendlier physicians, everybody, it didn't matter that you were still a student they were interested in you and what your story was and everyone was much more helpful if you had questioned because they weren't feeling over burdened by questions from every day getting more and more questions from students so they enjoyed the teaching opportunity of having the student there. Anytime there was special procedures going on, for our synthesis or something, on a different floor, they knew that there was a student up there so the shift coordinator would come up and see you want in on this, do you want to watch so they would make sure that when the time came that they would come up and get us to let us watch it. [rs5 Estelle: 930-959]

Working in a smaller and more isolated community than Estelle, however, Ilene pointed out the challenges for student learning opportunities that low density can pose: “*Some poor [students] have come here and we've had nothing, a patient count of two on the floor or three and the ER being totally dead*” [rn4 Ilene: 2789-2795]. This unpredictability (explored further below under Time) also emerged in a comment by Carla: “*We never got really anything, really busy that we couldn't manage both except for my last night and that was only because we had no nurses in the town. The town basically emptied, they all went biking together*” [rs2 Carla: 973-079]. In the latter case, it was apparent in another example

of how the effect of density on social relationships also translates into differences in professional experience.

Abbie spoke of how the smaller size of a rural community translated into nurses becoming more familiar with community members and becoming closer to the healthcare team as a whole.

And also since you're the only nurse on, you're the only nurse they see. And they see you the next day, and that sort of thing. Then it's also that the nurses recognize a lot of people there who come in, because it's a small town. [rs1 Abbie: 651-659]

I think that sense of community is really neat. Like the medical community. More the whole, what's the term for it, it was much more a picture of interdisciplinary team or whatever. People from all areas. Yes, because you were right there experiencing it. And they also had a dietician who would come on and talk and everything, the whole team there. With Springfield quite often it's the nurses. There's other people there. But you notice it much more there because it's such a smaller personnel, so fewer people. . . . You get a picture of what they're talking about when they teach that at school. [rs1 Abbie: 2460-2489]

In several conversations, nurses conveyed how low density translated into greater responsibility being borne by an individual nurse within the community or the hospital—a feature of the rural preceptorship already noted in the previous section.

You take one person [nurse] out of Springfield; you're not going to miss that. You take one person out of rural, that's huge. [rn3 Haley: 7723-7730]

During the week we have [the nurse manager] here . . . , other than that right now we have the undergrad [a supernumerary employed student nurse], and we are trying to get back one 4-hour care aid but basically there's just you and your partner all day. [rn4 Ilene: 1887-1900]

You know in the ER in Springfield they get something major come in they can still work around that because they have the staff and the flexibility to deal with that, we don't. [rn5 Jaime: 1960-1966]

I think a lot of it has to do with the small size. Because it is a small size you see the same people over and over again and you develop a culture where you have to get along and so you do get along with people so it ends up being a fairly friendly work environment, the staff are great to work with the doctors aren't doctor so and so they are [Jane or John], whatever, we have an excellent PCC [Patient Care Coordinator] out there who bends over backwards for the staff and still manages to keep things moving. That's not to say there aren't difficulties of course there are always going to be interpersonal conflicts but it is a very friendly place to work. [rn5 Jaime: 6467-6499]

At certain times, however, sparseness or low density challenged rural nurses' sense of security. As Bobbie observed, gender issues played a role.

There are no male RNs. There are two male care aides that work in the long term side. And that's it. The management is all women. Nurses are all women. . . . We, in Pleasantville hospital, they have, they're provided with beepers that if you hold the button down for I think it's 5 or 3 seconds, it automatically sends an alarm to the police station and they automatically come up. And the police have cards to get through the door. . . . and actually the nurses don't carry these beepers around. They just kind of "oh whatever." Kind of misses the point. But I've never felt unsafe and they never have either from what they've told me. [rs3 Bobbie: 1428-1504]

Gayle described vigilance on the part of rural nurses in rural hospitals to maintain safety given the limited human and technological resources. Interestingly, she suggests that the limited availability of physicians could aggravate the security risk for nurses.

Yes it [hospital] locks down at 8:00. . . . You have to let people in and out. So you have to be . . . I just say you have to be aware, you just don't let anybody in. You sort of have to get a sense of who's at the door before you open that door. . . . You're not obligated to let them in. If they want to just pass through and "I'm just passing through and I just want to use the phone." "There's lots of public pay phones so I can't let you in you know." Just like, it's not a medical related, just little things to not, to not let anybody in the door because you know you have to deal with what comes through the door with you know a small number of people. [rn2 Gayle: 643-670]

The other thing is security. You know because the fact that we don't have security that you know there is no, there's not a place where you push the magic button and hopefully somebody comes. Eventually if you're going to dial 911. So the fact that you don't get yourself . . . and you're always be aware of the situation that you walk into that you can walk away from if you have to. That you don't come on as to, you know, put on your best you know I'm here to help you face. Don't put yourself in a situation where somebody might get upset and security might be an issue. Because it's a big thing in a rural facility and you just don't have those options to call security. And then there are times when you have people on the ward with drugs and staying angry because of what's available here and what their expectations are and what they can have done type things. And the physician shortage that's going on too. Their expectations to see a physician versus it's not going to happen. You're going to see a nurse. And you're going to see a physician tomorrow or at a different time. [rn2 Gayle: 593-639]

From the interview data, however, it did not appear that security issues had materially affected the preceptorship experience for any of the students or preceptors.

Density thus emerged as a quality of place that shaped the preceptorship experience in multiple ways. Personal relationships, professional practice, and opportunities to learn were all influenced by the numbers of staff and community members present in the healthcare setting at various times. The implications of this for policy and practice are further explored in Chapter 5.

4.4.2. Time

Time emerged as a theme connected to place in subtle and diverse ways. Some of these had to do with the development of long-term relationships with healthcare providers and community members and are examined in a later section. Distance-proximity, seasonality, and variable practice pace were three further ways in which the particular qualities of time in a rural setting shaped the preceptorship experience.

Distance-proximity had a significant effect on healthcare decisions and communication. Availability of onsite healthcare providers was limited; depending on the time of day and number and type of patients, the time available to provide care could vary substantially. Response times to emergencies could differ between rural and urban contexts. Carla spoke to this difference in terms of the time it took to retrieve or recruit equipment or people in emergencies. Unlike most hospitals where physicians are present in the building 24 hours per day, the rural hospital was more likely to have a physician on call to come into the hospital in the event of an emergency.

Well, I think it's the stuff that, like the code, ok, yeah, you're involved in it but at the same time you call a code team [in an urban hospital] and they sort of come and for the most part take over. You're it in Pleasantville. There's no code team. . . . The doctor is 10 to 15 minutes away. [rs2 Carla: 1240-1253]

After 11:30 there was one RN and maybe one or two LPNs and then some care aides. And you could call people in but they were, at the quickest, 5 minutes away. That's once they've woken up and gotten into the hospital. [rs2 Carla: 3250-3257]

Gayle noted how the possible need to transfer a patient influenced the pace of care.

But in a small facility because time is such an issue and you don't have all the resources that you need, you have to quickly get in there and assess and you know determine how sick is this person. You know are we going to need to move fairly quickly to get this person, you know, either stabilized if they have to go to Springfield or carry on to a bigger hospital. [rn2 Gayle: 463-474]

On the other hand, Abbie, Bobbie, and Daniell all observed that different health services in a rural context often shared the same building or space, reducing the time and effort spent on communication and how this visibility and accessibility of other professionals allowed students to participate, rather than conceptualize, interprofessional or interagency relationships.

Public health was down the hall. They had homecare next door they could call. Everything was right there. . . . Instead of sending referrals here and phone calls there, it was yeah. Much more organized, much more smoothly run. . . . Yeah, even physically it was close at hand. [rs1 Abbie: 3959-3981]

And then right in the hospital is public health, community health. They all have their offices in the hospital. So it's actually pretty handy when we have someone on the ward who has a difficult wound or a complex wound, and the home care nurse they do that all the time. So we actually just had the other day her come in and talk to us about what we should be doing with this wound and how to dress it and stuff. So it's really handy. [rs3 Bobbie: 2746-2762]

Cause everything is right there maybe. That's what I like . . . yeah. And just if you need a community [nurse], you could just walk down the hall, yeah. So maybe things are more accessible in a way, really. [rs4 Daniell: 3405-3416]

Seasonality, or differences associated with the time of year, had a significant impact on rural nursing practice and the learning opportunities students encountered.

You would have the tourist population as well, just because it is a large southern community and stuff and you would get a lot of houseboat patients. . . . Well I am not sure there is a link or not but we had a number of appendicitis cases on younger females I don't know if that is just a typical age for that to happen or but a lot of them had come in from houseboats for that and it's something I'd like to look into in the future, myself but lots of people that were from out of town [rs5 Estelle: 1523-1565]

They have tourists coming through because there's a lot of camping lakes around there so all of that. [rs1 Abbie: 5245-5248]

And it is definitely different. There's a lot of tourists in the summer vacationing and that. It's . . . there's a language barrier lots of times. And lots of sort of hiking. Like it's a very . . . it's [a provincial park] so there's all kinds of biking and hiking. And lots of injuries in that respect. Particularly a lot of fish hooks in the skin. It's weird, but we get a lot of that. And in the

winter mostly we get the car accidents off the highway. Just in terms of patients that come through the doors, it's different. [rs3 Bobbie: 3483-3521]

Then it comes back to community a bit with us where here there is fishing season where they are down at the river fishing and you're going to see more cuts to the fingers, fish hook, knives filleting the fish. [rn5 Jaime: 2000-2007]

As observed by Gayle, such seasonal changes often had an impact on the kinds of resources required.

You see . . . funny in the winter time you see a lot of skiers from _____ who go to [a helicopter ski resort] which is kind of a world renowned facility. And their expectations of what we have in our ER versus the big city you know. Like "I want to see an orthopaedic specialist because I've broken my arm skiing. "Well . . . it's not going to happen here. . . . And we see lots of . . . and we don't have interpreters. Lucky we have a few staff that know a bit of French, some German, but we don't have access to . . ."Someone who knows Croatian, please come to ER." You know it just doesn't happen that way, so. You know, so I've had to make up the use of online stuff too. That's really been helpful with translations pages. [rn2 Gayle: 1454-1506]

The strongest time-related factor to emerge in the interviews was the variability of practice pace and its influence on student learning. Several nurses spoke of the variation in pace as a positive factor:

The fact that you know it's not hectic, crazy; you know go-go 12 hours straight type things. Sometimes there are times that you can sit back and read something or research something or do things as a big city. It's kind of an up and down type thing versus a big city. Go, go all the time. [rn2 Gayle: 1812-1821]

I think with rural practice, like, it solidifies everything that you have learned but the pace is a lot different from the floor you can do it . . . you can do . . . like sometimes it's totally crazy rural and sometimes it's very, very calm, quiet and you can solidify all your learning and experience together, whereas, depending on where we are in the cycle, like now the acute here it's more . . . multi illness, it's always multi illness now and it doesn't really give you a chance but on those quiet times you'll be able to sit back and bring it all together, [rn4 Ilene: 4894-4945]

You know trying to think of, especially in a rural setting trying to think when there are slow times, trying to think of things to do with the students to teach them. When I did my practicum there were two sets where nobody came through the yard and there were no patients on the floor . . . We did nothing. The student I had, we only had one or two people through the ER so it's a matter of coming up with things to teach the students so we started going over physical assessments, elbow exams, knee exams, special tests and trying to get them around to other departments to a least get exposure, somebody came up so she got to draw blood from somebody

for the lab. They are going to get to do things that you'll never get to do over at larger facilities. [rn5 Jaime: 1686-1720]

Bobbie and Estelle shared their sense of the educational importance of time when the rural practice pace was slow. Part of this involved coming to know patients more deeply than might otherwise occur.

I think it's a lot easier in Pleasantville because you have more time. You have more time to be with people and talk to them and listen to them. Whereas in Springfield you're just rushed all day long. Like you could say to people, "You know, I don't have time right now, but I'll be back." But you won't. You won't be back, because you don't have time. [rs3 Bobbie: 419-430]

For Bobbie, the different pace and degree of support in a rural context was empowering. Having had a rural experience at the end of Year 2 in the nursing program, she chose to return to the same place and credited, in part, the pace of the rural setting as a factor contributing to her ability to learn.

So, I guess just because it's so different that . . . and it's at a pace where I can learn effectively instead of being thrown all this stuff and ok "like do all this stuff and you have an hour before you can do this." So I can learn at a good pace and I have a lot of support and help in a rural setting compared to Springfield that, that's the main difference for me and why I chose to go to Pleasantville. [rs3 Bobbie: 4338-4351]

Yet although students tended to comment most favourably on the slower pace of rural nursing, it was clear those sudden shifts of pace also contributed to the value of the experience, as noted by Bobbie and Fern:

And another thing that I think they always are surprised is that you can go from absolutely nothing happening to a helicopter landing in your parking lot and having to deal with it. And, the actual ward things . . . I guess in the rural practice, we keep people longer. They stay in the hospital longer. [rn1 Fern: 2049-2059]

But she [preceptor] says it's [Springfield] just . . . it's like a 360 compared to Pleasantville. It's [Springfield hospital] always full. There's always a backup. And there is never enough doctors. There's never enough nurses. There's, it's just constant running in Springfield. And Pleasantville, I mean, some nights we don't get a single person through the door. And it's really dull, but. Of course when it rains, it pours. You get one person and then everybody comes in after that. We have really busy nights, or we have really dead nights. [rs3 Bobbie: 1386-1414]

But no, they have to be very much prepared from the nursing perspective of dealing with that change in pace. And that's probably one of the biggest things of going from nothing to being crazy. And that all students and staff are well advised to keep on top of things when you can. [rn1 Fern: 3805-3833]

As Gayle observed, the uncertainty of what a particular day will hold contrasted dramatically with the regular schedules of an urban context.

You know when you work in the big [urban] ER ok well the other nurses have to take over your patients and you have to go eat so they have to go eat and stuff. So it's more regimented. You have to take your breaks and do this. Whereas in ours [rural] you have to go with what . . . so I always tell my girls [students] you know "Come to work. Don't be hungry when you come to work. Because you don't know when you're going to eat." [rn2 Gayle: 1128-1139]

Thus, time assumed importance in a rural context particularly in relation to the urgency of the patient situation, the availability of expertise, and the variability of numbers and types of patient conditions from day to day and season to season. In certain respects, this appeared to enhance the quality of the educational experience. Time also emerged as a factor related to participant history in the community and familiarity with patients on a unit. These aspects of time are examined later in the section on interprofessional and community relationships.

4.4.3. Ethnicity

One aspect of place that interested me was how the diversity of the population might affect the preceptorship experience. In this study, the question about whether or not participants noticed different groups within the community normally led to answers that reflected ethnicity. Seldom did students comment on religion or spiritual beliefs as something that they noticed as diverse. Nor did the length of time people had lived in a community or the history of the community itself emerge as a clear theme.

The ethnic diversity noted by students and nurses varied considerably, not only from place to place, but also season to season. Student comments suggested that they had not

received any systematic education about the local population, but based their ideas on personal impressions and research.

There's a couple East Indians, although not nearly as there used to be because when [a forestry business] shut down, a lot of them lost their jobs. There is maybe two or three Asian families, Korean, Chinese, something. Other than that it is mostly Caucasian. [rs2 Carla: 1060-1068]

There is definitely a large East Indian population in Pleasantville, and to be honest I haven't, I can't think of a single one that I've seen in the hospital like in terms of ethnic origin. Like it's, I haven't seen a single East Indian like on the ward or . . . which is different from Springfield because you get everybody from everywhere. But that is something that's kind of weird. I don't know if they tend more as culture to deal with things more at home or if they just go automatically to Springfield, or . . . Or if I'm just not there when they come in. I don't know. But it's, yeah very rarely do we . . . because it's quite a high population in Pleasantville. [rs3 Bobbie: 3536-3571]

Ah, I think I did a little bit of research and I think Westmount was 70% Aboriginals, because of the different bands that live around the area. So there was a few Aboriginal people more than what I might see at Springfield, right, mostly white people. But I did see East Indian and I did see Greek too. So that was pretty diverse. [rs4 Daniell: 2675-2696]

. . . I would like to say that there were more Aboriginal people and there was maybe a minute amount of other people but it was very varied all the different backgrounds that we got coming into the hospital. And it might have just been my little month, I don't know. [rs4 Daniell: 5207-5213]

So I would have to say that certainly we have less cultural diversity. There is a different culture in rural areas. That's changing more and more as the social structure change and people move out and are able to live in rural areas and through networking and so on. Internet. But, on the whole, yes, there would be less diversity. : But again, like . . . everything . . . rural, you may not get enough diversity and then you may get a bus full of people from China that crashes and suddenly you're trying to find people that may speak the language. Someone that can deal with that. [rn1 Fern: 3456-3488]

Two nurses, Ilene and Jamie, noted the high Aboriginal population around their community of Westmount, although they had little to say about its impact on practice. Abbie, who did her preceptorship in Westmount, noted her surprise at the degree of diversity she encountered:

There's some [people] that come up from Urbania. So there's a lot of variety. . . . And then sometimes you have different communities, people passing through like that are homeless. There's that population. . . . I totally forgotten that there were Aboriginal populations around

there. I didn't know. And I really didn't think . . . I didn't know it was going to be diverse. [rs1 Abbie: 5240-5329]

Haley was the only nurse to refer to the importance of cultural awareness in nursing practice, in the context of her community of Windermere:

What the difference here in Windermere is the nurses are very culturally aware of the population in Windermere. We have a lot of First Nations which is a different culture into itself. That is huge. So if you don't understand some of the Aboriginal cultures you can step on a few toes very quickly. We have a small Indo-Canadian population. [rn3 Haley: 1227-1249]

Few comments related ethnicity to differences in patient behaviour. Estelle and Abbie noted the way in which family structures differed between ethnic groups.

I did notice is difference in family culture just large family population would come in to visit and making sure they were okay whereas some of the patients you would see would go a whole shift without a visitor. I did notice that a lot of the First Nations had quite a large family or community visitors coming in to visit and stuff. [rs5 Estelle: 1673-1683]

There's a lot of diversity. There's a lot of Indo-Canadians there. And they'll have the whole families in with them and they'll be helping out the patients. So there's that whole diversity. And then there's all the, of course the Caucasian people. There's a lot of them there. [rs1 Abbie: 5227-5236]

Overall, there was very limited student discussion about the history of the community and the people that were part of it. There were several possible reasons for this silence. With personal knowledge of Springfield curriculum, I was aware there were no specific learning activities designed to focus on community as context to support practice within a rural hospital. The length of the student placement was limited, less than 300 hours practice time in the hospital; this limited their opportunity to come to know the community history. Furthermore, questions about the influence of community history on student or healthcare practice were not at the forefront of my thinking during the interviews. It remains difficult to say which of these factors was most responsible for the relative invisibility of ethnicity in the interview data.

Given the substantial number and diversity of Aboriginal people in rural BC, and in several of the communities in this study, there were surprisingly few comments about nursing Aboriginal people. Since this population has specific and frequently serious health problems, such a silence was disturbing and worthy of further research (see Chapter 5).

4.4.4. Occupation and Economics

Surprisingly brief also were the participant conversations about economics as a social determinant of health. Several students and nurses referred to industry, particularly tourism with its seasonal patterns (discussed earlier under the theme of time), as an aspect of rural diversity. Preceptors spoke more of how the economics and industries of the surrounding community help shape rural nursing practice than did students. They provided examples of how they might need to change their practice in various rural communities, or how the income of particular groups could influence the timing, patients, and conditions nursed.

Then we also have huge homelessness. We're the third lowest social economic in the province. So with that comes your drug abuse. Ah, your welfares which usually often means poorly educated. [rn3 Haley: 1227-1254] So that really affects your teaching as a nurse. Their ability to seek the treatment that they need to seek. Whether it be financial or their ability to understand what you're teaching. It's learning to drop the medical lingo and really talk to laymen, and I mean very clearly laymen.. [rn3 Haley: 1258-1270] Also what we have here is a ranch culture in Windermere. These are the cowboys. Often again, lower education. You know "don't talk to me about this. Just tell me basically what it is I need to do and you know just do it." Now if I look at say another small and I'll go back to [another rural place closer to Urbania. Okay, that was a little bit more urban, so they understood a little bit more the dialect and that you're talking and it was not unusual for someone, a senior to come in with all their stuff on the internet, not on the internet, but all printed out from the computer, what they're on, their medical diagnosis and when their last physical exam was. And they came all prepared and it was all typed out. Seniors here, you know you don't even see that. Very few access computers. [rn3 Haley: 1274-1309]

So I always warn them [students] about welfare Wednesdays, Friday and Saturday nights, when the paydays are . . . how that shapes our work . . . it's very hard working with the native population, very hard . . . Well it's just, you know we have a lot of the frequent flyers so a lot of the students while they are here, they may get him every shift, or every set, pardon me, and sometimes twice a set. And it's just, very frustrating, so you know just teach them and encourage them to talk about their frustrations and you know either with a patient on the floor

or an outpatient and you know just what our expectations are with them, you know sort of run through the patient history with them. You know they may get very worried and they may look at us, Oh, you're pretty mean, you didn't treat that one very nice. Well, this is the scenario, you know this person may be dealing with an alcohol addiction or a drug addiction. [rn4 Ilene: 1279-1386]

Jaime and Carla linked economic diversity to both ethnic and industrial factors.

The sites varies anywhere between 3,500 to 5,000 people, predominantly native in the outlying communities. Some of those sites, it's quite a variety that come from those sites in that some of the bands are richer than others some are a lot poorer so you see quite a discrepancy between those bands themselves. [rn5 Jaime: 2315-2330]

Honestly, do you know what makes that town run? Tourism, the mill, and probably marijuana sales are all that makes that town run. Sort of, not necessarily in that order. . . . There's everyone from basically the entire spectrum of the economic scale. [rs2 Carla: 1020-1029]

Occupations and economics as a contributing element of diversity between and within communities were most evident to nurses. Students were less able to offer examples of how community economics influenced their day-to-day practice. For the most part students made generalized descriptive comments about the main industry or economy of the rural region.

4.4.5. Resources and Technology

Technology was one of the areas where my findings surprised me. I came to this research with a preconceived notion that students would be likely to comment on in the limitations or inadequacy of resources and technology within a rural context. My assumptions were based primarily on my history with nursing students and a general public perception that urban healthcare is somehow superior to rural healthcare. Such a standpoint, of course, is perpetuated by a focus on healthcare delivery as primarily a technological matter. Contrary to what I had anticipated, most students or nurses did not view rural healthcare as technologically inferior, only different. One of the primary themes that emerged was resourcefulness as a key quality of rural nursing practice, signalled by words and phrases including 'flexible',

‘improvisation’, ‘knowing a little of everything’, ‘do a basic job with what we have’. The notion that nurses had to do more, such as provide advanced care for diverse patients, with fewer resources and expertise was a recurrent message that links back to previously discussed aspects of rural nursing such as autonomy and reliance on others.

And how do you . . . I guess part of the rural challenge is, is that you don't have broad resources. How do you deal with each unique situation when suddenly you do get something that is unique, that's very . . . or at least not very unique, but very different from our day-to-day. [rn1 Fern: 3502-3510]

You get a whole different look in nursing and what's out there and greater appreciation for the whole aspect of nursing in the rural communities and that whole bit . . . But getting experience in that and seeing firsthand like how even an hour away from Springfield they don't have the same resources as these big hospitals [rs1 Abbie: 2539-2550]

The RN who I was working with spent at least 7 hours of her shift trying to figure out this cad pump. For two patients she had to set up cad pumps for, for pain medication and she had no idea how to do it. It was a brand new thing for Pleasantville. So she was on the phone with the pharmacist all day. [rs3 Bobbie: 3061-3075]

And it's the whole thing also, because they don't have a pharmacy there. The meds come in, so it's the whole thing like you have to go through a whole drawer of meds. . . . there's no way you can get things there. [rs1 Abbie: 987-998]

Jaime spoke of the resourcefulness of rural nurses as “being able to come up with a plan, improvisation. We don't always have the proper tools for doing the proper job” [rn5 Jaime: 3583-3596].

Bobbie, however, did not see rural tools as essentially inferior to urban ones:

I don't feel like there's a lack of resources. . . . Like if we needed something it would . . . I mean . . . apart from all the fancy equipment that they have in Springfield and bigger centres which we don't have . . . I feel that we have enough that we can get by without feeling like we're in the dark ages or anything. [rs3 Bobbie: 3031-3038]

Differences in available human resources were apparent to most students when compared to an urban context. Daniell noted the absence of allied healthcare professionals.

We didn't really have an RT [Respiratory Therapist], we didn't have physio. OT's [Occupational Therapists], no. . . . I'm trying to picture someone getting a walk or anything. I can't really think of the need for an OT at the moment. I think that we had someone who would have been probably seen by an RT if they would have been at Springfield. But no it was just the doctor and the nurse who had managed it. [rs4 Daniell: 4067-4104]

Abbie described how the rural hospital in Windermere had lost several healthcare support services to centralization in Springfield:

They had, there used to have a maternity wing. They used to do surgeries there. A paediatric wing. A medical/ surgical floor. And they showed me, like they have the whole operating room all set up still. All these things in. And they don't even deliver babies there anymore. And they think it's so sad. Everything went up to Springfield even had their staffing go to [another regional referral hospital]. And even their food and laundry and everything goes out. And they're quite happy that just a year ago they got their staffing back in Windermere. Which to me, like she said it makes it so much easier because staffing is right there, they can call everybody instead of someone like 2 hours away calling to find someone to come on. And they have their food back there now, so they have fresh food. All these little things are coming back, but it's just such a waste to see such a huge hospital . . . [rs1 Abbie: 1368-1394]

These differences led nurses to speak of their need to perform tasks that in urban contexts were normally associated with allied health professionals or other specialists, and to get by with less up-to-date equipment than in an urban centre.

But you don't have as many resources. You don't have an RT. You don't have a lot, so you have to kind of get a quick handle on what's going on and get them stabilized as quickly as possible. Like you do in every ER, but you have to do more things yourself. You can't call an ECG, you have to be the one who does it. [rn2 Gayle: 724-733]

I think the most I hear is the fact that we might not have fancy MRI's, CAT scans and all that stuff. But we do a good basic job with what we have is interesting and making use of what you have versus having to go to the next step. [rn2 Gayle: 1650-1656]

So that's something else, that if it's someone who's not familiar with the resources around that you try to go over with them. And actually students know more about resources than we do when you get right down to it. . . . What generally happens . . . and they're, they're awesome. Actually I must say that when we pick up the phone, we can call dietitians, we can call pharmacists, we can call all within the region. Most of them are real good. If we have someone that comes in and we put them on the ventilator, we'll do the initial setup and generally call whichever RT's on call and they'll talk us through and change the settings. [rn1 Fern: 1616-1666]

As seen in a previous section, differences in documentation and information resources between rural and urban centres were often apparent.

The fact that Pleasantville, and probably most rural centres is . . . a couple years behind Springfield in paperwork. Like the stuff that I had seen, like the paperwork and stuff that I

had seen in Springfield that I heard they were getting rid of is still in Pleasantville. [rs2 Carla: 513-526]

The only thing we have different is maybe the access to the supports, whether it be education, information, policy procedure, things like that, that's the only thing. [rn4 Ilene: 2695-2707]

Well like in the ER somebody will come in and I'll have done an assessment on them and I have no clue and I'll be sitting back there typing into Google okay what does this mean or what else should I be assessing, what else can I look for. . . . otherwise it would be trying to find the right textbook to read through, like we have a fairly good library of things we need, policies procedures manuals but it's still a matter of trying to find what you need and when it goes outside the scope of those then what do you do? Trying to find out for palliative ub, different ways you can give atropine to try to dry somebody up a bit so that it makes them a little bit more comfortable and it makes the family a little bit more comfortable. You know I couldn't have found anything in those textbooks if I tried. That was where I found a couple of things online but I ended up calling the hospice centre to see what they had and they confirmed some of things I had online plus gave me more advice on it. [rn5 Jaime: 3738-3803]

Despite comments like these, it came as a surprise to me how many students identified rural settings as having online and print resources. Standardization of communication information technology across most of health authority rural hospitals was becoming the norm, with the occasional exception.

Oh there's, oh yeah, tonnes of textbooks. And protocols and binders for every single thing you can think of. . . . Which in emergency, would be useless because you have no idea which binder has what information and where to find it. . . . Like the binders are like "this thick" so it would take a long time to find what you needed. But my preceptor and another nurse that I worked with quite a bit have little palm pilots. . . . And they have everything in that little computer and they can look up anything in a second. Anything you need to know. Whether you know, it's a definition or anything. . . . They have all these programs downloaded onto it, that it's just right at their fingertips so. And also computers. We have computers there. . . . And of course the doctors and we can just call if we need some information, or . . . [rs3 Bobbie: 2984-3028]

They had all the manuals that they do at the [Springfield] hospital. They had tonnes of textbooks on assessments and all that. No, that was fine and they had the Internet too. [rs4 Daniell: 2026-2031]

Onsite, well fortunately, because it is a rural site we have the internet readily available so you could always Google something. There is like a library of textbooks and stuff. [rs2 Carla: 1548-1554]

Or when looking things up; half way through I realized that the [health authority] online library, that really helped and it was quick and easy to look up stuff. Had it right there. Which I wish I would have figured out at the beginning. And they teach you about that stuff at

school, but I mean I've never used it before. Because there's so many books in the hospital. Yeah, they don't have too many resource books out there. But then again, that whole thing about being your own boss, the one huge thing I found is that they don't have protocol books there. [rs1 Abbie: 1071-1087]

Abbie's last comment highlighted a feature of rural settings: reliance on personal examples and word of mouth in conveying information. This communication feature relates to the reliance on others highlighted in a previous section.

I always talk about the healthcare handbook. If they have Internet access I tell them about the webpage about the nurse line and all that kind of stuff. You know, you try to help you know keep people informed about that. And the students definitely know their technology. [rn2 Gayle: 1593-1636] . . . And I got my little home page at my computer in ER and it's got 50 gazillion icons. That's where I go if I want to learn about drugs. And here's where I go if I want to do pharmacy stuff. And here's the thing, the interactions between herbal medicines and other medicines and stuff. But they [students] are really, really eager to find out what the online resources are too for nurses. [rn2 Gayle: 1634-1636]

They just seem, with all the vast technology out there now, it's incredible, just the means at their fingertips for learning. And that was different you know for learning we had all the textbooks but very little with the computer, you know that was just coming that was just starting. [rn4 Ilene: 655-677]

They don't have protocol books there and I was like, I'm used to, if you're unsure of something you look it up in the protocol book and you have guidelines and you know what you're allowed to do, what is the best practice at the hospital. But they didn't have anything like that there. So at times I would have to take the nurse's word for that that's the way things are supposed to be done or something because I didn't have the resources to look up really quick and I didn't have the time to look things up in books. So to me that was hard. So if I was there I would almost want to go look up after because you were so taught to be make sure you were doing it by the best practices and by the proper technique and not to just take the nurse's word for it. But then there you would have to rely on that because that's the way things were. [rs1 Abbie: 1091-1115]

An impression emerged from the interviews of the growing impact of information technology on rural nursing practice and the rural preceptorship. The degree to which information and communications technology stands to change the educational experience available in rural settings is a subject for future inquiry. Even in this small study, however, nurses commented on students' ready use of computer networks to acquire information.

The commitment of nurses to provide the best possible care within the limits of rural human and technological resources emerged as a positive message nurses and students wanted to share in these participant conversations, rather than messages of rural insufficiency. Resourcefulness emerged as a central feature of rural nursing. This value orientation was summed up by Gayle when she stated, *“I think that basically just showing what you can do. You know how well you can do with what you have” [1688-1691]*. Increasingly the availability of information and communications resources in rural contexts approaches urban levels. These features of the rural preceptorship should be taken into account by nursing educators, as discussed further in Chapter 5.

4.4.6. Diversity of Health Issues

The phrase ‘all in a day’ resonated with me when students and nurses spoke of the potential for anyone with anything at anytime to arrive at a rural hospital. The diverse and unexpected health issues in a rural hospital provided opportunities for students to participate in caring for patients in the emergency department, patients requiring long-term care, women in labour, people requiring palliative care or mental health services, the family experiencing a crisis or the tourist with an illness, to name a few circumstances. The variety of health issues garnered the most conversation from students and nurses regarding diversity. Students relayed this facet of diversity as interesting, challenging and having substantial educational value in preparing them for future nursing practice. Several examples from nurses and students in the following pages provide a picture of actual and potential health issues faced by rural healthcare providers situated in hospitals.

Oh I think that's pretty great. I mean I got a lot of 1-time things. I get to see this once, you know. Like someone came in for a-fib and what do we do about it. Or actually he came in because he fell and his back hurt, and then they found this. Yeah, and then he gets rushed off in an ambulance the next day you know, but. Yeah, little things like . . . Yeah, and it was nice

because we got to see the emergency department. And I wasn't actually in the emergency part, I was on the floor. But I still got to go in and do the IV's in the emergency department or a wound. Or if it's not very busy and I'm all done, I'll come and kind of just be there if they admit people, so I got a bit of an emergency feel. So I got that, that was nice. And that I got a bit of a broader education, I got to see a couple of different areas. So that was nice. [rs4 Daniell: 2581-2663]

It's a wonderful opportunity to get a bit of everything. You get pediatric patients to work accidents coming in to people coming in with shortness of breath. You get the whole range of pediatrics to geriatrics. You get a range of everything. I love it, it's always changing. You don't get bored. You never know what's going to come. It changes from day to day. That's what I love about it. [rs1 Abbie: 1026-103]

We had a bit of a good conversation about . . . one of the doctors was also there. And he was saying that every nurse should work in a rural hospital the first couple of years because that way they get right into the acuteness and right into a situation where they're fresh from nursing school where they can learn everything and have a bit of everything, whereas he said some nurses who go straight into a specialty area they are too scared after a couple of years to go ever work in an area more acute or something. So that was kind of neat and she totally agreed with that. She said she loves working in a rural setting because it's always diverse. Not like a specialty ward or something where you're always doing the same thing. She said you never know who you're going to have or what's going to happen. So she loved that about it. [rs1 Abbie: 315-339]

You're getting an all in one experience. And not just a ward, you're getting everything. From labour and delivery to mental illness to post operative, like everything. . . . It's definitely diverse. Like you have no idea what's coming in that door next. [rs3 Bobbie: 6684-6711]

And then even a lot of people that come in with motor vehicle accidents are a whole other diversity. Because they are travelling through because Windermere is, like on the [highway]. So all the accidents within a different place go there. [rs1 Abbie: 5260-5265]

I just . . . I think that it is so valuable for me to have done this in Pleasantville as a rural experience even though it might not be everybody's thing, and it won't be my thing either, but I feel so much more confident in my practice dealing with all different kinds of patients because of this. And I feel like I wouldn't have this confidence if I had been on the ward in Springfield. [rs3 Bobbie: 4326-4350]

It has a lot of good things I guess the variety of what you see on the floor that made the experience broader because it's not all cardiac patients it was med/ surg. So you had a huge range from ostomies to a cardiac patient coming back from major surgery, a hip replacement, like it was a wide variety so that way you really got to see a lot more, I felt rather than just being secluded on one type of floor. [rs5 Estelle: 949-1013]

Most nurses identified the diversity of health challenges in a rural context:

We have a lot of chronic diseases here in Windermere. So its understanding you know the liver cirrhosis, the alcoholism, the drug dependency, huge lung here in Windermere. In [my rural

community of origin] for example, you know you really do need to understand trauma. You really do need to understand paediatrics, it's a young population . . . [rn3 Haley: 1321-1335]

Just the variety I do believe, here you don't have a routine like [a rehab unit in] Springfield, the steady routine, day in day out routine. You always have something different going on here. [rn4 Ilene: 2677-2688]

Then you do a preceptorship like whether it is small rural they come to a rural usually they get maternity, they get acute, they get geriatrics and they get paediatrics so they get a taste of everything, I do believe. Whereas if you do a preceptorship at Springfield depending on where you're picked you're doing pre or post op. I think here you get a taste of everything, you know it's not so regimented it's not so routine, it's routine yet not routine. They get the availability to get a little taste of everything. And the technology that may or may not go with it. [rn4 Ilene: 2851-2883]

The type of practice, which was my case I wanted a more diverse practice to start with as opposed to a focused practice. [rn5 Jaime: 580-593] I'll see a little bit of everything from pick lines to psychological to surgical, recovery, physical rehab, emergency traumas, overdoses, poisonings, dialysis. [rn5 Jaime: 929-946]

According to Gayle, students were not normally prepared for the diversity of healthcare challenges; rather, they came with some pre-conceived aims as to what they want to achieve in the experience and leave having learned more than was on their original lists of technical skills.

It is really exciting. . . . [Students are] very task oriented. "Ok I want to do this and I want to learn this." And I think they just pick up a lot of life experiences at the same time because you know dealing with people. They don't come in with a list saying I want to assess a psychiatric patient and do something useful when they come in. That's just not something that's on their task list. It's something that they suddenly do learn to deal with. [rn2 Gayle: 997-1011]

Jaime and Gayle both noted that the diversity of health challenges encountered by rural nurses in hospitals required rural nurses to be resourceful in gathering information.

The exciting, wide variety of things a rural nurse does. You're not specialized. You appreciate the fact that you have to, when you work in rural practice you have to know a little bit of everything. And if you don't then you have to go and seek out the information because we can't be experts at, pick lines, and tube feeds and all that kind of stuff because you don't just see it as often. So when it comes up I think they are interested in how we find out the information in terms of you know being a small facility. [rn2 Gayle: 1789-1806]

Resourcefulness and your own self awareness and you'll learn how to assess in a rural site and you'll learn how to assess in an ER or you know general assessments on patients elsewhere or you'll learn how to deliver a baby in rural site and you can learn how to do that on Maternity in Springfield or the thing that you'll learn in a rural site that you wouldn't learn as a

practicum in Springfield is that you will learn all those things within one practicum, generally speaking to a certain degree. Whereas in a larger centre you will get one type of exposure so I think you will become a more rounded nurse out of it but as I said before you just won't have the same depth but there has always got to be a trade off. [rn5 Jaime: 4157-4190]

From my read of the transcripts, the diverse care situations encountered in rural hospital-based practice were experienced as a defining feature of rural nursing, and thus by extension the preceptorship experience, which contributed substantially to student learning. I was somewhat disappointed that foregrounded were diverse care situations while the social demographics served primarily as background, as noted in previous sections. I had expected more discussion from participants about the make-up of the rural community. Upon reflection, however, the day-to-day practice of hospital-based rural nurses and students was more likely to focus their attention on individual health rather than health of the population. Diversity might be foregrounded differently in community-based rural nursing practice.

Reflecting on the data, I came to consider how my background as nurse in primarily in urban general hospital units may not have given me direct exposure to tourists unless they became hospitalized on a medical unit. In rural communities where nurses are often front-line care providers in emergency rooms they would be more likely to encounter tourists or seasonal employees at various times of the year. It is possible that the timing of student placements (primarily spring and summer), along with the length of time and practice context, combined to narrow students' focus to diversity 'within' the hospital context rather than diversity within the community at large.

From the foregoing discussion of six place-related themes (density, time, ethnicity, occupation and economics, resources and technology, and diversity of health issues), it is apparent that the nature and educational value of the preceptorship experience is closely tied to the qualities of rural places. These factors vary from location to location, but they have an

impact in all of them. Nursing education programs typically ignore these effects of place, and so do little of the work needed to mediate the cultural transitions involved in the change from urban to rural place; nor are the potential educational benefits of rural placements made clear to students. As will be seen in the next section, the responsibility for cultural mediation is presently distributed across various relationships in the rural healthcare context. In Chapter 5, I suggest ways to include educators and educational programs more fully in this process.

4.5. Key Relationships

Four relationships within the context of a rural preceptored practice experience figure in this research. As reviewed in Chapters 1 and 2, the preceptorship literature tended to focus on the relationship between preceptor and preceptees. However, in the rural context, this relationship did not emerge as central to the student experience to the degree anticipated. Other key relationships included relationships with other rural professionals and hospital support staff, relationships with members of the community, and—to a lesser degree—the relationship with the nurse educator. Important relational themes included reciprocity of information exchange, interprofessional engagement in learning, intertwinement as a feature of personal and professional relationships, continuity as it influences students' experience of relationships, and the degree of physical and relational proximity between students and nurse educators.

4.5.1. Preceptor-Preceptee Relationship

Most students within the rural preceptorship were paired with experienced nurses—nurses who had lived and practiced extensively in a rural context. A significant aspect of the preceptor's activity identified in this research was cultural mediation, including facilitating student entry into rural nurse practice and guiding student interpretation of rural practice and place. Also important was the reciprocity of information exchange between students and nurses.

In addition to helping students develop their professional skills and confidence, rural preceptors have the added dimension of assisting the student to become familiar with the rural environment. The notion of cultural mediation emerged quite strongly from the interviews, but more from a sense of the ‘whole’ of participant conversations than it did from specific examples within the transcripts. The preceptors’ cultural mediation skills identified in the text included the ability to recognize and convey empathy for student cultural dissonance, the capacity to facilitate student interpretation of rural nursing activities through information sharing, cueing, and storytelling, and the ability to foster independence, interdependence, and confidence by accompaniment, and communicating what students might expect from being in place and from people in place. It is my cautious contention that these ways of being with students in a rural context serve to facilitate student entry and ‘fit’ into rural nursing practice.

Informing the student about the uniqueness of nursing in a rural hospital and what students might expect as part of the practice-education was central to the preceptor skill of cultural mediation.

But even if they come from a small town. Even if they come from this town, their perception of the hospital is not from the point of view from working there. So it may be that they need a whole new set of information to relate to it. [rn1 Fern: 996-1104]

It's not the insider I think it is your willingness to learn and share the information that you have learned already . . . It helps them fit in, just their openness and receptiveness. To giving and receiving and sharing information [rn4 Ilene: 5932-5966]

I usually talk to them and just say get to know them as a person what, you know, why are they here type thing. What do they hope to get out of it? How prepared do they feel? Their experiences and stuff. And then, ah, basically just talk to them and share what I do. What . . . a bit of my thoughts on rural nursing. . . . Basically I would want to convey it's not a specialized thing. It's kind of a jack all of trades. Master of maybe one or two, kind of thing. And that the experience here will be a little bit different than what they were, you know, in the city. If they hadn't really had any you know interactions with a rural hospital they might you know not have any idea of what's coming on. I think a lot of times they have no idea what to expect. They just kind of stand there and ‘Ok, I'll just kind of watch you and you know watch what you do and learn from that. [rn2 Gayle: 368-403]

My preceptor was great. She has several years of knowledge and she just . . . they told me sort of what they saw day-to-day running through the routine because we are a rural hospital we do some of the stuff in emerg that you wouldn't find here. . . . and then just giving me a rundown of the hospital and you know, what the LPNs have to do versus the RNs and how it's so much different from the big centre because we have to sterilize our equipment at night. And you know, all this stuff, and anything that we need, that we don't have has to come from you know, [another rural town] or Springfield. It's quite different. [rs2 Carla: 234-263]

I got to spend a day with the home care nurses. When we went out she was just telling me, you know, sort of the stuff that she had seen and you know, the homes that she has had to go into and stuff like that. The girls would talk about what they had seen in the ER. My preceptor would talk about the stuff that she not only had to nurse but had to deal with the Search and Rescue. . . . They were all, they were all . . . no, they were all too sort of give me examples of what they had seen and you know worst case scenarios and how they handled it and stuff. They did have a purpose. [rs2 Carla: 3199-3233]

The process of cueing students to what they might anticipate in rural practice (environment, people, care situations) included giving direct information about what to expect and how one might handle different situations, but it sometimes took the less direct form of story-telling. Fern told the story of caring for a family member, a nephew, to convey the importance of confidentiality and trust.

and so I had to start an IV on him for starters and so I said you know, you know, kind of . . . "You'll never let me hear the end of this if I miss hey?" And finally I said to them, "You know, what goes on in emerg, stays in emerg. The only way that anyone knows that you were even here is if you choose to tell them." And he can. And I said "I'm dead serious about that. When you walk through those doors that's as far as it goes and you choose it." And I bet you it was 6 months, and he never said a word to anyone, he was just wait and see. And fair enough. But that's really important because they need to know that they can come there. Everyone needs to have that comfort zone and to know that that's a safe place to come. . . . And I often tell the story about my nephew, because himself, eventually started chatting about that and we laugh about it now. [rn1 Fern: 1494-1528]

Cueing would sometimes focus on the particulars of others, reflecting the fact that within a rural practice-education setting there are fewer physicians, other health professionals, and support staff to come to know and more regular contact with the few who do work there. Jaime and Estelle provided examples:

Doctors in that there is one doctor that you give a report to on the phone and he doesn't say a word it's dead silence and it can be quite offsetting it's like alright do you think I am an idiot

do you want more info? And like the first time she did it I had warned her about this doctor and he did that to her and it's quite off putting for her. You know we've got one that can get into moods and be a little nasty to people if things aren't going their way and I was just warning her that don't take it personally the next day this person will be fine, get along with you great. And this doctor when they are writing orders stand behind him and listen to him because you can't read the writing but they talk about everything they do. So listen to him. . . . I didn't expect her to keep it all, you know remember everything but just as cues for later. [rn5 Jaime: 2397-2436]

They had an orientation the kind they give the new employees, they went through some of that with me making sure I knew where things were but probably not as in depth as a new employee would receive, but they did try and the great thing about being an only student there, is all the nurses that are on the ward that day know that you are a student and that you are new and it's your first day so they all go out of their way to try and help you know where things are and what procedures are and they are really open to questions [rs5 Estelle: 408-423]

As noted earlier, however, the process of mediation or exchange was 2-way. All of the nurses expressed appreciation for what they gained from working with students. Gayle emphasized student interest, their questions, their openness to ideas, and their enthusiasm. Haley conveyed the notion that students question the ‘taken for granted’ practices of rural nurses and this questioning contributed to nurse self-reflection and professional growth. Ilene and Jaime also acknowledged how students bring current information with them and how this exchange was valued as a professional development opportunity within a rural context.

The students . . . [they are] just maybe being less judgemental about things. Just being open to things because you know everything's kind of a fresh page for them versus having to kind of write on the back of the other pages that are already written on type thing for us in terms of just their enthusiasm. You know you kind of forget sometimes, you get dragged down by stuff, and you see your student you know, young and enthusiastic to get out there and work and do stuff. And get excited about things. You know you get dragged down by things. You kind of feed off their excitement about getting into the profession. Or their worries or scares about getting into the profession. You know just being eager and just asking questions about things that you wouldn't think to question. . . . They do make you think about your practice about things that you kind of take for granted. [rn2 Gayle: 2394-2417]

Kind of really to sort of re-look or examine your own practice in a way. You can't always have that feedback all the time except when you have a student you know it's always kind of a feedback with every situation. Whereas a lot of times when you work your day and especially in ER if I'm there and I'm dealing with everything and the ward nurse is busy you don't really have time to reflect on things. [rn2 Gayle: 2457-2470]

Because I know the value of students in bringing information that we [rural nurses] didn't know what's happening out there. Because you do get a tendency to be isolated, if you're not seeing a lot of new nurses come through. I mean when 60% of your workforce has been here for over 30 years, how do you get new things in? How do you learn what's new? [rn3 Haley: 1429-1439]

Our assessments become automatic. The tasks are automatic. We forget to tell the students or a new nurse each step that we're doing in a trauma. Because we just do it. It's just there. And so the students now coming through, the nurses are now looking at their own practice which is wonderful when we have the students through. We have to! They're asking questions. So that is, you would say that, no I don't know what you would say, but is that, that's a benefit of having students in this place is to have that. [rn3 Haley: 2558-2585]

Very different between then and now, it's just incredible. So now with the new grads, the new students, I learn from them, they learn from me. They learn the routine and I'll learn the newest theory. [rn4 Ilene: 187-199]

Here's an example, AIDS. We don't get a lot of that here but I know there is a few floating around in the community but still you don't get the information or the latest treatments available for them and there is one student that walked us through, did a top to bottom lecture on AIDS with all the new treatments and the new meds that they are on that are available for them. It was phenomenal. I wouldn't have known that, you can't even find that out on the site that we go to for all our information.. [rn4 Ilene: 627-655]

It [the preceptorship] brings in a lot of fresh knowledge. I'm not sure how many preceptors actually consider that but it's one thing I think of when we have new people come in, is they bring in new ideas with them things that maybe common practice elsewhere that we don't necessarily do you know just like one student brought in the idea of the brown bag covering multivitamins and thiamine for ETOH, you know something simple. [rn5 Jaime: 1558-1584]

The sense of being included and valued as a student member of the healthcare team emerged as a significant learning process within the rural nursing preceptorship experience. Students experienced professional respect for their knowledge, and this in itself was a valuable form of cultural inclusion.

And in Pleasantville they [rural healthcare team] completely include you. And they even ask my opinion sometimes. And I give them my input. And it's like I'm one of them. I am not just someone who's there to be in their way all the time. So I actually feel useful when I am there. [rs3 Bobbie: 1750-1764]

They [rural nurses] were a little bit curious on what things were now from maybe a few years before and stuff. So that was kind of neat. . . . Even just things that they teach us in school that maybe that will vary just a little bit from before. That sort of thing. . . . Like they were doing it their way and then, like even simple things like blood banks and different ways. They just wondered how they were doing things there and things like that. [rs1 Abbie: 1155-1195]

I think my preceptor maybe learned a lot about being with a student, just because of the . . . we had a pretty decent med error, that wasn't necessarily, well it was partially our fault, but it was also the pharmacy messing up. . . . So to have a pair of fresh eyes on the situation I think really helped her make . . . we did like a huge, big incident report that was like several pages long. Because this wasn't the first time, but to have a student's input, someone who was new to the area, but yeah. . . . Well she just really appreciated having feedback from someone who hadn't been in the area. And to realize that it wasn't just be, you know it wasn't just her having this problem . . . you know, me. That a student would have even a bigger problem. Like being even more confused by the whole thing. [rs2 Carla: 3601-3656]

I think that staff there enjoy teaching and when they teach, they learn too at the same time. There's always more to learn about what you're teaching somebody. So it makes them, I don't know, I guess stay on their toes a bit with their information. And they enjoy imparting knowledge. So even the LPNs, they love showing us things and . . . I don't know I guess it helps them feel more like they've done something good. [rs3 Bobbie: 5478-5493]

Anytime there was special procedures going on, for our synthesis or something, on a different floor, they knew that there was a student up there so the shift coordinator would come up and see if you want in on this, do you want to watch so they would make sure that when the time came that they would come up and get us to let us watch it. A lot of times you don't have that opportunity in the larger centre, right, it's got to be done and they just do it they don't wait for a student to watch it. [rs5 Estelle: 949-959]

They had an orientation the kind they give the new employees, they went through some of that with me making sure I knew where things were but probably not as in depth as a new employee would receive, but they did try and the great thing about being an only student there, is all the nurses that are on the ward that day know that you are a student and that you are new and it's your first day so they all go out of their way to try and help you know where things are and what procedures are and they are really open to questions. [rs5 Estelle: 408-422]

The interdependence between students and preceptors appeared to be a crucial aspect of the cultural mediation process. It was co-constructed. Students experienced support when the preceptors demonstrated presence, patience, and respect, while preceptor trust was enhanced when students recognized their limitations and asked questions.

It was always a "we" I was doing my preceptorship, I was never working alone. It was always me and my RN, so it was never . . . like, near the end of my preceptorship, I became a lot more independent, but I was never by myself. [rs2 Carla: 2746-2753]

She wasn't a person of many words for sitting down and talking, so just working with her she never made me feel, the very first patient, she was always there with me, just a little emergency room, the department had little rooms, she would never leave me alone so if I had any questions she would be there to help me. Or show me stuff. [rs1 Abbie: 296-307]

I was pretty open with what I wanted assistance with and what I needed assistance with and she was pretty trusting most of the stuff she would kind of hang out with me but if she had seen in once or twice then some stuff not even ask if I was capable of, I think she thought I was capable, yeah, definitely better trust I think she knew that I would ask a question if I was unsure. [rs5 Estelle: 2047-2058]

A lot of times, especially when things get busy . . . not a lot of times, but sometimes, the skill sets aren't there. But it's coming and having some patience for that too. . . . And as long as the student recognizes where they need to work on and is straight up with you on it, that's pretty easily worked around too. And I think that we touched on that before, how it's important that everyone knows their limitations. [rn1 Fern: 4094-4107]

You have to know when you've had enough when you don't know what you're doing and then that's where the wonderful phrase that everybody got sick of in school, critical thinking, ha ha. Yes, it's a lot of critical thinking because quite often you don't know what is happening you don't know what is going on and what are you going to do, as I said, you have to know your limits but a lot of times you have to go past those limits and, but knowing those limits you have to know when to go for help and that's one of the biggest thing when we have students up there or undergrads is if you're not sure ask. [rn5 Jaime: 1315-1345]

I trust her because she asks a lot of questions. You know, I know she'll ask if she doesn't know. She doesn't go do something and then I have to go and correct her mistake. [rn3 Haley: 2526-2541]

What emerged strongly for me in the data, however, was the fact that students did not rely exclusively on the relationship with their preceptor. In the following passages, Estelle, Ilene, Haley, and Jamie noted the receptiveness of the rural healthcare team, while Gayle introduced the idea of it taking “a village to raise a child” in the preceptorship context.

I think special kind of [relationship] does work as a term just because they [rural nurses] are not over burdened by students. So having one student on the floor compared to 10 students on the floor it's not oh my goodness here comes another question oh they want to know the same thing again and being just one student it's something new for people on the floor that don't normally have students so they're interested in sharing and showing and talking. . . . I guess it's kind of the same thing you're not just another number, yeah, you're actually, and it's more about a relationship than just the experience too. [rs5 Estelle: 4579-4609]

I will help you out with that and it didn't have to be your designated preceptor there were, anyone else was really willing to do it. [rs5 Estelle: 1029-1051]

I think they [rural healthcare professionals] are interested once they meet them and stuff and get to know them then you know if something interesting comes up they'll say “Oh do you want to do this? Or talk about it. Or do you want to come in and watch this type thing.” If things come up. Even the physicians get that way too. They're pretty good. Some of them are more instructors than others. Some of them will question what they've [the student has] done. Or “do

*you want to come in and see this or do this?” And so it kind of pulls everybody together because everybody wants to make this a meaningful experience for the student. So even if it's your [the preceptor's] primary responsibility they'll say “Do you mind if I get her to do this?” “Oh sure, she wants to learn all this stuff!” Cheryl: So it's sounding a little bit like a team approach although there is a primary person. Gayle: Yeah, it's kind of like **it takes a village** to raise a child in terms of everybody has to come together because you want to make this a meaningful experience for the student. So it kind of pulls everybody together to kind of give them a little bit, to share their stories and to share their experiences and the student gets to learn from all of this. [rn2 Gayle: 2578-2618]*

I mean if you want to learn a skill or you want to learn your assessment in teaching, this is the place. They allow you to do more than what a tertiary site will allow you to do. They [i.e. at the tertiary site] put a label on you as a student. Here [i.e. at the rural site] “Hey, do you want to see this. I know you're not ready for this, I know you're only 2nd year, but here bag the patient for me.” You know, “Come on in.” “Here's what I'm doing, come watch.” “Pass me that.” So they're very much more involved in a rural site. They're brought into it. [rn3 Haley: 1900-1925]

They'll [physicians] come and get them, well, “I'm doing this in the E.R. do you want to come and see it?” or they'll come and get them, “Come and look at this x-ray.” Everybody shares with them; everybody is very open to making their experience quite positive here. [rn4 Ilene: 6147-6176]

The other team leaders they will pick up some of the load if there are opportunities, I don't think there has been anyone that is unwilling to help teach someone or to have somebody as part of an experience unless we are just too overworked as it is or too busy for it even then we will generally put things off to let somebody have an experience. [rn5 Jaime: 4286-4300]

While nurses and students spoke positively of the preceptor-preceptee relationship, it became increasingly clear to me that the process of cultural mediation, while not fully explored in this research, involved far more than this relationship alone. This led me to contemplate the notion of the ‘rural team as preceptor,’ an idea explored further in the next section.

4.5.2. Interprofessional Relationships

As already noted the student perception of being an appreciated member of a rural healthcare team was substantial and differed from their previous perceptions of being a burden within an urban healthcare context. Most students felt warmly welcomed by rural healthcare professionals. Students commented on the sense of closeness between themselves and other professionals as they came to know individual names, spent time getting to know others, and

began to experience being part of the healthcare delivery team. Several students noted the quality of intertwining personal and professional relationships.

Abbie shared a story wherein she was able to offer her knowledge to support the development of another healthcare provider and her learning was enhanced by other healthcare provider interactions. Her story captured the sense of coming to know and feel part of a larger healthcare delivery system along while simultaneously experiencing a diminishing sense of power differential.

But just that whole relationship that even I got with the police officers. They would bring people in. They were quite really friendly, quite nice. And the ambulance personnel just that relationship, because it's such a small area. Like one night when I was on and I know this guy who was studying to become, like the ambulance guy was studying to become a higher-up thing . . . the ALS. So he came in to see if he could get [my preceptor] to help him with some math problems. And she's like well get Abbie to help you. So I was helping him with the stuff I've done. Like medication problems I was helping him. And then the doctor ordered pizza and we all, the ambulance personnel and the doctors and the nurses were all in this nursing station and the nursing staff or whatever were all having pizza. It was just, it was neat. I really liked that interaction. And then the police officers were there and I was getting to know them by names and the ambulance personnel and stuff. Because the ambulance station is right below the hospital, so they would come up. It really makes it more supportive and you feel like, not closer, you feel a bit closer to them, but you can ask them things. They can help you, you can help them and you are all on the same level. And also, that whole thing about the nobody's alone in the community. [rs1 Abbie: 2464-2418]

Daniell also sensed a difference in power differential.

I guess . . . I think what that example is . . . at Springfield the nurse . . . ah, suggests a little bit more about, or kind of asks really politely what they would want. Whereas I think ah . . . you know if they need furosemide and that's what the nurse thinks and she will suggest it nicely, politely to the doctor there right. The hierarchy there. Whereas in Westmount there's a little bit less of a hierarchy because it's such a small community. Everyone knows each other and they work closely together that the nurse can just be like, "ok I would like to give this." You know a little less towing to the hierarchy I would say. [rs4 Daniell: 5285-5304]

Ilene relayed how students noticed differences in relationships between rural nurses and physicians. She conveyed the notion of physician respect for rural nursing knowledge.

We always get [from students] boy you guys are really close or wow you know them well. How did you know [the physician] was going to say that? [rn4 Ilene: 3059-3066] More of a mutual respect and the students see that. [rn4 Ilene: 3186-3189]

That you don't notice the distinction anymore like they [students] do when they come here, like you know we [nurses and physicians] call each other by our first names, you know, and there is a respect and they [students] are in shock that the Dr. will ask us well what do you think we should do and they just look at you and, think oh wow. But it's a working relationship, . . . the culture of rural. [rn4 Ilene: 3210-3246]

Abbie also noted the rural context set a comfortable tone for the development of interprofessional relationships. She highlighted the professional trust developed between rural nurses and physicians and physician respect for rural nurses' knowledge as an example of this tenor. Likewise, Bobbie echoed the notion that the personal-professional rural environment promoted communication.

Because it's a small town and all the nurses know all the doctors really good, they have a personal relationship. So that makes the professional one that much better. Because they know each other, they worked together for a long time, and they just don't have that professional trust, but they know each other personally. So that means they also have much more, the doctors think more highly of the nurses' opinions I found. And for instance, the doctors will say "well what do you think we should do?" And then that sort of thing. . . . Like if you recall at a bigger hospital and you just have that professional relationship. And there are so many doctors, the doctors might not even know you on a professional level. Then they're just going to give you off orders there and like that sort of thing and whereas the nurses are the ones doing all the observation. Whereas the doctors there, there are so few of them and so few nurses in a small town that there is much more positive working relationship and professional relationship. And then because they have that they would also talk more personally while they are working. Like if they were just sitting here and waiting. It's much more relaxing, much more inviting of an area to work in. [rs1 Abbie: 3647-3695]

There are [doctors] who really get along and they have practices in the same building and they would come in and they live on ranches and they're friends with my preceptor because she owns a ranch. And they're just talking as friends, so there's that bit of it too. There was one doctor he was buying something from my preceptor to de-hormone his cow. So she said like bring it into the hospital and they were switched over talking about castrating a cow in the hospital and at first I had to pick up the conversation because I knew they weren't talking about a person. But that whole inter-twining of personal relationships with professional stuff. [rs1 Abbie: 2951-2971]

It's so much more personable than any ward in Springfield where there's so many different staff members and nobody knows anybody and, it's not . . . it's just not a happy atmosphere. And in Pleasantville, everybody knows each other. They know how to work well together. There isn't a

tonne of, there is not a lot of nurses there, and there's definitely not a lot of doctors. So everybody knows each other and it's totally comfortable talking to each other and communicating and working together. [rs3 Bobbie: 183-198]

Ilene also noted the respect rural nurses gave students for their nursing knowledge.

I think here it is noticed [by students] that we work as a team but usually what they can't get over is the respect that we give them as being a member of the team. [rn4 Ilene: 2947-2955]

The closeness of interprofessional relationships, despite differences and overlaps in professional roles, was imbued with a sense of the personal. Students witnessed mutual respect, trust, and admiration for individual abilities and contributions, and an apparent lessening of power differences. Nurses also recognized the value of this for students, although they put less emphasis on it as a central feature of rural healthcare. Fern's example illustrated how respect for all healthcare providers is important in developing team relationships.

One of the things that I think is different in a small area and you really have to set that tone early is that we're a really small team. At night, it's you and the LPN and there has to be solid, mutual respect. And you can't . . . you know sometimes I have seen with students . . . they can be a little bit, almost arrogant, for want of a better word. And you have to respect your LPN and all of your staff as important team members. The housekeeper might be the guy writing down the meds that you're giving when you're dealing with an arrest. You know that's just the nature of it . . . it sounds crazy, but it happens sometimes. [rn1 Fern: 1108-1127]

Nurses noted closeness of rural relationships among healthcare staff in addition to those relationships with physicians. The closeness of relationships among staff seemed imperative and inevitable. The notion that each professional depends on others, despite the acknowledged autonomy of individuals, came through in participant conversations. Gayle in particular captured this notion of interdependence:

I think they [students] enjoy the camaraderieship that comes from all the staff that has to work together. You have to depend on each other in a small facility. I think they maybe appreciate that. [rn2 Gayle: 1806-1811]

I think in rural it's more of a fact that you know, the very variety of people come together and become friends and depend on each other maybe more than a big city. Like I say the housekeeper and you know even the physician and knowing them so well and having to call them at home and getting to know them. We just kind of know them a little bit. And share

you know meals together or just little things. Like we have a focus instead of going off to the lunch room to do something. Our conference room is kind of the place where we eat and do all our stuff and so you kind of share a lot of aspects. You're right into it when you're there, you don't walk away from it for 1/2 hour to go to the lunchroom or whatever. You're kind of in the midst of it. [rn2 Gayle: 1084-1106]

One of the most common things is sort of the connectivity amongst the staff. How the housekeeper relates to the cook relates to the nursing staff. There's a tighter link there. There has to be. So I think that's one of the more surprising things that they learn. [rn1 Fern: 2032-2049]

The opportunity for the student to bear witness to the closeness and qualities (such as respect and trust) required in teamwork beyond the nurse-physician relationship in a rural context was evident to nurses.

I think there is, at least from my experience, and I've worked both settings, there's more a sense of team in the rural area. Like a camaraderie. And part of that is because you're on your own there in the middle of the night. Like there is yourself and an LPN. That's about it. So you really have to learn to work together, trust each other, and that develops a sense of teamwork like nowhere else. [rn1 Fern: 4126-4137]

Haley relayed the notion rural nurses were bound to come to know one another both professional and socially.

I think it's a different culture. In a city, if you're working on a ward, you're not always working with the same nurses. You don't socialize with them after work. You know you can go after work and you can just leave them. So if you don't get along with that nurse, well big deal I don't ever see her. You don't get along with the nurse that you're working with. You don't make that team connection. Guess what? You see her outside of work. You see her the next few times. You see her coming on. You can't seem to get away from your staff in a smaller site. You'll see them downtown. You'll see them at coffee. So that trust element has to be there. [rn3 Haley: 2189-2215]

Fern spoke to the notion of the close interprofessional relationships and hinted at the potential for continuity in rural relationships over time.

That relationship [nurse-physician] too, again is closer. . . . they . . . takes a bit of the relationship taking in and getting orders and so on or sitting around in the morning and shooting the breeze a bit. I think that surprises them [students]. I mean some of our physicians have been around here forever so they may well have delivered that student. That changes the dynamics a little bit. But I think most students are pleasantly surprised by the culture. [rn1 Fern: 2086-2110]

Fern, however, saw this continuity of rural relationships as under threat. Because of the increasingly frequent delivery of rural healthcare by physician locums, doctors who go to a community only temporarily to provide health services rather than living and working there, she believed that preceptorships would change for students.

That's going to be interesting to say the least particularly when you throw in rotating locums. That's a whole new twist . . . that, that changes things. And something like that, that changes too the role that the student plays because if you've got your regular docs and they get the feel for the student. Plus they trust the nurse that's doing the preceptoring role. And says "Ok, Susie is ready to be phoning for doctor's orders. To be doing that. And she in essence is going to be me. I trust her. I trust her judgement, so you have to too." And they're pretty good about that. They're very good about that. As long as they trust us, then they trust our judgement regarding the student and they work with the student who also has generally been there for a week or two by at that point anyway. And who has built some of her own [student nurse] well, she's, she's demonstrated her own accountability as well. So that works. But when you're dealing with a locum who's looking at brand new staff, patients that he is not familiar with, a working environment that's unique and probably different to him. [rn1 Fern: 5088-5145]

A sense of being welcomed and included by the rural professional community was a key process of cultural mediation that facilitated student learning in a rural context. The importance of the rural healthcare team members, including the auxiliary staff, allied health professionals, physicians, and nurses, and the interconnectedness of these people, both professionally and personally made a significant impression on students. The team approach to healthcare delivery as lived by rural practitioners allowed students to bear witness to mutually respectful relationships and engage substantially as a valued member of the team. In rural preceptorship experiences the team, with its members' particular ways of being personal, professional, inclusive and respectful, also became a teacher.

4.5.3. Community Relationships

The distinctive quality of community relationships in a rural context has already been noted in earlier discussions of continuity, confidentiality, density, time and other themes. To some extent, these relationships differed for students from and not from the community. While

the ‘outsiders’ (Abbie and Daniell) had limited time to form social bonds with the community in general, ‘insiders’ (Carla and Bobbie) built on pre-existing relationships and offered more varied explanations about the nature of the relationship. Nonetheless, there were common features, including the ability to provide nursing care from admission to discharge, having more time to interact with hospitalized persons, and experiencing outsiders as novelty.

The insiders, at times, saw their personal history with the community as creating positive conditions for caregiving (continuity, feeling valued), and other times tied it to negative factors such as preconceptions and generational discomfort. Carla described some of the tensions arising from having lived in the community most of her life, and her attempts to suspend her personal judgements to provide professional nursing care. Jamie witnessed the same phenomenon as an outsider.

It's really hard. Especially when the people are, you know they have a history of drug abuse, or alcohol abuse or whatever. It's really hard to you know, sort of treat them like with a clean slate every time. And ok, sure they might have at one time been doing this, but they're not now. And just keep an open mind and be impartial. It's really quite difficult. [rs2 Carla: 765-796]

I think the people from Westmount that work there I think tend to take a little more for granted, they may know the staff more they know the community better they generally have some sort of linkage with the patients that are coming in. So they've already got a connection with them and so they tend to take more for granted because they know more of their personal history behind them too, being a small community oh yeah so and so he's been doing drugs his whole life or he's doing whatever. Whereas the new people not from there are starting with a blank slate, they don't take anything for granted. [rn5 Jaime: 6529-6569]

Both Bobbie and Carla alluded to the discomfort that arose when providing care in the context of long-term relationships, although Carla also saw this as a learning opportunity.

And, a couple of people who I'm friends with, it's their parents or their grandparents that I'm caring for and that's been a little awkward a couple of times. Because I feel like it's uncomfortable for them to have me doing things for them and caring for them when I know them and I know their families. And it's almost like they look at me like . . . like a child almost and I feel kind of stupid sometimes asking them questions and . . . it's a little awkward I guess, but. Definitely the community is very small and the nurses definitely know pretty much

everyone that comes in and then can tell me a little bit about their histories and stuff. [rs3 Bobbie: 827-846]

Even if I hadn't grown up there or known anybody, I sometimes feel that because of my age, I have to step away. I can give you an example of right now we have a gentleman on the ward who is palliative. And I have developed a relationship with him that is almost like grandfather-type and I feel him getting uncomfortable when we have to do his personal care. [rs3 Bobbie: 5208-5219]

Just the way that I felt when I was nursing, you know friends' grandparents and stuff. That was, that was, it was really harsh, that was one of the worst things that I had. Also discussing with one of my clients her dead grandson who was, I was in school with, and he died sort of a couple days after graduation or a couple of days before. And he was a friend of mine. That was, that was kind of, and the funeral . . . yeah. . . . The good was knowing, was recognizing my limitations and how I felt and how comfortable I felt with them and . . . you know how emotional I got and how attached I got to them. So yeah, just really learning my boundaries and you know what sets me off, what I can handle and what I can't. [rs2 Carla: 2592-2639]

Both insiders and outsiders, however, noted that rural nursing offered far more opportunity to get to know patients regardless of the nurse's background.

It's hard to explain I guess, I don't know. I mean I feel like even if someone comes in that I don't know, I get to know them very quickly because we have such a small staff and you're on four shifts in a row, you get to know people very quickly. And I don't know if this is just a small town-type thing, but, people are very . . . they want to talk . . . like they want to get to know each other. And I feel like all the staff already knows everyone that comes in, so I'm the one that has to get to know the people. And it's pretty easy. It sort of just happens. When you don't have a lot of people to care for, you get to spend more time. [rs3 Bobbie: 4764-4786]

Just warmly welcomed. I think people [patients] were excited just having me come in and interested in their town. That was definitely nice. And telling me about where they're from you know. If they're not directly from Westmount, telling me about "you should come see my place, it's really nice." . . . just cause I wasn't from Westmount, a foreigner who was interested in Westmount. It was exciting for them, right. [rs4 Daniell: 2917-2949]

Quite often you would have a patient come in doing the whole triage assessment and doing everything instead of like one nurse doing one piece, one nurse doing the next, you got to follow through the whole, everything with the patient. And then calling the doctor up and having the doctor come up, because they're never there. So they come up from where there at, and then you're the one who gets to discharge and send them home and everything. So that was really neat for me to have that relationship with the patient. And also you might do like, if food comes up you bring it to them. I really liked that aspect of that. The nurse-client relationship going on more than I noticed than in bigger hospitals. [rs1 Abbie: 517-537]

According to Gayle, students often underestimated the importance of people skills before they gained experience in rural nursing. In part she linked this to the lack of specialists and hence to the nurse's need to cope with a wide range of patient situations.

[Students] don't come in with "I want to assess a 3-year-old and get through it without them screaming or resisting me." But they come in and they go through it so. It's funny when they come in. They always have these little lists of skills. . . . they don't realize that they're going to learn a lot about people skills too at the same time. . . . It's . . . you have to establish a . . . you know it's the two of you so you have to establish a good rapport right off the bat. You know it's the screaming 3-year-old that you have to establish a rapport with because there's nobody else. The paediatrician isn't going to come along and fix things. [rn2 Gayle: 1013-1046]

Both Ilene and Jaime saw relationships with community members as contributing to the education of preceptees. Expressing appreciation, asking for advice, and acknowledging their status as nurses outside the confines of the hospital itself helped them to develop the professionalism and self-confidence required of a rural nurse. Ilene also noted the value of following patients all the way through care, an aspect of relational continuity described earlier.

They enjoy it and the one right now, we have 1/3-year just watching her grow and her come home and all the young adults know her so you see when certain people come into the E.R. and they say [student name], you're back and it's like you just see her grow in the eyes of her friends and her family or the community and just see the respect take after she has given them care and given them advice and it's sort of neat to watch. "Oh, I knew you when you were a little girl." And she'll do something kind and considerate, or you know just do her job and, "oh, you're just such a wonderful person." And you know you hear these comments and you think yeah she'll stay here for a bit. And it's really good because the town does feed its own ego. [rn4 Ilene: 4161-4202]

But you'll see a lot of the people phoning her and she'll say I got stopped on the street, so and so is asking me. So it's the advice seeking. . . . How should I handle this? . . . And she'll get it, she'll get it. Yeah, you know, you just say okay you talk to me as a friend and if you need medical advice go to the doctor's clinic. [rn4 Ilene: 4281-4317]

You get to know them [community members] and being a small town you're going to see them again, you are going to see them at the grocery store you're going to see them at the bar, you're going to see them out jogging, you're going to know who they are and so any care that is provided to them is going to have a direct reflection on the way they interact with you outside the hospital and vice versa. Anything you do or say out on the civilian street is going to directly impact the hospital and people are going to know that you are speaking possibly at least from some version of authority and chances are it will get back to you. [rn5 Jaime: 647-669]

It's a lot different [from urban nursing practice] because you get to follow that one person from start to finish and I think it helps, it enriches the student's all over experience to follow someone right through. [rn4 Ilene: 790-801]

They receive a vast, ah, it's just that the learning is so intense and focussed on the whole, not just, bits and pieces you know from entering the hospital to exiting, so that can incorporate an ER visit to the floor so it like it follows the.. a few patients from beginning to end. [rn4 Ilene: 7131-7156]

As noted earlier, the importance of relational continuity—a sense of closeness, connectedness, reliability, stability—for rural nurses and students in caring for community members over time made an impression on me I had not expected. The rural context provided a rich environment for students to explore the meaning of continuity and its influence on healthcare delivery. Community relational continuity and its influence on student learning and care delivery should figure more significantly in the design of rural practice-education—an idea explored further in Chapter 5.

4.5.4. Educator Relationships

Traditionally, the relationship between student and nurse educator should support and make meaningful contributions to the rural preceptorship experience. Common practices include orienting students and preceptors to student performance expectations, advising students as to what they might expect within a rural practice context, orienting preceptors to their role, and collecting information from students and preceptors in order to make a professional judgement as to whether or not the student adequately met the performance indicators within a particular context.

However, in this research I found the connection between students and nurse educators before and during rural preceptorship experiences to be relatively limited. Challenges included distance, technology, and the degree of rural awareness on the part of the educator. Some students appreciated less educator involvement, while others found it dissatisfying.

Being there, just being there around when they know you are starting so that you have access to them. They were supposed to call if you had a shift or whatever but after the first few weeks I got like one call. Just because I know they get busy and stuff because it's summer time and stuff. But just having more of that support. She came out and saw me once, but . . . because before that when you're doing your, your instructor is there all the time with you. Somebody who is there for you because when you're doing a preceptorship with the nurse they're a stranger to you and you don't have any peers around so just having a bit more support. I don't know how you would set it, how you would . . . [rs1 Abbie: 3336-3357]

The nurse educator was supposed to make a visit because there was two of us last year. And she happened to only have come on a day that I wasn't working, so I didn't get to meet her. . . . But the other girl did. And this year she didn't come at all. And she said she was going to but, she, I guess she just didn't have time. But there was no reason unless she just wanted to see where I was working and the atmosphere and stuff. There was nothing that, nothing negative that happened that required her to come out, so, yeah I think she was just "you know you're fine, I don't need to check on you" so. [rs3 Bobbie: 4203-4233]

I guess you could say there was a brief discussion from our instructor at the time about what she wanted for reflection and whether she would come see us or not or just call. And that was about it. But no real talk about what to expect of a rural setting. [rs4 Daniell: 409-437]

She might have called twice to see how I was doing. Like I think I talked to her on the phone once. I'm not sure how many times she called my people, but. . . . It didn't give me confidence. I don't feel like she might have gotten the fullest picture maybe you know. Like she was talking to the one who wasn't my main preceptor you know. . . . Although really, I mean I had one main preceptor but she got sick. Yeah. So maybe a little bit more of the teacher there maybe, even though it's 2 hours away. Not necessarily that she has to show up physically, but maybe at least call a couple of more times to see how I'm progressing maybe. [rs4 Daniell: 3690-3726]

I know that they are supposed to at least once or twice to come visit you in my experience I didn't oh sorry in Public Health I had one instructor come out to meet my preceptor and stuff but in my two acute [care experiences] I didn't have them come out. They did make phone calls [to me and to my preceptor]. . . . that was one thing that I did find a little bit challenging because they're talking to you when your preceptor is there, you're on a floor with other nurses there so you couldn't always be quite as open [as you might want] to be, "Yeah, I'm having a few problems with the preceptor but I am managing", right you couldn't really say that type of thing and for the preceptor to be open and honest about the student I think that makes it hard for them too. [rs5 Estelle: 2742-2771]

Nurses expressed considerable dissatisfaction with the lack of educator involvement in rural preceptorships, for a variety of reasons.

I just found that they [nursing faculty] really, they don't have any idea of what we do in rural. But you know I think that before you place these students I would really like to see some of the instructors come and check it out for a day, see exactly what we do because when you have an instructor saying well I have no idea of what goes on and the student is looking basically at her

and thinking hmm, well, game on, you know pretty well, I can get away with a lot, but you know it's just that I think they should know what we do here too, you know, and what they are letting their students in to and you know if they are strong enough to come here sort of thing. [rn4 Ilene: 6481-6545]

. . . if it was more of a you know talk to them like we're talking together versus a voice over the phone. I'm more of a . . . you have to kind of . . . I can't really get a sense of a person over the phone that well. So more of a face-to-face and if there was the opportunity to do that either you know going to the instructor or the instructor come to you or whatever works out. That's I think that's important I think. More person oriented and probably even giving more of a backup of a . . . I'm not really that terribly familiar with the 4-year nursing program just because you know I was a diploma nurse and you know I hear things but I'm not really sure of you know little things other than what the students kind of tell you their take on it. [rn2 Gayle: 3366-3388]

Haley: It [educator-preceptor relationship] does need to change. I totally agree with that. We don't hear from the instructor prior to them coming. We don't know where their difficulties are. Where there challenges are. Where their successes are. We don't know their strengths. Their weaknesses. Hopefully during the course of the student being here, the instructor will come up at least once. Not usual that they come up. It's usually a connection by phone. Really and especially in the winter, because we're a rural site. I've seen that a lot from the instructors. I've only met one instructor since I've been here and I've had a lot of students.

Cheryl: Ok, so you would think . . . how might that change?

Haley: Maybe to contact the preceptor maybe ahead of time. Even just a phone call, that connection. And letting and having that conversation with that preceptor. So they [preceptors] kind of see where their {educator's} heads at. You know, I would like to see that. I would like to see you know let's touch base part way through. Again, what do you want to touch base about? What are the expectations of the supervisor or the teacher? instructor? Don't know? What do you [educators] want to know? So that conversation is . . . that whole missing link. [rn3 Haley: 6282-6347]

The lack of meaningful relationships between the rural preceptors and preceptees and nursing educators in this research led participants to see nurse educators as having little significance for the rural preceptorship practice experience. Although the desire of preceptors to have greater professional contact with educators was evident, and shared by some of the students, this did not lead to a wealth of suggestions for how the relationship might be improved. Since this was a clear area of weakness in the rural preceptorship as it existed, at least as revealed in this study, I give particular attention to this question in Chapter 5.

In this research the preceptor-preceptee relationship was an important but not necessarily the predominant relationship. For these students and nurses, both interprofessional and community relationships played an important role in the process of personal and professional development. Relationships with educators, however, played only a minor role. It is not clear whether this apparent disconnection between educators and practitioners could contribute further to rural nurses' experience of professional isolation.

Cultural mediation to diminish dissonance in students emerged as a central feature of the preceptorship, yet it was not solely the responsibility of the preceptor. Rather, it was a process distributed over several relationships and learning activities. However, the best practices to diminish dissonance and foster culturally mediation remain unclear, and require further research.

4.6. Common Learning Outcomes

This section attends to the question of *what* students learned rather than *how* they learned. In the course of the interviews, students identified three key learning outcomes they would readily share with others if asked about what they learned from rural preceptored practice. These learning outcomes included advanced understanding about the need and complexity in preparing for the unexpected within a rural context; increased development of their clinical decision-making skills; and an expanded repertoire of, and confidence with, technical skills. These interlinked and mutually reinforcing learning outcomes were connected in fairly self-evident ways with the previous conversations about time, resources/technology, the diversity of health issues to which students were exposed, and the experience of increasing independence and interdependence within the rural healthcare context.

4.6.1. Preparing for Who Knows What

The art of being prepared in the context of a less structured and predictable environment emerged as a theme common to students and nurses. Developing organizational skills was emphasized, not as a way to keep up with the required tasks of a rural nurse, but rather because one never really knew who might come through the emergency doors, when, and in what condition. Unpredictability was high, and thus there was value in getting tasks done ahead of routine timeframes in order to enhance readiness for ‘who knows what’. Letting go of routine tasks and structure learned from previous experiences, while learning to be as ready as possible for the unexpected, was a key learning outcome for students.

It's still you know . . . you just never know what's coming in next. . . . they expect it [the unexpected] but they aren't surprised about anything that comes in the doors . . . they know that it could be anything. . . . be prepared for anything at all times. . . . And I . . . it took me a long time to become comfortable in that atmosphere where . . . I mean you just don't know what's coming in next. Whereas my experience here [Springfield], is you know what's coming up from the ER onto the ward because they tell you. . . . I don't think it's something that people [students] can be preparing for. I mean it's just something you have to go and do . . . and learn for yourself . . . and from the nurses there. [rs3 Bobbie: 6761-6840]

Preceptors agreed that they wanted students to gain confidence and ability in responding to the diverse and unpredictable healthcare situations common to rural acute care hospital-based settings.

Fern: And that's probably one of the biggest things of going from nothing to being crazy. And that all students and staff are well advised to keep on top of things when you can. Because it can change in a hurry.

Cheryl: And there's some element of uncertainty about what will walk through that door.

Fern: That's right. Yeah. And sometimes it does walk through. Sometimes it comes via ambulance. . . . Oh, I forgot about that. So somewhere that helicopter's going to land in the parking lot. And I guess that's the diversity of the practice. Especially charge nurses. . . . and we did have one just last week where a fellow was skiing, heli-skiing and he had a massive MI and so they were working on him. And suddenly we get a call saying a helicopter is coming in. They're bringing someone in. Initially we didn't know what was happening. We knew it was serious. So, but you're not just thinking about the actual patient at that point . . . you go a little bit crazy because you think “ok I have to clear the parking lot.” . . . you know like,

yeah, exactly. You delegate that obviously. Get that parking lot cleared. Get someone out front to block off that road because you can't have people coming and going. [rn1 Fern: 3827-3905]

A rural nurse is someone who can critically think. Can multitask. And enjoy what's not known is coming through that door. If your life is set in routines and you live by that schedule book in your purse, you're not going to make a good rural nurse. You know. It's a different concept. [rn3 Haley: 4202-4210]

So it's just the elements of working rural they have to be prepared for almost anything and they really have to be able to think ahead, they really, I always stress organization because you have to be organized working rural. You really have to be prepared whether it be for that patient that has the pneumonia, that is going to stay there instead of for the average 4 days, stays there for the average 10 and because the doctors get too lazy and they don't want to listen to you and they'll keep on giving the patient IV antibiotics for 7 days which you know theoretically is 4 days and then switch to PO but depending on who you are arguing with, you know it's just that they have to be prepared and make sure that you have the amount of medication in that little pharmacy that you need, so you know nursing in rural you always have to be thinking ahead. [rn4 Ilene: 1771-1821]

When you work rural the routines are very flexible, like you know you get all your work done on the floor, and it's totally different than working in say Springfield or Centerville, it's just very different, you have to have a broader knowledge base, you have to know a little bit of everything, so it's just the flexibility and you know where you can go from delivering a baby 1 minute to having a full blown code, dealing with that and then have an MVA coming in on top of that so it's always just a little bit of everything. [rn4 Ilene: 59-90]

Today is Wednesday so on Monday, on Monday, here's an example. Monday they are waiting on pins and needles all day, Search and Rescue, 10 missing hikers. They were prepared all day walking on pins and needles until they arrived here at what 2:00-1:30, and it's just you so you are organizing everybody, so kitchen, err, nursing is actually, you know 10 people, where you don't know the condition because nobody is able to get a hold of them. Dispatch has a radio, they haven't checked in so you don't know the severity of their injuries so you are going directly from the kitchen to housekeeping to laundry to front to clerical and then you have your support you have lab and X-ray everybody standing by. Everyone's on pins and needles until you hear so you always have to be prepared because you never know what you'll get. [rn4 Ilene: 1910-1957]

Fern suggested that not all nursing students are suited to rural nursing practice given its unstructured nature.

But again, it's not that they shouldn't be nurses, it's that they need a more controlled structured environment and they'll probably be just fine. . . . Well it is. Because in one context they might function differently because of the structure and the support than in another context such as rural practice where it's less structured, and less resources, and. . . . I guess that's the other thing in rural practice . . . is knowing your resources. Because that again changes . . . you can't really . . . you don't have those immediate help lines, those kinds of things. [rn1 Fern: 1582-1610]

While this aspect of learning in a rural practice education setting was commonly emphasized by students and nurses alike, there were no references to it being the focus of prior orientation for either preceptors or preceptees. It was simply a feature of the experience that both parties “managed” as best they could.

4.6.2. Diverse Technical Skill Development

Of note in this study is the way in which the rural context offered enhanced opportunities for diverse technical skill performance. The variety in patient situations and practice pace, combined with the presence of fewer students within the practice context, was perceived positively by students. In other contexts, allied health professionals such as medical laboratory technicians or respiratory therapists, for example, would normally perform an electrocardiogram (ECG). In the absence of these professionals, nurses and students had the opportunity to acquire technical skills not common to entry-level RN education.

Abbie, Bobbie, and Daniell all saw the rural experience as providing enhanced opportunities compared to their urban counterparts:

I had a wonderful opportunity to get lots of IV's [starting intravenous therapy] to do which is fun. Because I know there's a lot of settings where a lot of my peers were that they didn't get a chance to do that. So I got to really do all my skills. I got to do like 30 IV's and got them all and stuff. I had opportunity to do a lot of skills which was really like a bonus to me. [rs1 Abbie: 1534-1544]

I mean I can do a simple dressing on a hip, but, you get everything in Pleasantville. Like all kinds of sores and ulcers and wounds. [rs3 Bobbie: 2895-2900]

It was a good place to go. And I got lots of skills in and I got to do a lot of different things like an ECG and all that. And a lot of various, different things. [rs4 Daniell: 2117-2121]

Both students and nurses emphasized the availability of guidance:

It as well just in down times they would take you up to show you where different wards were, what went on there, show you different things that went on there, interesting patient on another team or an interesting skill that they had there. They would make sure to come and get you. [rs5 Estelle: 1044-1051]

And they're eager to learn things. They have a list of things they want to do. They want to manage a trach. Well that's not going to happen in a small facility. Hopefully never. You know "I want to put in an NG tube. I want to catheterize. I want to do this." And usually we can get through most of it in terms of . . . maybe sometimes maybe only one but you know definitely get things done and a few adventures that they don't plan on. [rn2 Gayle: 956-969]

In a larger centre, they might see it [technological skills] but it's done by somebody else. . . . Whereas when they're here, they're more included or you can try it [a technological skill] under guidance. [rn4 Ilene: 2587-2603]

When asked specifically about what she thought students most appreciated in their rural practice experience, Haley conveyed several ideas including skill and knowledge development and appreciation from others.

I'm going to say the diversity in the skills they are able to acquire. The knowledge that they are able to acquire. It's, there almost valued for what they are able to do. I think more so as we've said "Well when I go to Springfield [medical unit] I just do this regular routine and I'm just you know, workload. Here, I'm utilized. Here, I'm needed. Here I get to learn." That's what I hear a lot when they [students] do a comparison. [rn3 Haley: 2772-2786]

4.6.3. Clinical Decision-Making

As in other preceptorship experiences at the end of a student's program, rural preceptored students began to experience growing confidence in their ability to practice. This process was enhanced in a rural context because of such factors as increased agency, the diversity of patients' care situations, less structure and fewer professional resources 'at hand', and a sense of interdependence with preceptor and team. Students saw these things as supporting their development of clinical decision-making skills.

My assessments of emergencies, I mean . . . I would know nothing if I hadn't been in Pleasantville. . . . Because usually you got your routine assessments like from Springfield [medical or surgical unit] depending on what the illness is. They're all pretty much the same questions you ask. But when you have somebody who's fallen, been bucked off a horse. And you have no idea where their injuries are, like the assessment is way different. . . . And it's got to be fast. And it's got to be accurate. [rs3 Bobbie: 2822-2847]

But I try not to listen to everything [rural nurses] say because sometimes they make assumptions and stuff that might not be completely accurate to that person in this time. Maybe in the past. But maybe it's different this time so we can't just automatically assume that the person is coming in for the same thing all the time. So I try to make my own presumptions about people

after talking to them. Because I'm new, even if they're not, I'm still new here and whether they're being completely honest or not, I still want to find out about what their issues are so I do a lot of my own . . . and they want me to . . . to do my own assessments. And report back. And then they [nurses and doctors] tell me "ok did you ask this and this." And I would be "no." I'd have to go back in and . . . [rs3 Bobbie: 850-868]

And also again, not that independence, but because you're the only nurse, you're sort of in charge. Not like you're working for yourself, but you go in there so you get to plan how you'll do your day, you don't have anybody telling you what to do. So that too helps a lot. Like your own boss. Call upon your own knowledge and that sort of thing. [rs1 Abbie: 1051-1061]

And as a nurse you had to rely again on your own knowledge. And what you have learned. And not hoping and praying but just hoping that it's the most up-to-date best way because that's what I knew but there was no other way to . . . Quite often the nurses were checking back and forth with each other. You would have to have that trust also. [rs1 Abbie: 1131-1140]

It's good to see that different aspect of nursing. I think it's [rural practice] just good to see really. And you do get lots of skills and lots of assessments and all of that and so you're still getting all your skills and all those . . . that nursing aspect in. So, and that's really . . . I think we [students] really need that I think so. [rs4 Daniell: 3071-3086]

Several nurses spoke of the importance of student development of assessment and decision-making skills, and of the benefits of the rural experience for enabling and encouraging such development.

So you do this breadth of tasks and assessments as well as being perhaps overly . . . not overly, I don't mean that in a negative way, but doing a really thorough assessment because you're the only one. And just developing that 6th-sense thing. Paying attention to it, don't ignore it. "Oh this patient looks kind of pale. Kind of looks this way. But maybe it's nothing. Maybe it's ok." Don't go with that. Don't say "It's ok, I'll . . ." . . . maybe it's something. [rn2 Gayle: 758-778]

So when I think of rural nursing why I think it's so important for the nurses to have it. It's your critical thinking skills. It's your assessment skills. If you can learn those two things early in your nursing career, you will be able to do anything in your nursing career because you have your basics. [rn3 Haley: 950-958] But, like I said, after in rural nursing and I developed that, those sets of skills [assessments and critical thinking]. The confidence for me to go back to [an urban practice setting] and worked in the emerg and the ICU . . . it was no biggee. It was like. Oh, you mean, I don't have to do that? I've got the good life in the big centre. [rn3 Haley: 1007-1027]

They should be able to practice their skills and bring it all together. Their assessments it's just to watch them grow. Just to let them have the freedom of doing an assessment in the ER, their total head to toe and just seeing the lights click, Wow, I get it now. You know, just doing the ABC's just watching them bring all that information that they have learned into play. So I

think it's just the freedom and such a laid back atmosphere where they are able to, laid back but they have the variety. [rn4 Ilene: 2759-2788]

For Bobbie and Jaime, assessment skills were at the heart of preparing students for rural practice. Each of them questioned what formal nursing programs could realistically provide, given the diverse and relatively unstructured environment of rural nursing.

We did exchange a couple of emails before she came up, she [the preceptee] was wondering what sort of things she should prepare for and I told her yeah cover everything because we do broad but I did clarify that a little more I told her to focus on assessments. The biggest thing is to assess them because if you can assess them, if you've got a good assessment you can always ask somebody else what to do about it but somebody over the phone can't assess them for you. . . . So, yeah to work on our assessments our head to toes, you know how to assess cardiacs, that sort of thing that was the biggest thing I told her to work on coming up there. [rn5 Jaime: 2234-2265]

The difference I think you really have in preparing someone for rural nurse as opposed to urban nursing is probably the change in structure. It is the only thing that beginning out starting out while they are learning as new nurses having that structure to work within is very important having, being able to fall back on critical thinking fall back on the basic steps and I can only speak for my site I can't speak for other rural sites we're sort of there, say just as much, there are certain regimented things but it's also very chaotic and you could you probably could train somebody for that but that would be I think a totally different focus. You would probably have to change one of your years to focus on being able to you know on that whole thinking outside the box improvisation working outside your scope doing all these other tasks and trying to incorporate that into your work day so unless the school massively expands and you start offering elective courses and things that's probably not going to be a feasible thing to accomplish. [rn5 Jaime: 8726-876]

I think that a rural experience is so . . . I don't know how you would teach people about that unless you were actually there doing it. So I can't even think of . . . I mean I just preparing them saying "you know rural experiences are not . . . you know, you don't have flow sheets. You don't have a 12-hour assessment sheet. You have to look at the patients and assess them based on your experience and knowledge about their illness. And maybe it's a little easier that way in Springfield, but Pleasantville doesn't have those sheets that you just check off every day and put in their chart. You have to do everything just out of memory and knowledge. So it requires a little more, I guess, of the person, of the student, in terms of knowing what to ask and what to write down. And lots of communication, which is still the same as Springfield, but I honestly don't know how they [nurse educators] could have prepared you for that in any . . . differently than they did without having a rural aspect in Springfield than . . . if you have to be there, I think doing it to know what it's like. [rs3 Bobbie: 2938-2970]

Fern echoed this perspective that experience was the best teacher of assessment skills in the varied and unpredictable context of rural nursing.

Ab . . . so that might be something that the school should be looking at more too, is the assessment skills. How do you make that judgement? . . . In, in . . . say in Springfield [hospital] someone shows up at 2:00 in the morning with chest pain. They'll probably want to see a doc real soon. If they ever get past triage! [laughter] . . . Here, again and then so much of it goes on your level of experience. And that makes it hard . . . I guess that's something else to bring back . . . what do you tell students if they're planning to practice here [rural] straight away . . . is, those judgement skills and the doctors too. . . . And so that patient comes in with chest pain at three in the morning . . . with my 30 years of experience and God knows how many cardiacs, jug bleeds, you've seen, you generally have a pretty good idea right from the first look. You know . . . and it might be something as simple as sick, really sick, or . . . what the hell are you doing here? . . . But that's, and that's something only experience can bring to you anyway. [rn1 Fern: 2248-2307]

For Jamie, the educational challenge involved went beyond clinical knowledge and skill development to the development of self-reliance.

That is the biggest thing that scares me is the things I don't know and that is one of the things you are going to have to come into, uh, agreement with yourself, I can't think of the word, something you have to become comfortable with is that you can't know everything and deal with it. . . . Learn how to research fast. Trust yourself to be able to deal with it. We are kind of living a little bit you know that feels a little edgy sometimes to feel like, well I could be presented with things I really don't know how to and so how does one instil or help the student feel confident in that setting. [rn5 Jaime: 3993-4028]

Summing up this section, rural place and rural culture provided a rich environment for learning how to be flexible and self-reliant, to use the resources and expertise available, to think critically and to expand one's technical repertoire. Beyond these commonly identified learning outcomes, the complexity of rural nursing nurtured a deeper understanding of interprofessional practice, of the role of health services in the lives of individuals and communities, and of professional concepts such as confidentiality.

4.7. Summary of Analysis

Rural nursing practice education was shaped not only by the professional environment, but by rural place itself. From the motivation to engage with the preceptorship as a nurse or a student, through the unique qualities of professional practice in a rural setting, to the actual learning outcomes noted by participants, themes connected to place consistently emerged.

Rural means, in part, non-urban. The students in this research were enrolled in an urban-based nursing program where their previous practice experiences had taken place; for all of them, even those who had grown up in a rural setting, urban nursing practices were experienced as the norm. The urban was always present in the rural context, as a source of greater specialized expertise and more authoritative practices, a destination for transfer patients, and the students' academic home. Distance, dissonance, and conflict between urban and rural formed part of the background to the rural preceptorship, and helped shape the context for cultural mediation by preceptors, the rural healthcare team, and members of the rural community. Relational reciprocity and continuity were central features of the rural practice-education experience.

Students were confronted with many differences in the rural setting and these differences lead to the experience of cultural dissonance. In particular students noted how the context required nurses to be fairly autonomous, relying on self while also fairly dependent on other healthcare providers both within and beyond the context of the hospital. Confidentiality as a professional standard emerged as an intrapersonal and professional conflict for nurses and students, particularly insiders, that highlighted differences in the professional and personal relationships within and beyond the rural hospital walls. Urban-rural cultural conflict was also evident to students in the case of patient transfer, which came to symbolize the cultural divide experienced by rural nurses and nursing students.

The density or sparseness of people within rural health care settings influenced personal relationships, professional practice, and opportunities to learn. Both rural nurses' enhanced sense of autonomy and self-reliance, and their sense of dependence or reliance on other rural professionals, were related to this aspect of place. Notions of physical distance from dense urban resources and proximity and sparseness of rural healthcare resources/expertise (technological and human) were central intervening elements that shaped students' experience. This applied

especially to learning how to make clinical decisions using local resources, and having opportunities to observe and participate in interprofessional and interagency collaboration. Relational continuity emerged as a key element of students' experience, including a sense of familiarity with other professionals and support staff that comes from being in close contact with a relatively limited number of people over time, a sense of coming to know patients more intimately than previously experienced, and an enhanced understanding of the interconnectedness of the rural healthcare system and how information is exchanged across the system.

Time was manifested in different ways in rural place, most strikingly in the emergence of continuity as a key quality of rural relationships. This positioned students differently depending on their relationship with the community, and continuity or familiarity had a profound effect on the experience and practice of confidentiality as a key professional norm. Another defining quality of the rural preceptorship, related to both time and density, was the unpredictable rhythm of healthcare challenges, layered over seasonal variability. The data gave no indication that any of these aspects of rural nursing were included in orientation programs for students or nurses.

Participants, particularly students, had relatively little to say about the social and economic determinants of health in these rural communities. This silence was particularly striking in the case of Aboriginal populations, and suggested that more could be done to integrate the preceptorship experience with community nursing perspectives and knowledge. Another significant educational gap was identified in the lack of meaningful relationships during the preceptorship with nurse educators outside the rural context.

The student's presence in a rural context contributed to the professional development of nurses and other members of the health care team (relational reciprocity). Cultural mediation

emerged as a key practice-education process that was most evident in the preceptor-student relationship. The interconnectedness of the healthcare team and their welcoming attitude towards the students played an important role in the preceptorship experience, and differed from the dyadic relationship described in the preceptorship literature. The healthcare team became important cultural mediators for students by engaging the student with the integrated nature of rural healthcare delivery.

Overall, a picture of the rural preceptorship emerges from this study that both confirmed its educational value and suggested that current practice does not realize that value as fully as it might. These findings will be further examined and elaborated in the final chapter, in the context of the current research literature and rural nursing initiatives in British Columbia.

5. Discussion of Findings, Limitations and Recommendations

5.1. Findings in the Context of the Academic Literature

My purpose in this final chapter is to make evident similarities and differences between my study and other more recent research; to propose or support practice-education and policy recommendations when substantial evidence exists; and to identify questions for future research. In particular, the nature and value of place and relationship to the culture of rural nursing practice and student learning leads to a proposed revision to aspects of rural practice-education for the undergraduate student.

5.1.1. Motivating Factors

Nurses cited reciprocal information exchange and professional development as key reasons for volunteering to preceptor. It was evident in my study that, as other researchers have suggested (Armitage & McMaster, 2000; Neill & Taylor, 2002; Playford et al., 2006; Shannon et al., 2006), several nurses believed rural preceptorship experiences also have the potential to serve as a recruitment strategy.

Student motivation was much more varied and individual. Not surprisingly, the role of personal connections to rural places contributed to a student's choice (Bushy & Leipert, 2005; Orpin & Gabriel, 2005; Playford et al, 2006). Most student participants had lived at one time during their life in a rural context and generally knew what living rurally meant. Students also opted for a rural practicum because of the opportunity for diverse clinical experience

(McAllister, McEwan, Williams &, Frost, 1998; McDonough et al., 1992; Orpin & Gabriel, 2005; Ross & Bell, 2009; Sedgwick, 2008; Yonge, 2007; Yonge et al., 2006). Two students sought a rural experience partly because of the likelihood of getting perinatal practice experience not otherwise available in an urban context due to high student demand. Recruitment strategies that emphasize access to diverse clinical experiences may serve to motivate students to opt for rural despite the barriers of additional cost and lack of personal connections.

5.1.2. Cultural Themes

In examining cultural themes in the data, I looked both at the shared beliefs and values developed by preceptors and students in order to solve problems and give meaning to their actions (Schein, 1992), and at opposing individual or group goals giving rise to conflict (Polkinghorne, 2004). The themes that emerged most strongly for me were relational continuity, independence-dependence, confidentiality, and conflict.

Relational continuity was a theme that I had not anticipated and therefore did not fully explore during the research interviews, but which emerged from review of participant transcripts. Relational continuity, it became clear, was a rural nursing practice cultural norm: a notion that traversed place and relationships, expressed as a sense of familiarity that developed over time, knowing what to expect and how to respond in terms of people and place and events and the values and beliefs that permeated them. Both nurses and students subtly conveyed the importance of relational continuity in their practice and learning experience, as a quality that served to strengthen rural nurses' capacity to provide care and contribute to student learning.

While rarely highlighted as an element of rural hospital-based practice-education, continuity does appear in the research literature primarily focused on patient care delivery. For

example, McAllister et al.(1998) noted ‘continuity of care’ as being important for students in rural healthcare delivery:

Some students commented favourably on the continuity of patient care able to be provided in the rural setting. For example, a social work student who went to Darwin wrote: “it is easier to follow-up on clients and provide a high quality service. One did not have the same impression of losing people ‘in the system’ which is a common occurrence in large urban centres. (#68,p2).” (p. 271)

Likewise, Neill and Taylor (2002) in a student narrative (see Chapter 2 “Relations with Rural Community”), conveyed how the quality of time and attention students had to offer patients in a rural hospital allowed for continuity of care to develop.

In an important formulation, Reid, Haggerty, and McKendry (2002) define three aspects of continuity in healthcare practice: relational, informational, and managerial. Two of these notions of continuity emerged in my research under the theme of relational continuity. The value of relational continuity, according to the authors, was in the trusting therapeutic relationship that developed between care provider and patient. The value of informational continuity was in knowing a patient’s history and their present circumstances. Wong and Regan (2009) spoke to the significance of rural relational continuity in healthcare delivery when they reported on a thematic analysis of 50 rural British Columbians’ perspectives of access, continuity, and efficiency collected via focus groups and questionnaires. They reported that “having a continuous relationship with a regular provider was important for participants across communities in order to ‘feel comfortable’ receiving care, having confidence in the provider’s recommendations about treatments and developing trust” (p. 6). Informational continuity was important for healthcare providers to be able to contextualize and individualize treatment recommendations based on personal knowing rather than simply issuing standardized recommendations according to the health condition (Wong & Regan, 2009).

Just as continuity emerged as important when associated with patient care, my study suggests continuity supports student learning. The continuous and intertwined nature of rural relationships contributes to the development of trusting relationships between students and preceptors, between nurses and patients, and among professionals. The rural preceptorship experience offers students the opportunity to come to understand how these relationships, particularly over substantial time periods, contribute to informational continuity and thus to the quality of patient care.

In my study relational continuity was based on a number of important factors. These included constant contact with a preceptor, the close physical proximity of healthcare providers, having only a limited number of professionals and patients one needed to come to know, along with time for relationship building with all of the above. As students became increasingly familiar with the surroundings, the rural norms of practice, the various patients and their health status and healthcare, they built their understanding of the interconnectedness of healthcare delivery across contexts (hospital and community, rural and urban), to an extent not previously experienced in other practice contexts wherein units are specialized and often physically distant from one another, the number of care providers are high, and time more circumscribed.

Continuity may be important, but it is endangered. Wong and Regan (2009) point to the potential of a changing landscape of rural healthcare providers, such as physician locums and temporary professional healthcare staff, contributing to the patient's sense of discontinuity and limiting patients' comfort, confidence, and trust in their care providers—particularly for individuals with chronic health challenges. For the community members in their study, a lack of continuity in healthcare providers was perceived as diminished access to rural healthcare services (Wong & Regan, 2009).

In my study, participants hinted at the potential for similar changes. As the theme of continuity helps to make clear, such developments would have significant implications not only for healthcare provision, but also for practice-education experiences. Inconsistent or inexperienced rural preceptors, or changing and temporary medical staff, may not have the knowledge or ability to act as cultural mediators; the relational continuity consistent with the integrated *Gemeinschaft* nature of rural healthcare delivery may become disrupted. Policy makers need to be aware of these potential educational consequences of changes to funding or service delivery models.

A second cultural theme was the tension between independence (or autonomy) and dependence (or reliance). Student and nurse observations of wide-ranging autonomy and responsibility in rural nursing were similar to findings by Yonge et al. (2006) and Ross and Bell (2009). Furthermore, Kulig et al. (2008) and others found that rural and remote Canadian nurses had expanded roles in comparison to their urban counterparts; the more removed nurses were from specialist expertise and newer technologies (in particular, the further north they were), the more responsibilities and independence they assumed. In my research, the key variable appeared to be who was present within the hospital or community at particular times, as the numbers and types of patients, physicians, allied health professionals, and nurses shifted across days, nights, weekends, and the seasons of winter and summer. For example: the absence of a physician in the hospital sometimes required the nurses to temporarily fill that role, particularly in urgent or emergency situations until a physician arrived, or to act as the allied health professional such as a respiratory technologist as none were available in the community.

This increased level of responsibility, however, was associated with increased reliance on a relatively few local healthcare professionals. One effect I noted in my study was the very

limited degree of overt conflict present in these rural hospital settings. Sedgwick (2008) notes that in the interests of patient care and team cohesiveness, rural nurses “actively engaged in professional behaviours with the colleague with whom they had a disagreement so that the team could continue on with their work” (p. 73). In my study, in addition to relying on each other and other local health professionals, rural nurses had to rely on professionals at a distance, as there were times when a particular type of professional support was not readily available locally. Student observations of nurses’ broad responsibilities and reliance on self (autonomy), in concert with their reliance on others for informational support from within and beyond the rural context, fostered student understanding and practice of clinical decision-making in a rural context. Interdependence of the healthcare team became evident to students and was modelled in the preceptor-student and student-team relationships particularly when it came to clinical decision-making.

Other researchers focused on rural nursing have also noted the need for greater professional autonomy and for close collaboration. For example, Hunsberger, Baumann, Blythe, and Crea (2009) reported that expanded responsibilities and autonomy added a unique dimension to rural nursing practice that was rewarding, challenging and at times overwhelming, particularly in the absence of other professional support and consultation. Likewise, Chipp, Johnson, Brems, Warner, and Roberts (2008) report practice adaptations became necessary when fewer professionals have broad responsibilities within a rural practice context:

It is likely that the smaller the community, the greater the need for providers to become broader and more proficient in their healthcare skills. These providers also will have a greater need for a comprehensive network for referrals as they will be confronted with many issues outside their own scope of practice that will require assistance from specialists. (p. 544)

Complicating these issues in the rural context is the tension between *Gemeinschaft* relationships, that tend to develop as a natural consequence of living within a rural community, and *Gesellschaft* relationships of the professional form (Tönnies, 1887/2002). The contrasting demands of these two kinds of relationship create conditions for potential intra- and inter-personal conflict among healthcare providers and healthcare recipients, reflecting differences in social norms and professional norms. Scopelliti et al. (2004) reported a comprehensive literature review of ‘everyday’ dual relationships and the implications for rural mental healthcare practice.

Because there are fewer relationship options, rural residents and healthcare providers are likely to occupy several roles and encounter each other in a number of different situations. Unavoidable relationship overlap and greater interdependence among individuals are fundamental aspects of the social norms inherent within smaller communities and may occur at personal, business or other professional levels. (Scopelliti et al., 2004, p. 953)

Such interdependence contributes to confidentiality concerns arising from the closeness of a community that affords both personal and professional knowledge of community members (McAllister et al., 1998).

Confidentiality emerged in this study as a significant professional practice challenge both for insider students and for rural nurses. The cultural norm of gossip within a rural context, and differences in practice of confidentiality across geographic boundaries, contributed to intrapersonal conflict for some rural nurses and students. Participants suggested different ways to promote the practice of confidentiality, such as reminding family and friends not to ask about patients, advising friends or acquaintances to seek health advice from other professionals in the community while they are ‘off duty’, and removing oneself from caregiving if the situation permits. Nurses and students in my study noted how their family and friends tested their standards of confidentiality, and shared their strategies for responding to casual questions regarding neighbours’ or friends’ health circumstances. Likewise Zibrik, MacLeod, and Zimmer

(2010), in an interpretive descriptive study of rural acute care nurses in B.C. and Alberta that focused on the day-to-day experience of professionalism, affirms rural nurses' public visibility with the associated challenges and strategies to safeguard client confidentiality. These researchers note that nurses generally aspire to be positive role models for community members and in doing so affirm their professionalism.

In her recent focused ethnography drawing on a sample of students and nurses (preceptors) from northern Alberta and the Yukon, Sedgwick (2008) makes similar observations with respect to the lack of anonymity that comes with being a rural health professional and rural community member. Most of her student sample had some knowledge of rural places from having worked and/or lived in small rural towns. However, nurses in my study did not express the perception of Sedgwick's (p. 7) participants that the lack of anonymity was intrusive. Rather, the lack of anonymity was accepted as a way of life, and maintaining confidentiality, while challenging, was perceived as a professional responsibility to promote community trust. This lack of anonymity was more challenging for the insider students and rural nurses than for the outsider students, as the former experienced intimately what it was like to live among the rural residents and be connected to them over considerable time.

The customary distinction between public and private enacted in urban contexts can be less clear in rural settings. Sedgwick (2008) claims "some information in some nursing settings is considered private, but in the rural hospital setting is considered 'public' knowledge" (p. 117). She surmises that information gained by virtue of a nurse's familiarity with a patient's history is public by nature within a rural hospital and shared readily among professionals. Students and nurses in my study expressed greater deliberation when it came to the tension between private and public information, particularly as it related to confidentiality. While I agree with Sedgwick

that maintaining confidentiality is complex, given the closeness of community members and professionals, it does not necessarily imply anonymity. Rather, a more nuanced relational ethic of confidentiality needs to be developed that can encompass the range of situations encountered in rural healthcare settings. A professional conceptual lens through which to understand and practice confidentiality in a rural context would benefit student insiders and outsiders alike.

A final cultural theme deserving mention is the tension or conflict between rural and urban nursing. Rural nurses perceived a lack of respect from some urban nurses, particularly in the absence of a prior relationship. They attributed this attitude to a general lack of understanding of rural nursing practice. Students also noted this tension between urban and rural nurses. Hunsberger et al. (2009) is one example of many reports that have documented nurses' sense of being demeaned and criticized about their practice decisions by urban professionals when accompanying an unstable patient to a tertiary hospital. Exposing students to rural nursing practice may limit uninformed or urban centric critique of rural practice (Courtney et al., 2002).

5.1.3. Perspectives on Place

Throughout my conversations and interpretations, in order to limit a tendency towards structural-spatial representations that negate the importance of place, I looked for the interplay of social and physical characteristics of the location in which people were situated. For theorists of place, it is this interplay that gives rise to culture (Escobar, 2001). For example: the notion of time as a physical measurement was de-emphasized in favour of an exploration of the experience of time and how it underpinned continuity of rural relationships and mediated student learning.

I found, first, that rural hospitals and communities tend to be environments conducive to student learning. The size of a rural hospital, the fewer patients cared for, and the infrequency

and limited numbers of students within a rural context led to students being treated as someone novel and interesting rather than familiar and tedious. Much like Arlton (1984) reported in early rural nursing scholarship and several scholars since, students in my study experienced a welcoming environment and felt appreciated by the healthcare team. Similar findings were reported by Van Hofwegen et al. (2005), whose community-based rural nursing education research in BC had a small sample size of 11 undergraduate students, two nurse preceptors and one university faculty member and extended over a 3-year period. They concluded that “intrinsic characteristics of small population, isolation from larger urban centers, and availability of fewer health services, provided positive and productive student learning opportunities” (p. 11).

The physical proximity of rural healthcare resources, such as equipment, other healthcare services, or professionals, played an important part in shaping rural nursing care. Armitage and McMaster (2000) reported their study participants as commenting on the physical closeness of healthcare services that supported broad practice experiences and opportunity to observe the interprofessional team in action. This observation of physical connectedness is similar to my own: students often commented that they would go to another area close by to participate in the performance of a new or unfamiliar skill, witness a different patient situation, or watch and participate in interacting with other healthcare professionals or community members in the delivery of rural healthcare. This physical closeness within a rural hospital connected students more directly to the patients and healthcare team, and facilitated student learning about the rural healthcare delivery process.

The combination of physical distance from dense urban healthcare resources, juxtaposed to the physical closeness but sparseness of rural healthcare resources within the immediate environment, emerged as a defining feature of the preceptorship experience. Although not

explored in depth, it seems that the rural experience of separation from other people, things, and experiences may contribute to rural reliance upon one another; to the closeness of the healthcare team that formed an important part of the student learning experience.

Time emerged as an element of place in various forms in this research, including the sense of historical familiarity or the knowing that comes from living and working in place, the variable pace of practice, seasonality, and the degree of importance ascribed to time. 'In the moment' changes in distribution of responsibilities, according to patient care circumstances such as emergencies and available healthcare resources, appeared as a typical feature of rural healthcare. Likewise, Yonge et al. (2006) identified the unpredictability of patient numbers and diverse care situations as contributing to variation in practice pace. This influenced student learning. In particular, slower paces offered students time to anticipate nursing care requirements or reflect upon and learn from past events.

Dalton (2005) explored undergraduate student nurse initial experiences in rural practice settings in Australia, concentrating on the interplay of time and professional identity. Dalton's study identified time as a source of intrapersonal conflict for students, based on the expectations of rural practitioners and educators. Students experienced a restructuring of their thinking about time—from a focus on 'doing the work' of nursing to one of 'being there' for others to provide humanistic care. This theme of 'time in place' to develop relationships connects in part to a sense of coming to know the patient in a rural hospital, and the sense of continuity that is fostered with repeated interactions within and outside of a professional role (see earlier discussion). The pace of practice was not discussed in Dalton's (2005) work, however, and needs to be part of a more comprehensive understanding of the meaning of time in rural practice-education.

Seasonality, and its interplay with occupation or recreation, had an impact on the student's learning experience in a rural context. It is well understood that there is a seasonal pattern to most illnesses (Harris, Glazier, Eng, & McMurray, 1998). The form of tourist activity influences the frequency and type of illness or injury (Matter-Walstra, Widmer, & Busato, 2006). In Canada, tourist activities are often linked to the changing seasons and the natural landscape. Additionally, in rural Canada, employment activity such as agriculture, ranching, hunting, forestry, and fishing may vary according to the seasons and geographical location. Hence, the nature of the geographical place with its natural resources and associated livelihoods contributes to the differences in type of patient conditions seen in a rural context at various times throughout the year. The student's close proximity to, or actual practice in, the rural emergency department lent them an opportunity to bear witness to this seasonal nature of rural hospital-based nursing practice.

Not all researchers attribute equal educational value to the experience of continuity over time. Playford et al.(2006) reported a shorter rural placement time, such as 2 to 4 weeks:

were associated with future rural practice. Strategies to increase the time spent in the country during the course may be unnecessary or even counterproductive, if the goal is to increase the rural workforce. For urban-based allied health and nursing students, rural placements mean separation from family and friends and loss of work income as well as transportation and social dislocation issues over which the student has limited control. It is likely that shorter placements minimise these negative non-work-related factors while giving an adequate window into rural practice. (pp. 17-18)

My own study wherein students had 5 to 8 weeks or 200 to 300 hours practice-education, however, leads me to have concerns about what shorter placements might do to the depth and diversity of learning from continuity in a complex environment, and to the possible development of community commitment and rural citizenship. Short-term rural placements may permit more students to access the rural context without substantial financial or family burden

and may promote rural nursing understanding in a very general way. However, from an educational standpoint the quality of the experience for senior students engaged in rural practice-education over a longer time is also meaningful.

This research provides no compelling evidence that ethnicity, occupation or economics as qualities of place had any noteworthy influence on the nursing students' rural hospital practice-education experience. These qualities resonate for me, at least in part, as social determinants of health (Commission on Social Determinants of Health, 2008). Several of the research sites served significant populations of Aboriginal people, and in retrospect I am surprised more conversation did not touch on specific Aboriginal health issues. The Public Health Agency of Canada (2003), for example, notes the impact of cultural factors characteristic of Aboriginal communities:

some persons or groups may face additional health risks due to socio-economic environment, which is largely determined by the dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate healthcare and services. ("Key Determinant 12: Culture," "Underlying Premises," para. 1)

Adelson (2005), after a review of literature on the health disparities in Aboriginal Canadians, notes that differences between Aboriginal and non-Aboriginal health result from a complex confluence of personal health behaviours and "social, economic, cultural and political inequities; the end result of which is a disproportionate burden of ill health and social suffering upon the Aboriginal population of Canada" (p. S45). Attending to Aboriginal health inequity requires an approach that recognizes how the colonial history of oppression can emanate in the present daily lives of Aboriginal people, and mindfulness of how cultural identity, social determinants of health, and environment "interact to shape health in local places" (Richmond & Ross, 2009, p. 410). MacLeod, Browne, and Leipert (1998) identified the need for nurses in rural

and remote communities to explore culturally safe ways to “keep their practice in synchronisation with the unique needs of diverse communities” (p. 75). My study indicates that such efforts were lacking in the communities, hospitals, and nursing program involved in this study, and suggests that this dimension of rural nursing education urgently requires more attention.

Armitage and McMaster (2000) reported, in an Australian-based study, that the “high Aboriginal population in remote areas resulted in the students embarking on a steep learning curve relating not only to cultural matters but also to the nature of nursing” (p. 178). Reimer Kirkham, Van Hofwegen, and Harwood (2005), in their research on innovative clinical settings including rural and Aboriginal contexts, noted student narratives of social justice: developing critical awareness bearing witness, critical engagement through critical reflection on cultural dissonance, and heightened social awareness that engenders social justice commitment. Tang and Browne (2008) “argue that the work of recognizing and mitigating racialization in health care cannot be accomplished by avoiding the difficult discussion of ‘race’ or by denying the existence of racism and other forms of inequities” (p. 124). There are thus precedents for incorporating a greater focus on Aboriginal issues in the context of education for the health professions. In a rural practice-education experience, student attention to Aboriginal health, guided by a philosophical foundation of social justice and cultural safety, may take several forms: orientation materials; self-study; assignments that focus on the historical, political, economic, and cultural aspects of Aboriginal health; meaningful engagement with Aboriginal people; and developing attitudes and skills that promote Aboriginal health.

Both students and nurses expressed a growing reliance on information technology to support nursing practice. Stewart and Carpenter (2009) note the growing importance of

communications technology in limiting professional isolation and supporting professional development of rural nurses. While young student nurses may readily adopt communications technology for information sharing, older rural nurses may have to acquire new skills and processes of accessing usable information (Mountour, Baumann, Blythe, & Hunsberger, 2009). In this study, preceptors and healthcare team members shared practice knowledge primarily by word of mouth and students supplemented this expert knowledge with available clinical print resources. In particular, students increased the managerial continuity of patient care by using e-technologies to explore best-practice guidelines or other online sources of expert knowledge. Students occasionally acted as role models for preceptors in terms of accessing e-technology for supporting their clinical decision-making.

5.1.4. Relational Resources

A key aspect of the rural preceptor-preceptee relationship was the reciprocal quality of information exchange between the student and the nurse. The student, primed with theoretical understandings of nursing, intersects and exchanges information with the nurse, fortified with practice understandings. The theme of rural nurses learning from students was a point of confluence between Baird-Crooks, Graham, and Bushy (1998), Van Hofwegen et al. (2005), Playford et al. (2006), Sedgwick (2008), and my research. Yonge (2009) described the foundation of a positive preceptorship relationship as lying in the “mutual respect for the wealth of experience of the preceptor and the post-secondary education of the student” (p. 19). As noted earlier, the prospect of learning from students emerged in this study as a considerable component of rural nurses’ motivation to be a preceptor, and proved valuable for students as it buoyed their practice confidence. Other researchers including Arlton (1984), Koehler et al.

(1988), and Van Hofwegen et al. (2005) have affirmed that reciprocity of information exchange contributes to professional development of rural nurses and cultural mediation for students.

Cultural mediation was an explicit focus for Mills et al. (2007), who claimed that working towards diminishing cultural barriers has positive outcomes for the experienced nurse and novice student. They identified rural mentors in Australia as acting to demystify local practices, coaching to increase competency of novice skills, and protecting novices from situations or other people perceived as personal threats. “Strategies used by the experienced rural nurses and the expected outcomes from these strategies include orientation to the local cultural mores and an increase in neophyte nurses’ confidence to practise” (Mills et al., 2007, p. 589). Limited yet promising evidence of preceptor cultural mediation skills emerged in my study, including recognition of and empathy for cultural dissonance, information sharing in preparation for new or unique situations, and cultivating interdependence and trust in the student.

In this research, the importance of the rural healthcare team emerged as a central feature of the rural preceptored hospital-based practice experience. Rural team relationships promoted student learning about the team as a healthcare delivery process, and by providing oversight and sharing information. The engagement of students by healthcare team members (asking questions, explaining perspectives, guiding student practice, and offering diverse learning opportunities) was a key aspect that contributed to cultural mediation and alleviation of student dissonance. Students and nurses recognized and appreciated the interconnectedness of personal and professional relationships among healthcare providers.

Similar to my study, the notion of feeling part of a team (including making contributions to the team and to healthcare delivery) and the opportunity to obtain a variety of practice experiences ranked high as factors that influenced the quality of student learning (Edwards et al.,

2004). In 2007, Yonge reported a grounded theory study of preceptorships from the perspective of nursing students in Alberta, noting the importance of “the relationship they formed with their preceptor and the rest of the healthcare team. Through these relationships they gained entry into learning about nursing and health care systems” (p. 8). Likewise, Sedgwick, Yonge, and Myrick (2009) reported that “rural-hospital-based preceptorships are inherently team oriented where most of the staff members assume a one-on-one relationship with the student at some point during the experience” (p. E5). This emphasis on combined effort is also reported by Yonge et al. (2006) and Sedgwick (2008) who described rural hospital preceptorships as ‘joint’ ventures’ between student, preceptor, and staff. Sedgwick (2008) also reported similar findings about the strong affiliation of rural nurses with the team coupled with, at times, a profound sense of being alone or isolated. Recalling my cautious claim (under Culture above) that the low incidence of professional conflict may reflect rural reliance, I take note of Hunsberger et al.’s (2009) assertion that “rural nurses found meaning in their work through commitment to their colleagues, patients, and the community. Since they had few resources on site to support them, they relied on one another” (p. 21).

Sedgwick (2008) reported challenges in the preceptorship experience that did not emerge in my study. These challenges included newcomers feeling isolated, finding it difficult to create social relationships in a rural context where longstanding relationships existed, and preceptor desire to take a break from preceptoring after encounters with students who were unable to keep pace with them. A difference in student experience of isolation and preceptor desire for a break from preceptoring between Sedgwick’s study and my own may reflect the differences in our sample. Eighty percent of my sample participant students had lived or worked in a rural context previously and all placements were within a 2-hour drive of the university, or community of program origin. In contrast, Sedgwick (2008) indicated in her study that while some of the

sample were located in, or close to, their hometowns, others were at rural hospitals at “long distances from their place of residence” (p. 29). The program criteria for student placement selection and assignment were not stated in Sedgwick’s study. In my own institution, students could be denied rural placements if they were judged to be developmentally not ready; such a process may account for some differences in observations between the two studies. The utilization rates of rural placement sites and rural preceptors over time were unknown in both studies. Likewise, the type of faculty support offered in these preceptorships across rural contexts in each of these studies was unknown. Differences in places, preceptorship process, and differences in students may contribute to the differences in our findings.

Although nurses were not included in their study of interprofessional education among pharmacists, occupational, and physical therapists, the results of Mu et al. (2004) complement my understanding of the rural team as a healthcare delivery process and teacher. Research participant perceptions were evaluated using quantitative and qualitative measures. The specific findings affirmed the value of interprofessional training, with emphasis on improved communication and sharing of information, appreciation for other healthcare professionals, and enhanced learning from each other about the provision of healthcare services (Mu et al., 2004).

In the study of Van Hofwegen et al. (2005), as in mine, the community of practice learning emerged as central to the student experience. However, in my study this learning community emerged primarily among the immediate healthcare team and the patients they encountered because of hospitalization. There were some indications within my study that students did become aware of the larger community beyond the hospital, and appreciated the rural experience for increasing their understanding of interprofessional and interagency cooperation that promoted continuity of care. Whereas for Van Hofwegen et al. (2005), the

community of practice learning was shaped substantially by student relationships with the community members-at-large. However, this population health perspective did not emerge in my research.

As highlighted by MacLeod, Martin-Misener, et al. (2008), based on a narrative analysis of 152 interviews with Canadian rural and remote nurses, multidisciplinary, cross-professional relationships both internal and external to the rural context are a significant aspect of support in a context of limited healthcare resources. In my study, several nurses spoke of continuity in their relationships with urban agency personnel, and affirmed the usefulness of exchange of information between urban and rural nurses in certain care circumstances. Drawing upon diverse relational and informational supports for clinical decision-making was communicated to and modelled for students.

The intertwining of the personal and professional relationships in a rural context emerged strongly and was perceived largely as unproblematic. The degree of student or nurse familiarity with the rural community beyond the hospital influenced their experience of continuity. Most students, regardless of their insider or outsider status, expressed a general ease at coming to know patients in a rural hospital in comparison to an urban hospital, and this growing sense of familiarity contributed to their sense of continuity of care delivery. Similar to Arlton's (1984) early finding, students in a rural practice experience develop a growing sense of holistic care through coming to know the person (patient) embedded in the social fabric of a rural community.

Neither students nor preceptors perceived substantial value in relationships with postsecondary nurse educators, as the educators were physically and relationally distant. Nurses conveyed the desire to have nurse educators more engaged and present in the rural setting, if not

more available by telephone contact (Yonge et al., 2006) in order to facilitate greater understanding of rural practice and shared expectations of student performance within a rural context.

Through the broad conceptual lens of Wenger's (1998) social theory of learning, which underpins the notion of communities of practice, I view the changes rural nurses and urban educated students experience from meaningful engagement in rural preceptorships as constituting a modern, adapted version of "the master-apprentice relationship, in which the master and apprentice learned from and through each other, and the apprentices' interactions with each other and their wider community enabled successful learners to move from the edge (or 'periphery') of the community to full participation in its socio-cultural practices" (Le May, 2009, p. 5). An expanded notion of preceptorship as a process of cultural mediation moves from an emphasis on individual educational relationship to the nurturing of a web of relationships present within and beyond a rural healthcare context. An individual preceptor, while significant in terms of their cultural mediation role, can be viewed as part of a larger network of relationships that must be engaged to maximize the value of rural practice-education. Conceptualizing rural preceptors as entry points for students to reduce cultural dissonance, and building on the nature of rural relationships to facilitate student engagement with the larger community of practice and the community-at-large in partnership with students and educators offers an expanded opportunity for all to learn the intrinsic qualities of rural practice.

5.1.5. Learning Outcomes Compared

A key common learning outcome identified by students and nurses was becoming comfortable with the potential for the unexpected in a rural context, in particular the admission of a person or persons with an atypical care situation. Students in this study became very aware

of the day-to-day changing nature of practice pace and the possibility of the unexpected, and how this influenced their day-to-day organization. “Part of the professional role of rural nurses is recognizing the need to be flexible and being prepared to manage unrehearsed events” (Zibrik et al., 2010, p. 26). Yonge et al. (2006) have also noted that unpredictability of patient numbers and diverse care situations such as emergencies contribute to variation in practice pace which students needed to learn to adapt to in order to accommodate changing circumstances. Unlike Ross and Bell (2009) who highlighted poor staffing as a rural nursing practice challenge, my study emphasises the variability of staff deployment and responsibilities based on the day-to-day changing nature of practice, pace, and available expertise.

Students in this study expressed appreciation for the diversity of rural hospital-based practice and how this diversity, along with unique resources available, challenged and developed their clinical decision-making ability. Other researchers confirm that rural practice experiences provide opportunities to practice nursing with diverse patient populations (Barney, Russell, & Clark, 1998; McAllister et al., 1998; McDonough et al., 1992; Orpin & Gabriel, 2005; Ross & Bell, 2009; Sedgwick, 2008; Yonge, 2007) and clinical areas (Yonge et al., 2006). Comparable to Baird-Crooks et al. (1998) and Edwards et al. (2004) students developed confidence and increasing capacity for clinical decision-making. Yonge (2009) claims the rural context provides greater opportunity than an urban context to develop critical thinking skills given there are fewer experts available to seek answers from than an urban context. Correspondingly, MacLeod, Martin-Misener, et al. (2008) recommend that students learn how to practice within a resource-limited setting and enhance their abilities to access information independently and to think critically in order to limit the *fear factor* associated with practicing in a rural context—a quality associated with the sense of unpredictability that emerged in my research as well. Hunsberger et al. (2009) likewise observed that the interruption of the daily routine of rural hospital-based

nursing by life-threatening or unfamiliar patient conditions challenged rural nurse recall of skills and knowledge to manage the presenting emergency.

The opportunity to develop diverse technical skills not normally available to nursing students in an urban context is less widely supported in the literature. Recently, healthcare students in Ontario found a rural practice experience provided opportunity to participate “in more hands-on procedures than those available in larger urban centres” (MacRae, Van Diepen, & Paterson, 2007, p. 25).

The common learning outcomes identified by nurses and students in this study are consistent with recent research about rural nursing and practice-education over the past decade. The unique qualities of place, such as resources, people, technologies, and unpredictable health situations, provided diverse learning experiences and subsequently develop both the clinical decision-making skills and broadens the students technical skill repertoire. Common learning outcomes from undergraduate rural practice-education research provide one source of information for the development of recruitment, orientation, and practice-education assessment tools. Notwithstanding, the nuanced aspects of rural nursing practice as discussed in cultural, place and relational themes should be considered to inform the development of undergraduate rural practice-education objectives.

5.2. Findings in the Context of Current Rural Initiatives

While the academic research literature provides one context for interpreting the findings of my study, equally important is the current context of rural healthcare practice-education in BC. Accordingly, I chose to review four program evaluations from initiatives that originated in BC within the past 10 years. Three electronically published reports are available on various

organizational web sites; a fourth unpublished report comes from a project where I was the lead coordinator and investigator.

MacLeod, Lindsey, Ulrich, Fulton, and John (2008) reported on phased work to design and implement a continuing education program for RNs practicing in, or transitioning to, rural acute-care hospitals. This program, now the Rural Nursing Certificate Program (RNCP), was developed in partnership with health authorities and their regional educational institutions. It emphasizes rural relevant content and methods in order to support and recruit qualified nurses through continuing education. The RNCP began in 2007 at the UNBC, Prince George, and the authors' report provided an overview of the environmental scan and curriculum development process.

The environmental scan included focus groups with nurses employed in rural hospitals from 51 communities across the province with a population less than 25,000. The categories for analysis included rural approaches to learning, educational delivery, core curriculum and rural acute care hospital nursing. Consistent with my research, those authors described rural nursing as “multifocal and diverse, requiring a broad range of knowledge and skills” (MacLeod, Lindsey, et al., 2008, p. 300). As also emerged in my study, the identified *fear factor* for nurses and students was not knowing what (who and with what health condition) might present at any given time. MacLeod, Lindsey, et al. found that limited staffing and availability of specialist expertise required RN's to assume considerable autonomy, including broad responsibilities and decision-making; this also was consistent with my findings.

The expected core content recommended by nurses moved beyond traditional ‘subjects’ such as trauma or perinatal nursing to include concepts such as ‘living and working’ in a rural context, accessing resources, organizational skills, and “transdisciplinary care (nurses acting in

multiple roles in the absence of other disciplines [e.g., social work, physiotherapy, and respiratory therapy])” (MacLeod, Lindsey, et al., 2008, p. 300). These concepts, similar to the themes within my research, traverse traditional nursing subjects. In particular, the themes of diversity of patient care situations, living the concept of confidentiality, interplay between nurses’ independence and dependence, and learning and preparing to manage unexpected patient situations, align with the findings of MacLeod, Lindsey, et al. (2008).

Simultaneously, the University of British Columbia (UBC) through their College of Health Disciplines began the Rural Academic Health Project (RAHP). The RAHP was funded by the BC Ministries of Health and Advanced Education via a Practice Education Innovation Fund, and governed by the BCAHC (Bainbridge et al., 2008). The RAHP goal, as outlined in its final report, was to design a consensus-based model for “strengthening rural academic health capacity in BC” (p. 8). To that end, the RAHP final report outlined a set of community development principles upon which to grow rural capacity for practice placements. These four principles are:

- include community participation in the design and support of rural practice placements;
- foster partnerships between educational institutions, health authorities and rural communities;
- embody the community as teacher wherein learning occurs outside clinical sites and within the community at large;
- incorporate service learning as part of the practice experience to foster students ‘giving back’ to host rural communities.

The RAHP outlined key program components to support students such as housing, travel, internet access, and community orientations. Suggested supports for preceptors included preceptor training and other professional development activities, recognition, and remuneration. Rural communities were advised to have a community champion, to facilitate inter-

organizational collaboration, and a local community coordinator to support students on site. At the provincial level, the recommendations included coordination of rural placements across various programs and disciplines across the province, promotion of rural placements for their valuable learning and associated challenges, networking across various provincial initiatives designed to foster rural practice-education, and linking rural students with potential rural employers.

The RAHP report affirms the value of rural practice-education experiences regardless of the learner's intent to stay rural:

Rural communities provide a unique and powerful learning environment which facilitates competence in assessment, decision-making, teamwork, communication, leadership and more. Students are able to experience firsthand the continuum of care, the influence of culture, and the impact of the broader determinants of health. Participating in rural life and practice fosters “well rounded” health professionals regardless of where these emerging health professionals practice in the longer term. The lessons learned through rural health professional education can be applied in all practice settings: a deeper understanding of social determinants of health, a clearer picture of rural life that improves discharge planning from urban tertiary centres, and improved communication across urban and rural settings to name a few. (Bainbridge et al., 2008, p. 5)

In most respects, these claims are consistent with my own findings. There is however one important exception. It was not evident from my interview data that students gained greater understanding about the social determinants of health through their rural practice experience—a point taken up further in my recommendations, below.

One RAHP recommendation echoes my findings of the limited engagement of faculty in the rural practice-education experience: “Further work should be undertaken in exploring options for faculty support to students and rural communities, in particular across programs. Interaction with faculty varies across programs ranging from telephone and internet communication, online courses and site visits” (Bainbridge et al., 2008, p. 16). While not central

to my own study, there were hints in the interviews of the vast potential for the Internet to revolutionize the engagement of students, nurses, and faculty in rural practice-education and research. Communication technologies that are simple, sustainable, and align with practice and educational intent are most suitable for a rural context. Variation of user ability across generations (Montour, Baumann, Blythe, & Hunsberger, 2009) and differences in infrastructure across geographical areas (Curran, Fleet, & Kirby, 2006) can challenge the adoption of communication technology, but this area clearly deserves more attention and resources on the part of nursing educators, researchers, administrators, health authorities, and governments.

In the early 2000's, the Interprofessional Rural Program, a consortium of practice and education leaders throughout the province, was started as an initiative funded by the BC Ministry of Health Services and overseen by the BCAHC (Charles et al., 2006). The program was based on the concept of four to six students from 12 health related professional groups going to one rural community in each of the five BC health authorities at the same time for a period of 12 weeks, in order to experience living and working in a rural context and practicing as an interprofessional team. The goals of the program were to promote interprofessional competency, enhance capacity for rural communities to provide learning opportunities for health professionals and influence healthcare students to opt for rural practice upon graduation. By 2006, 62 students had taken part in the program (Charles et al., 2006). Like my study, Charles et al. students' understanding of rural practice, collaborative team-based practice, other professionals, and the continuum of healthcare delivery increased. Unlike my study, students' practice-education experience spanned the continuum of healthcare services such as hospital, home-care, and prevention and engagement with community enhanced their understandings of the unique healthcare needs of rural communities. "Students came away with a strong understanding about how the health of people is influenced by such factors as employment,

housing, education and culture” (Charles et al., 2006, p. 47). Professional practice standards, such as the practice of confidentiality, were not reported as an issue or area of student learning. The program has been reported as highly successful in meeting its stated goals. However, some tensions are apparent in this approach between the needs of healthcare students from a traditional large urban practice-education context and students from smaller regional institutions. The limited availability of practice placements, juxtaposed with the growing needs of educational institutions for meaningful placements through the province, sets up a competition for placement sites between large groups of urban students and individual rural students and their associated programs.

The fourth program evaluation report is drawn from my own professional context. In 2005 and 2006, I led the design and evaluation phases of a rural practice-education initiative within the TCSHSA, in collaboration with Shona Johansen and Carolyn Hosking. The initiative, funded by a grant-in-aid from the IHA Professional Practice office, was intended to increase undergraduate student exposure to rural practice-education, to expand TRU’s capacity to facilitate rural undergraduate learning experiences, and to increase student and rural RNs’ access to resources to support rural undergraduate practice in hospital settings.

The project resulted in the development of a website for students and nurses to access rural learning activities, organizations and people, and to serve as a way for students and nurses to be in contact with one another across multiple sites. In addition, several resources were developed for rural nurses, including a rural-relevant preceptor manual and a compact disc orientation designed specifically for rural preceptors. Each preceptor also received a copy of the 2005 book by Florence Myrick and Olive Yonge titled: *Nursing Preceptorship Connecting Practice and Education*. Program changes included the introduction of a stipend of \$1,025 per

student (preceptee) to a maximum of 15 students during a preceptored practice-education experience within the IHA and an honorarium of \$150 per preceptor (nurse). Twelve students (2 male and 10 female) opted for the rural preceptored experience and 12 nurses volunteered to act as preceptors.

An evaluation of these initiatives (Zawaduk & Johansen, 2006) confirmed the value of the stipend, which by reducing financial stress contributed to improved student learning. Students experienced diversity, multi-tasking, a rural sense of agency/autonomy, and collaboration. Several students conveyed the perception that they were less well received or accepted within the rural context if they made it known they would not return for employment upon graduation. For several students who were uncertain about rural as an employment option, the experience was an opportunity to expand and clarify their post-graduation employment plans.

Most students reported that the website was a learning resource; several students noted they coached preceptors in how to access the website. The preceptors found the print materials useful, but their uptake of electronic resources (website and CD) varied according to their experience with computing and preceptoring, as well as the accessibility of technology at their place of employment. Preceptors indicated that the major educational benefit of having students in their rural hospital was the way that the context exposed students to different experiences and health challenges, as learning to handle this diversity was essential for preparing novice nurses for rural practice. Preceptors also emphasized that students needed to build relationships with support staff, both within the hospital and external to the hospital, and to work with the interprofessional team.

I remain troubled by the RUN project finding (Zawaduk & Johansen, 2006) that students perceived being less well received in a rural context when they voiced an intention not to return to rural practice after graduation. The fact that it did not emerge in my present research (with the exception of one student) may reflect the relative “insider” status of the students in this small sample: two were returning to their rural town of origin while another two grew up in a rural context. The RUN project was designed to encourage students to go rural who without the financial aid might not have made a similar choice; the majority had not intended to practice in a rural setting after graduation, nor did they come with previous rural associations. What this finding suggests is an instrumental orientation on the part of preceptors, who saw the preceptorship as being more about the recruitment of rural nurses than as a valuable educational opportunity for nursing students from any background. Providing educational incentives for ‘outsider’ students to opt for a rural placement in the absence of financial support remains a challenge. Encouraging and supporting nurses to engage in rural preceptorships despite the potential for recruiting future employees’ warrants further attention by educators.

In general, the 2006 findings support my present research findings; however, they failed to draw out the nuances of rural practice and rural preceptorships. From my present perspective, important missing points include the concept of cultural dissonance, the complexity of confidentiality, the notion of the rural team as preceptor, the importance of continuity, and the growing reliance on technology to support nursing practice. The difference and depth of findings reflects my personal and professional growth in understanding rural nursing preceptorships, and illustrates how mindfulness in the analysis method expands what is noticed.

5.3. Limitations

This study was limited in a number of aspects, including my being an ‘insider’ researcher, the geographical scope of the study, its extension across time, and the size and representativeness of my participant group. Each of these limitations may have affected my findings in different ways.

- Researcher as part ‘insider’ left me with the possibility of being too familiar with the local nature of rural preceptored practice and the situation of the participants. This could have led either to some patterns in the data not being ‘seen’ as important, or to certain lines of questioning not being pursued. I sought to minimize my potential insider deafness by actively listening to the participants during the interview and seeking clarification even when I thought I understood something the participant said by rephrasing the comments or by asking for examples from the participants to help illustrate a point they were attempting to convey. I listened to each digital recording of the first interview to identify areas where I might not have a full sense of the participants’ perspective and prepared questions to ask during the second interview. I occasionally introduced an assumption I held about rural nursing practice to check out whether or not my assumption held true for that participant.
- The localness of the study, and my professional and educational connections with the participants as students and nurses, may have curbed what people would tell me in light of the ethic of confidentiality and the likelihood that we would remain acquaintances or possibly work together in the future. While I did not notice censorship by participants, I thought participants may have experienced less freedom, despite the promise of anonymity, to speak freely given the possibility that others might recognize their stories. The desire to maintain a particular public image and preserve close working relationships within a rural context may have encouraged a more deliberate disclosure rather than an uncensored exposé. Interestingly however, of the 10 invitations that went out to rural nurses beyond the local health area catchment, not one invitation was accepted. It would appear that my situatedness within the local health area was a benefit in terms of recruiting participants.
- The localness of the study also limited the generalizability of the results. In particular, the heterogenous nature of each rural community, its setting, population, environment, history, healthcare resources, and the people who live and work in these places makes replication of the findings in another rural context difficult. Additionally, the uniqueness of the Springfield preceptorship program justifies caution with respect to generalizing findings. Moreover, given this research is in the ethnographic tradition, restraint regarding generalization of findings and recommendations was imperative.
- Time limited this study in three ways. The recruitment of volunteer participants took 2 years; however, the findings of the research are not likely to have been

affected by the length of time for recruitment. Nonetheless, caution regarding recommendations is warranted given the potential for change in the nature of rural healthcare and nursing education over several years. Secondly, the lapse of up to 6 months between the experience of a rural preceptored practice and the interview process meant that some participants had difficulty recalling details of their experience; this was evident in their limited ability to share specific practice examples that might highlight a particular perspective. Third, in-depth transcript analysis did not occur until the last interview was transcribed; this limited the opportunity to discuss with participants some of my emerging themes such as continuity and cultural mediation.

- The limited sample size was dictated both by feasibility considerations, such as the difficulty of extended access to rural sites, and by contextual factors, such as the relative infrequency of practice placements within the local health area. The small sample size limited the confidence to generalize from my findings to make recommendations for rural practice-education in general. However, the fact that many of my findings agree well with observations from larger studies suggests that the picture I draw is certainly recognizable for scholars and practitioners; and some of the specific issues that emerged, such as confidentiality in rural settings, would be meaningful even if they proved not to arise in every context of rural practice.
- By relying on interviews, I was dependent on the participants' accurate representation of their experience in the field. Any factors which limited or biased their perspectives or their ways of expressing their understanding of the realities of the preceptorship experience would decrease the internal validity of the research. By opting not to include the participants in the interpretive phase of the research, I deprived myself of one useful way to control for internal validity. However, the fact that the various participants did not know each other and yet provided broadly congruent perspectives on the rural preceptorship process suggests that internal validity was nonetheless quite high. Going back to participants for a second interview was a useful step that strengthened the validity of the study.
- Another limitation of this inquiry is the exclusion of nurse educators. This lack of faculty representation in the study is a constraining factor, particularly for recommendations that have to do with faculty support of rural preceptorships. I opted not to include faculty in this study given the potential for me to be in a supervisory-subordinate relationship at the time of the research.

5.4. Towards Place-Based Practice: Reinventing Rural Undergraduate Practice-Education

My research helps to establish the vital importance of relationality in the process of becoming a rural nurse. Rather than a straightforward teacher-student or mentor-novice relationship, the reciprocity between preceptor and student is situated within a process of

cultural mediation in which relationships with the healthcare team, community members, and place itself all play important roles. In this sense, “it takes a village” to foster the situated, continuous, dynamic, and responsive understanding of nursing practice required in rural settings.

The central recommendation from this study, therefore, is that urban-based nursing education programs acknowledge the distinctive nature of rural hospital-based preceptorships, and improve the ways in which they support and foster this process of cultural mediation. So far in this chapter I have drawn attention to specific aspects or dimensions of the process that emerged as significant in my research. My concern in this section is to highlight implications for the design and delivery of undergraduate rural nursing practice-education by regional-rurally located colleges and universities in British Columbia and elsewhere. Because my study does not speak to all of the important contextual factors involved, the following section augments this discussion with a broader educational vision grounded in research and practice.

Rural nursing practice-education realizes particular educational value that arises from the integrated nature of rural healthcare delivery. In the *Gesellschaft*-dominated settings of healthcare, students have relatively few opportunities to establish meaningful relationships with patients or other healthcare staff, to observe or participate in specialized practices such as labour and delivery, or emergency care, or to interact with the wider community. To put it another way, multiple boundaries, both physical and symbolic, divides the social space in which students learn to practice nursing. In the *Gemeinschaft*-type settings of rural healthcare, many or most of these boundaries are weakened. This provides students with access to a wider range of experiences and relationships, with multiple consequences for the kind of practice learning that takes place. The opportunity to interact intimately with other providers for the collective purpose of patient care and community healthcare delivery fosters the student’s understanding of interprofessional

and interagency collaboration. In this differently structured environment, a function of place (density, time/continuity, resources/expertise), students come to the understanding the necessity of increasingly autonomous practice and the inevitability of professional reliance on both self and others.

The nature of rural place provides a foundation for a rural-practice education model that incorporates cultural mediation as a process between nurse and student, healthcare team and student, community and student, educator and student. This differs in significant respects from a practice-education model based on a single educational relationship between preceptor and preceptee. Continuity and reciprocity as a quality of rural relationships become essential components in the re-design of any rural practice-education model. Despite limited delineation of the notion of cultural mediation in this research, it is my contention that cultural mediation supports student preparation, entry into and success in rural hospital-based practice-education experiences. To that end, I recommend the re-envisioning of rural-undergraduate practice-education process and outcomes in order to reduce cultural dissonance and enhance the quality of student learning.

5.4.1. Doing Better at Pre-Practice Orientation

Maximizing the potential educational value of rural undergraduate practice-education begins with an orientation to common themes students might expect to encounter and pay attention to. This emphasis can be found in the literature, e.g. orientation “should include cognitive and psychological preparation, as well as the acquisition of common advanced clinical skills. Nurse educators must take on a pivotal role in assisting students to prepare comprehensively for the rural hospital experience” (Sedgwick & Yonge, 2008, p. 625). However,

rather than seeing this simply as a variation on urban practice-education, I propose a focus on the unique characteristics of the rural preceptorship.

Some of the important themes in such an orientation would include:

- continuity and dissonance;
- autonomy and reliance;
- living professional standards in a rural context (for example: confidentiality);
- social determinants of health in rural populations;
- rural health issues, diverse health concerns, resources/expertise, adapting to expect the unexpected;
- principles of interprofessional practice.

The diverse nature of landscapes, seasons, types of employment, and cultural history of people in rural places should become part of student preparation. Students could be actively involved in the examination of how the natural and economic surroundings shape the challenges of nursing care during a particular season. Several learning activities could enhance student opportunity to come to know the rural place more broadly, beyond the walls of the hospital. Examples of learning activities include a windshield survey (Russell & Hymans, 1999) that provides a broad overview of the physical surroundings and the rural community infrastructure; exploring population statistics and health related statistics to develop a community profile; exploring local libraries for written community histories with an emphasis on economics, cultural groups and health; attending local public events; focussed observations in public places; and engaging in purposeful conversation with identified community informants (Eide, Hahn, Bayne, Allen, & Swain, 2006). Development of common learning outcomes and performance standards specific to undergraduate students in a rural context that focuses on the key concepts outlined above, and learning outcomes outlined within this study and other research literature, is an essential step in orienting students to the experience and expectations.

5.4.2. Recognizing and Fostering Cultural Mediation

Relationship reciprocity is key to successful rural practice-education. When possible, appointed faculty and student(s) should make pre-practicum site visits to provide an opportunity for the student, preceptor and faculty to become acquainted, to discuss student and program goals, and to review preceptor responsibilities and strategies as a cultural mediator. If travel is not feasible, electronic or print correspondence may facilitate the development of relationships and diminish cultural dissonance. Student histories of practice-education, their perceptions of strengths and limitations and their practice-education goals can serve as letters of introduction for the student in advance of a rural practicum. The nurses practice and education history along with some general information about the healthcare agency and the rural community in general could serve as a way of introducing the student to both preceptor and the place.

Many opportunities exist to build relationships and innovate by adopting and adapting electronic connections to support student and preceptors in practice-education. Nurse educators should develop web-based interfaces to link students, nurses, and faculty (Neill & Taylor, 2002; Sedgwick, 2008; Zawaduk & Johansen, 2006), and engaging students in pedagogical content and processes such as orientations and student seminars (Liaw et al., 2005). Internet-based communication tools including, but not limited to, email, live voice, video and text connections such as Skype™ or web conferencing systems such as Webinar™ provide new opportunities to bring together students, educators, and preceptors from various places. In part, such connections ought to become another platform for urban-rural cultural exchange. Students can be assigned activities that advance their teaching skills while offering professional development opportunities for rural nurses. Regular practice-education placement reviews by students, preceptors, and rurally minded faculty that examines the suitability of the placement area, the

learning outcomes, the orientation process, the role of the preceptor and educator, the role of healthcare team members, and the benefits and the challenges would be another way to leverage the notion of information exchange to advance the professional development of students, nurses, and educators while continually developing the rural practice-education experience.

The cultural interpretation work of rural preceptors mediates the cultural dissonance experienced by students. Students benefit from preceptors who are particularly sensitive to the need to interpret their surroundings and the diverse responsibilities and actions of others in a rural context. For example, a preceptor might anticipate a student's need to be 'cued' to take on the responsibilities of allied health professionals and support staff in certain circumstances, and to coach them through these unfamiliar processes. In general, effective rural preceptor practices signal they are there to assist students as needed, to foster a sense of 'togetherness' and build a sense of interdependence.

Students ought to be assured that the experience of diverse clinical opportunities will provide them with transferable knowledge to other clinical situations and places, in addition to providing a foundation upon which to enter rural practice. Students and preceptors must also acknowledge that there will be some responsibilities with which the student may not be able to take on, given the broad scope of rural practice. Recognizing and supporting students through new clinical experiences, particularly those that are unpredictable and of an emergent nature, is an essential part of cultural mediation provided by preceptors and healthcare team members alike.

Reconciling professional ethics with rural norms is a common challenge for nurses and for insider students. Story-telling of confidentiality issues and how individual nurses resolve intrapersonal and professional conflict facilitates a community of practice learning. Rural preceptors have rich personal and professional examples of how confidentiality is promoted in a

rural hospital and the community, and should be encouraged to share these perspectives with students. Educational faculty, particularly when they are urban-based, need professional development to understand how to maintain *Gemeinschaft*-like relationships and foster trust in rural communities. Only armed with this knowledge can they support preceptors and students when they encounter boundary-related ethical conflict.

In rural practice-education experiences the team should be acknowledged for their contributions. Normally a preceptor will receive a form of recognition (letter, certificate, honorarium, etc). However, in a rural context this recognition should be extended to the healthcare team, particularly where the team contributes substantially to culturally mediating the practice-education experience by welcoming and engaging students in various unplanned learning activities. Team members that were particularly helpful to the student should be identified and acknowledged. Students are to be encouraged to recognize and thank the preceptor and others who contributed to their learning. Such appreciation fosters *Gemeinschaft*-like relationships, not only among the individuals involved, but also among the institutions they represent.

In order to develop contextually and culturally relevant performance expectations of undergraduate students and preceptors, various forms of documentation and learning activities may need to be reinvented or revised. Examples of such learning activity documents include student and preceptor orientation manuals, student pre-rural practice-education self-assessments, and rural nurse self-assessments as cultural mediators. Redesigning practice performance assessment tools to address the unique nature of a rural hospital and/or community practice is essential since a standardized generic instrument can fail to capture the salient, different, and often-nuanced aspects of rural place and practice (Zawaduk & Johansen, 2006).

5.4.3. Engaging Students with Community

Activities that engage students in examining the meaning of continuity in rural practice stand to foster greater appreciation of the *Gemeinschaft* nature of rural community. This requires time for immersion in rural nursing practice and the community-at-large. Understanding of the integrated nature of rural health is enhanced by learning activities that engage students in exploring the culture of the community, the uniqueness of place, and the ways in which the qualities of the place and social determinants of health influence rural nursing hospital practice (Bushy & Leipert, 2005; McDonough et al., 1992; Sedgwick & Yonge, 2008).

Notwithstanding the value of hospital-based experience, rural practice-education ought to include community engagement to varying degrees, depending on the practicum goals, in order to foster greater knowledge and skills in the areas of population health and rural healthcare delivery. Such engagement would also promote understanding of the degree to which community-based and hospital-based systems link in a rural context, and how health is linked to the general welfare of society. “With their knowledge of community as well as institutional nursing, they will be able to draw upon the skills of both groups to bring the two areas of nursing into continuity of care for patients” (Fuszard, 1991, p. 402).

Where Aboriginal populations or diverse ethnic groups are present, it is important to locate forms of cultural mediation, or specific individuals willing to act as cultural guides, to facilitate culturally safe student engagement with unique populations.

5.4.4. Building Educational Continuity

The measures already proposed—better orientation, support for cultural mediation, and building of community relationships—can all be seen as contributing to the continuity of the

educational experience for students. Continuity needs however to be enacted at the institutional level as well. This suggests, for instance, maintaining consistency with faculty who oversee rural placements in order to develop meaningful relationships with the rural community of practice. It also reinforces the ongoing importance of the preceptor, as a named nurse students can go to for assistance in times of uncertainty, taking into account the uniqueness and unpredictability of the practice environment and the possibility that practice standard documents may not be readily accessible in a timely fashion.

The nurse educator in this research emerged as disengaged. Nurse educators ought to take a much more active role in supporting these rural relationships, not only between the student, the preceptor and healthcare team, but also between healthcare agency personnel and the university; and not only with respect to practice-education, but also on other mutually beneficial projects. Academic leaders need to continue to focus on regionally relevant initiatives to expand the capacity for rural practice-education, using the principles outlined by RAHP (see previous discussion). These include principles of community participation; partnerships among health authorities, educational institutions, and rural communities; practices to incorporate the community as teacher; and the notion of community reciprocity.

One model along these lines is the University of New Hampshire Clinical Home Community approach to practice-education, which was designed to support student practice across community specific healthcare agencies and foster student contributions to the health of the community (Williams-Barnard, Sweatt, Harkness, & DiNapoli, 2004). This model entails learning about and engaging in health promotion, disease prevention, and secondary and tertiary healthcare for people across the life span. Educational institutions in Canada should design, pilot, and implement models similar in approach and intent in order to build upon and expand

the benefits of rural practice-education beyond those achieved through a traditional preceptorship model. Such a model would include one or two faculty members committed to the ongoing development of a relationship with selected rural communities in order to facilitate continuity, relationship building, and reciprocity. In such a model, the nurse educator for the particular rural region could act as the faculty-of-record for nursing students from their academic institution as well as for students from other nursing programs throughout the province.

A blend of clinical home communities and regional coordination offers the potential to promote educator engagement in community or service scholarship and to build a community of practice learning. In such a model, several healthcare providers would agree to become the rural community home team, with an appointed nurse leader (or cultural guide). Student learning experiences would be supported across various rural healthcare sites in the same community, such as hospital, public health, home care, and long-term care. Participatory action research (Whyte, 1989) is well suited to inform the development, implementation, and evaluation of such a rural practice-education model.

5.4.5. Rural Practice-Education Research Recommendations

Further focused exploration of rural practice-education relationships through a cultural lens is recommended to develop new insights into the long-standing preceptorship educational model. Investigation is needed into when and how rural nurses and healthcare team members act as cultural mediators and what, if any, difference do certain cultural immersion and coaching strategies make for student learning and the uptake of rural practice norms. In particular, it would be valuable to know what preceptor, educator, and student practices reduce cultural dissonance and support professional development in rural settings. Such research would build on the scholarship of Mills et al. (2007), Sedgwick and Yonge (2008) and my own.

Various questions around motivation and recruitment need clarification. How, if at all, are students treated differently if their motivation for going rural is simply professional development rather than potential employment? What, if anything, does a preceptor or healthcare team members do differently after a student declares their career intentions? What could be the content and outcomes of a promotional campaign highlighting the educational value of rural preceptorships for students and rural nurses? What is the (potential) value of rural practice-education experiences for nurse educators, other healthcare team members, and rural healthcare administrators?

Further research is warranted on how time in place influences student learning in rural practice-education, as well as students' potential commitment to a rural place and eventual rural employment. Denz-Penhey, Shannon, Murdoch, and Newbury (2005), in a study of medical students in rural clinical schools, concluded that students who were based in one rotation for extended periods, such as 6 weeks or more, developed a sense of connection and contribution to the healthcare team and made more meaningful social associations outside their role as a student. An extended period within the context of a rural community is more likely to foster meaningful connections between the student and the community, particularly if learning activities were designed with that purpose in mind. While a short practicum experience might be less costly financially to a student, it may be more costly to the rural healthcare providers and community members to host an increased number of student 'tourists'. Whether or not any development of rural citizenship, or caring about the community-at-large, would result from a lengthy practice-education experience is not clear. As identified by Van Hofwegen et al. (2005), exploring strategies to foster and maintain student commitment to the rural community-at-large is an area for future research.

A better understanding is needed of how social and professional relationships and norms influence healthcare provision in a rural context. Significant issues include the different experiences of insider or outsider students, and possible best practices of maintaining the professional standard of confidentiality in a rural context. In my research, the closeness of relationships among a rural professional community was characterized primarily as positive, particularly in relation to continuity. However, Nelson, Pomerantz, Howard, and Bushy (2007), in a literature review of rural healthcare ethics, identify overlapping relationships as problematic due to confidentiality issues and boundary related ethical conflicts. They call for further research on how regional differences influence healthcare delivery decisions, on the development and outcomes of rural-relevant ethics committees, and on education/training in rural healthcare ethics for practitioners and policy-makers (Nelson et al., 2007). Likewise, Scopelliti et al. (2004) also call for more research on how the social norms of rural relationships and professional norms influence the provision of rural healthcare.

The way in which nurse educators and practice leaders draw on the notions of *Gemeinschaft* as a lens to examine issues of health and healthcare delivery is a larger question. For example, Braithwaite and Westbrook (2009) indicate that “the challenge is to establish how naturally occurring interactions at work—between friends, respected colleagues or multidisciplinary clinical communities—have measurable influences on staff wellbeing, health care delivery and patient outcomes” (p. 1). Increased understanding about how relational continuity and intertwining of professional and social relationships influence rural healthcare delivery would serve as knowledge to prepare students for rural practice.

Rural nurses’ use of networks, including information communication technology, to support clinical decision-making and rural practice is another promising area for future research.

Such research could inform the way in which healthcare students reconceptualise knowledge development and clinical decision-making in a practice context.

The disconcerting quietness concerning Aboriginal health within my research findings, in combination with the extremely limited Canadian research regarding Aboriginal health and student learning particularly in the rural hospital context, suggests a need for more research into rural nursing practice through an indigenous lens. Tarlier, Browne, and Johnson (2007) highlight the need for such research, particularly as it relates to how nurses become aware of ‘othering’ practices and how to overcome these behaviours so as to promote Aboriginal access to healthcare. Research facilitating the understanding of Aboriginal healthcare experiences within rural hospitals should be guided by Aboriginal leadership, interests, and values and be consistent with Aboriginal knowledge development and transformation.

A final set of issues concerns the changing demographics of the healthcare team and their impact on future rural preceptorship experiences. It is possible that the student experience of a being a close member of the rural healthcare team might differ significantly when physicians and nurses who serve rural communities do so only on an irregular basis. Loss of continuity may become the norm for rural nursing, should recruitment and retention efforts meet with marginal success. Fragmentation of healthcare delivery by temporary providers will undermine the benefits to both education and healthcare delivery and will create conditions that require alternative and complementary practice-education models to the present preceptorship model. The educational value of relational continuity in rural contexts is an area that warrants further investigation, particularly if new policies and practices can be identified that promote both the health of rural residents and the effectiveness of rural practice-education.

5.5. An Educational Vision

The following recommendations are not limited to the findings of this study, but extend and contextualize them in the light of personal perspectives and insights from other scholars. These recommendations move beyond the specific educational concerns of the last section to address provincial and national infrastructures that would generally support rural undergraduate practice-education. The fields of education, policy, and research are considered interrelated, particularly when viewed from a perspective of engaged community scholarship wherein the nurse educator role moves beyond direct responsibilities to the student to include obligations to the practice communities and the patients they serve, to knowledge development and communication, and to the professional community at large.

5.5.1. Academic-Practice Reciprocity

Academic institutions need to assume a more consistent leadership role in the development or enhancement of rural practice-education innovations. To that end, engagement between the rural professional community, the community-at-large, and educator-researcher is a desirable goal. This places rural nursing scholarship squarely within the scholarship of engagement:

Scholarship of engagement addresses critical community concerns, uses the expertise and insights of scholarship to help solve pressing public problems, and contributes to the public good. It does so in a true collaboration with community partners who help define the problem, develop plans to address it, and play an important role in assessment. These collaborations are two-way streets in which University-based scholars and community partners contribute equally—if in different ways—to the project and learn from one another. (Bowling Green State University, 2005, p. 3)

In this context, nursing program practice-education scholarship needs to move beyond conceiving of the ‘healthcare site’ as simply a clinical site for student learning. In its place, a

perspective is needed that resembles the one developed here, which emphasizes the existence of a complex community of practice extending beyond the hospital site itself, in which reciprocity is a central principle. Nurse educator-researchers and their affiliated educational institutions could provide rural healthcare agencies with many kinds of service as part of their scholarship, including but not limited to:

- Enhanced continuing education offerings accessible to rural nurses and other rural healthcare providers through either face-to-face on site delivery or electronic media;
- A regional academic course fee waiver system for rural nurses who volunteer to be preceptors and provide accommodation for students;
- Enhanced access to faculty and university resources such as regional university library services, including partnerships that promote practitioner skill at using library resources such as exploring peer reviewed literature to inform best practices for a rural context;
- Joint research between faculty, students and nurses or rural healthcare providers.

Creating opportunities for engagement between the university and the rural healthcare community is imperative. In institutions that for geographical or philosophical reasons have rural student placements regularly, a complement of faculty should be cultivated whose scholarship focuses on rural health, nursing, or education. Additionally, endorsement of the scholarship of engagement by academic leaders, its recognition in institutional tenure and promotion processes, and financial support of various kinds might encourage faculty to focus on rural practice-education.

5.5.2. Accessibility

Rural undergraduate preceptorships are under-utilized, in part, because of misperceptions of the value and appropriateness of a rural practice-education experience, in conjunction with the instrumental challenges of housing, finances, travel, and social or family

obligations. Helping all nursing program students to improve their understanding of rural nursing is an important educational goal in order to meet nursing's societal obligations. Strategies to increase student exposure to rural theory and practice and foster interest, understanding, and skills in rural nursing should be encouraged throughout nursing programs, from entry-level to senior students. An early and integrated curriculum strategy may encourage senior students to opt for a rural immersion experience. While a practice experience may not be feasible for all nursing students, exposure to rural nursing concepts and practice, and to clinical decision-making from a rural nursing perspective and context, is desirable and increasingly feasible with simulated learning environments. The complexity of rural nursing practice and the diversity of care situations encountered in a rural context suggests that students should be provided with diverse educational experiences in conventional yet increasingly specialized contexts, in order to have a broad foundation upon which to draw while in a rural practice-education context.

Notwithstanding the valuable learning associated with teams of multidisciplinary healthcare students entering rural practice as a group, the need to have timely and relevant practice options for nursing or health students who are unable to access limited-entry placement initiatives cannot be overstated. Finding a balance of specialized programs for a few and universally accessible opportunities for the many is essential. Development of positive rural regional practice-education relationships with the goal of public service serves both rural healthcare delivery and practice-education. If nothing else, access to education about rural practice may augment the sensitivities of all healthcare providers and promote policy development that recognizes rural as a unique practice context and rural healthcare as a vital component of healthcare in Canada.

Another model of access is provided by the RNCP, a provincial program that drew together healthcare professionals and academic expertise across BC “to address the challenges of delivering practice-driven curriculum via e-learning modes and practical experiences to RNs in rural communities” (MacLeod, John, et al., 2008, p. 1). This provincial interagency collaboration stands as an example of engaged scholarship that promotes stakeholder understanding of the realities of rural practice. Not only did the program provide academic credit, it built upon the practice knowledge and educational needs identified by rural practice communities. Such inclusiveness serves to strengthen the practice-academic relationships that support the implementation of rural nursing programs while advancing the knowledge and skills of practicing rural nurses and nurse educators. While this program was conceived for RNs working in rural acute-care contexts, the same model of engagement for curriculum development and evaluation could support the alignment of education and practice expectations for rural undergraduate nursing students. The recommendations emerging from this study are an example of this kind of scholarship.

I strongly support Kenny and Duckett’s (2003) recommendation that “universities, particularly those located in regional areas, need to refocus to ensure that they are preparing graduates to meet the needs of rural hospitals and the communities that they serve” (pp. 619-620). At present in BC, undergraduate or entry-level student options for courses focusing on the nature of rural practice are limited to traditional subject courses, such perinatal and emergency nursing skills and knowledge. I recommend that the an introduction to the complexities of rural practice, beyond subject specific content and some core rural nursing theory, be integrated into the undergraduate program. Rural concepts that traverse traditional subjects should be available to undergraduate nursing students in the form of an elective course (Reimer & Mills, 1988), if not integrated into a regional curriculum which students take to advance their practice (Baird-

Crooks et al., 1998). Unlike Orpin and Gabriel (2005) who contend that rural courses tend to dissuade students from opting for a rural practice experience, I recommend both an elective course of study regarding concepts and practices relevant to rural nursing, and the implementation of policies that promote student orientation to culture and place of rural practice before they begin a placement (Killam & Carter, 2010).

Nurse leaders in both educational and practice settings need to begin to examine innovative ways to scaffold rural education at the undergraduate level into rural practice at the novice level and throughout the career development of a rural nurse. The present patchwork approach, based on individual learners' financial capacity and interest in returning to education to advance their careers, is not one that works well within a rural context, nor does it serve rural healthcare delivery. Learning through experience, while valuable, can be strengthened through supplemental (if intermittent) opportunities to reflect on and expand thinking about rural nursing care delivery. Short of the time and financial commitments of a master's degree, nurses should have the opportunity to obtain continuing, rural relevant education that goes beyond managing diverse patient care situations in hospital to include creating relationships with community and fostering the ability to practice in several settings within a rural context (emergency, perinatal, home care).

Like Nelson et al. (2007), I recommend the development of a senior level interprofessional undergraduate rural healthcare ethics course for healthcare students, professionals and administrators. The course ought to be designed to encourage conversations across professions, and connections and interactions with expert rural practitioners using emerging rural accessible technologies. Additionally, the development of an interprofessional course for undergraduate health students focused on rural health and practice is recommended

(Medves et al., 2008). Designed to bring interested students from various disciplines and institutions together, this course could be interprovincial in scope, at least in the initial stages, to gauge interest, transferability, and need or capacity for expansion.

A similar approach might also be useful in an interdisciplinary Aboriginal rural health course created and delivered by rural Aboriginal people. Even without such a course, however, the concept of cultural safety in healthcare practice, in or out of hospital, should be a primary consideration when designing rural educational theory or practice courses. Developing such an understanding is one of the potential benefits of a rural practice experience in BC (McAllister et al., 1998).

These various possibilities should be integrated within provincial and national frameworks outlining levelled theory and competencies for undergraduate, post-diploma and graduate degree prepared nurses. Such frameworks would help advance rural nursing practice, education, and research in a coordinated fashion that leverages the expertise of educators and practitioners while improving access to rural nursing education to serve the long-term needs of health and human resource development. A framework of levelled core knowledge and skills would provide a template for curriculum development that enables recognition and transfer of studies to certificates, diplomas, and degrees.

To enhance individual student access to rural practice-education, funding sources are required to support student travel and accommodation. It is commonly understood that financial barriers prevent students from opting for a rural practice-education experience, and experiments with student stipends have been encouraging (MacRae et al., 2007; Zawaduk & Johansen, 2006). “Students emphasised that the type and amount of funding for accommodation and transportation during clinical placements strongly influenced their willingness to participate in

these [rural practice-education] opportunities” (MacRae et al., 2007, pp. 25-26). The Ministries responsible for education and practice need to devise an equitable distribution of funds that accounts for cost differences between urban and rural practice-education. Such differential funding ought to be earmarked to reduce individual student costs, to build in student incentives to opt for rural practice-education, and to support rural faculty scholarship of engagement.

The way in which rural practice-placements are implemented throughout the province needs closer examination by all relevant stakeholders to further enhance the capacity for rural practice-education. I recommend the establishment of a platform for regional coordination of placements for all provincial health students, along with stakeholder commitment to an investment in regional infrastructures to sustain rural practice-education (Lyle et al., 2006). Such a system would build on the strengths of local faculty, build or extend networks across institutions providing professional education for health providers, and provide new opportunities for enhanced education and service delivery at both regional and provincial levels.

5.5.3. Advocacy and Recognition

Nurse leaders must be prepared to lobby politicians, health and education ministry staff, and post-secondary education administrators, both to inform them about the importance of rural nursing education and its implications for the delivery of healthcare in rural communities, and to communicate the significance of the scholarship of engagement involving healthcare programs and rural communities. The differences between urban nursing education and rural nursing education must be clarified for non-nurses in order to justify additional funding to support rural practice-education, particularly for those students living and going to school in a rural region. Relevant governing bodies should be advised of the inadequacy of present standardized funding formulas, and presented with proposals for new sustainable funding

formulas to support rural practice-education (Kulig et al., 2003). Nurse leaders also need to explore the availability of governmental and non-governmental funds, particular those in rural regions, for expanded rural bursaries and scholarships.

Regardless of additional funding to promote student access, faculty must convey the value of rural practice education to a wider audience of students and nurses. Providing students with information about the qualities and outcomes of rural practice-education is a beginning. Among the qualities to be emphasized are the fact that rural sites allow for a broader range of learning opportunities than those bound to a particular unit, as is typical in urban hospital-based practice-education; that rural placements serve rural population health and allow students to focus on regional or rural health needs by coming to understand the unique geographic, demographic, cultural, and socio-economics of a rural community; and that rural places offer a rich resource for learning nursing as a holistic human endeavour.

I recommend that rural nurses and leaders raise the public and nursing profile of rural nurses by creating a Canadian Nurses Association (CNA) Certificate Program that recognizes the core knowledge and skills of rural nurses. There are 19 certificates achievable through CNA (2010), all of which focus primarily on the traditional expertise required for one area of urban nursing practice (e.g. medical-surgical nursing, neuroscience nursing, critical care nursing, and perinatal nursing).

Finally, nurse leaders should revise nursing education program accreditation and regulation processes to incorporate a focus on rural and regional population health when reviewing nursing programs geographically situated to serve rural communities. Actions to counteract homogenization and urbancentric development of programs and encourage responsiveness to local needs are important to promote rural healthcare delivery and rural

practice-education. I further recommend that any review of a regional university for purposes of accreditation explore the degree to which the scholarship of community engagement is enacted, particularly in relation to rural communities and nursing practice.

5.6. Conclusion

The intent of this study was to explore and describe the nature and educational value of the hospital-based rural preceptorship experience for nurses and students. The findings of the study indicate that the nature of the experience is complex, reflecting the uniqueness of the rural culture and the particular formative qualities of rural as a place of healthcare practice. A culture of rural nursing practice embedded in relationship was evident, both within the rural context and across rural-urban interfaces. Particular cultural tensions that became evident in this study included living the professional ethic of confidentiality, the autonomy and interdependence of rural nurses, and how relational continuity supported learning and patient care delivery in a rural context.

There was educational value for students, preceptors, and healthcare team members. The educational value for students lies primarily in the development of student understanding of the dynamic nature of rural healthcare delivery, its embeddedness in place and community, and the advancement of their skills towards professional nursing practice. Vital aspects of this educational value consisted in students coming to understand the exceptionality and nuances of rural nursing practice, over and beyond the commonly identified learning outcomes (learning to expect and prepare for the unexpected; technical skill development; and advancement of clinical decision-making). It is postulated that this increased understanding of rural practice may serve rural healthcare delivery over time.

For nurses there is professional educational value in acting as a preceptor. The process contributed to their continuing professional development through reciprocal information exchange with students, enabling them both to better articulate and understand their own practice and to gain access to current developments in nursing education. The process of student learning from both preceptors and healthcare team members was valuable, particularly in terms of culturally mediating urban-academic norms and rural norms, and is consistent with the concept of a community of practice.

Place qualities such as density-sparseness, time, economics, human and technical resources, ethnicity, and local health issues emerged as salient in structuring rural practice and student experience. In general, these structuring elements allowed for both diverse learning opportunities and a practice pace that enhanced learning. Students came to understand rural healthcare delivery from a day-to-day nursing perspective and gained insights into the intersectoral and interprofessional nature of rural healthcare delivery through regular interactions with various professionals both in and out of the hospital.

The notion of cultural mediation as central to the preceptorship experience encompasses both the processes that preceptors engage in to reduce dissonance and promote student learning, and the influence of the rural healthcare team on the student's sense of feeling welcomed and valued. Relationships with community members were more significant for students who had previously resided in the rural community; they also posed particular challenges to the maintaining of professional norms of confidentiality. Relationships between educators and students or preceptors seemed inconsequential, and an important focal area for improvement in the preceptorship experience.

This inquiry affirms the substantial educational value of rural preceptorship practice-education. It is the nature of rural nursing that makes this form of educational experience uniquely valuable. This study shows how the size of a community, its physical location, its human and technical resources, and its inhabitants' experience of health, in combination with the relational closeness of professionals and community members, coalesce to create a particular kind of healthcare context in which continuity (or *Gemeinschaft*-type relationality) is an important and widely shared value. Such a setting also entails characteristic challenges, such as conflicts between social and professional norms, exposure to complex or infrequent healthcare challenges, and the building of relationships inside and outside the practice setting. Although the preceptorship model is well established as an effective approach to practice-education, the facilitation of student learning through cultural mediation by nurses, educators, students, team members, and residents/patients is a relatively unexplored and potentially valuable educational lens and process from which to examine and improve this important facet of nurse professional development.

The evolving landscape of healthcare delivery in Canada challenges scholars to explore strategies that assist in sustaining and improving rural healthcare practices for quality patient outcomes. I contend that the rural preceptorship experience is valuable for undergraduate nurses, and that it can continue to play an important role in rural healthcare education. In important ways, however, the present common conceptualization of the rural preceptorship as a triadic relationship among student, nurse, and educator does not maximize its educational potential. This study points to the need for a scholarship of engagement, developed and supported in post-secondary institutions with a rural education mandate, that fosters practice-education relationships going far beyond the traditional triad to encompass the rural team, the local community, and networks of rural practice and scholarship. This approach will best

support rural healthcare delivery, rural practice-education, and rural knowledge development in the long term.

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Appendices

Appendix A. Simon Fraser University Ethics Letter of Approval


OFFICE OF
RESEARCH ETHICS

June 11, 2007

street address
Simon Fraser University
Multi-Tenant Facility
Room 230, 8900 Nelson Way
Burnaby, B.C. Canada
V5A 4W9

Ms. Cheryl Zawaduk
Graduate Student
Faculty of Education
Simon Fraser University

mailing address
8888 University Drive
Multi-Tenant Facility
Burnaby, B.C. Canada
V4A 1S6

Dear Ms. Zawaduk:

Re: Rural Nursing Preceptorship Experience - Appl. #: 37350

I am pleased to inform you that the above referenced Request for Ethical Approval of Research has been approved on behalf of the Research Ethics Board. This approval is in effect until the end date June 8, 2010, or only during the period in which you are a registered SFU student. This approval is contingent on approval from:

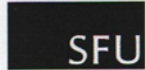
1. Thompson Rivers University, including the written consent form shown in your application.
2. Interior Health Authority, including the written consent form shown in your application.

Please forward a copy of the consent documents from 1 and 2 above to the Office of Research Ethics before the study begins.

The Office of Research Ethics must be notified of any changes in the approved protocol. Request for amendments to the protocol may be requested by email to dore@sfu.ca. In all correspondence relating to this application, please reference the application number shown on this letter and all email.

Your application has been categorized as "minimal risk" and approved by the Director, Office of Research Ethics, on behalf of the Research Ethics Board in accordance with University policy R20.01, <http://www.sfu.ca/policies/research/r20-01.htm>. The Board reviews and may amend decisions or subsequent amendments made independently by the Director, Chair or Deputy Chair at its regular monthly meetings.

SIMON FRASER UNIVERSITY THINKING OF THE WORLD



OFFICE OF
RESEARCH ETHICS

Page 2

“Minimal risk” occurs when potential participants can reasonably be expected to regard the probability and magnitude of possible harms incurred by participating in the research to be no greater than those encountered by the participant in those aspects of his or her everyday life that relate to the research.

Please note that it is the responsibility of the researcher, or the responsibility of the Student Supervisor if the researcher is a graduate student or undergraduate student, to maintain written or other forms of documented consent for a period of 1 year after the research has been completed.

If there is an adverse event, the principal investigator must notify the Office of Research Ethics within five (5) days. An Adverse Events form is available electronically by contacting dore@sfu.ca.

Please continue to check your SFU email address for notices from the Office of Research Ethics regarding this ethics application.

Best wishes for success in this research.

Sincerely,


Identity Protection

Dr. Hal Weinberg, Director
Office of Research Ethics

c: Dr. Mark Fettes, Supervisor

/jmy

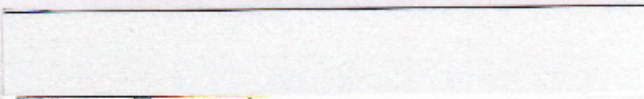
Appendix B. Thompson Rivers University Ethics Committee Certificate



THOMPSON RIVERS UNIVERSITY

Research Ethics - Human Subjects Committee

Certificate of Approval

PRINCIPAL INVESTIGATOR Cheryl Zawaduk	DEPARTMENT Nursing	NUMBER 2006-0747
INSTITUTIONS WHERE RESEARCH WILL BE CARRIED OUT TRU Rural Communities within the Interior Health Authority, British Columbia, Canada and in Kelowna British Columbia at the Thompson Rivers University or any other meeting place the participant and researcher mutually agree upon. The research interviews will be arranged at a time and place that is convenient, comfortable and serves to protect participant privacy.		
(X) INVESTIGATOR(S) None		
SIGNING AGENCIES None		
TITLE Rural Nursing Preceptorship Experience		
APPROVAL DATE October 12, 2007	TERM 1 Year	AMENDED
SUBSEQUENT CERTIFICATES ISSUED n/a	TERM N/A	AMENDED n/a
<p>CERTIFICATION</p> <p>The protocol describing the above named project has been reviewed by the Committee and experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.</p> <div style="text-align: center; margin: 20px 0;">  <p>Robin Tapley Chair, Research Ethics - Human Subjects Committee</p> </div> <p>This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.</p>		

Appendix C. Interior Health Authority Research Ethics Committee Certificate of Approval



Interior Health

Research Office
Research Ethics Board
Suite 104 - 1815 Kirschner Road
Kelowna, B.C., V1Y 4N7

Certificate of Research Ethics Board Delegated Approval

Principal Investigator: Cheryl Zawaduk	Institution of Primary Association Simon Fraser University	IH Research File Identifier 2007-029
Research Study Title: Rural Nursing Preceptorship Experiences		
IH Sponsor Tom Fulton	Co-Investigators None	
Sponsoring/Funding Agencies None	IH Departments Involved in Research Study Registered Nurses in TCS HSA	
Documentation received and reviewed IH REB Application Research Proposal April 2006 Letter of invitation: Rural Nurse Preceptor (version 2: Oct 8/07) Letter of invitation: Rural Student (version 2, Oct 8/07) Interview guide: Preceptor (version 2: Oct 8/07) Interview guide: Preceptee (version 2: Oct 8/07) Rural Research RSVP (v: Oct 8, 2007) Informed consent: (version 2, Oct 8/07) SFU request for ethical approval of research IRU request for ethical review		Certificate of Approval from Primary REB Simon Fraser University June 11, 2007
Certification It is the assessment of IH that this research study poses minimal risk to human subjects and therefore qualifies for delegated review. This Certificate of Approval is valid for the term specified below provided there are no changes in the experimental procedures. <i>The Interior Health Research Ethics Board is in compliance with the ethical principles presented in the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans</i>		
Conditions for Approval It is the responsibility of the principal investigator to inform the IH Research Office if the assessment is deemed at any time to be greater than minimal risk for human subjects. It is the responsibility of the principal investigator to inform the IH Research Office if there are changes to consents or other materials used with human subjects – these must be submitted to the IH Research Office for review and approval prior to implementation.		
Approval Date Oct 12, 2007	Approval Term 1 year	
Reporting Requirements: Investigators must provide the Research Office with a Notice of Closure of the study and a final report.		
Principal Investigator Signature B. Ann Ferguson, Chair, Interior Health Research Ethics Board		Date Oct 12, 2007

Appendix D. Participant (Nurse) Invitation



Thompson Rivers University



Simon Fraser University

Dear Rural Nurse Preceptor,

Rural Nursing Preceptored Experience: Research Participant Request

This letter is sent to request your participation in a research study. I, Cheryl Zawaduk, am a Thompson Rivers University (TRU) faculty member in the School of Nursing and a doctoral student at Simon Fraser University (SFU). This letter was sent to you through the TRU Clinical Placement Coordinator who was been briefed on the nature of the inquiry and has knowledge of nurses and student nurses who have agreed to a rural preceptorship experience.

It is my interest, based on previous faculty experience with preceptorships in both rural and urban settings, to come to a greater understanding of the experience of nurses and students engaged in preceptorships situated in rural hospital contexts. The question focusing this inquiry is **“What is the nature and educational value of the rural preceptorship experience for nurses and students?”** Few research studies in Canadian literature report on the experiences of nurses and student nurses in a rural hospital settings. Most preceptorship studies reflect the urban experience. The research is being pursued to fulfil part of the requirements for the Simon Fraser University EdD (Education Doctorate) program and is designed to contribute to nursing knowledge concerning cultural contexts of practice, the influence of place and relationships on undergraduate practice-education and expand understanding of diversity as it experienced in rural nursing practice.

Involvement in this rural research endeavor requires you to:

- Be (or have been) a preceptor for a third or fourth year nursing student within the last 6 months in an Interior Health Authority hospital rural practice setting for a minimum of 100 hours.
- Complete and return the enclosed notification of interest form in the researcher-addressed stamped envelope or contact me at the following phone number [REDACTED] or email [REDACTED] in lieu of this notification process or to ask me questions about the research within 2 weeks of reading this letter.
- Consent to participate in two semi-structured interview sessions of approximately 2 hours each, first in a face-to-face conversation and subsequently through a telephone conversation. A mutually agreeable time and place for these conversations will be arranged to protect participant privacy.
- Consent to review for approximately 1 hour individual transcripts of their taped interviews and return to researcher.

Your decision to participate in this inquiry is voluntary and confidential. I will not disclose your participation decision and am committed to efforts to maintain confidentiality. Nursing students with rural nursing preceptorship experience will also be sent an invitation requesting participation and I will not disclose

their participation decision. Please note there is no intention of ensuring that pairs of rural nurse preceptors and student preceptees are included in this study. Your participation in this study is **not** contingent on student (preceptee) participation in the study and vice versa. The nursing student you preceptor(ed) will **not** be apprised of your decision to act as a research participant unless you choose to inform him or her. Interview tapes, transcripts and researcher notes will be kept in a locking filing cabinet and in a password protected electronic file. Only myself will have access to the research data and the electronic files will be destroyed by e-shredder and paper files destroyed by paper shredder by May 2010. Should you agree to be a study participant and subsequently decide not to continue this decision would remain confidential and without prejudice so as to maintain the integrity of your current and future relationship with Thompson Rivers University. You can discontinue your participation at any time during the study. Should information about your decision to participate or the contents of your interview given in confidence be divulged in a manner inconsistent with the purpose, process and products of research you have the right to counsel/advice.

If you require more information about your rights as a research participant, about researcher responsibility or you have any concerns, complaints or questions about the manner in which you are treated in this study you may contact the Simon Fraser University Office of Research Ethics Director H. Weinberg via email (██████████) or phone 604-268-6593, the TRU Research Ethics Committee Chair (R. Tapley @ 250-828-5495 or 250-828-5000), the Chair of Interior Health Research Ethics Board at 250-870-4649, the TRU School of Nursing Dean (S. Duncan @ 250-828-5476), the Chief Nursing Officer of the Interior Health Authority (T. Fulton @ 250-870-4740). Please note that this study has research ethics approval from Simon Fraser University, Thompson Rivers University and the Interior Health Authority. Dr. Mark. Fettes is the doctoral dissertation supervisor and any concerns about this research can also be discussed with Dr. Fettes by calling 604-291-4489. You will be advised about how to get a copy of the dissertation once filed with S.F.U. graduate studies.

You are advised that, given the nature of rural research and the likelihood that only one nurse and one student will be interviewed from several different rural settings, their comments made in the research interviews may be thought as recognizable to others in the research products (dissertation, publications, and presentations). Your name will not be used in the research products to protect the privacy of students, nurse preceptors and any other identities revealed in the research processes. It is likely that direct quotations of your interview will be used in the research products therefore attention will be given to writing in a manner that your and your specific circumstances are unlikely to be recognized and associated with the text.

I thank you, in advance, for your considered response to this request to share your time and perspectives in order to promote greater understanding of the nature and value of rural preceptorships.

Best Regards,
Cheryl Zawaduk, R.N., M.S., Ed.D. (Cand.)
Assistant Professor
Thompson Rivers University
P.O. Box 3010
Kamloops, B.C. V2C 3B5

Appendix E. Participant (Student) Invitation



Thompson Rivers University



Simon Fraser University

Dear TRU Nursing Student.

Rural Nursing Preceptored Experience: Research Participant Request

This letter is sent to request your participation in a research study. I, Cheryl Zawaduk, am a Thompson Rivers University (TRU) faculty member in the School of Nursing and a doctoral student at Simon Fraser University (SFU). This letter was sent to you through the TRU Clinical Placement Coordinator who was been briefed on the nature of the inquiry and has knowledge of nurses and student nurses who have agreed to a rural preceptorship experience.

It is my interest, based on previous faculty experience with preceptorships in both rural and urban settings, to come to a greater understanding of the experience of nurses and students engaged in preceptorships situated in rural acute care hospital contexts. The question focusing this inquiry is **“What is the nature and educational value of the rural preceptorship experience for nurses and students?”** Few research studies in Canadian literature report on the experiences of nurses and student nurses in a rural acute care hospital settings. Most preceptorship studies reflect the urban experience. The research is being pursued to fulfil part of the requirements for the Simon Fraser University EdD program and is designed to contribute to nursing knowledge concerning cultural contexts of practice, the influence of place and relationships on undergraduate practice-education and expand understanding of diversity as it experienced in rural nursing practice.

Involvement in this rural research endeavor requires you to:

- Be (or have been) a third or fourth year nursing student who within the last 6 months has had a preceptored experience in an acute care hospital rural practice setting within Interior Health Authority for a minimum of 100 hours.
- Complete and return the enclosed notification of interest form in the researcher-addressed stamped envelope or contact me at the following phone number [REDACTED] or email [REDACTED] in lieu of this notification process or to ask me questions about the research within 2 weeks of receiving this letter.
- Understand the researchers' commitment and associated efforts to maintain confidentiality.
- Consent to participate in two semi-structured interview sessions of approximately 2 hours each, first in a face-to-face conversation and subsequently through a telephone conversation. A mutually agreeable time and place for these conversations will be arranged to protect participant privacy.
- Consent to review for approximately 1 hour individual transcripts of their taped interviews and return to researcher.

Your decision to participate in this inquiry is voluntary and confidential. I will not disclose your participation decision. Rural nurses will be sent an invitation requesting their participation and their decision will

remain confidential. Please note there is no intention of ensuring that pairs of rural nurse preceptors and student preceptees are included in this study. Your participation in this study is **not** contingent on the nursing preceptors participation in the study and vice versa. The nurse preceptor will not be apprised of your decision to act as a research participant unless you choose to inform him or her. Should you agree to participate in the study and subsequently decide not to continue your confidentiality will be maintained without prejudice so as guard the integrity of your current and future relationship with Thompson Rivers University. Interview tapes, transcripts and researcher notes will be kept in a locking filing cabinet and in a password protected electronic file and will be destroyed upon completion of the dissertation. Should information about your decision to participate or the contents of your interview given in confidence is divulged in a manner inconsistent with the purpose, process and products of research, you have the right to counsel/advice.

If you require more information about your rights as a research participant, about researcher responsibility or you have any concerns, complaints or questions about the manner in which you are treated in this study you may contact the Simon Fraser University Office of Research Ethics Director H. Weinberg via email ([REDACTED]) or phone 604-268-6593, the TRU Research Ethics Committee Chair (R. Tapley @ 250-828-5495 or 250-828-5000) or the TRU School of Nursing Dean (S. Duncan @ 250-828-5476). Please note that this study has research ethics approval from Simon Fraser University, Thompson Rivers University and the Interior Health Authority. Dr. Mark. Fettes is the doctoral dissertation supervisor and any concerns about this research can also be discussed with Dr. Fettes by calling 604-291-4489. You will be advised about how to get a copy of the dissertation once filed with S.F.U. graduate studies.

You are advised that, given the nature of rural research and the likelihood that only one nurse and one student will be interviewed from several different rural settings, their comments made in the research interviews may be thought as recognizable to others in the research products (dissertation, publications, and presentations). Your name will not be used in the research products to protect the privacy of students, nurse preceptors and any other identities revealed in the research processes. It is likely that direct quotations of your interviews will be used in the research products therefore attention will be given to writing in a manner that you and your circumstances are unlikely to be recognized and associated with the text.

I thank you, in advance, for your considered response to this request to share your time and perspectives in order to promote greater understanding of the nature and value of rural preceptorships.

Best Regards,
Cheryl Zawaduk, R.N., M.S., Ed.D. (Cand.)
Assistant Professor
Thompson Rivers University
P.O. Box 3010
Kamloops, B.C. V2C 5N3

Enclosures: Researcher Addressed Envelope, RSVP Card, Study Information Document

Appendix F. RSVP Card

To Cheryl,

I _____ am willing to be a research participant in the Rural Nursing Preceptored Experience Study.

You may contact me the following ways:

Home Phone _____

Cell Phone _____

Alternate Contact # _____

Email _____

My permanent mailing address is:

Please note preferred contact times:

Rural Research RSVP

Fill Out Reverse and Return in Rural Research Addressed Envelope
Final Version of Rural Research RSVP
October 8th, 2007

Appendix G. Informed Consent Form

SIMON FRASER UNIVERSITY Informed Consent by Participants in a Research Study

The University and those conducting this research study subscribe to the ethical conduct of research and to the protection at all times of the interests, comfort, and safety of participants. This research is being conducted under permission of the Simon Fraser Research Ethics Board. The chief concern of the Board is for the health, safety and psychological well-being of research participants.

Should you wish to obtain information about your rights as a participant in research, or about the responsibilities of researchers, or if you have any questions, concerns or complaints about the manner in which you were treated in this study, please contact the Director, Office of Research Ethics by email at [REDACTED] or phone at 778-782-6593 or the Chair of the TRU Human Subjects Committee, Robin Tapley by email at [REDACTED] or by telephone at 250-372-5569 or you may contact the Chair of the Interior Health Research Ethics Board by telephone at 250-870-4649,

Your signature on this form will signify that you have received a document which describes the procedures, whether there are possible risks, and benefits of this research study, that you have received an adequate opportunity to consider the information in the documents describing the study, and that you voluntarily agree to participate in the study.

Any information obtained during this study will be kept confidential to the full extent permitted by the law and the College of Registered Nurses of British Columbia Professional Standards for Registered Nurses and Nurse Practitioners as they relate to the research indicators (CRNBC,¹ 2005, pp. 7,9,11,13,15,17). Please be advised that the researcher in this study is NOT the faculty assigned to oversee preceptored educational experiences. Any immediate concerns involving a preceptorship experience, such as performance, relationship or practice issues, should be reported as normally expected to the appropriate assigned faculty member, employment supervisor or College of Registered Nurses Association of British Columbia by the person(s) directly involved.

Title: Rural Nursing Preceptorship Experience

Investigator Name: Cheryl Zawaduk

Investigator Department: Simon Fraser University, Education, Graduate Student and Thompson Rivers University, School of Nursing, Faculty Member.

1 College of Registered Nurses of British Columbia. (2010, July 28). Professional standards for registered nurses and nurse practitioners. Retrieved from https://www.crnbc.ca/downloads/128_prof%20standards%202005.pdf

Having been asked to participate in the research study named above, I certify that I have read the procedures specified in the Study Information Document describing the study. I understand the procedures to be used in this study and the personal risks to me in taking part in the study as described below:

Risks to the participant, third parties or society: Although the researcher is not involved in a supervisory relationship with participants, institutional relationships may affect the participants' sense of comfort and security. Examples:

1) students may question whether or not the researcher will be a future teacher and what, if anything, would participation mean in terms of a student-teacher relationship;

2) practicing nurses may question whether or not their participation may influence their employment relationships within IHA or affiliation relationships with TRU. Given the nature of rural nursing, the small study sample, and the potential for participant quotations to be included in the research products (dissertation, presentations, articles), participants and non-participants may claim recognition of words, circumstances or stories despite the absence of attributions such as name/place/date/titles. The researcher will take steps to minimize these potential risks throughout the research process.

Procedures: Participants will be asked to consent to two tape-recorded semi-structured interviews for approximately 2 hours duration per interview. The first interview is intended to be face-to-face. The second interview may occur via telephone or face to face at the discretion of the researcher. For purposes of clarification and elaboration, the transcribed interviews will be returned to the participant via Canada Post with instructions for review and return of reviewed text via pre-paid postage within 7 days of receipt. Participant review estimated to take about 1 hour.

Benefits of study to the development of new knowledge: The purpose of this study is to explore the experience of undergraduate preceptorships situated in rural acute-care placements, from the perspectives of nurses and nursing students. The study is intended to increase nursing knowledge about cultural contexts of practice, the influence of place and relationships on undergraduate practice-education and expand understanding of diversity as it is experienced by nurses in rural practice. Insights concerning the nature and educational value of a hospital rural preceptor practice experience will be shared with the professional nursing community and interested stakeholders in the form of a dissertation, presentations and articles. This work will contribute to the re-evaluation and enhancement of the professional training of rural nurses in British Columbia and elsewhere.

I understand that I may withdraw my participation at any time and that there will be no negative results or repercussions should I withdraw during the time of the study. I also understand that I may register any complaint with:

- Director, Office of Research Ethics, 8888 University Drive, Simon Fraser University Burnaby, B.C. V5A 1S6 778-782-6593 email: [REDACTED]
- Chair, Research Ethics Human Subjects Committee, Thompson Rivers University, Box 3010, Kamloops BC V2C 5N3 250.371.5569 Fax 250.377.6049 email: [REDACTED]
- Chair of the Interior Health Research Ethics Board #104-1815 Kirschner Rd Kelowna, BC V1Y 4N7 by telephone at 250-870-4649.

I may obtain copies of the results of this study, upon its completion by contacting:
Cheryl Zawaduk [REDACTED] or email [REDACTED]

I have been informed that the research will be confidential. I understand the risks and contributions of my participation in this study and agree to participate:

The participant and witness shall fill in this area. Please print legibly

Participant Last Name:

Participant First Name:

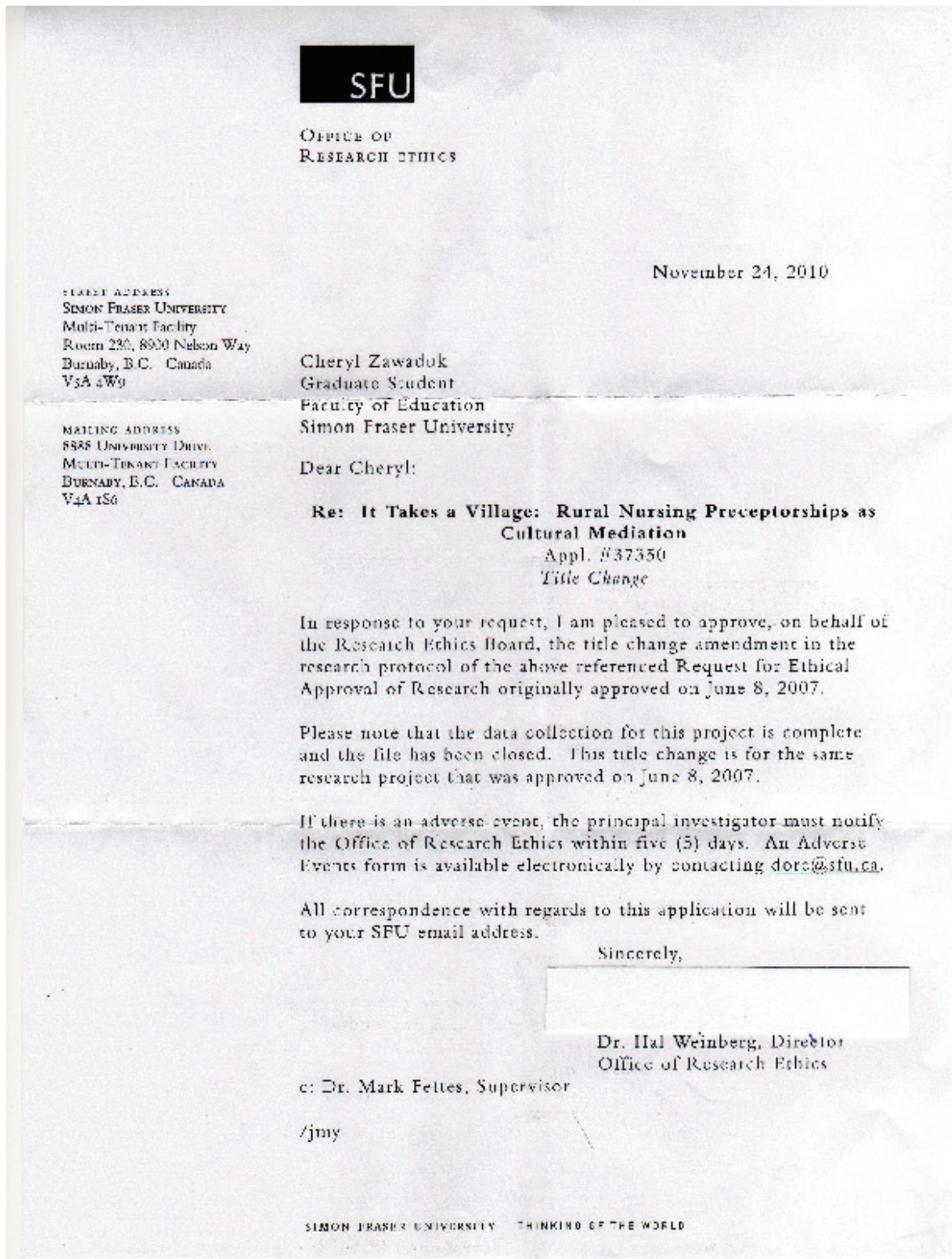
Participant Contact Information:

Participant Signature:

Witness (if required by the Office of Research Ethics):

Date (use format MM/DD/YYYY)

Appendix H. Title Change Amendment Letter



Appendix I. Sample of Nurse-Preceptor Questions

Preceptor Interview Guide

These following questions are provided as a general outline for the two interview sessions with preceptors. The questions, while ordered into a frame of past, present, and future, are not meant to be asked sequentially. These questions are designed to serve as points of initiating conversation with participants leaving open the possibility that other questions and conversations may emerge in the course of the interview that can be explored so as to practice reflection-in-action within the immediacy of the interview.

Self-History

Tell me a little about your background in nursing. How long have you nursed? How long have you nursed in this community? How long have you nursed in rural communities.

Thinking back, how well did your experience and education prepare you for rural practice?

What brought you to practice in a rural setting?

What brought you to the precepting experience? Is this your first or have you precepted before? What is your personal history with preceptorships?

The Here and Now So to Speak

Qualities of the Experience/Educational Value

Tell me what it has been like for you to be a preceptor in a rural hospital setting?

Tell me about the conversations you first had with the student as they began their experience? When you first meet with the student constitutes what most of your conversation with the student in order to help 'set the stage' for the rural nursing practice experience?

Tell me about the conversations you have with the student about rural nursing practice once you get to know the student.

Talk about whether or not you purposefully try promote the student understanding about the uniqueness of rural nursing? If so, how do you go about that?

Are there elements of the rural nursing experience you think the student nurse ought not to have during their preceptorship? If so what are these and why do you think this?

Talk about the kinds of stories you might tell students about the community you work and live in? What are the messages you are trying to convey?

Talk about aspects of the rural preceptorship experience you appreciate the most.

As you practice in a rural setting, what skills and knowledge do you think are highly valued by yourself and others?

Talk about what you think students learn from a rural preceptorship that they may not learn in an urban setting?

What skills and knowledge are developed most by students practicing in rural setting?

If you have preceptored before in the rural context, what, if anything, strikes you as different about this preceptorship experience and what strikes you similar?

If you have preceptored before in an urban context, what, if anything, strikes you as different about this preceptorship and what strikes you as similar/familiar?

From your conversations with the most recent preceptorship did you get a sense of what the student valued about the rural experience? What about other students you may have preceptored prior to the most recent student? (if applicable).

Looking back on the preceptorship experience did you notice any particular struggles the student had in terms of appreciating (understanding) the rural practice context?

To what degree, if at all, are your beliefs/values/practices challenged by the introduction of student into this practice setting?

Talk about your perceptions of the student's ability to 'fit in' with respect to this rural hospital context? Did the student settle into the experience relatively easily or not and what do you make of this?

What do you think the student(s) found particular strange or unfamiliar about the rural nursing experience and how do you come to think this.

Does anything stand out for you about the students' presence in rural practice environment? Does their being present in a rural practice setting change the environment?

Did you experience any conflict in relation to the preceptorship experience?

If it was at all possible, would a rural preceptorship experience be appropriate for all nursing students? Tell me what you think about this idea.

The Reflective Element and Practice Community Conversations

When you are away from the practice setting, what aspects of the rural preceptorship do you reflect upon?

What have you struggled with during this, or other, rural preceptorship experience(s)?

Talk about what you might not have enjoyed or perhaps enjoyed the least about the experience of being a rural preceptor.

Is there a time when you regretted taking on the role of preceptorship in the rural hospital and if so can you talk about this instance or other instances?

Tell me about a time when you talked to other rural nurses about your experience as a rural preceptor? Do others want to know about the experience? What questions do other nurses ask of you? Why do you think they ask these questions?

Talk to me about your conversations with administrators you might have about what it is like to be a rural preceptor. If you haven't spoke, what would you like administrators to know about your experience as a rural preceptor?

What have you enjoyed most, or been the most rewarding aspect, of the rural preceptorship experience. Tell me more about that.

Considering the current conditions of rural hospital nursing, what would you suggest needs to be changed in relation to the rural preceptorship experience.

Imagining the Future

Thinking about the future of rural hospital nursing in 5 or 10 years from now, what would you imagine might need to change in relation to rural preceptorships?

Talk about one of the enduring memories you are likely to have from the rural preceptorship experience? What are some key experiences you are likely to remember of this preceptorship? Or other preceptorship experiences you may have had in rural settings?

What enduring or lasting memories do you imagine the student(s) take away from their rural preceptorship experiences.

Over our two conversations are there any aspects of the rural preceptorship experience that you have reconsidered? Tell me about this.

How has it been for you to set aside this time to talk about your experience as a rural preceptor? Is there anything you really wanted to tell me about your experiences but we didn't talk about? Are there any ideas we touched on in our conversations but you would like to talk more about?

Appendix J. Sample of Student Questions

Preceptee Interview Guide for the Research Question

What is the nature and educational value of the rural preceptorship experience for nurses and students?

The three guiding ideas/questions are:

- Is there a culture of rural nursing practice expressed in the rural nurses narratives about preceptorship, and how, if at all, does a cultural context of practice influence the preceptorship experience for the nurse or student nurse?
- What is the rural nurses' personal meaning of place and how, if at all, does this personal meaning of place influence the preceptorship experience for the nurse or student nurse?
- What understandings of diversity do rural nurses have and how, if at all, does diversity influence the preceptorship experience for the nurse or student nurse? .

These questions are provided as a general outline for the two interview sessions with preceptees. The questions, while ordered into a frame of past, present, and future, are not meant to be asked/answered sequentially. These questions are designed to serve as points of initiating conversation with participants leaving open the possibility that other ideas may emerge in the course of the interview that can be explored so as to practice reflection-in-action within the immediacy of the interview.

Self-History

Tell me a little about your background as a student nurse, where have you had practice experiences, what stage of the program are you in,

Tell me about your decision to choose a rural preceptorship?

The Here and Now So to Speak

Qualities of the Experience/Educational Value

Tell me what it has been like for you to be preceptored in a rural hospital setting?

Tell me about the conversations you first had with the preceptor as you tried to familiarize yourself with this practice setting?

Tell me about the conversations you had with the preceptor about rural nursing practice once you had been in the practice setting for awhile.

Tell me about what you consider to be unique or special about the rural preceptorship experience?

Are there any aspects of the rural nursing experience you think the preceptors or faculty should talk to students about before beginning a rural preceptorship. What makes you think this?

Tell me a story you might tell other nursing students about the rural community you were practicing in?

Talk about the aspects of rural preceptorship experience you appreciated the most.

As you practice(d) in a rural setting, are there any particular skills or knowledge unique to a rural setting you were able to gain that you might not have otherwise developed.

If you had a previous rural practice experience, what (if anything) strikes you as different about this preceptorship experience and what strikes you similar?

From your conversations with the preceptor did you get a sense of what the preceptor valued about their rural preceptorship

Looking back on the preceptorship experience did you have any particular struggles in terms of appreciating (understanding) the rural practice context.

Tell me about your 'presence' in the rural practice setting, do you think your presence made a difference to the day to day practice of nurses ? the preceptor?

Talk about your ability to 'fit in' with respect to this rural hospital context. Did the settle into the experience relatively easily or not and what do you make of this?

Talk about whether or not you found anything particularly strange/unfamiliar or about the rural nursing experience.

If it was at all possible, would a rural preceptorship experience be appropriate for all nursing students? Tell me what you think about this idea.

The Reflective Element and Practice Community Conversations

When you are away from the practice setting, what aspects of the rural preceptorship do you reflect upon?

What have you struggled with during this (or other) rural preceptorship experience?

Talk about what you might not have enjoyed or perhaps enjoyed the least about the experience of rural preceptorship.

Is there a time when you regretted opting for a rural preceptorship experience and if so can you talk about this instance or other instances?

Tell me about a time when you talked to other rural nurses about your experience as a rural nursing student? Do others want to know how the experience is for you? What questions do other nurses ask of you ? Why do you think they ask these questions?

Talk to me about your conversations with administrators you might have about what it is like to be a student in a rural preceptorship. If you haven't spoke to any administrators, what would you like administrators (education, practice) to know about your experience as a rural nursing student?

What have you enjoyed most, or been the most rewarding aspect, of the rural preceptorship experience. Tell me more about that.

Did you experience any conflict in relation to the preceptorship experience?

Considering the current conditions of rural hospital nursing, what would you suggest needs to be changed in relation to the rural preceptorship experience.

Thinking back how well did your student experiences and education prepare you for a rural preceptored practice experience?

Imagining the Future

Thinking about the future of rural hospital nursing say 5 or 10 years from now what would you imagine might need to change in relation to rural preceptorships?

Talk about one of the enduring memories you are likely to have from the rural preceptored practice experience? What are some key experiences you are likely to remember of this preceptorship? Or other preceptorship experiences you may have had in rural settings?

What enduring or lasting memories do you imagine preceptors or other nurses have about your presence in the rural setting?

Over our two conversations are there any aspects of the rural preceptorship experience that you have reconsidered? Tell me about this.

How has it been for you to set aside this time to talk about your experience as a student in a rural preceptored practice experience? Is there anything you really wanted to tell me about your experiences but we didn't touch on that idea, or is there any ideas we touched on but you would like to talk more about?

Appendix K. Letter Accompanying Transcripts

Dear _____,

Thank you once again for being part of my research study on the Rural Undergraduate Preceptorship Experience. Attached please find the transcript of our two taped conversations.

Although you may treat this simply as a record of your participation in the study, you may also choose to review, clarify or elaborate on any ideas within. As you read the words of our research conversation, it may seem that they don't communicate exactly what you intended or what you remember saying. It is common to doubt our conversational words when we see them on paper. The distant nature of the text often doesn't seem to have the same tone or imbue the same meaning as does the spoken word.

If you opt to review the transcript, you may find some or all of the following questions to provide useful guidance.

- Does the transcript capture the main ideas of what you intended to communicate to others about rural undergraduate acute care preceptorship experiences?
- Is the cultural context of rural nursing practice evident in our conversations? Is there anything more you would like to say about the culture of rural nursing and preceptorships with undergraduate students?
- Is your personal experience of the rural as a place of practice evident in the transcript? Is there any clarification or elaboration you wish to make about your personal understanding of the rural as a place that influences your nursing practice?
- Did we talk about diversity and rural nursing practice in relation to the experience for the nurse and student in a preceptorship experience? Are there additional comments or clarifications you would want to convey about diversity, preceptorships and rural practice?

Enclosed is a postage-paid self-addressed return envelope for you to send me your comments, should you choose to review the conversational transcript. Also enclosed is a separate thank-you letter to express my deep appreciation for your participation and to provide you with evidence of having participated in research, should you wish to use this experience as part of your CRNBC continuing competency portfolio or for other professional purposes.

I shall let you know when my dissertation has been completed and successfully defended. Please let me know if you have any questions regarding the research process or the contents of my dissertation.

With best regards,

Cheryl Zawaduk

Appendix L. Thank You Letter

Dear _____,

Thank you once again for being part of my research study on the **Rural Undergraduate Preceptorship Experience**. Attached please find the transcript of our two taped conversations. Although you may treat this simply as a record of your participation in the study, you may also choose to review, clarify or elaborate on any ideas within. As you read the words of our research conversation, it may seem that they don't communicate exactly what you intended or what you remember saying. It is common to doubt our conversational words when we see them on paper. The distant nature of the text often doesn't seem to have the same tone or imbue the same meaning as does the spoken word. Should you opt to review the transcript, you may find some or all of the following questions provide guidance.

- Does the transcript capture the main ideas of what you intended to communicate to others about rural undergraduate hospital preceptorship experiences?
- Is the cultural context of rural nursing practice evident in our conversations? Is there anything more you would like to say about the culture of rural nursing and preceptorships with undergraduate students?
- Is your personal experience of the rural as a place of practice evident in the transcript? Is there any clarification or elaboration you wish to make about your personal understanding of the rural as place that influences your nursing practice?
- Did we talk about diversity and rural nursing practice in relation to the experience for the nurse and student in a preceptorship experience? Are there additional comments or clarifications you would want to convey about diversity, preceptorships and rural practice?

Enclosed is a postage-paid self-addressed return envelope for you to send me your comments, should you choose to review the conversational transcript. Also enclosed is a separate certificate of appreciation to express my deep gratitude for your participation and to provide you with evidence of having participated in research, should you wish to use this experience as part of your CRNBC continuing competency portfolio or for other professional purposes.

I shall let you know when my dissertation has been completed and successfully defended. Please let me know if you have any questions regarding the research process or the contents of my dissertation.

With best regards,

Cheryl Zawaduk