‘PLACE’ MATTERS TO RURAL NURSES’: A STUDY LOCATED IN THE RURAL OTAGO REGION OF NEW ZEALAND

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This thesis has been my journey, a journey with the intention from the onset to uncover the ‘What, Why and How’ of rural nursing in New Zealand and ultimately to understand rural nurses’ contribution to the growing theoretical base internationally and nationally. More importantly my overall aim has been to offer rural nurses the opportunity to discuss their practice and their contribution to the rural health care sector. In essence this thesis is my gift to my rural colleagues, in an attempt to offer you further insight into your dynamic speciality field of practice.

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ABSTRACT

Rural nursing is recognised internationally as a speciality area of nursing practice, situated within the general field of nursing. This specialist area of practice is an underrepresented aspect of nursing in New Zealand, and its professional identity is challenged, misunderstood and does not fit easily within the national imaginings, wider nursing profession and policies governing nursing practice. This thesis explores the social construction of the evolving professional identity, of rural nurses’ between the 1990 and early 2000s. This period of time was associated with two significant national directives impacting on the professional practice of rural nurses and their contribution for the delivery of health care, from the rural Otago region, of the South Island of New Zealand. The first of these national directives in the 1990s was the restructuring of the health care system, driven by the National government, to improve the social determinants of health that shifted the governance of health care from the state to local community control. Parallel to these changes was the motivation from the profession to reposition nursing, with the aim of advancing nurses’ practice so that their full potential could be harnessed, to improve the delivery of health care and reduce health inequalities.

Situating this research within the interpretive paradigm embeds this retrospective study within the discipline of nursing and social geography, and engages with the concepts of place and governmentality. Place is considered a concept, in which meaning is made throughout, with the associated concepts of ‘location’, ‘locale’ and ‘sense of place’ revealing how the professional identity of the rural nurse was constructed. Further, engaging with governmentality creates a deeper understanding of rural nurses and their practice and exposes the different levels of governance, including state, discipline and the self, which govern the nurses’ conduct. National key informant and regional rural nurse interviews generated data and were analysed using thematic analysis. Stemming from the analyses, an analytical diagrammatic matrix has been developed which demonstrates rural nursing as a place–based
practice governed both from within and beyond location. This analysis further demonstrates how the nurse aligns the self in the rural community as a meaningful provider of health care. In contrast, understanding the rural nurses’ professional identity is acknowledged from beyond the rural community, as a critical component of engaging within the wider nursing profession and is recognised as different to urban nursing. Difference in this context is considered a valuable and positive concept in which to recognise the unique features aligned with rural nursing, meaning that the rural identity is associated with the rural nurses’ relationship with the physical context, community members and specialist scope of practice. The significance of place in relation to rural nurses’ practice is an imperative and noteworthy factor which cannot be an underestimated aspect driving the evolution of this study.
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PREFACE

A brief geographical overview is presented in this Preface to provide background information related to New Zealand’s geographical, demographic and the health disparities, particularly between urban and rural populations and between the emigrant and the Indigenous population of Aotearoa, New Zealand. The aim of presenting this information early on in this thesis is to provide the reader with a degree of contextual information through which to establish, the particular nuances, associated with New Zealand’s distinct contexts, and in particular the rural Otago regional study location (situated within the South Island of New Zealand) which impact on the research participants in this study.

Aotearoa, (the Māori term for New Zealand) comprises six inhabited islands, the North Island, South Island, Stewart Island and Great Barrier Island (refer to the map on page xiii in this Preface), the Chatham and Pitt Islands are also a part of New Zealand and are situated to the east of Christchurch and Wellington (not presented on this map). The North and South Islands have some similarities each comprising over 150,000 kilometres of diverse coastlines, as well as mountain ranges. The geologies of both Islands are significantly different, as the North Island is primarily volcanic (Wright, 2013) and reveals a fertile landscape (New Zealand Geography and Geology, n.d.). The South Island comprises the Southern Alps that run up the centre of the South Island exposing the mountainous ranges, glaciers, fjords and the Canterbury plains (Wright, 2013). The South Island covers 150,437 square kilometres, which comprises 33 precent more landmass than the North Island (Hogarth and Rapata-Hanning, 2015). The topography of the South Island (in which the study location is situated) is interesting as it reveals an isolated geographical context with a relatively sparse population (in the rural areas) in comparison to the North Island. The following map depicts the geographical location of New Zealand that will be referred to throughout this thesis.
Preface: Map of Aotearoa, New Zealand
Source: Created and published with permission from Chris Garden

The contemporary population of New Zealand is approximately 4.5 million as of June 2014 (Statistics New Zealand, 2015) of which 85% live in the urban regions of this country. Three out of four people live in the North Island leaving the remainder residing in the larger but generally more sparsely populated geographical region of
the South Island, which includes both urban and highly rural and remote locations (Statistics New Zealand, 2006).

There are other features that differentiate rural and urban people, one is ethnicity including between Māori (the Indigenous population of Aotearoa, New Zealand) and non-Māori. The Māori population is approximately 15.6% of the total population of New Zealand with 52.8% of that group identifying as Māori (Statistics New Zealand, 2015). The majority of the remainder of the population identified with the following ethnic groups, including New Zealand European at 74.6%, Asian at 12.2%, Pacific peoples at 7.8% and Middle Easton, Latin American and African at 1.2% (Statistics New Zealand, 2015). Hogarth and Rapata-Hanning (2015) reveal that 85% of the Māori population resides in the North Island while the proportion of the population identifying as Māori is higher in smaller urban centres and more remote rural areas (Fraser, 2006). In this context Strasser (2003) and Bushy (2012) caution that in the more remote rural areas there are disparities associated with health care provision, leading to higher deprivation rates especially amongst the Indigenous population groups (Durie, 2001).

Health disparities are linked to socioeconomic deprivation and poor health outcomes including mortality, hospitalisations, health risk factors, chronic disease and many acute conditions (Hefford, et al., 2005; National Health Committee, 2010, Hogarth and Rapata-Hanning, 2015). Social, political and the environmental contexts play a role in health outcomes as the socioeconomic status of residents’ from those rural areas have a high degree of urban influence, as defined on the urban-rural continuum (Statistics New Zealand, 2006) (presented in Figure: 3.1 in Chapter three). It is in these contexts residents’ experience lower levels of health deprivation than the more isolated rural areas. However, this is not the case for highly rural/remote areas where the residents experience high deprivation rates and Māori experience both high levels of health deprivation and the lowest socioeconomic status (National Health Committee, 2010; Hogarth and Rapata-Hanning, 2015; McMurray and Clendon, 2015). Life expectancy is similar for both rural and urban populations in New Zealand. However, there is a difference in the life expectancy between Māori and non-Māori populations (National Health Committee, 2010; Hogarth and Rapata-Hanning, 2015). Rural Māori have a shorter life expectancy than urban Māori with
1.2 years difference for women and 1.5 years difference for men (National Health Committee, 2010). Māori experience a higher rate of cancer, higher incidence of obesity, and higher rates of chronic illnesses stemming from obesity (Hogarth and Rapata-Hanning, 2015). Examples of chronic illnesses such as diabetes mellitus, coronary heart disease, stroke, and high blood pressure are experienced (Hogarth and Rapata-Hanning, 2015). Māori have expressed they experience stress and mental health problems with resulting dependence on alcohol or substance drugs. Hogarth and Rapata-Hanning (2015) explain, “Māori are less healthy than their non-Māori counterparts and these disparities have existed for decades” (: 1182). These disparities have been a priority for Māori working with Te Tiriti o Waitangi1 (The Treaty of Waitangi) partners including the governments of the day, as expressed through the release of ‘He Korowai Oranga: Māori Health Strategy’ (Ministry of Health, 2002a) which addresses health disparities related to Māori. A more detailed discussion in relation to Te Tiriti is presented in Chapter four as it relates to the research process aligned with this thesis.

The regional study location, rural Otago is situated in the lower central part of the South Island (as depicted on the map presented earlier in this Preface and is further presented diagrammatically in Figure: 1.1 in Chapter one). Rural Otago has a landmass of 32,000 kilometres and a population of 215,100 as of June 2015 (Statistics New Zealand, 2015) which is approximately only 5% of the total of New Zealand’s population (Otago Regional Council n.d.) resulting in a large land mass which is relatively unpopulated. This area comprises large mountains, rivers and high country locations. The weather plays a significant part of the rural Otago region in which the coastal areas have a milder climate, compared to the warmer inland areas associated with this region. Plate one (on the following page) opens up the opportunity to become acquainted with an aspect of the rural Otago region through image. The purpose of including this information is to engage the reader with the distinct features in which the rural nurses’ from this region associate their practice and identity.

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1 Te Tiriti o Waitangi is New Zealand’s founding document and comprises a broad set of principles (Hogarth and Rapata-Hanning, 2015). Te Tititi is one of the most controversial documents in New Zealand’s history and remains challenged by Māori as to its interpretation and meanings (Ka’ai and Higgins, 2004). Confusion around certain terms, led to Māori misunderstanding (at the time of signing in 1840) what they were agreeing to and ultimately Māori have not received the same benefits as non-Māori people of New Zealand leading to health disparities (Hogarth and Rapata-Hanning, 2015).
The introduction to the study area in this Preface concludes with a poem titled, “What its like…” by the renowned poet, Brian Turner who is a resident of the rural Otago region. The intention of including this poem evokes a sense of place from the rural Otago region and aims to engage the reader with this landscape.

**WHAT IT’S LIKE**

When someone asks you to explain what it’s like where you come from you say you’re still finding out, and its not because you enjoy being vague, or smart-arse, a sophist if you like, it’s just because it’s true.

This morning frost then the fog like smoke from a damp wood fire, then the sun breaking through in lame-like patches until there’s not even bandannas left on the hills, and order’s restored: blue sky above incandescent snow.

Source: Reprinted with permission from the author (Turner, 2012: 020)
ABBREVIATIONS

ACC  Accident Compensation Corporation
AHB  Area Health Board
BNS  Backblock Nursing Scheme
CSS  Community Services Card
CRH  Centre for Rural Health
CTA  Clinical Training Authority
DHB  District Health Board
GMS  General Medical Service
GP   General Practitioner
HFA  Health Funding Authority
HPCA Health Practitioner Competency Assurance
IPA  Independent Practitioner Association
NCRH National Centre for Rural Health
NCNZ Nursing Council of New Zealand
NERF Nursing Education Research Foundation
NNS  Native Nursing Scheme
NP   Nurse Practitioner
NZMA New Zealand Medical Association
NZNA New Zealand Nurses Association
MHNS Māori Health Nursing Scheme
ODHB Otago District Health Board
PHC  Primary Health Care
PHO  Primary Health Organisation
PNSS Practice Nurse Subsidy Scheme
PRIME Primary Response In Medical Emergencies
RCT  Rural Community Trust
RHA  Regional Health Authority
RN   Registered Nurse
RNNN Rural Nurse National Network
RNS  Rural Nurse Specialist
SDHB Southern District Health Board
SRHA Southern Regional Health Authority
CHAPTER ONE: INTRODUCTION

Nurses experience rural reality and move toward becoming professionals who understand that having gone rural, they are not less than they were, but rather, they are more than they expected to be. Some may be conscious of the transition, and others may not, but in the end, a few will say, “I am a rural nurse.”

(Scharff, 1998: 38)

1.1 Introduction

Identifying as a rural nurse is not necessarily an easy or straightforward process, as highlighted by Scharff (1998) in the above quote, which raises the question as to what constructs the rural nurse and how do they identify with this professional role? This thesis has set out to investigate how the identity of the rural nurse, who predominantly performs their practice in the rural Otago region of the South Island of New Zealand, (Figure: 1.1) became established. From the mid-1990s some Registered Nurses (RNs) who practised in this location moved beyond the traditional identity as a district nurse, practice nurse or public health nurse (refer to Table: 1.1 on page 4 of this Chapter for a more detailed explanation of the occupational titles and employment settings of RNs) and looked towards a more appropriate identity which reflected their emerging practice. These nurses identified with either the professional title as a rural nurse or Rural Nurse Specialist (RNS) that has given them a shared sense of belonging. This sense of belonging has revealed a number of core characteristics that are associated with nursing in rural contexts and have been challenged and misunderstood by urban nurses and the profession as a whole (Howie, pers. comm., 2004; Ross, 2008; Rural General Practice Network Conference, 2013; Hutton, 2016). Despite the rural nurses’ efforts to defend and explain the particular nuances which make up their practice, there has been very little recognition and engagement from the profession to accommodate this specialist area of practice. The aim of this study has been to
investigate what were the contributing factors that led to the development of this new professional identity. This research has also sought to address a gap in the literature by striving to identify and strengthen the awareness of and increase the rural nurses’ understanding and articulation of their changing and adapting professional identity. Furthermore, this thesis has attempted to both identify those nurses who associate themselves with the concept of the rural nurse, and to provide for them, the opportunity to appreciate their contribution to the delivery of rural health care from the identified study location. Figure: 1.1 (below) presents Otago in comparison to the lower part of the South Island of New Zealand in which the rural study location (excluding Dunedin) is situated.

Figure: 1.1  Map representing the Otago location
Chapter One

1.2 Positioning this study within New Zealand

There is very little understanding about the rural nurses’ contribution in the delivery of rural health care in New Zealand and the effect this has had on the repositioning of their professional identity (Thompson, 2006). There are however, three main New Zealand national studies that have specifically investigated whether the practice of rural nurses have been adapted in response to the changing health care reforms of the 1990s, which were aligned with the neo-liberal changes (discussed in Chapter two).

The first of these studies was conducted by Litchfield (2001) who investigated whether models of rural nursing practice altered in response to the changing delivery and funding of rural health care between the 1990-2000s time period. Litchfield’s (2001) findings revealed that in areas where the funding remained unchanged the models of nursing practice remained constant. However as the funding structures changed so too did the models of rural nurses’ practice, which benefitted community access to health care.

Thompson’s (2006) study investigated the development of models of rural and remote nurse-run-health care clinics, including the provision of being the first point of contact for the delivery of health care, within the remote parts of New Zealand, including its off-shore Islands (refer back to the Preface for a detailed map of these geographical sites). Thompson’s (2006) study sought to understand if these nurses did indeed adapt their practice in response to not only the changing health care reforms of the 1990s but also with the release of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) and its focus on preventative health care in the early 2000s. Thompson (2006) found that as rural primary health care nurses broadened their practice they encountered boundaries between medicine, paramedics and within nursing, that she refers to as boundary work and which required the nurse to be a self-governing health professional. Thompson (2006) was also concerned with the retention and recruitment of rural nurses which was a consideration in O'Malley et al.,’s (2009) national study.

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2 Medicine refers to medical practitioners or doctors who contribute to the health care sector consulting with patients or clients (Tully and Mortlock, 2005).
3 Paramedics are highly skilled professionals who deliver emergency health care to the population via rescue teams, ambulances and helicopters (New Zealand Paramedics, n.d.).
O’Malley et al., (2009) study focused on the issues and challenges facing the rural nursing workforce. As the rural nurses’ role was expanding O’Malley et al. (2009) were interested whether there was sufficient professional and educational support for the advancement of this role.

The three studies mentioned above, were undertaken over an eight year period of each other, and were all focused on the progression of rural nurses’ practice nationally. These studies have demonstrated that some rural nurses, but not all, have adapted their practice to accommodate the changing focus of the health care system. In addition these studies have shown that rural nurses’ practise in collaboration with rural community members, as emphasised within the mandate and practise of the newly established community trust environments (Barnett and Barnett, 2001). Given the parameters in which these nurses’ work, it is therefore essential to build up a strong awareness of how, in a complex and changing socio-political, cultural and economic context, the influence of ‘others’ shapes nurses’ practice (Thompson, 2006).

The investigations by Litchfield (2001), Thompson (2006) and O’Malley et al. (2009) add to the growing body of the New Zealand research related to rural nurses and their emerging practice. This thesis complements these New Zealand studies, in so far as it positions the scope of this research and supports the notion that the rural nurses’ role is fluid, adaptable, flexible, personal and relevant to the unique and diverse context and health care requirements, associated with the rural community. What positions this thesis apart from the studies mentioned above, is that they are all national studies, whereas this thesis concentrates on one New Zealand identified location, the rural Otago region, at a time when Rural Community Trusts (RCTs) were being established. It is the intention of this thesis to expose the particular nuances associated with the rural nurses’ practice, from rural Otago, in which the nurse needs to understand the rural community’s political, economic, and cultural dynamics including the social relationships that develop between rural residents and rural health care professionals, in order to position their evolving practice that is receptive to the community’s health care needs. The scope of this thesis is now presented.
1.3 The scope of this research

Central to this thesis is the question of how the rural nurses’ professional identity was constructed in rural Otago specifically, and what has been their contribution to the delivery of rural health care, specifically within the changing socio-political, economic contexts of the 1990s and early part of 2000s.

The establishment of the rural nurse identity within the rural Otago region developed during a particularly volatile period of significant national and local health care restructuring and professional nursing directives throughout the 1990-2000s time period. In particular, the contemporary domain of Primary Health Care (PHC) in the rural context has shaped the identity of the rural nurse. Blue (2002) notes the provision of rural PHC requires the nurse to align and adapt their practice with the individual conditions created by the rural context, community’s health needs and in particular in New Zealand, health promoting activities (Health Workforce Information Programme, 2009). This unique context shapes the character of nursing in which many rural nurses negotiate their practice in-between national professional obligations and local rural community demands (Blue, 2002).

The motivation for this research developed in response to the regional and national challenges and misunderstandings that emerged, as introduced previously and which will be discussed in-depth in relation to the study location and the thesis analysis presented in Chapters five, six and seven. Rural nurses in New Zealand are not immune to the difference of opinion from non-rural colleagues since, as Scharff (1998; 2010) and Bushy (2012) from the USA, and likewise Blue (2002) and Hegney et al., (2002) from Australia explain, internationally rural nurses and their practice are also misunderstood, citing geographical and professional isolation, partners’ employment and family commitments as noted issues. To strengthen rural nurses’ awareness of their identity and to discuss what is unique about their practice is the intention of this research. In my opinion, the occupational title ‘rural nurse’ is not an adequate portrayal of their practice and there are a range of key differences which distinguish them from their urban colleagues, in respect to defining their practice which is directly associated with their rural locations (Blue, 2002; Thompson, 2006). Thus, this study investigates the identity of the rural nurse from the regional rural
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Otago location (Figure: 1.1) at a time when the identity and practice of nursing nationally was being constructed in an especially dynamic, discursive context and time period (Jacobs, 1998; Jacobs and Boddy, 2008). The rural context was not immune to these changes (Thompson, 2006) in the 1990s and early 2000s.

To understand the identity of the rural nurse, this study is situated within the disciplines of nursing and social geography. This study takes a broad appreciation of the concept of identity and how identity is acted out within the context of place in which the physical location assists in defining identity construction (Cresswell, 2004; Goodrich and Sampson, 2008; Vancly, 2008; Sampson and Goodrich, 2009; de Leeuw et al., 2011).

Social geographers have concluded that identity and place are mutually constituted (Massey, 2005; Antonish, 2013). It is therefore fitting in this thesis to further engage with the concepts of identity and place, identity formation, transformation and identity and difference, all of which have been studied by a number of renowned geographers allied to political, social and rural geographies respectively (Agnew, 1987; Cresswell, 2004; Panelli, 2004; Massey, 2005; de Leeuw et al., 2011; Woods, 2011). I have engaged in particular with their work in relation to the key concepts, which make up the six defined elements aligned with the conceptual framework guiding this thesis (presented in Chapter three). The six key concepts include the theories of identity and place, the theoretical understandings of the ‘rural’ and professional caring, the notion of governmentality and the ‘Funnel (Metaphor) Model’. The first of these key concepts includes, identity, and is further extended to include ‘place’ which is associated with social geography (Agnew, 1987; Massey, 1994; Cresswell, 2004; Thompson, 2004, 2006). Further, ‘place’ as articulated in nursing is also engaged with (Liaschenko, 1994; 1996a; 1996b; 1997; Jones and Ross, 2003; Malone, 2003; Lee and McDonagh, 2010; Ross, 2012; Thomas, 2013) and takes an alternative perspective to social geography (Carolan et al., 2006).

‘Place’ in the form of the ‘rural’ is further elaborated on as discussed by Cloke (2006a; 2006b), Edensor (2006) and Woods, (2011). While the fourth concept considers professional caring (Sherwood, 1991; Papps, 2001; Tully and Mortlock, 2005; Keleher, 2014) and the relevant theoretical underpinnings associated with rural
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nursing practice (Torras and Yura, 1994; Scharff, 2006; 2010; Winters and Lee, 2010). The fifth key concept associates with the notion of ‘governmentality’, while the sixth concept presents the ‘Funnel (Metahor) Model’, which captures the previous five concepts and acts as a vessel in which to guide the relational aspects aligned in this conceptual framework. These key concepts are further engaged with as the analysis and discussion unfolds from Chapter five onwards. In the meantime the aims of this study are now considered.

1.3.1 The aims of this study

This study aims to generate awareness as to how the professional identity of rural nurses’ from the rural Otago region has been constructed during this significant time period of change between the 1990 and 2000s which in turn provides the potential to:

1. strengthen the nurses’ understandings of their changing and adapting identity and whether ‘place’ does shape this identity, and
2. provide nurses’ with an ability to articulate the significance and contribution of their practice to the rural health care and national nursing sectors.

Building a strong self-awareness is necessary in a complex, dynamic and changing socio-political and economic context, where the influence of ‘others’ shape nurses’ practice (Crowe, 1998; Thompson, 2006). This thesis is positioned to uncover how the professional identity of the rural nurse from the rural Otago region was constructed in the 1990s and early 2000s time periods. As rural nurses become more informed about their practice they may be in a positive position with respect to discussing the significance and impact that their practice has within the rural health care sector. These nurses’ would then have the ability to participate, dialogue and contribute locally, regionally and nationally with the national nursing sector, politicians, policy-makers, employers and researchers, where non-rural people and organisations begin to contribute to rural nurses’ discourses aligned with their practice. In determining the aims of this thesis I posed three main research questions, which are introduced in this Chapter and discussed further in the methodology and methods, Chapter four.
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1.3.2 The research questions:

Q.1 What constitutes being a rural nurse, and where do rural nurses work?
Q.2 How do rural nurses practice, and what is their contribution to the rural health sector?
Q.3 How can rural nurses advance their practice and contribution to the rural delivery of health care, leadership, policy development, nurse education and research?

To answer these research questions I chose to position this study within the discipline of nursing. The discipline of nursing has built on and analysed other disciplines’ theories and knowledge in its search for identifying the caring concepts associated with nursing practice. Examples, have been obtained from an anthropological (Leininger, 1981a); historical (Leininger, 1981b) and philosophical (Ray, 1981; Fry, 1990) perspectives and have assisted the work of nurse theorists. Nurse theorists including, Rogers (1970), Benner and Wrubel (1989), Newman (1989), Gadow (1980), Gaut and Leininger (1991), Parse (1998) and Watson (1998) have debated that the caring essence of nursing ranges from and includes; a phenomenon Boyle (1984); a life force (Bevis, 1981; a potential science (Watson 1985); a process (Guthrie, 1981); a behaviour (Leininger, 1984) and an ideal (Watson, 1985). I am therefore following in this trend with similar aims through which to further extend and develop the knowledge and theories of the caring aspects of nursing in rural contexts, by engaging with the discipline knowledge from nursing and social geography.

1.4 Positioning this thesis in the disciplines of nursing and social geography

My academic work to date has provided me with a sound background with respect to nursing in a rural context within New Zealand. As I4 progressed into the development of my PhD proposal I began to question the most appropriate academic discipline in which I could position this research. This led me to enquire whether the discipline of nursing, in which I had previously situated my Master of Arts (Nursing) research, was

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4 Throughout this thesis the term ‘I’ is used referring to my own thinking from the first person perspective.
appropriate for this study. My original perspective on rural issues had broadened during the period I was the co-director of the National Centre of Rural Health (NCRH) and convener of the interdisciplinary Postgraduate Diploma in Primary Rural Health Care between 1998-2003. During this time I was introduced to a variety of disciplines’ perspectives related to health, nursing and rural society. It was through these encounters that I become aware of the relational aspects associated with rural community, residents, culture, economics, health and the dynamics associated with the evolving relationships the nurse engages with in rural geographical settings. This led me to seek a discipline that could accommodate the emerging aims of this research (further elaborated later on in this Chapter and Chapter four).

The Department of Geography at the University of Otago, situated in the South Island of New Zealand embraced my research topic while noting my difference as a nurse academic, rather than a social geographer. I originally approached this research as a social scientist within the academic discipline of nursing with a curiosity towards the discipline of social geography. As I worked through this research over a number of years in dialogue with the academic staff within the Department of Geography, University of Otago and delegates at the Royal Geographical Society conference in London in 2011 (where I presented the analysis of this study), I came to associate myself within the field of social geography and the potential connections this has for the discipline of nursing (discussed in Chapter nine). Situating this thesis within social geography offers a fresh, exciting, yet challenging approach to understand how the identity of the rural nurse has been constructed. Positioning this research in particular theoretical and academic ways produces different knowledge and different meanings from what a single discipline would have offered. Social geography offers a lens through which to open up the possibilities of acknowledging rural nursing as different and that understanding is a transformative experience which lends itself to identity construction (de Leeuw et al., 2011).

Knowledge from the disciplines of nursing and social geography have guided this research in its consideration of how social relations are enacted through the practice of nursing, as it is performed in rural place. I positioned this research with the aim of developing a deeper understanding of the social relations and social differences nurses may encounter in their practice. This evidence forms a platform from which to
engage the reader with the rural knowledge from the perspectives of both nursing and social geography.

Literature from both social geography and nursing could be presented as separate discipline entities however, there are several shared themes associated with rural disciplinary knowledge that flow through this literature, binding the knowledge generated from both disciplines’ perspectives together. This Chapter is a crucial component of this thesis, as it blends these two separate disciplinary perspectives with the ‘rural’. It is, however, interesting to consider that during the 1980s, both rural nurses (Bushy, 1991a; 1991b; Scharff, 1998) and rural geographers (Woods, 2011) were reflecting on their own understanding and contribution to the broader knowledge of rural issues (Cloke, 2006a). This reflection focused academics’ attention on understanding the rural, in order to generate a better understanding of how to go about understanding rural as a distinctive entity, which was worthy of further investigation within the academic world (Larson, 2002a). This debate is aligned with the provision of accessible, affordable and appropriate health care for rural residents who experience numerous barriers to access health care these barriers will be discussed later on in this Chapter. The aim for health care professionals and community leaders is to influence those whose positions could have an effect on policy, education, and government funding, for example, about issues associated with rural health care and health disparities (Walker, 2002).

Lee (1998) from the USA considered rural nurses contribution to the knowledge generation associated with concepts related to rural people, their work ethic and their health beliefs. At a later date, Litchfield (2001) from New Zealand was also investigating rural nursing practice which has led more recently, to a further expansion on these concepts revealed by Lee and Winters (2006) and Winters and Lee (2010) in the early 2000s. In the same era rural geographers’ academic thinking shifted with the ‘cultural turn’ in geography that introduced different ways of approaching, researching and thinking about social and rural geography (Cloke, 2006a; de Leeuw et al., 2011). A move away from the traditional social geographers’ research focus on socio-economic conditions to a broader appreciation concerning identity, difference and resistance, occurred. This approach enabled academics to seize an opportunity to make sense of how and where the traditional ideas initially
related to ‘regional geography’ and the rural was aligned with its functional (food and natural sources) relationships to the urban. These traditional ideas have been challenged by new understandings, methodologies and embracing the concepts of human geography, and more recently associating with ‘the introduction of post-modern and post-structural theories into rural geography’ (Woods, 2011: 8). These theoris have been exposed or uncovered by different experiences and meanings and to understand the rural more clearly (England, 2011). It is now timely to introduce how this thesis has drawn on the knowledge generated from social geography before looking at the links with nursing theory.

1.4.1 Social geography

By engaging with social geography an opportunity is provided through the process of studying how the rural nurses’ identity was constructed from the study area. This thesis draws on a background of written accounts by New Zealand nurses who discuss their nursing practice in rural contexts, and will be discussed further in this Chapter. To a great extent this existing literature describes nurses’ practice, focusing on what they do, rather than determining their identity, related to their unique social and community encounters in rural areas (O’Connor, 2003a; 2003b; 2003c; 2015) and more recently O’Connor (2016a; 2016b) has linked the context and rural nurses’ practice together. It will be through this investigation that the relationships, which connect the rural nurse with place, emerge.

Social geography challenges the world, while encouraging individuals not to take the world for granted, it is a diverse sub-discipline of human geography, and is better described as a discipline that overlaps with geography rather than retaining strict boundaries defining how it is constructed. As Panelli (2004) explains, social geographers are “prepared to investigate the intimate connections and collections of interactions that occur between diverse people and the spaces and places in which this occurs” (: 4). Social geography is therefore an open discipline, offering a dynamic approach to researching the connections and interactions people have with space and place (Cloke, 2004; Agnew and Duncan, 2014). Taking this approach has given this discipline openness to research within and about other fields of knowledge, while adapting to moves within other disciplines which also study the social world (Panelli,
2004; Del Casino et al., 2011; Porter and Howell, 2014). Nursing is one such discipline that has sought to study the world and the relationships that develop within this world (Watson and Smith, 2002).

Traditionally, the discipline of nursing has not considered utilising and engaging its research within the discipline of social geography. Therefore, theoretical concepts associated with relationships between rural nurses’ practice and ‘place’ have not generally been identified within the nursing literature. Conversely, Thompson (2006) an ex-nurse (as expressed by herself) situated her study in which she investigated rural and remote primary health care nurses’ professional identities situated between nursing and medicine, nursing and paramedic and intradisciplinary boundaries in isolated regions of New Zealand and based this study within the discipline of human geography. Thompson (2006) set out to understand more clearly the rural nurses’ professional work and challenge the alleged notions and beliefs that for the provision of first contact primary health care, that it was necessary those doctors provide that care. Including Thompson’s (2006) study into the discussion indicates that social geographers and nurses are interested with activities that occur in space and how people respond to them.

By situating this research within the discipline of nursing and utilising social geographies’ theoretical engagement of ‘place’ and identity, I have sought to enrich this study of nursing practice. Social geography is concerned with the study of social relations and where social practice occurs. It is the interaction between people, people of similar and different ways who enact their lives both, in a “material and socio-cultural sense” (Panelli, 2004: 3) which is of particular interest in this study. Social geography therefore recognises forms of social difference and social interaction and acknowledges that these differences occur within specific places or locations (Valentine, 2001; Panelli, 2004; England, 2011; de Leeuw et al., 2011). It is therefore fitting to engage with the discipline of social geography, particularly since difference is typically experienced, within and amongst rural health care and rural nursing practice (Blue, 2002; Litchfield, 2001; Thompson, 2006). In consideration of rural health care and nursing practice, the international and national aspects aligned with the provision of rural health care are now introduced.
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1.4.2 Nursing

The nature of rural nursing is summed up in the quote at the commencement of this Chapter by Scharff (1998), however I was intrigued to establish as to what encouraged a nurse to identify as being a rural nurse? It is in this study that this investigation occurs. I initially engaged with Scharff’s (1998) work in the early 2000s and have been interested, ever since, as to how she has captured the essence and significance of rural nursing. Each time I have read this extract of her work either in silence or out loud to colleagues, or student nurses, I am emotionally connected and engaged with the concept. Scharff initially published this work in 1998 (: 38) and then in 2006 (: 196) and again in 2010 (: 268) and has fascinated my curiosity as to why this same piece of work (which has not changed its focus) has continually been referred to for nearly two decades. It is therefore evident that through and since Scharff’s continual engagement with this piece of work, nurses’ who practice in rural contexts continue to associate with the identity, of a rural nurse. In this thesis, using this lens means examining the ways in which the rural constructs the nurse, in so much as the nurse recognises and associates with the rural and with their professional identity as a rural nurse which is discussed in Chapter eight and concluded in Chapter nine. As I progressed with this research I was interested to investigate why rural nurses are intimately connected and constructed through relations associated with rural place? To answer the ‘why’ question I have positioned this study within the interpretivist paradigm in which retrospective data was generated between 2006-2007. The study design will be further elaborated on later on in this Chapter as well as in the methodology and methods, Chapter four.

Throughout this thesis I engage with the occupational title referred to as the rural nurse, which is an internationally recognised term to describe a nurse who practises in the rural hospital (Ray, 1991; Bushy, 2000; Rosenthal, 2010) as well as rural community settings, namely the PHC nurse as defined by Davidson (2008), O’Malley et al. (2009) and Troyer and Lee (2010). PHC nurses offer a diverse range of health services including “child services, district or domiciliary nursing, health promotion, communicable disease screening and management, minor injury care and chronic disease management” (Carrey et al., 2015: 151). However, the rural PHC nurse in New Zealand may offer all or some of these health services as listed above, including
Primary Response In Medical Emergencies (PRIME)\(^5\) (Ministry of Health, 1999a; Davidson, 2008; Horner, 2008; Health Workforce Information Programme, 2009; O’Connor, 2015; O’Connor, 2016a; O’Connor, 2016b) and practice within the mobile surgical bus\(^6\) (Jamieson, 2008). This thesis has focused primarily on the rural nurse whose practice predominantly relates to the community within the domain of PHC. However, for some of those rural nurses who participated in this study, their practice did not fall discretely into either the community or the hospital setting, instead for a few of the nurse participants, their practice spanned both settings, which will be discussed further in Chapters five and six. This thesis has sought to add to the growing international and national theoretical underpinnings that inform an understanding about rural nurses and their practice, which is now elaborated on.

Rural nurse academics from the USA initially began investigating the particular aspects specific to rural nurses’ practise in the 1980s. Academics including, Lee (1998), Long and Weinert (1989) and Scharff (1998) believed that the existing nursing theories underpinning nursing practice were inadequate in capturing the core of rural nursing (Bushy, 2012). The work of these academics helped in developing the theoretical base for rural nursing practice. This was originally pursued by members of the Montana State University College of Nursing (Lee, 1998), supported by Anna Shannon the Director of this School of Nursing and which was further pursued by Helen Lee and her colleagues. This work concentrated on the situation in Montana during the 1980-1990s and was related to the regional rural population’s distinct beliefs and attitudes about health care and was based on the understanding that rural health provision was unique within the rural encounter. Scharff’s initial research was more focused on the “[w]hat of rural nurse identity” (Scharff, 2010: 268) and engaged with a framework to describe the nature and scope of rural nursing practice in which Scharff (1998; 2006; 2010) has highlighted the distinctiveness of rural nursing practice. These distinctive concepts include, the nature of rural nursing, and the scope of practice that aligns with the intersections, dimensions, boundaries and the core affiliated to rural nursing practice.

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\(^5\) PRIME provides pre-hospital emergency health care including accidents, trauma and medical care and was created to ensure a systematic and coordinated approach to deal with trauma and medical emergencies. PRIME is only available in rural New Zealand and engages with rural nurses and general practitioners to provide this health care service (Ministry of Health 1999a; Horner, 2008).

\(^6\) Purpose built mobile bus comprising an operating theatre service which travels to rural regions throughout New Zealand providing elective surgery (Jamieson, 2008).
Between 1980 and 2005 Lee and her academic team (Winters and Lee, 2010) continued to examine the key aspects revealing the particular nuances associated with rural nursing practice and have sought to add to the original theory published in Lee (1998). On-going work has been extended internationally and includes the research produced by MacLeod, et al. (1998) and Kulig, et al. (2010) from Canada as well as Hegney (1997a), Blue (2002) and Frances and Jacob (2012) from Australia, while Ross (1999); Litchfield (2001), Thompson (2005; 2006) and O’Malley et al. (2009) are some of the academics who have contributed from New Zealand. Despite this on-going national and international work, according to Bushy (2012), as of yet, there is no conclusive theory that integrates and underpins the practice of rural nurses’ and that what has been developed, is still in the early stages. As a result of this situation rural nurses have been misunderstood internationally and nationally (O’Connor, 2003a; Armstrong, 2008; Hutton, 2016). Chapter three engages with this broader discussion combining the international research related to the development of rural nursing theory which is aligned with the rural literature. In the meantime situating this research in context is now considered.

1.5 Situating this research in context

The context associated with this research is a particularly important aspect of the research methodology engaged with in this study. This qualitative study is positioned within the social sciences, and adopts an interpretivist approach. Unique to the interpretivist paradigm is the notion of ‘context’. Briefly, context is associated with the national and regional contexts of New Zealand and considers the broader social, cultural and organisational circumstances, as well as the physical locations which impacts on the study participants.

The context associated with this research is situated in rural Otago as discussed previously (in the Preface) and as the thesis progresses, this context will be further referred to both in the written form and through pictorial plates. The aim of this presentation is an attempt to engage the reader and enable them to become familiar with the unique aspects that could potentially have an influence on the rural nurses’ professional identity construction, in this region. In an effort to uncover the particular nuances associated with the rural context, the disciplinary knowledge and theories
from nursing and social geography are discussed in depth in Chapter three and aligned with the key concepts which are comprised in the conceptual framework guiding this thesis. What is interesting to consider is the notion of difference between the rural and urban contexts, as discussed in the literature (Bushy, 1991c; Ray, 1991; Blue, 2002; Farmer, et al., 2003; Cloke, 2006a; 2006b; Thompson, 2006; Barnett and Barnett, 2009; Hughes, 2009; England, 2011). This rural-urban debate links well with the challenge of defining why rural nurses consider themselves and their practice as different to urban nurses both internationally and nationally (Ray, 1991; Larson, 2002a; Bushy, 2012; Thompson, 2006; Davis, et al., 2014) and forms the basis of the aims of this study. To engage with the aims of this research discussed previously, insights into the broader aspects of the provision of rural health care are now briefly introduced.

1.6 The provision of rural health care: the international and national contexts

The provision of rural health care is of international concern (Hughes, 2009). Acknowledging and addressing the inequalities in the provision of rural health care is of significant importance for governments and health care practitioners (Ministry of Health, 2001; 2002b; Walker, 2002; Strasser, 2003; Bushy, 2012 and Hegney et al., 2014). Hughes (2009) recognises there are numerous disparities between the health care provision in developed and developing countries, while the need for all rural people to receive assessable, affordable, and appropriate health care is essential in both groups of countries (Bushy and Rauh, 1991; Larson, 2002b; Strasser, 2003; Bushy, 2012). The challenge for rural health professionals, such as doctors, nurses, midwives and pharmacists, who make up the majority of rural health care providers, is to increase access for the provision of health care. Numerous barriers exist which reduce health care access (Chapman et al., 2014) such as, transportation and communication (Wakerman and Lenthall, 2002; Hughes, 2009), technology, including limited cell phone coverage and broadband access (National Health Committee, 2010), poverty (Bushy, 2012) and challenges with the retention and recruitment of rural health care professionals (London, 2002a; Thompson, 2006; Hughes, 2009; O’Malley, et al., 2009; Crooks, 2012). Rural residents may experience all or some of these barriers in their attempts to access health care services in rural locations, either in the developing or in developed countries. Both Bushy (2000) and
Strasser (2003) have identified that health care resources are concentrated in the urban environments, limiting access and appropriate health care models for rural people.

The planning of specific and unique rural health care in developed countries has been, up until the latter part of the last century, essentially overlooked (Hughes, 2009). In developed countries health care planners assume health care services and policies developed for urban environments, can be easily adapted for rural areas, with the notion that the only difference is population distribution (The College of Family Physicians of Canada, 1999; Larson, 2002a; Long and Weinert, 2010). Equally, Strasser (2003) is concerned that the health care resources for rural residents are focused in urban environments. These realities raise significant concerns for rural health care practitioners, who seek to promote the planning of rural health care services, which requires the fair distribution of resources, and which takes into account individual rural communities’ health needs and associated barriers when accessing health care (Bushy, 2000; National Health Committee, 2010; Matsumoto, et al., 2013). It is essential that planners, with an urban or rural focus, acknowledge the differences between urban and rural health care requirements (Lee, 1991; Larson, 2002a; Matsumoto et al., 2013).

Urban dominance can partially be explained by the dramatic decline in the developed world’s rural population over the last century (Hughes, 2009) and the increase in urbanisation rates (Woods, 2011) which has caused an urban-rural divide, resulting in services and resources being dominated by the urban centres (Murray, 2012). As urbanisation increases it is important to note that the rural population worldwide is still equal to about half of the total global population (Hughes, 2009; Murray, 2012). This total global rural population is not representative in New Zealand as the proportion of the rural population is only 15 percent, as compared to about half of the global population (Statistics New Zealand, 2015). In consideration of these statistics, the planning and delivery of appropriate, affordable and accessible health care for rural people is the responsibility of governments, rural health care organisations, and rural health care practitioners (National Health Committee, 2010). Worldwide rural health care practitioners, including rural nurses, know only too well of the sacrifices made by themselves and the rural population as self-reliance and hardiness remain...
dominant features in contemporary rural locations and continue to be played out within the health care system (Bushy, 2000; Molinari, et al., 2012).

Rural health care practitioners generally care for small populations in isolated and physically remote locations that are considered a unique aspect of rural practice (Blue, 2002; Francis, et al., 2013). Rural health care practitioners tend to be associated with practising in rural locations in either small rural hospitals or in the community, based within the framework of PHC (Bushy, 2012; Carryer et al., 2015). PHC is normally the first point of contact patients or clients have with the health care system (Ministry of Health, 2001). The activities provided by PHC practitioners promote the health of the population they care for, manage episodes of illness, including acute and chronic presentations, disease management and end of life care as well as providing for health emergencies (Horner, 2005; 2008; Carryer et al., 2015). Rural health care practitioners care for all ages of the residents, visitors, and transient and seasonal workers (Fitzwater, 2008) as they engage with the health care system. Health care is provided within numerous models to ensure residents can access health care ‘24 hours’ a day. However, for some health care practitioners this means being on call for long lengths of time or sharing the on-call component with other health care members of their team (Armstrong, 2008).

The rural practitioners as mentioned above, work closely with rural residents, experiencing residents’ health and social issues as well as the barriers related to access to health care (The College of Family Physicians of Canada, 1999; Bushy, 2000; 2012; Davis et al., 2014). Practitioners have a unique dual-relationship with rural residents, as they generally both work and live in the same rural community as the people they care for, “providing much-needed care in the community setting” (Hughes, 2009: 208). A dual-relationship relates to a person who has more than one kind of association with another person, for example the nurse has a professional relationship with a rural resident but at the same time this resident is also the nurses’ neighbour and/or friend or family member.

The majority of rural health care practitioners experience dual-relationships as both an opportunity and as a challenge. Opportunities can be considered as engaging with the community and its residents while developing a long-term relationship with patients
and their families (The College of Family Physicians of Canada, 1999; Crooks, 2012). Some of the challenges affecting rural health care practitioners can be associated with working in the context of frequent socio-economic deprivation (National Health Committee, 2010), geographical barriers and reduced transportation (Bushy, 2009) as well as experiencing poor road conditions (Wakerman and Lenthall, 2002). Challenges such as these, together with the recognised barriers associated with personal and professional isolation, limited on-going education; lack of anonymity (Blue, 2002; Thompson, 2005; Crooks, 2012) limited professional development opportunities (Bushy, 1991a; Ross, 1996; 1999; Lee, 1998; Conger and Plager, 2008; O’Malley et al., 2009; Ministry of Health, 2009; Bushy, 2000; 2012; Molinari and Bushy, 2012; Davis, et al., 2014), and conflicting professional boundaries and role conflict, add to the complexity of the factors impacting on the retention and recruitment of health professionals as they practise in rural locations (Bushy, 1991c; Burton, 1997; London, 2002a; Palumbo, et al., 2009).

Further challenges compound the difficulties of practising health care rurally, as worldwide there is an uneven distribution of rural health professionals per capita of population in rural locations, when compared with urban areas (Martin and Martin, 1991; Hughes, 2009). Allied health practitioners, including physiotherapists, occupational therapists, radiographers, dentists and pharmacists are less likely than doctors and nurses to practice in rural and remote locations (Hughes, 2009; Hegney, et al., 2014). A reduction of health care practitioners leads to the lack of availability and recruitment of experienced health practitioners and a corresponding lack of rural planning and dedicated funding. These challenges, together with the limited financial resources and the “uneven geographical distribution of the… health care workforce” (Hughes, 2009: 205) are evident, as the rural geographical location becomes more isolated or remote over time. It is in these rural, geographically isolated locations, as described above in developed countries, that rural nurses form the majority of health care practitioners. These rural nurses deliver a diverse range of health services, often in demanding circumstances (Bushy, 2012). Martin and Martin (1991) appealed to the profession of nurses two decades ago stating that ‘[n]urses… must be willing to take a risk-to take a professional leap forward-and to assume an active role in addressing a national crisis’ (: 207). The national crisis these authors are referring to relate to ensuring the equity and access of health care in rural locations would be
maintained and delivered by rural nurses, which is extremely fitting with this research and will be discussed throughout this thesis. Background details about rural nurses who provide health care are now introduced.

1.6.1 Rural nurses who provide health care

In investigating the professional identity of the rural nurse and the connection between identity and place, this thesis draws on the international and national literature on rural health care and rural nursing. This literature has helped inform this topic while placing the study within the New Zealand context. A wealth of literature has been accessed addressing issues that are shared internationally, rather than being aligned with the situation in any one country. International studies from America (Bushy, 1991a; 1991b; 2000; Bigbee, 1993; Lee, 1998; Winters and Lee, 2010); Australia (Siegloff, 1995; Hegney, 1996; Keyzer, 1997; Blue, 2002); and Canada (MacLeod, et al., 2004; Kulig, et al., 2008) demonstrate that these rural circumstances are challenging, as nurses “assume many roles because of the range of services that must be provided in a rural health care facility, given the scarcity of nursing and other health professionals” (Bushy, 2012: 14).

Likewise, in New Zealand, throughout the past century anecdotal documentation has been captured, nurses have told their stories’ about their varied and complex rural practice which has been situated in diverse locations, examples include the far rural north of the North Island (Ancott-Johnson, 1973) the east coast of the North Island (Rutherford, 1953) as well as Great Barrier Island (Wise, 1949). Further examples include the pioneer nurses from the Marlborough Sounds situated at the top of the South Island (King-Turner, 2004) and Stewart Island, located south of the South Island (Swain, 1970). Nurses throughout New Zealand are continuing to provide the health care no longer available locally from allied health practitioners and at times, medicine (Frizzell, 1994; Ross, 1996; Echkoff, 1997; Litchfield and Ross, 2000; Litchfield, 2001; Jones and Ross, 2000; 2002; Fitzgerald, 2004; Thompson, 2005; 2006; Armstrong, 2008; O’Malley et al., 2009, National Health Committee, 2010). Rural nurses’ practise is further impacted on in this context as they experience professional isolation from other health professionals other than by telephone access (Ross, 2002; Armstrong, 2008). A New Zealand study by London (2003) noted the
rural nurses on the West Coast of the South Island “provide nurse led rural primary health care services… [t]hey are supported by a GP adjacent to each area who visits periodically to run clinics, [and] is available for telephone back-up” (: 6) (refer to Figure: 1.1 in the Preface to be acquainted with these geographical locations). Nursing practice in rural New Zealand varies depending on the availability of health care providers (Ross, 1999) and particular nuances associated with rural community health needs and their geographically distinct rural locations. Nurses have advanced their practice into the domains normally considered within the traditional boundaries of other health professionals (Hegney, 1997b; Thompson, 2006), filling a necessary gap left by health providers that would otherwise go unmet.

Rural nurses work in intradisciplinary, interdisciplinary and multidisciplinary teams, either in the same geographical location or at a distance from these teams (Ross, 2001; Armstrong, 2008). Also, some rural nurses practise in physical and professional isolation from colleagues which generally requires them to advance their scope of practice to include on-call functions incorporating emergency services. The work of rural nursing internationally is recognised as needing to be multi-skilled and a ‘jack of all trades’ (Hegney, 1997b).

In New Zealand, rural nurses’ practice is recognised as multifaceted (Ross, 1999), and their practice is considered as being generalists in the specialised practice area of rural health care (O’Malley et al., 2009). In addition some clinical rural nurses from New Zealand (nurses in clinical practice who have completed a piece of research as a requirement of their Master of Nursing degree) have also contributed to the growing body of knowledge, which underpins rural nursing practice. The variety of research topics examined have included the education requirements for rural nursing practice (Ross, 1996; O’Malley et al., 2009) advanced nursing practice (Ross, 1996; 1999; Jones and Ross, 2003; Maw, 2008), the establishment of nurses providing twenty-four hours on-call (Armstrong, 2008; Horner, 2008; Thompson, 2008), and specialist clinical practice areas, such as the mobile surgical rural bus which takes mobile operating services to rural communities (Jamieson, 2008). Campbell (2008) studied the experiences of rural women who cared for their partners through a terminal illness; likewise Boyd (2005) studied the experience of a rural nurse practising with dying clients. Ferguson (2008) studied diabetes prevention for rural Māori. Pederson
(2008) studied a nurse-led telephone triage service situated within a rural hospital, while Grimwood and London (2003a; 2003b) and Litchfield (2004) studied the effects of rural community development. Ross (2001) took a different approach and studied rural health professional teamwork. In addition, the particular nuances connected with the practice of nursing in rural settings has been researched by Thompson (2005; 2006) and Barber (2007) who studied the personal and professional issues associated with living and working in the same isolated rural community, which has been further developed by O’Malley et al.,’s (2009) rural nursing workforce strategy. Stratton’s (2009) research focused on her own lived experience of practising in a rural location and Patterson’s (2008) study acknowledged advancing nursing rural practice, which is supported by the use of clinical practice guidelines to inform, guide and ensure the rural nurses’ practice is safe and consistent.

The above mentioned studies have led to increased understanding of rural nursing practice in New Zealand and have demonstrated that rural nurses’ practice faces similar issues as rural nurses practising in other countries, such as discussed previously. Particular issues relate to the necessity for the rural nurse to adapt their practice to accommodate the particular health needs of rural residents, the implications of isolation linked with the challenges of practising rurally and the limited availability of other health care professionals. Rural nurses’ practice can be defined as a unique style of practice, which adapts and intervenes as necessary, to ensure that the best outcomes are met for individuals, families and community residents as a whole. In addition, rural nurses support other health care professionals, including their availability to practise in the rural context. The activities mentioned above are generally established through informal systems situated locally within the rural location (Thompson, 2008).

Studies such as those discussed above have ultimately influenced, challenged and changed numerous perceptions of nursing in rural locations. These perceptions relate to the professions of nursing and medicine, policy development, workforce planning (Health Workforce Information Programme, 2009) and government legislation linked to rural nurse education and practice (Ross, 2008; O’Malley, et al., 2009). In order for nurses to practise rural nursing it is imperative they understand the rural, their professional identity and how they practise in the way that they do, which is one of
the main foci of this thesis. However, despite a lack of an agreed understanding amongst researchers (as identified above) they do, however, agree that rural nursing practice is diverse and fragmented and that it is difficult to define a collective understanding of the work of this group of nurses which leaves a gap in the literature, which this thesis aims to help address.

1.7 Defining the professional nurse in New Zealand

Nursing, for the purposes of this thesis, is defined as an activity provided to the public by a registered group of professionals, practising within the occupational identity of a nurse. To be a member of this professional group all RNs in New Zealand must have undertaken formal education and have their name entered onto a professional register as governed by the Nursing Council of New Zealand (Goodwin, 2002). The RNs scope of practice is the predominant scope engaged with in this thesis however, and to a much lesser degree the Nurse Practitioner (NP) scope of practice (first established as a position in 2001) has also been referred to. NPs practice both autonomously and in collaboration with other health practitioners (Nursing Council of New Zealand, 2001). The differences between the RN and NP scope of practice is that NPs assess and treat health conditions, including health interventions such as; diagnosis of conditions; ordering and undertaking tests and administering the management of health needs. NPs prescribe medications under the regulation of the Medicines Regulations 2005 and the Misuse of Drugs Amendment Regulation 2005. In comparison to the NPs scope of practice, the RNs scope utilises the nurses’ comprehensive knowledge and skills to assess, plan, implement and evaluate health care to a broad section of the population in numerous settings. RNs are also involved with education, research, management of health care and political action (Nursing Council of New Zealand, 2007).

The practice of nursing takes place in numerous settings and geographical locations (Carryer et al., 2015). For simplicity, settings can be defined into two overarching contexts, the hospital and the community, including in various organisations, while geographical locations include urban and rural places (Dempsey, et al., 2009). Nursing practice can occur in a variety of hospital settings including, tertiary, secondary and regional hospitals. Hospital nursing is not always confined to the
physical hospital setting, some nurses’ practice is extended into the community, for example in people’s homes in the form of district nursing and outreach nursing services, for example, palliative care, paediatric, and wound management. Recently, surgical services are brought to the people who require minor surgical and screening services in rural areas in a purpose built bus which is termed the mobile surgical theatre (Jamieson, 2008). Nurses whose practice is linked to the hospital generally focus on illness and rehabilitative models of practice.

In contrast nurses who practise in the community focus on wellness, health promotion and education provided to individuals and groups within the community setting and practise within the PHC (Ministry of Health, 2001) philosophy. The goals of PHC are based on equity, access, self-determination, social justice and empowerment (McMurray and Clendon, 2015). Nursing within this model of practice is different to nursing practice in a hospital environment; nursing practice in the community is responsive to the community’s health needs and therefore presumes a preventative and monitoring aspect to maintain the health of community members (ST John and Keleher, 2007; Carryer, et al., 2015). Community nursing practice occurs in a number of diverse settings, for example, educational settings, workplaces, health care centres, correction facilities (prisons) and wherever people live and work for example, in residential aged care settings (older adult facilities) (ST John and Keleher, 2007) and nurse-led clinics held on the marae (a component of Māori culture related to the Indigenous people of Aotearoa, New Zealand). The marae represents an open space including buildings such as the meeting house where a number of community activities take place including planning the health needs and provision of health care with the local Māori7. Table: 1.1 provided on the following page provides a more detailed explanation of nurses’ changing occupational titles and employment settings over time.

7 The marae is an important communal place in respect to holding gatherings such as ceremonies, welcoming visitors and farewelling the deceased.
<table>
<thead>
<tr>
<th>Occupational Titles</th>
<th>Established</th>
<th>Description</th>
<th>Setting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registered Nurse</td>
<td>1901- continues to this day</td>
<td>Nurses’ Registration Act legislates nursing practice</td>
<td>Community and hospital urban and rural</td>
</tr>
<tr>
<td>District Nurse</td>
<td>1901- continues to this day</td>
<td>Established by Nurse Maude Association to care for people in their own homes</td>
<td>Community initially in Christchurch</td>
</tr>
<tr>
<td>Plunket Nurse</td>
<td>1907- continues to this day</td>
<td>Infant wellbeing</td>
<td>Community-urban</td>
</tr>
<tr>
<td>Backblock Nursing</td>
<td>1909-1930s</td>
<td>Established to care for the European settlers</td>
<td>Rural isolated community</td>
</tr>
<tr>
<td>Native Nursing (including School Nursing)</td>
<td>1911-1930</td>
<td>Established to care for Maori and become known as district nurses in the 1930s</td>
<td>Community, rural and Marae</td>
</tr>
<tr>
<td>Public Health Nurse</td>
<td>1911- continues to this day</td>
<td>Environmental health care</td>
<td>Community</td>
</tr>
<tr>
<td>Practice Nurse</td>
<td>1969/1970s- continues to this day</td>
<td>Initially aligned with rural general practice and later in the 1970s urban general practice</td>
<td>General Practice/rural community</td>
</tr>
<tr>
<td>Rural Nurse Specialist (RNS) &amp; Rural Nurse</td>
<td>1990s- continues to this day</td>
<td>Identified area of nursing incorporating a mixture of Practice Nursing, Public Health Nursing, District Nursing, Hospital care &amp; PRIME</td>
<td>Rural community</td>
</tr>
<tr>
<td>PRIME Nurse</td>
<td>1998- continues to this day</td>
<td>Emergency ‘24 hour’ on call practitioner</td>
<td>Rural community</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
<td>2001- continues to this day</td>
<td>Autonomous and expert practitioner with or without prescribing authority</td>
<td>All settings</td>
</tr>
<tr>
<td>Mobile Operating Theatre</td>
<td>2002- continues to this day</td>
<td>Rural nurses contributing to the delivery of surgical health care</td>
<td>Rural communities</td>
</tr>
</tbody>
</table>

Table 1.1 Nurses’ occupational titles and employment settings 1900-2000s
Source: Compiled by the author.
The following section of the Chapter now moves on to position myself as a component within the research process. This qualitative thesis is recognised as a subjective engagement with the research process. The subjective elements offer the researcher the ability to make choices concerning the research methodology and methods which reflect values, beliefs and circumstances, including the presentation of analyses and findings (Weaver and Olson, 2006).

1.8  My positionality within this study

I am stating my position early on in this thesis so the reader has a fuller picture through which to better understand my subjective position, my rationale for the study design, my relationship with some of the participants and my background association with the research topic. In the process of establishing my subjective position I am unable to separate myself from this research process. To do so would be misleading and not in keeping with this qualitative method. For this reason I engage with the first person and therefore I use the term, ‘I’ (as discussed previously) to discuss my positionality throughout this thesis.

Throughout this thesis I stipulate my relationship to this research topic and have positioned myself as part of the social and research context. In doing this, I draw on the participant’s understandings and make clear my relationship to the topic. Atkinson (1990) describes this as reflexivity. I understand that as part of my reflexive position it has been impossible for me, as the researcher, to stand outside and be totally separate from this research, therefore my engagement throughout the study has been a central component of the research process. I bring a strong sense of myself to this study and the reason for this is that I first registered as a RN in 1982 in Wales (where I trained as a RN). I registered in New Zealand as a RN in 1991 and I have continued to maintain my annual practising certificate and practise as a RN in the clinical domain and the educational and research areas, throughout this duration. I have also involved in a number of distinctive rural nursing activities in New Zealand throughout the past two decades. I have been a qualified registered nurse since 1982 and practised as a rural clinician in the UK in North Wales and Oban in Scotland. In New Zealand I have also worked as a rural clinician in rural Canterbury and have been involved with the development and co-ordination of the interdisciplinary
Chapter One

postgraduate rural health diploma and supervision of student master’s research (offered through the Christchurch School of Medicine and Health Sciences, University of Otago in Christchurch and the Otago Polytechnic in Dunedin, respectively). Currently, I am involved with developing the educational rural content within the Bachelor of Nursing degree at Otago Polytechnic, in Dunedin (the Preface details these geographical locations).

In addition, I have previously been involved with the New Zealand Ministry of Health’s rural development initiatives with the aim of improving the health of rural people which was also a priority interest for me. This initiative was based on the use of a multifaceted approach aimed at formalising a rural strategy as well as improving the health care of rural people (Ministry of Health, 2002a) and there was an energetic focus on retention and recruitment of staff, particularly directed at General Practitioners (GPs) (London, 2002a). During 1994-2002, I was a member of a multidisciplinary team focussing on the improvement of rural health care, situated in the Canterbury region of the South Island and a national team of dedicated health professionals, rural community residents, researchers, educationalists, Ministry of Health analysts and politicians. This work was very much guided by international colleagues particularly from Canada and Australia, in their attempts to develop parallel strategies to also improve rural health care in their own countries (pers. comm. Rural General Practice Network, 2006).

During the time of the developments mentioned above, I was introduced to a number of influential international rural health care academics who guided and supported the work we were progressing within New Zealand. This work led to the setting up of the Centre for Rural Health (CRH) and the National Centre for Rural Health (NCRH) between 1994 and 2003 in which I was co-director and involved in planning, developing, lobbying for and working with rural nurses. The main areas of this work have been in the development of rural teamwork and interdisciplinary postgraduate education and the development of the political and professional profile of rural nurses. This has been achieved thorough the medium of the Rural Nurse National Network (of which I was founder and co-ordinator) established in 1996 and which continued to politically support rural nurses until 2005. The Rural Nurse National Network joined with the New Zealand Rural General Practitioner Network in 2006/7 (Rural General
Chapter One

Practice Network, n.d.). With the joining of these two networks, the New Zealand Rural General Practitioner Network changed its name to the New Zealand Rural General Practice Network. Through my position as the co-director of the NCRH I demonstrated my commitment to the nursing profession, education, research and the support and career development of rural PHC nurses. During this time I worked with colleagues facilitating the development of the advancing practice of rural nurses and the more recent development of the NP in New Zealand (briefly introduced above).

My research activities and interests have included studying the aspects of rural practice nursing (Ross 1996; 1999), career development strategies (Jones and Ross, 2002; 2003), rural teamwork (Ross, 2001) and the rural content for student education (Ross, 2012). These activities were developed between 1995 and 2010 time periods (Chapter two provides a more detailed account of how this work evolved) and provided me with valuable experience that led to further engagement with colleagues at international and national conferences, meetings and networks. These professional relationships have further extended my contribution within the academic rural health community. My varied rural experiences have increased my interest in the dynamics of the provision of rural health care and increased my curiosity and desire to continue to add to the growing theoretical knowledge aligned with rural nursing in New Zealand.

The work I undertook with the NCRH focused my curiosity about rural nursing practice and my particular interest has been to answer the questions relating to the: ‘What, How and Why’ of rural nursing in New Zealand which are also the aims of this study (as highlighted previously). By fulfilling these research aims I hope to gain significant insight to add to the growing body of international and national knowledge on this topic. Additionally, this knowledge may enhance rural nurses’ insights about their practice and how their contribution evolved in the delivery of rural health care services. My aim throughout this thesis has been to be as transparent as possible I have embraced the academic research process and I have been able to reflect critically on my involvement with the advancement of rural nursing during the 1990s and early part of 2000s. However, during the course of progressing with this thesis my direct participation in national rural developments has been significantly reduced as my role
in this research has developed resulting in very limited national engagement, other than rural conference presentations and attendance.

Panelli (2004) explains social geographers write “from somewhere… from locations that are physical, cultural, political and [epistemological]” [emphasis removed] (1). Writing from somewhere provides me with the opportunity to consider my differing positions such as the researcher, clinician, nurse and community member, in relation to the context and evolving interpretations of the field over time. I understand this as my positionality which is discussed in more detail in Chapter four and throughout this thesis.

1.9 Thesis outline

This thesis is presented in nine chapters. The aim of this study has been presented in Chapter one. Chapter two discusses the contextual events related to the socio-political, professional and economic events in which nursing and particularly rural nursing was constructed prior to and during the identified study time of the 1990s and the early 2000s. The contextual events are engaged with, in order to consider whether they were responsible for constructing the professional identity of the rural nurse. This discussion is presented diagrammatically by engaging the reader with the first of three phases of the adapted ‘Funnel Model’, initially developed by Robèrt (2000) but presented diagrammatically throughout this thesis by Broman and Robèrt (2015). This Model, which forms a key element of the conceptual framework guiding this research and presented in Chapter three. This Model also plays a part in the overall analysis and is explained in Chapter eight. The first phase of the Model, focuses on the 1980s-1990s time period, and reflects how neo-liberalism progressed and the associated restructuring of the health care system both nationally and regionally. The visibility of rural nursing practice set against the neo-liberal ideology of the health care reforms in the 1980-1900s draws on the notions of ‘governmentality’ in the repositioning of the provision of health care as state, discipline and self-governance as discussed by Foucault (Gordon, 1991). It is recognised that, during this time, the nursing profession was going through significant national changes relating to advancing nursing practice, education and legislation. These national changes also impacted on the establishment of the rural nurses’ professional identity associated
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with the rural Otago region and leads onto the ongoing developments of PHC in which the contemporary rural nurse is currently positioned.

Chapter three establishes the conceptual framework and includes six key concepts that frame up this study and which when aligned together provide a framework in which to guide this study. These six key concepts include identity, ‘place’, the ‘rural’, professional caring, the notion of ‘governmentality’ and also presents the ‘Funnel Model’. To appreciate the identity and practice of rural nursing, this study draws on the disciplines of nursing and social geography to underpin the six key concepts guiding this study and takes a broad appreciation of identity and how identity is ‘acted out’ within the context of place and in particular rural place.

Chapter four discusses the research process including the philosophical underpinnings and methodology associated with the interpretive paradigm. Chapter four, further moves on to discuss the research methods I engaged with, including the semi-structured interviews conducted with, which traces the steps I undertook, including securing ethical approval for the study. The method of data analysis, which is aligned with a thematic approach, is discussed, including how I uncovered the themes and subthemes including the use of photo image to further enhance the analysis. The national key informant and the regional rural nurse participants are introduced and the rationale for their inclusion and the use of semi-structured interview techniques I used, are detailed. I present the approach I took to present the research analysis and findings as well as the credibility of the research is discussed together with my positionality.

Chapters five, six and seven, each present different but complementary aspects of the study’s analyses and findings in the written and through the aspects of image as identified from the rural nurse participants as well as my interpretations. Through answering the research questions exposes how ‘place’, as discussed by Agnew (1987) constructs the identity of the rural nurse, where the rural nurse works, how the rural nurse practices and further, how these nurses contributed to the rural health care sector during the 1990-2000s. The rural nurses’ identity is further understood by applying the four nursing’ core concepts of care, ‘environment’, ‘person and health’ and ‘nursing’ (Torres and Yura, 1994) which are aligned with Agnew’s ‘place
framework’, ‘location’, ‘locale’ and a ‘sense of place’ and corresponds with Chapters five, six and seven (respectively). These three Chapters present rural nurses’ identity construction from the identified location, as the outcome of having a ‘sense of difference’, a ‘sense of change’ and a ‘sense of self’. Chapter five identifies with the first aspect of Agnew’s (1987) ‘place framework’, ‘location’, and nursings’ theoretical perspectives ‘environment’, which is associated with the key analysed theme, ‘sense of difference’. This approach assists to position this analysis, while uncovering and highlighting the conundrums of rural nursing practice that is ‘different’ to urban nursing practice and, therefore does not always meet national nursing aspirations.

Chapter six further engages with Agnew’s (1987) ‘place framework’, ‘locale’ which aligns with the second analysed key theme, ‘sense of change’. ‘Sense of change’ has been identified from the rural nurse participants’ and the national key informant participants’ data, presented as the most appropriate place in which to align the contextual issues which occurred during the identified study time period 1990-2000s which could have contributed to the rural nurses’ professional identity construction. Chapter six also demonstrates how the rural nurses’ practice is governed from a distance and how the rural nurse governs their own conduct within ‘locale’ (the rural context). Further, this analysis is associated with the second of the nursing core concepts of care, ‘person and health’ to add to growing understanding of the construction of the identity of the rural nurse (Torres and Yura, 1974).

Chapter seven engages with Agnew’s (1987) third aspect of his ‘place framework’, a ‘sense of place’, which corresponds with the third identified key theme, ‘sense of self’. The analysis and findings associated with the rural nurses’ professional identity in relation with ‘place’ has been deduced from the participants’ contributions and this Chapter explores the notion of the ‘self’ (the rural nurse) as a moral agent who practices and governs through a ‘sense of place’ and is further developed to enhance the understanding of the construction of the identity of the rural nurse by engaging with the fourth concept of the nursing core concepts of care, ‘nursing’ (Torres and Yura, 1974). It is the embodiment of local rural realities that also construct rural nurses’ practice, which is a cue leading into the discussion and argument presented in Chapter eight.
Chapter eight presents the discussion of the thesis argument and demonstrates how the professional identity of the rural nurse was established from the identified study location. This argument is central to this thesis and is presented by engaging with two forms of media and includes a written dialogue, which is further elaborated on diagrammatically in what I have termed the ‘analytical place-based matrix’. This ‘matrix’ consists of three phases, the ‘contextual phase’ which positions the neo-liberal changes including the national and regional events and economic conditions related to the establishment of the professional identity of the rural nurse that was identified in Chapter two. The second aspect of this matrix presented in Chapter eight, the ‘performance phase’ comprises two main features analysed from the data including ‘place’ and ‘governmentality’. The ‘performance phase’ demonstrates the role played by governance structures, including state, discipline and self-governance, which further construct the rural nurse’s professional identity in ‘location’, ‘locale’ and ‘sense of place’ while engaging with the four aspects of nursing core concepts of care. The third aspect of the matrix, the ‘transformational phase’ also presented in this Chapter, which engages with both ‘place’ and ‘space’ simultaneously, with the intention of positioning the rural nurses’ identity as, transformational. It is in this Chapter I argue that understanding ‘place’ matters to rural nurses and that rural nursing and rural place are mutually constitutive. Framing up the argument in this way provides a unique approach through which I can potentially capture the interest from the rural nurses, the discipline of nursing and others related to nursing practice, including policy-makers and use this as a basis to initiate ongoing dialogue. It is in this Chapter I summarise how the thesis discussion has unfolded, which moves on to Chapter nine to present the thesis conclusion, and which reveals future research possibilities as well as the limitations associated with this research.

The focus of Chapter nine is to provide a conclusion of this thesis and in it I reflect on my contribution to the development of knowledge created in the process of undertaking the research. In nursing terms, this thesis informs the conceptual and theoretical basis of rural nursing practice and in terms of social geography it has the ability to further contribute to rural identity and place theory development. I also offer my interpretation of the limitations of the thesis and set out future recommendations and suggestions for further research.
1.10 Summary of Chapter

In this Chapter I have positioned the delivery of rural health care as an international and national concern and has offered some insight into the theoretical understanding of the delivery of health care by rural nurses’. The aims, research scope and the significance of the research have been discussed together with my positionality associated with this study. Also considered are the rationale for situating this qualitative and interpretivist study within the disciplines of nursing and social geography, which are of particular interest in this study. In the following Chapter the contextual events related to the socio-political, professional and economic events, through which rural nurses were constructed prior to and during the identified study time period, are presented.
CHAPTER TWO: THE CHANGING HEALTH CARE LANDSCAPE
CONSTRUCTING RURAL NURSING PRACTICE

The move towards greater population focus and emphasis on a wide range of services will increase the need for well-trained primary health care nurses. Such nurses will share a common set of generalist knowledge and skills as well as developing advanced skills in particular areas of professional practice… [p]rimary health care nursing will be crucial to the implementation of the [s]trategy...

(Ministry of Health, 2001: 23)

2.1 Introduction

In this Chapter I present the socio-political and economic contexts leading up to and including the major health care reforms introduced in New Zealand in the period from the 1980s. These health care reforms had a profound effect on the health care system and those health care practitioners, including nurses, and in particular rural nurses, who practised within those systems. A synopsis of events is presented and the application of different ideologies, which occurred over a significant period of time in which nurses transformed from an unregulated to a regulated workforce. These events have lead up to the recognition of the crucial role nurses played in the success of PHC as highlighted in the quote above. This retrospective study is situated in the time period between the 1990s and the early 2000s in which the professional identity of the rural nurse was constructed, as the rural health care sector was undergoing significant changes. The major health care reforms of the late 1980s and more specifically the 1990s reflect the adoption of neo-liberal ideology in all aspects of the management of the society and economy by the government (Gauld, 2001) and will be discussed throughout this Chapter. These reforms challenged the previous traditional welfare focus and the state reforms of the 1930-1980s (Dalziel and Saunders, 2014). A general overview of these changes and what led up to them, is introduced and the effects these had on rural New Zealand and the delivery of rural health care and nursing practice is discussed. Detail is then provided into the effects,
which these health care reforms and the associated development of the RCTs had on
the delivery of health care within the study location, the rural Otago region (refer back
to Figure: 1.1 for this geographical location).

The nursing profession was also going through significant changes during the 1990s.
These changes were associated with advances in nursing practice, the provision of
postgraduate education and variations to professional regulations. Both national and
regional nursing developments impacted on the rural nurses’ practice in the study
location and are critiqued in the light of these imposed changes with the rural
contextual background drawing on the interpretivist paradigm (the research
methodology) presented in Chapter four and further engaged with in Chapters five,
six and seven as a way to position the thesis analysis.

2.2 Outline of Chapter

The content of this Chapter is divided into three sections. The first section
commences with an overview of the changing health care system in New Zealand in
which the rural nurse has been positioned from an unregulated to a regulated nursing
workforce to provide a health care service that has evolved and adapted in response to
a shifting health care system. The three significant periods associated with the
changing health care system, commencing from New Zealand’s pioneering period in
the 1840-1930s is introduced in section two. Included in this section is the health care
reforms instituted between 1938 and the 1980s, including the establishment of the
welfare state (Dalziel and Saunders, 2014). This section also includes New Zealand’s
major health care reforms of the 1980s, and the associated shift in the philosophical
position from that of state welfare which was established by the Labour government
(in the 1930s) to a neo-liberalist approach founded initially by the Labour government
and continued when the National government which came into office. The associated
restructuring had major consequences for nursing practice that are discussed in this
section, together with the nurses concerns and what they achieved to promote their
practice and the recognition of their role. The successful work of national nurse
leaders associated with the improvement and the advancement of nurses’ practice and
how they responded to the health care reforms are discussed in relation to the third
section of the Chapter. This third section focuses on the more recent health care
reforms, associated with yet another significant change to the political ideology, this time embarked on by the Labour-led coalition government from 1999 (Barnett and Barnett, 2005). The health care system at this stage was transformed by situating PHC at the centre of health care, while also considering nursing as crucial to its success (Ministry of Health, 2001). The changes that occurred during the 1990s and early 2000s which had an effect on the health care system and nursing practice are discussed and represented diagrammatically in Figure: 2.1 in this Chapter, termed as the ‘contextual phase’. The ‘contextual phase’ layers a basis for later discussion related to the thesis analysis and discussion (represented in the ‘performance phase’ in Figure: 8.1 and the ‘transformational phase’ in Figure: 8.2 and finally presented collectively in a synthesised form, diagrammatically in Figure: 8.3 in Chapter eight). The overall focus of this Chapter is to present the nurses’ contribution to a changing health care system which has been positioned throughout an evolving socio-political and economic context.

2.3 The changing health care system and nurses’ contributions

Nurses are a registered group of professionals, practicing within the occupational identity of a RN. However the professional identity of nurses in New Zealand has not always been related to this systematic process as nursing has undergone significant changes over the past 160 years. During this time nursing practice has transformed from an unregulated to a regulated profession. In the 1840s unregulated nurses provided health care to the European settlers in their own homes, as there was limited availability of hospitals during this time (Tennant, 1989). These women became known as ‘nurses’ even though they had not undergone formal training (Burgess, 1984; Rogers, 1985). These ‘nurses’ (all women) were in a position to provide health care if they proved they had “medical knowledge and skill” (Papps and Kilpatrick, 2002: 1) to prospective employers.

The New Zealand health care system, which has evolved over an approximate one hundred and sixty year period, was originally based on a British style of health care, which has had a profound influence on the developments of this country’s health care system (National Health Committee, 2010). The developments of the health care system evolved through a number of differing phases, initially associated with the
Chapter Two

pioneering phase, secondly the state welfare phase, and latterly the neo-liberal phase, leading to the PHC phase. Nurses have been a part of all of these phases in different guises and to differing degrees as representative of their commitment and response to the delivery of health care. During different times throughout this period (from the late 1880s including and up to the early 2000s), there have been various approaches and changing attitudes to the governance and practice of health care. Nurses’ have adapted their practice to accommodate these changes and the health needs of community members and this will be discussed throughout the remainder of this Chapter, commencing with nurses’ relationship with the pioneering phase.

2.3.1 Establishing a health care system in the pioneering phase 1840-1930s

The provision of a nationally formalised health care system did not eventuate in New Zealand until the 1860s (Burgess, 1984; Gage and Hornblow, 2007). Prior to this there were “only a small number of cottage hospitals in the main centres of settlement and the gold fields of Otago and Westland, and a small and unregulated health workforce” (Gage and Hornblow, 2007: 330). During the latter part of the nineteenth century there was no public health system, and there was a belief that residents “who could afford to do so were expected to see to their own [health] needs. Those who could not were served by hospitals and the benevolence of practitioners forgoing their fee” (Oliver, 1988: 114). The gold rush in the South Island of New Zealand during the 1860s and 1870s, resulted in the arrival of gold seekers from Asia and Australia, and as the European population increased and settled in the rural regions to farm the land\(^8\), the provision of health care needed to become more organized, however funding was unreliable and difficult (Gauld, 2001). To counteract this problem the state acknowledged its responsibility and commitment to provide health care to the residents of New Zealand, while at the same time attempting to limit the amount of state funding committed to health care (Gauld, 2001). In response, the state passed the Hospital and Charitable Institutions Act in 1885. The aim of this Act was to

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\(^8\)To establish farming the native bush was cleared (an issue for Māori with the confiscation of their land and their identity) and replaced with grass with the prospect of rearing sheep initially and later cattle (Jones, 2007). The effects of farming continued from this time to support and prosper the New Zealand economy until the 1980s when there were substantial changes to the economy (Jones, 2007) which had a profound effect on the identified study location, and will be discussed in the third phase of the health care changes associated with the continued restructuring of the health care system (National Health Committee, 2010).
create local Hospital Boards whose task was to take on the full responsibility for generating local funds from ratepayers, voluntary donations, and patient fees and to a much lesser extent to rely on a subsidy from the state, to pay for local and regional health care.

The state had good intentions when it strove to unify the health care system, which was comprised of hospitals (secondary care) and the community (primary care) (Barnett, et al., 1998). The subsequent increase in the population prompted the development of new local and regional Hospital Health Boards, which further complicated co-ordination in the provision of state health care. Furthermore, a growing population increased the number of public health concerns linked to epidemics such as smallpox and typhoid fever (Gauld, 2001; Wood, 2001). At another level, there were medical practitioners (referred to as Officials) responsible for sanitation, food hygiene, notifiable diseases and ‘public nuisances’. Other diseases came under the responsibilities of the province or regional locations (Oliver, 1988). The state worked to deliver the health system and, at the same time, gave the local Hospital Boards authority to govern and run their hospitals. What eventuated from this governance structure, which has continued to this day, was the emergence of influential groups such as the medical profession (Barnett, et al., 1998) and members of local communities that were positioned to influence the policy-making processes (National Health Committee, 2010). Nursing during this time was also going through significant changes, which will now be discussed.

2.3.2 From an unregulated to a regulated nursing workforce 1880s-1900s

This pioneering phase increased the population which eventually resulted in the provision of more hospitals. However, the standard of care provided in these hospitals was minimal, with untrained staff and convalescing patients helping to provide care to sick patients. Hospitals were not very pleasant and only the very sick, poor and destitute patients used these facilities. The unpleasant aspects of the provision of health care led to the then medical hospital administrator, encouraging British trained nurses to come to New Zealand and provide the necessary health care in these hospitals (Stewart and Austin, 1962; Burgess, 1984).
British nurses had received significant training, which was based on Florence Nightingale’s educational model that originated out of the Nightingale School situated at Saint Thomas’s Hospital in London (Orem, 1991). These British trained nurses demonstrated they could indeed improve the health care provided in New Zealand hospitals. These improvements had a profound influence on the future success of the provision of health care and nurse education and ultimately their professional identity. Nightingale is a respected figure within the nursing profession and her work has been influential in shaping the education and regulation of nurses in New Zealand (Papps, 2001). Formal education and regulation continues to construct and regulate the contemporary RN to this day (introduced in Chapter one) and significant changes to this formal education and legislation have eventuated (Papps, 2001) which will be further discussed later on in this Chapter and in relation to the rural nurse participants’ practice and their overall identity construction in Chapter six. In the meantime the formalisation and the regulation of nursing that took place in rural New Zealand is discussed in the following sub-section.

2.3.3 Formalization of nursing practice in the rural context 1909-1970s

In 1909 a formalized nursing service referred to as the Backblock Nursing Scheme (BNS) was created in New Zealand to provide health care for the increasing European settler population which was establishing itself in more remote rural locations (Wood, 2009). Formal nursing practice was established as a result of the 1901 Nurses Registration Act, which was linked to nurses’ receiving formal, hospital training (Burgess, 1984; Papps, 2001), and which raised the “status and social position of nursing” in New Zealand (Gage and Hornblow, 2007: 331). The BNS was one aspect of formalised nursing practice which provided a health service comprising nursing, public and emergency health care as well as midwifery services (refer back to Table: 1.1 in Chapter one for a description of nurses’ occupational titles) to the European settlers, in the remote areas of New Zealand (Wood, 2008; 2009).

In these remote rural locations, referred to as the ‘Backblocks’, the recruitment of doctors was difficult, because of the isolation and sparsely populated areas (Wood, 2008). Therefore, the responsibility of the Backblock nurse was to become the local health resource for the settlers and would maintain in regular contact with the nearest
resident doctor, who was at a distance (often some fifty miles away) and located at the district’s base hospital (Wood, 2008). The BNS was funded by several initiatives. If settlers from the same region requested to have a local nurse to care for their community members, they would group together to pay the cost of half of the nurses’ salary and their expenses (Wood, 2008). In addition to this upfront payment, there was an additional charge to the settlers and family members if and when they used the services of the nurse. Settlers who paid into the BNS were charged a lesser consultation fee when they used the service. Settlers not part of the scheme were charged a higher amount and for those settlers who could not afford to pay for the service, their fees could be waived on the discretion of the nurse. The fees collected were sent to the Hospital Board (by the nurse), and added to the settlers’ contributions, while any outstanding amount owed, was paid by the hospital board through a government subsidy to reimburse the nurses’ salary (Wood, 2008).

The BNS served to provide accessible health care for settlers and their families for illness, accidents and childbirth and as time progressed (and the need arose for such public health initiatives) in other areas such as such as sanitation. This availability of health care reduced the expense, time and difficulty for settlers and their families of travelling to access medical care in larger, distant centres. Through this scheme, the Hospital Boards could demonstrate their commitment to the wellbeing of the settlers’ health in relation to them working on and opening up the land, while contributing to New Zealand’s primary economic sector through farming (Wood, 2008). Hospital Boards “considered those [settlers] in rural areas had the same right to a health service as their urban counterparts” (Wood, 2008: 169). Backblock nurses demonstrated their contribution to the delivery of an extensive range of health care activities as a result. Backblock nurses responded to the changing health care environment and over time adapted and expanded their practice. In the process of this adaptation, so too did the professional status of these nurses change, according to Wood that,

[…] for nurses taking on the role, it provided a chance for independent practice and greater responsibility, far from the hierarchical systems and practice in hospitals. …sometimes with the resentment of the districts’ doctors who felt their income would be threatened.

(2008: 169)
As the years progressed into the 1920s and 1930s, the retention and recruitment of Backblock nurses became problematic. This occurred despite the opportunities to practise in an autonomous and solo capacity in which Backblock nurses utilized all of their clinical experience and skills to care for the settlers and their families. On the negative side, these nurses practised in harsh and professionally isolated conditions, their role was demanding and most of them only stayed a maximum of two years in the role (Wood, 2009). Despite the physical isolation these nurses were able to communicate together by writing letters and responding to each other in which they discussed issues relating to their practice (establishing a clinical peer review process). The letters and responses by the Backblock nurses’ were published in the New Zealand nursing journal, Kai Tiaki Nursing New Zealand, which was founded in 1908 (Kai Tiaki Nursing New Zealand, 2016) by the most prominent nurse in New Zealand at the time, Nurse Hestor Maclean (Maclean, 1932). Her prominent role included being assigned, the assistant inspector of hospitals and director of the Division of Nursing in the Department of Health.

A similar nursing scheme to the BNS was established in 1911 to care for the rural Māori population and was referred to initially as the Native Nursing Scheme (NNS) (Maclean, 1932; Burgess, 1984; Wood, 2001), and was renamed the Māori Health Nursing Service (MHNS) in 1922. It was recognized in this scheme that Māori nurses would be the most appropriate practitioners to provide health care and health education to (Maclean, 1932; Burgess, 1984).

The nurses associated with the BNS and the NNS continued to practise up until and including the 1940s when these categories of nurses were merged for the first time with urban nurses. The occupational identities of nurses who practised in the community were, at this time, defined as either the district nurse which was initially established in Christchurch in 1901 and referred to as the Nurse Maude scheme (Burgess, 1984; Wood, 2001), the public health nurse, or the Plunket nurse (developed in 1930s as a part of the Royal Plunket Society, established in Otago). In the 1970s, the role of the rural practice nurse was established (Docherty, 1996) with a similar ideology as the Backblock Nurse, namely to support the health care services in rural locations and to support the doctor (discussed later in this Chapter). These nursing developments laid the basis for another phase in the restructuring of the health
care system during the 1938-1980s period which were aligned with the New Zealand health care reforms and the welfare system established in the twentieth century. Between 1909 and 1970 nursing continued to contribute to the delivery of primary health care services, (referred to during this time as community health care). Nurses were no longer employed as Backblock nurses serving the remote rural communities, but nurses from the 1940s onwards were referred to as district, public health, and Plunket nurses, generally visiting people in their homes and workplaces as well as children at school both in the urban as well as rural settings. The district nurse, public health nurse and the Plunket nurse, all worked independent of GPs (Hasler, 1992; Wood, 2001). It was in the 1980s that nurses commenced working alongside GPs with the setting up of the practice nurse within general practice (and will be discussed later on in this Chapter). These nursing developments are now discussed in relation to the health care reforms of the twentieth century.

2.4 New Zealand’s health care system and nurses’ contribution throughout the twentieth century

The New Zealand’s health care system in the twentieth century changed from the pioneering phase of the nineteenth century (discussed previously) to one of a welfare phase. The establishment of a universal welfare state (Barnett and Barnett, 2005) was championed by the first Labour government in 1938 with a plan to develop a “nationalized, integrated health service, accessible to all regardless of socio-economic status” (Gauld, 2001: 24). This health care phase (referred to as the ‘welfare phase’) persisted without any noteworthy change until the major health reforms of the 1980s and 1990s, despite episodic attempts by governments at reshaping the health system (Dalziel and Saunders, 2014). The most significant change that occurred in the second phase of the health care reforms in the twentieth century was the passage of the Social Security Act of 1938. This Act attempted to restructure the health care system and establish a universal welfare state (Burgess, 1984).

2.4.1 The Social Security Act 1938

The first Labour government sought two main aims with the passing of the Social Security Act of 1938 (Gauld, 2003). The first aim was to provide numerous benefits
for people experiencing hardship such as widows, orphans, the unemployed or those affected by other circumstances which could lead to poverty (Oliver, 1988; Dalziel and Saunders, 2014). The second aim was to create a health care system where secondary and primary health care services would be free of charge (Prince, et al., 2006; Dalziel and Saunders, 2014). These services included health care in the community and the hospital as well as included mental health care, dentistry and health promotion activities (Gauld, 2003), as well as maternity care and medications including prescriptions (Oliver, 1988).

At the same time, there was a concerted effort by the medical profession to offer health care services in the community, which was recognised as general practice, and towards the end of this period (in the early 1970s), nurses (referred to as the practice nurse) were established in general practice (what is important to note is the practice nurse, was initially constructed to practice only in rural locations) as discussed in the following part of this section. The Labour government’s plans to provide free health care for all New Zealanders did not fully eventuate, mainly because of GP resistance to becoming a salaried practitioner (Oliver, 1988; Easton, 2001; Barnett and Barnett, 2005). The following section engages with the establishment and funding of general practice and the setting up of this new nursing role in the late 1960s that of the practice nurse.

2.4.2 General practice and the establishment of the practice nurse (rural)

Between 1938 and the 1980s, GPs could set up practice wherever they wished to. Traditionally this was as solo practitioners and at times GPs set up practice in their own homes. The government, whom they contracted their services directly to, did not have any means to regulate the number of general practice clinics (Barnett, et al., 1998). Payment for health care services came from the government who paid public hospitals on a per patient basis, while health care provided by GPs was paid a subsidy, which came to be known as the General Medical Services (GMS) subsidy scheme (Gauld, 2001). General practice was funded through a payment system comprising of a partial fee-for-service subsidy from the government and a part payment for services from patients. These payments were paid to the GPs in his or her capacity as a private practitioner at the time of face-to-face consultation with patients. GPs, who were the
main non-salaried providers of PHC at this time, “fought for, and won, the right to continue practising independent of the state” (Prince, et al., 2006: 257). The change in the funding to a fee for service payment was a significant move away from the private and part-charitable funding of the pioneering phase of the funding of health care which were phased out initially in response to the state controlled welfare associated with the establishment of the Social Security Act 1938 (Easton, 2002) and will now be discussed.

i. Fee-for-service funding

Fee for service means the patient or client can be charged the full cost for a consultation with a GP. However, some residents in New Zealand have been eligible for a subsidised payment, though this subsidy has not remained constant, instead the subsidy has changed numerous times during its inception in the late 1930s. Examples of different approaches include subsidies which have been allocated to children under the age of six years, the older adult population and people who held a Community Services Card9 (CSC). Children, youth and adults without a CSC were not eligible to receive a government subsidy, and therefore have been required to pay the full consultation fee (Barnett, et al., 1998). Additional subsidies could be obtained from the Accident Compensation Corporation (ACC)10 on applying for a subsidy associated with an accident. Further payments have also been available through individual insurance companies and for maternity care (these are also available to independent midwives11).

A number of health reviews were undertaken between 1938 and the 1980s and these led to the increasing cost of health care, and the inequality of health provision turned out to be problematic. Primary care was underfunded, as the GMS did not keep up with inflation and patient fees were being increased by GPs, creating inequalities in health care due to some patients’ being unable to pay the fees (Barnett and Barnett, 2005). As a result of these health reviews a group of rural GPs identified to the government the benefits of having a nurse working in their rural practice. What

9 The Community Services Card is income dependent and usually applies to lower income earners.
10 Accident Compensation Corporation established in 1974 ensures people who sustain an injury are offered health care, rehabilitation and if appropriate compensation (McMurray and Clendon, 2015)
11 Independent midwives in New Zealand are autonomous practitioners who practice in the community.
eventuated was the establishment of the rural practice nurse (Docherty, 1996; Davidson, 2008).

ii. The establishment of the practice nurse in the 1970s

The establishment of the practice nurse had two main objectives. Firstly, it was thought that the availability of a subsidised (by the government) practice nurse might encourage GPs to remain in practice or even consider entering rural practice where there was once again, as was the case at the turn of the century, a shortage of doctors (Working, 1987; Docherty, 1996; Goodyear-Smith and Janes, 2008). Secondly, it was anticipated that a nurse working alongside a GP could assist in the more routine medical tasks that the GP could delegate. It was thought that the nurse could free up the GPs’ time, so they could practice medicine (Hasler, 1992; Collins, 1996; Docherty, 1996; Hounsell, 2000). The establishment of this scheme was challenging for the New Zealand Nurses’ Association (NZNA) as the New Zealand Medical Association (NZMA) lobbied the government and introduced the scheme, with limited discussion with the nursing profession (Working, 1987; Collins, 1996). The Practice Nurse Subsidy Scheme (PNSS) was rejected by the NZNA because of lack of consultation with nurses. However, despite this, the NZMA indicated their wish to continue with the employment of a subsidised assistant, even if it meant the employment of “non-nursing personnel to whom they would teach nursing and semi-medical skills” (Collins, 1996: 85). This was not acceptable to the NZNA, who suggested setting up a committee to focus on the issue. NZMA agreed and a committee comprising representatives from both the NZMA and the NZNA worked through the issues. This led to the development of the PNSS, which, in 1970, enabled the employment of the first practice nurse in rural New Zealand (Docherty, 1996).

During the early stages of the PNSS, nurses were not initially invited to develop their role, rather their role in general practice was prescribed by GPs (Collins, 1996). Practice nurses were described at this time as “the doctor’s assistant” (Collins, 1996: 84). Their role included a variety of skills, some nursing and some other tasks such as office duties, reception work and cleaning (Mortlock, 1997; Hounsell, 1993; 2000). The way practice nurses worked was generally directed by the needs of the GPs, rather than being led by the needs of the community. The contribution the practice
nurse made to the rural context demonstrated their worth in the improvement of medical and nursing services so much so that urban GPs wished to duplicate this model in the urban context (Docherty, 1996). In 1974, urban solo GPs were invited to join the PNSS (which was extended in 1977 to GPs who practised together in group practices).

Also, during 1974, the subsidy by the government termed Health Benefits was increased from fifty to one hundred percent of the practice nurse salary which released the pressure off GPs to contribute (McLennen, 1984). Health Benefits made clear the terms of the subsidy. In order to participate in this scheme there was a number of conditions to be agreed to, as well as the understanding that the individual GP, was the employer of the practice nurse. During the following years the subsidy was altered numerous times, the allowance was reduced and in 1999 the number of hours that could be claimed, were also reduced (Docherty, 1996). These changes were a result of the ACC changes which allowed practice nurses to register as an ACC provider and payment for the nursing services could be claimed from Accident Compensation Corporation (Online, n.d.). However, this payment went directly to the GPs and not to the nurse. Likewise, no GMS payment was available for a nurse consultation unless the GP also consulted with the patient as well. In my experience this double up of health care limited the authority of the nurse, was a nuisance for the GPs and furthermore an inconvenience for the client who was required to wait longer in order to have two consultations. These conditions of payments have resulted in significant implications for the autonomous role of the practice nurse and their advancing scope of practice (Toop, et al., 1996). Practice nurses could charge the patient a fee for the health services they provided but this was minimal and has remained so. It was noted by Carryer et al. (1999) that the changes to the PNSS were not beneficial for the professional development or the sustainability of the specialty of practice nursing.

During the first two decades of the existence of the practice nurse there was little chance for practice nurses to widen their scope of practice (Hounsell, 1992), especially in light of the many practice nurse subsidy changes. The conditions of employment and wages for practice nurses were also perceived as being problematic (Hounsell, 2000; Williams, 2000). Docherty (1996) has noted that the problems with
the PNSS had not been straightforward and had contributed to the tension between GPs and practice nurses (Docherty, 1996) and has since involved nurses’ lobbying the government to restructure the health reforms and funding structures, to enable a shift in the medical discipline’s ‘turf guarding’ of their position (Barnett and Barnett, 2005). Funding general practice through capitation, rather than the GMS funding would alter the way practice nurses and GPs worked together as an efficient health care team. As capitated funding was rolled out this indeed did increase more effective general practice teamwork (Toop and Hodges, 1996; Barnett and Barnett, 2009).

iii. Capitated funding payment

The capitated payment structure originally funded a minority of general practice services and its intention was to provide a flexible delivery of rural health care. Flexibility indicated that it was not necessary for the GP to see each patient at every visit in order to gain the government funding (as was the case with the GMS fee for service funding system). The capitated funding scheme provided the practice nurse with an opportunity to work alongside the GP in a more autonomous role, complementing the GP and avoiding duplication and fragmentation of services (Barnett and Barnett, 2005). The capitation scheme assisted in the development of more integrated PHC teams while enabling practice nurses to be part of the decision-making processes in general practice. Newland (1998) implied that one advantage of capitation was that it assisted practice nurses to provide autonomous health clinics with the management of chronic illness such as asthma and diabetes and nurse-led services, while meeting the health needs of disadvantaged groups.

Under the capitated funding system patients still paid a fee-for-service, which was based on the age and income of the patient. The capitated funding structure came directly from the government and was based on the number of people (the population) situated within a specified region which were served by the general practice team who provided PHC services to this population. This funding model required patients to be enrolled with the general practice (Toop and Hodges, 1996). The amount of funding received depended not only on the number of patients, but also on the distribution of their ages and demography as set out in the ‘New Zealand Health Strategy’ (Ministry of Health, 2000a) under the capitated funding scheme. Initially capitation funding
was a system that aimed for equity of access of health care and was seen as a means to reduce funds directly from the government (Barnett and Barnett, 2005). The capitation system has also assisted union health clinics that are associated with the Trade Union establishment in New Zealand, including the support Māori with the aim to improve health disparities (Barnett and Barnett, 2005). It was envisaged PHC services would be accessed locally and would be appropriate and affordable as set down in the Primary Health care Strategy (Ministry of Health, 2001) and He Kotowai Oranga (Māori Health Strategy) (Ministry of Health, 2002a). This funding, to some extent, encouraged the delivery of population-wide health care and health promotion, and provided continuity of care to the patient population (Toop and Hodges, 1996). However, GPs throughout New Zealand were slow to take up this opportunity and become a capitated practice (Barnett and Barnett, 2005; Matheson and Neuwelt, 2013). One reason for this may have been because, unlike fee-for-service, GMS funding (with the ability to generate income which was not capped), capitation funding provided the GPs with a fixed annual income. Further funding adjustments continued into the 1990s with the effects of the major health care reforms which are discussed in the following section.

2.5 New Zealand’s major health care reforms 1980s-1990s

Change in the national and global markets in the 1980s had a dramatic effect on the New Zealand economy and in particular the rural sector. The rural economy was affected as a result of national financial changes and the reduction of government support for the agriculture and rural communities (Statistics New Zealand, 2001). New Zealand had grown financially between the end of World War II until the mid-1980s in what was known as ‘the long boom’ (Gauld, 2001). New Zealand’s industry had also contributed to the global market and enjoyed the associated financial benefits (Barnett and Barnett, 2005).

However, the effects of the economic downturn of the global market, and the loss of guaranteed access to the UK market led to a reduction of public services, including the restructuring of, and a decrease in, the subsidies provided by the welfare state, established as a component of the Social Security Act 1938. Changes in welfare highlighted that there were health disparities through the inability of some members
of the population to access and pay for the increase in general practice fees (Barnett and Barnett, 2005). As a result of limited funds associated with the economic downturn, the government enacted major health reforms resulting in a change to the provision of health care (Hounsell, 1992; Prince, et al., 2006). This restructuring during the early 1990s aimed to improve efficiency and access to health services (Barnett and Barnett, 2009) and was influenced by a neo-liberal philosophy (discussed in the next section). The change to the health care system from this point onwards is presented diagrammatically in an adapted version of Broman and Robèrt’s (2015) ‘Funnel Model’ or Framework for Sustainable Strategic Development (FSSD) (refer to Figure 3.4 in Chapter three). I have adapted this model to present the issues related with the study context, in the first section of this ‘model’, namely the ‘contextual phase’. This ‘contextual phase’ aligns with the analysis presented in the second section of the ‘model,’ the ‘performance phase’ and presented in Chapters five-seven. The ‘performance phase’ progresss in Chapter eight and presents the thesis discussion and advances onto the ‘transformational phase’, the third component of the ‘model’.

The ‘contextual phase’ (Figure: 2.1) positions the factors that occurred during the neo-liberal movement and contributed to the major health care reforms, resulting in changes to nursing practice. Two separate branches have been positioned to present the impact of the contextual issues and the factors that occurred during the 1990-2000s time period are representative of the factors, associated with the ‘contextual phase’. The uppermost part of the branch represents the declining national resources and changes to the availability of health care resources and contractual arrangements, legislation and workforce retention of health professionals in rural areas (Prince, et al., 2006). The lower part of the branch is representative of an increasing regional demand on the local health care resources from the rural Otago region in which to establish new models of health care, support nursing practice advancement and engage with the community involvement in the planning of health care. This pair of branches, have been designed to project inwards to visually reflect a build-up of a sense of pressure that was being experienced at that time.
Figure: 2.1 'Contextual phase'
Source: Compiled by the author.
Each of the factors included in Figure: 2.1 are representative of the time period during the 1990-2000s, these are now discussed in relation to the neo-liberal health care reforms and the changing nursing practice, including that of rural nursing. A brief introduction to neo-liberalism and the neo-liberal reforms is provided to build on the previous extracts aligned with the economic downturn and the effects of globalisation on the New Zealand markets and the rural sector, in particular the reduction of government financial support for agriculture (Statistics New Zealand, 2001; National Health Committee, 2010).

2.5.1 Neo-liberal reforms

The neo-liberal reforms emerged towards the end of the twentieth century and reduced the responsibility of the state and the welfare sector to the individual and, in doing so, increased competition amongst health care practitioners and service providers (Prince, et al., 2006). The philosophy underpinning neo-liberalism reflects the aspirations of a capitalist society (Crowe, 1997) being situated on competition and individualism, as opposed to collaboration (Hornblow, 1997). Neo-liberalism in Western societies is based on a political ideology grounded on the intention of establishing a free global market and hence the development of a liberalised society (Woods, 2011) while assuming individuals take responsibility for their own actions and furthermore the outcomes of these actions. Individuals conduct and govern their own practice, by enhancing a certain form of freedom in which the government and the governed develop a close relationship (Frejes, 2008). Larner (2000) divides neo-liberalism into three categories: neoliberalism as policy, neo-liberalism as ideology and neo-liberalism as governmentality.

Neo-liberalism as policy originated from the neo-classical School of Economics with the aim of influencing the financial programmes of governing institutions (Larner, 2000). In New Zealand these programmes have more recently been associated with Rogernomics12, which influenced the governmental financial policy since the 1980s and 1990s (Prince, et al., 2006). These governmental reforms resulted in major rural economic, social, political and health care restructuring in the late 1980s and 1990s

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12 ‘Rogernomics’ referred to as a particular ideology to manage the economy and named after New Zealand, Minister Roger Douglas (Dalziel and Saunders, 2014).
These reforms had a major influence on peoples’ livelihoods, economics and the provision of health care services (Prince, et al., 2006; Dalziel and Saunders, 2014).

Neo-liberalism as ideology or the ‘new right’ movement promotes the idea that individuals are responsible for their own success (Larner, 2000). The assumption is that individuals have the ability to promote their own achievement and, in so doing, they accept more responsibility for their practice and their managers became, as Prince, et al. (2006) express, ‘hands off’.

The third category, according to Larner (2000), considers neo-liberalism as governmentality and relates to a government that has a broader viewpoint than just considering government as ‘the state’ and the regularity authority. Neo-liberalism as governmentality brought about a change to the nursing workforce in New Zealand and in particular the rural nurses associated with the study location, at the end of the twentieth century. Therefore, understanding ‘governmentality’ is beneficial to appreciate how the rural nurses’ professional identity was constructed during this time period. ‘Governmentality’ is included as the fifth component of the conceptual framework guiding this study. The concept of ‘governmentality’ as referred to in this study is discussed in Chapter three. What is particularly meaningful to this study has been expressed by Woods (2011) who notes that governmentality has been applied to the rural sector, since the time of the neo-liberal movement and associated with the transformation in rural policy which is discussed in the following section.

2.5.2 The influence of neo-liberalism on the health care reforms

The health care reforms commenced with the Ministry of Health’s, Health and Disability Act 1992 (National Health Committee, 2010). This Act was based on the assumption that health services would be delivered more effectively with the separation of the purchaser and provider roles of the Area Health Boards (AHB)13 and the establishment of a competitive approach for the provision of health services. The new management structure separated the funder (the government) from the purchaser

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13 The health care governing structures at the time.
(the provider). Purchasers consisted of four Regional Health Authorities (RHAs), three in the North Island and one for the whole of the South Island. A tendering process for the delivery of health care services was established as the RHAs purchased services from the public or the private sector. The aim of the government was to reduce its responsibility for the provision of health care, while weeding out unviable health services, with the aim of establishing “an internal market system, with a series of state-owned purchasing agencies contracting for services delivery with competing providers” (Eyre and Gauld, 2003: 189).

The South Island RHA, known as the Southern Regional Health Authority (SRHA) is of particular interest in its contractual obligations with the rural health sector in this study and will be referred to later in this Chapter. The SRHA contracted services from a range of providers, including health care professionals, and public and private health organisations (Barnett and Barnett, 2001) that offered these health care services. RHAs’ responsibility included monitoring the health needs of their populations, purchasing the appropriate health and disability services and evaluating the performance of providers with whom the RHAs established contracts. The RHAs were funded according to a population-based formula which was set and funded through the Ministry of Health, intent on ensuring the efficient provision of health care. These health care reforms changed once again with the disestablishment of the RHAs and the establishment of one Health Funding Authority (HFA) in 1999. Organisations and/or individual health professionals were at times put in a position of competition with each other to tender for the same health service contract (Hornblow, 1997). Additionally, providers of primary services were no longer guaranteed their traditional funding under the health reforms.

Changing the system of funding to a competitive model allowed the HFA to contract with a number of different providers (Hornblow, 1997). The health reforms, under the National government, supported innovative models of health care delivery. These models influenced the delivery of traditional health care structures including iwi Māori and tribal affiliation, health providers (Durie, 2001) and other independent groups, for example the Independent Practitioner Associations (IPAs) (Malcolm, et al., 1999). IPAs were the main contractors with the HFA for general practice services (Coster and McAvoy, 1996; Hornblow, 1997). GPs were motivated to join IPAs as
this offered general practice services security and allowed them to engage with a single united contract (per IPA) for the provision of health care (Malcolm, et al., 1999). The HFA wanted to have larger funding contracts for general practice services so encouraged GPs to group together rather than continue with individual contracts where funding was seen as ‘getting out of control’ (Malcolm, et al., 1999). This structure resulted in health professionals and health care groups being accountable to a number of different organisations with a variety of funding structures, each with their own goals and visions. In addition, the independent contracting status and the differing employment status of GPs, practice nurses, and other primary health providers led to tensions within the health care team (Toop, 1998). The funding for general practice has been an ongoing controversial aspect of the delivery of health care in the community and in particular that of practice nurses (as discussed in the following section). Nurses during the 1990s made a concerted effort to voice their concerns about the health care system and the limited contribution nurses could make, is now considered.

2.5.3 Nurses’ voice their concerns

There was significant frustration amongst practice nurses and national leaders of nursing during the 1990s. Nurse leaders such as Jenny Carryer and Barbara Docherty expressed their concerns about the lack of utilisation of the practice nurses’ role and contribution, for the provision of health care (Hounsell, 1992; Docherty, 1996, 1998; Carryer, et al., 1999). Mortlock’s (1997) research based in New Zealand, reported that practice nursing during the 1990s was invisible in general practice.

Further, in the 1990s, national nursing leaders brought to the attention of the then Minister of Health (Hon Bill English, of the National government) the barriers preventing the realisation of the full potential of both urban and rural nurses’ contribution to the health care sector. Under the direction of the Minister, a Ministerial Taskforce on Nursing was launched. The aim of this Taskforce was to see how nursing could be changed so nurses could contribute fully in the new health care environment, particularly in PHC. It was noted there were conflicting issues relating to funding GPs to provide, what is supposedly to be a team responsibility, for the delivery of PHC services, including separate lines of control and different payment
systems (as discussed previously) aligned to one health professional (the GP) rather than the general provision of health services. It was considered that these issues could in turn lead to suspicion over motives, diverse objectives, professional barriers and perceived inequalities for the status of the profession. A consultation process took place in which a number of focus group meetings were held around the country (Jacobs and Boddy, 2008), which I attended and contributed to in Christchurch. As a result of this consultation a report was produced in 1998 titled the ‘Report on the Ministerial Taskforce on Nursing: Releasing the Potential of Nursing’ (Ministry of Health, 1998) that was launched by the Minister of Health who recommended

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\text{[...]} \text{strategies to remove the barriers which currently prevent registered nurses from contributing to a more responsive, innovative, effective, efficient, accessible and collaborative health care service for New Zealanders.}
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The Ministerial Taskforce Report (Ministry of Health, 1998) noted practice nurses frequently were unable to contribute as full and equal team members, because they had limited access to resources (discussed later on in this Chapter). The resources mentioned included being unable to claim a fee for service subsidy, being unable to refer to other agencies, and having no authority to use diagnostic services. Many practice nurses also had limited physical workspace and had a potentially strained employer/employee relationship with the GP. Carryer, et al. (1999) raised their concerns and expressed the view that the barriers which affected the practice nurse’s role, if not challenged would keep the practice nurse as that of being an assistant to the GP, while preventing the much-needed collaboration between nurses and community health care services. Equally, Docherty (1998) stated that if practice nurses were able to define their own parameters of practice, in response to local community health needs, and not have their role extensively defined by the GP, they could more fully complement the care provided by that of the GP. Despite the barriers, limited scope of practice and employment structures associated with the development of practice nursing, Hounsell (1992) described how practice nurses, because of the geographical isolation from one another, their employment status and their relatively new professional identity, grouped together and become a progressive nursing group in New Zealand. The coming together of practice nurses from an early stage assisted them to become innovative (Hounsell, 1992) for example taking on the
responsibility for their own continuing education and expansion of their roles (Collins, 1996; Mortlock, 1997).

The rural practice nurses at this time also identified their concerns and lobbied together to improve their own educational status and professional support networks which are discussed later in this Chapter and are associated with the work of the CRH. A formal distinction was becoming evident at this time between rural and non-rural practice nurses, as their professional identity was being constructed and strengthened through different socio-political and economic contexts. The Ministerial Taskforce Report identified thirty-seven recommendations, including the need for the advancement of nursing practice. The focus was to support and develop nurses working in advancing practice and to reduce the inequalities in health between members of the population. The Minister of Health acknowledged that nurses were underutilised as a result of the health care restructuring in which managers (non-health related) had brought into the health sector a business model and nurses had lost control of their practice, leadership and employment, which was identified in the Taskforce Report (Ministry of Health, 1998) and further discussed by the College of Nurses Aotearoa (2001). The Minister also noted that the way for nurses to regain leadership and to contribute significantly to the provision of health care was through advancing nurses’ practice; recognising specialist practice, and nurse prescribing. The nursing profession responded to these suggestions positively indicating there was a need to establish educational frameworks and standards for post-registration nursing education and nurse prescribing (Ministry of Health, 1998; Jacobs and Boddy, 2008).

The establishment of postgraduate education aimed to advance nurses’ practice, and was funded by the Clinical Training Agency (CTA). The CTA identified the education and clinical training required to support health professionals in high health need priority areas (Jacobs, 1998). Mental health postgraduate education was one of the first nursing specialties to be recognised as high priority (Ministry of Health, 2006). Postgraduate education for rural nurses was developed later in 1996 based on a similar educational framework to that of the mental health postgraduate education and more recently additional specialties of nursing were also considered high priority. Rural nurse education being a priority was identified following a study commissioned by the SRHA in 1995 with the aim of understanding the needs of the evolving role of
the rural practice nurse in the South Island (Ross, 1996; Thompson, 2006; Maw, 2008). This study acknowledged there was specific educational knowledge necessary to fulfil the practice of the advancing role of rural nurses. The need for identified rural nurse education was further evidence that rural and non-rural nurses’ were now not only being acknowledged as having different requirements but also recognised nationally by CTA and the Ministry of Health as well (and will be discussed further in the analysis Chapters five and six).

Nurses continued to voice their concerns related to the health inequalities and in 1999 a discussion paper was published exploring nurses’ contribution for the delivery of PHC, titled, ‘Locating Nursing in Primary Health Care’. This discussion paper was developed by Carryer, et al. (1999) for the National Health Committee and explored a nursing approach to reducing inequalities in health based primarily on the principles of PHC. The principles of PHC are based on equity, access, self-determination and empowerment (St John and Keleher, 2007), which are in opposition to the traditional views of health. Health traditionally has been understood in biomedical terms, while contemporary understanding of health is much broader than the biomedical discourse; it recognizes individual people’s own understanding of health as a lived experience (St John and Keleher, 2007).

Health includes the social, economic and political conditions related to health. Understanding health in social terms is related to the social model of health associated with social inequalities, community engagement and participation and empowerment of individuals and communities (Duncan et al., 2014). Nurse leaders from New Zealand ensured a statement relating to the practice of nursing was included in the development of the philosophy of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001), which promotes PHC nurses as central to the delivery of care for the community (as presented in the quote at the commencement of this Chapter). For nurses to practise within the PHC philosophy, a shift in thinking by nurses and educators was necessary to ensure nurses could acquire autonomous practice and guarantee they were in a strong position to practise in the community. Practising in the community required the nurse to focus on wellness, health promotion and provide education to individuals and groups based within the framework of PHC nursing. The models of PHC nursing practice evolved out of necessity rather than formal design as
is discussed in the following section which the effects the health care restructuring had on the rural sector.

2.6 Restructuring the health care system and the effects on the rural sector

The restructuring of the health care system during the 1980s and 1990s had a profound effect on rural communities. Kearns and Joseph (1997) explain that in parallel New Zealand rural communities’ general economic status were particularly affected by trends associated with a reduction of farming productivity, trade and the national economy. This was despite being a major contributor during the previous decade’s economic rural boom (National Health Committee, 2010). The result according to Kearns and Joseph (1997) was the rural community’s increasing “marginality within the national economy” (p. 21). This was aggravated in the latter part of the 1980s, by further major economic restructuring and the growing urban dominance (National Health Committee, 2010).

2.6.1 The effects of the restructuring on the rural Otago region

The significance of restructuring the health care system, within the rural Otago region during the 1980-1990s, was coupled with a decreasing rural population and the economic downturn, which had a further dramatic effect on the region’s economy (Barnett and Barnett, 2001). The economy suffered as a result of the downturn of the global market and the subsequent withdrawal of farming subsidies from the New Zealand government, which has had an ongoing effect on the economic viability of rural communities. As a result of reduced income in rural regions, community services were gradually being withdrawn, for example the closure of banks and post offices with a further reduction of public services resulting in the reduction of employment opportunities (Barnett and Barnett, 2009). These changes were linked to an ideological shift in the country in the 1990s from one of state welfare to one of neo-liberal managerialism (National Health Committee, 2010) as discussed previously. These ideological shifts led to the first significant national directive (since the 1930s), resulting in major health care changes in New Zealand and a change to the delivery, funding, governance structures (National Health Committee,
2010; Dalziel and Saunders, 2014) and models of health care, both in the urban and rural contexts (Carryer et al., 2015). The importance of providing quality health care was being placed on health care providers who were, for the first time (in the 1990s), in competition with each other in tendering for health care service contracts (Hornblow, 1997). The government’s aim was to increase efficiency of health care and address needs resulting from increasing health disparities and chronic disease (Carryer et al., 2015) such as diabetes and heart disease. There was a parallel need to provide health care in the most fiscally prudent way (Barnett and Barnett, 2009). These national challenges also imposed concerns for the rural health care sector with the new provision of community governance and funding of health care, leading to significant changes to the rural nurses’ models of practice which will be discussed later in this Chapter.

The health reforms provided an alternative approach in the funding model for PHC in the rural areas of New Zealand (Gauld, 2003). Community health care trusts emerged in the late 1980s as a response to the threats of the closure of several smaller hospitals throughout the country. By the 1990s these trusts were developed with some government support as an alternative mechanism for the ownership and continuance of health services in rural areas (Barnett and Barnett, 2005).

2.6.2 Community Trusts

Initially, in the 1980s, the government intended to close or down-size rural health care facilities, and expected that local rural communities would take on owning and managing their own health services as set out in the ‘Green and White Paper’ \(^{14}\) (Upton, 1991). The government came to see community trusts as a viable option for many of the fifty-seven public hospitals with fewer than fifty beds. Trusts encouraged community involvement in health care decision-making (Gauld, 2001; Eyre and Gauld, 2003) and assisted in the development of ‘by Māori for Māori’ iwi providers (Gauld, 2003). Financial assistance was available to community trusts through the Community Trust Assistance Scheme and by 1999 a sum of $18 million

\(^{14}\) The ‘Green and White Paper’ (Upton, 1991) challenged dominant approaches to the delivery of health care and established a separation between the provider of health care and the purchaser through four Regional Health Authorities, the purchasers, which established a competitive market (Barnett and Barnett, 2005).
had been allocated through this scheme (Gauld, 2003; National Health Committee, 2010).

2.6.3 Rural Community Trusts and funding payments—the rural Otago experience

The government was particularly concerned that remote rural hospitals would be unviable and the major health reforms “posed an immediate threat to rural hospitals which were not thought to have the economies of scale necessary to achieve the ‘profit’ required by the government” (Barnett and Barnett, 2001: 230). The National government informed rural communities that the current hospital services, which included maternity care and some elective surgical interventions, were not economically viable and even, unsafe (Barnett and Barnett, 2001).

In rural Otago, a number of local communities were encouraged to support the government’s concept of setting up Rural Community Trusts (RCTs). The rural hospitals had originally been built with local community money and members of these communities saw their closure as an attempt to take away local assets, as well as services (Barnett and Barnett, 2001). However, the government had a different view and thought that rural communities would be in agreement to help identify and shape the health care services which best met the needs of their community members. Some community members resented the fact that the government expected communities would take over the responsibility of managing their own health service. One of the major issues with the RCTs was that there was no local consensus on how services in the area would be developed. However, at least half of rural communities believed that the health care services should remain consistent with the traditional model of community health care in which the state continued to regulate the provision of health care delivery (Barnett and Barnett, 2001)

There were seven RCTs established in rural Otago during the time period studied, the first was formed in Lawrence in 1992. Further RCTs were established in Ranfurly, Milton, Tapanui, Balclutha, Roxburgh and Dunstan. Figure: 2.2 on the following page situates these trusts within the rural Otago region and also show the base hospitals in the larger urban centres of Dunedin and Invercargill.
These RCTs were very diverse in size, organisational arrangements and the services that they provided, however they all represented a unique community strategy designed to secure health services for their individual rural areas. All trusts eventually protected the feasibility of community health services as they were redesigned to strengthen local community health services (Barnett and Barnett, 2001; Eyre and Gauld, 2003). All RCTs including nursing services were driven by the health needs of the community which has over time positioned rural nurses with a strong community involvement while enhancing the communities’ social capital. Some rural hospitals accommodated maternity services, and provided the availability to care for local residents with minor health issues (which came to be known as general practice beds or respite care). RCTs were able to fund respite care in the local rural hospital and more comprehensive home care was offered, enabling older people to stay in their community, even when long-term care was not available. General practice as well as community nursing, day care for the elderly and other support
services, such as meals on wheels, were generated out of the ‘new look’ rural hospitals (Barnett and Barnett, 2001). RCTs generally employed all of the health care staff including the GP. The new employment arrangements were a significant advantage in the RCTs’ success from the traditional model of self-employed GPs aligned with the GMS fee for service payment and the employment of nurses (Barnett and Barnett, 2001) discussed previously. GPs employment of practice nurses’ was recognised as one barrier associated with the practice of nurses in particular, the ‘practice nurse’ as noted in the ‘Ministerial Taskforce Report’ (Ministry of Health, 1998) and equally stated by Mortlock (1997); Docherty (1998) and Carryer, et al. (1999). Shared rosters between general practitioners and rural nurses covered ‘24 hours’ of health care at the weekends and during the weeknights. There was a noticeable difference between rural and urban nursing practice in terms of the expectation that rural nurses would provide an emergency health care service in the form of PRIME (discussed further in Chapters five and six) and this is important to acknowledge in respect to the changing models of health care and funding and the provision of sustainable health care by rural nurses.

The establishment of RCTs was one positive outcome of the major health care reforms of the 1980-1990s (Gauld, 2000; Eyre and Gauld, 2003). The establishment of RCTs with local community members designing and managing their own individual local health services were regarded by the government as innovative and linked, with associated cost savings. An additional innovative model developed during this period as discussed below, was the establishment of rural health units to support rural health professionals, the first of these being the CRH in 1994.

2.6.4 Centre for Rural Health

The SRHA aimed to maintain and improve the quality of community health care services in the climate of a competitive market. This section discusses one benefit of the major health care reforms, which was the establishment of the CRH under contract with the SRHA. A contract was established in October 1994 through the Post-Registration Educational Department at the University of Otago, Christchurch School of Medicine, Christchurch, New Zealand. This contract set out to improve the quality of community health care in both urban and rural general practice and was
initially focused in the Canterbury region (refer back to the map in the Preface). The newly founded CRH agreed to undertake the work required to improve the quality of rural general practice services in that region but soon expanded into the rural regions of the South Island of New Zealand in 1995. The broader aspects of the CRH were introduced in Chapter one, whereas what is discussed in this section is the relationship between the SRHA and quality improvement and the contractual arrangement with the CRH.

The vision to establish the CRH was originally the idea of Dr Martin London\textsuperscript{15} who initially undertook the planning phase and developed strategies in accordance with the SRHA’s contract specifications which sought to maintain and improve the quality of rural general practice and its health professional team (the urban component of the contract was the responsibility of another team of health professionals). Following years of discussion with New Zealand rural GP colleagues about geographical and professional isolation and limited networking, a Rural Action Group was developed (Rural General Practice Network History, n.d.). At the same time, rural GPs in Australia were lobbying their government to get some traction and acknowledgement to support the plight of rural doctors in remote locations in Australia. Professor Roger Strasser from Australia was invited to a conference in Wellington, New Zealand in 1992, to present his experience about bringing rural issues to the attention of the Australian government related to the lack of personal and professional support for rural GPs. Following on from this conference it became evident to Dr London that setting up a rural unit to support rural GPs in New Zealand was necessary (Dr Martin London, pers. comm., 2013).

Dr London pursued his vision for the following two years and secured interest from Dr Fran McGrath from the SRHA who indicated the importance of supporting innovative models that could assist with improving the quality of health care. What eventuated from these discussions was the establishment of a contract between the SRHA and the CRH in late 1994. This contract assisted in the formation of the first rural health unit in New Zealand which was situated in Christchurch. The CRH was

\textsuperscript{15} Dr Martin London a rural general practitioner who practised in Akaroa, Canterbury in the South Island of New Zealand spearheaded the rural health care environment in New Zealand with an overall focus to support and make life more tenable for rural general practitioners and their families.
modelled on similar rural units in rural Australia. The overall aim of the SRHAs contract was to promote a stable workforce, improve rural healthcare and support and provide continuing education for rural health practitioners.

I became involved in the CRH in 1994 following an invitation from Dr London to join him with the aim of establishing an improved rural practice nurse workforce. At that time I was practising in a rural location as a rural district and practice nurse. I was also the local rural GP’s partner, and we both lived and worked in the same rural community. Dr London’s innovative strategy aimed to maintain and even improve the quality of rural community health care by retaining and recruiting rural GPs, which was becoming extremely problematic because of demanding on-call responsibilities (London, 2002). As a solo rural GP, Dr London knew only too well of the perils that rural general practice may have on the retention of rural practitioners. Between 1994-2003 Dr London and I became joint co-directors of the CRH, and in the latter part of this time period, of the NCRH.

Throughout 1994 and 1998 the CRH continued to be contracted by the SRHA to improve the quality of rural health services. Initially the CRH approached this task by listening to rural health practitioners’ professional needs and requirements, which could maintain their competence and confidence to practise skilfully in rural communities. One overall theme practitioners mentioned was isolation from peers and education and they indicated they would welcome an attempt to resolve this issue. The CRH sought to help address these concerns through providing interdisciplinary educational workshops under the umbrella of continuing professional education, which also helped address the problem of reducing professional isolation as rural nurses and rural doctors were able to meet together in rural locations at such events, which also, encouraged peer support.

Between 1996 and 2000 a number of additional rural health units were established to support rural practitioners throughout New Zealand. In the North Island in 1996 Dr Graeme Fenton established the Northern Rural General Practice Consortium and in 2000 he also held the position of co-director of Rural Health for the North Island. This position was jointly held with Mrs Kamiria Gossman and was situated within the New Zealand Institute of Rural Health, based in Hamilton. The late Dr Pat Farry held
the position of Director of Rural Health for the South Island and established the Te Waipounamu Rural Health Unit situated in the Department of General Practice at the Dunedin School of Medicine, University of Otago in Dunedin. A collaborative relationship between the Directors of each of these rural units together with the co-directors of the CRH developed, which was later formalised in 2001 by the Ministry of Health as the Directors of Rural Health Aotearoa. This group acted as a resource to rural health practitioners and communities and as a reference group for the Ministry of Health, from 2001-2008. This group was dissolved when the National government came into office in 2008, as was the Minister of Rural Affairs.

However, the success of the CRH’s work moved on from focusing on the rural areas of the South Island of New Zealand, to a National focus, that was led by the Health Funding Authority (HFA) in 1999. The CRH’s new direction and energy was diverted into undertaking a number of core rural research projects. At this time the CRH became the NCRH, and secured additional funding directly from the Ministry of Health for a further four years (between 1999-2002) to undertake additional research and rural development (Ministry of Health, n.d.). Between 1999 and 2002 further contractual work focused on projects across a spectrum of rural health issues, including rural nursing and models for practice (Litchfield, 2001; Litchfield and Ross, 2001; Jones and Ross, 2003), the recruitment and retention of rural doctors (London, 2002a), the development of standards for rural general practice locum services (Brown, et al., 2001; Brown, et al., 2002), and the investigation of rural teamwork (Bidwell and Ross, 2001; Ross, 2001) were developed. In addition the examination of success for both rural health providers and service users (Bidwell, 2001; Litchfield, 2002) and the enabling of rural community participation in the planning and delivery of rural healthcare (Grimwood and London, 2003a, Grimwood and London, 2003b) were established.

At the end of the contracting period in 2002 an additional 12 months was granted to the NCRH to complete project work. One of the NCRHs most significant legacies was the development of a website located on the Ministry of Health’s webpage which provided access to all the relevant research reports and rural work tools. This website provides an historical background on the work of the CRH and NCRH (National Centre for Rural Health, n.d.). An example of one of the CRHs projects which had a
profound effect on the future development of rural nurses is discussed next, namely, the ‘Rural Practice Nurse Skills Project 1995’ (Ross, 1996) which is now considered.

2.6.5 Rural nurses’ education and practice requirements

In 1995 the SRHA contracted the CRH to undertake a research project to study the evolving role of the rural practice nurse in the South Island (Ross, 1996; 1999; 2008). The research noted that nurses’ experienced a lack of formal education in support of their practice and, similarly to the rural GP, they too experienced professional and personal isolation (London, 2002a). Many nurses had developed skills and knowledge over years of clinical experience in rural practice however, in an ‘ad hoc’ fashion which was often driven by the necessity to provide services in the absence of other providers (Ross, 1996; 1999). This study confirmed that rural nurses, at times, found themselves as the only health practitioner in the immediate community, taking on an expanded practice. They required adequate and appropriate education and professional support to ensure they were in a position to provide competent and clinically safe practice. The study’s findings led to a number of recommendations, which were put forward to the SRHA. The main one being to develop a tailor-made postgraduate programme of study, to include knowledge and advanced clinical skills which could accommodate the rural nurse’s advancing practice which links with the ‘Report on the Ministerial Taskforce on Nursing’ (Ministry of Health, 1998) recommendations which was discussed previously.

The SRHA supported the recommendations set out in the ‘Rural Practice Nurse Skills Project 1995’ (Ross, 1996) and work began to develop a postgraduate programme of study for rural nurses, which was initially offered to nurses in the South Island (Ross 1999). This programme of study was delivered for the first time in 1998 through the Centre for Postgraduate Nursing Studies, through the University of Otago, Christchurch School of Medicine, New Zealand. In the same year the CTA, who were responsible for the support of health professionals post-registration education (O’Malley, et al., 2009) approached the CRH to develop the first national postgraduate interdisciplinary Primary Rural Health Care Diploma to up-skill rural health care practitioners. This programme incorporated an adapted version of the original rural nursing paper offered in 1998. The postgraduate interdisciplinary
diploma in, Primary Rural Health Care, run by the Department of Public Health and General Practice, University of Otago, Christchurch School of Medicine was contracted through the CTA between 1999 and 2003. At the completion of this contract in 2003, a further tender was made available to offer a new rural postgraduate programme available only for rural nurses. Auckland University’s School of Nursing in collaboration with the New Zealand Institute of Rural Health based in Hamilton (New Zealand Institute of Rural Health, n.d.) successfully tendered for this contact, which was fully funded through the CTA, and ran for the first time in 2004.

The restructuring of the health care system continued and in the early part of the twenty-first century this system was aligned with the ‘New Zealand Health Strategy’ (Ministry of Health, 2000a), and in 2001 the release of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) which is now discussed in the following section.

2.7 New Zealand’s health care system in the twenty-first century

The New Zealand’s health care reforms established in the early twenty-first century were yet another change in focus (Gauld, 2003) and were the outcome of the vision and work of the Labour-led coalition government. The Labour government introduced a radical change in the delivery of health care, by putting PHC at the centre of health care (Barnett and Barnett, 2009).

The new health system aimed to change the philosophy of how health care was to be delivered in the community (previously articulated as general practice and community health care) and nursing was at the centre of this change (Ministry of Health, 2001). The 2000s saw further restructuring of health care and the establishment of twenty-one District Health Boards (DHBs) with the disestablishment of the HFA. The DHBs were established as a result of the Public Health and Disabilities Act 2000 with the overall aim to reduce health disparities and increase community participation in the organisational process for the delivery of health care (Matheson and Neuwelt, 2013). This health care system continues to remain in place in 2016 but with twenty DHBs16.

16 There were 21 DHBs situated in New Zealand up until 2010 when the Otago DHB merged with the Southland DHB and became the Southern DHB (http://www.southerndhb.govt/pages/about0southern-dhb/)
DHBs continue to be the responsible authority that plan, manage and purchase the full range of health services for their geographical population. Each DHB had and still has a number of Primary Health Organisations (PHOs) to deliver health care in the primary (community) settings.

The stimulus for this restructuring was the government’s acknowledgment that there continued to be inequalities in the health of some population groups in the community and in particular, Māori and Pacific people (Matheson and Neuwelt, 2013). The cost of general practice health care was escalating and people were experiencing difficulties accessing health care. The ‘Primary Health Care Strategy’ (Ministry of Health, 2001) was the framework developed to assist the Labour government’s vision to become a reality. The ‘Primary Health Care Strategy’ was guided by the principles, goals and objectives set out by both the ‘New Zealand Health Strategy’ (Ministry of Health, 2000a) and the ‘New Zealand Disability Strategy’ (Ministry of Health, 2000b). The ‘Primary Health Care Strategy’ (Ministry of Health, 2001) was the vehicle used to implement the principles of PHC which was guided by the discussions which occurred at the time of the Declaration of Alma Ata in 1978 (World Health Organisation, 1978).

2.7.1 New Zealand’s ‘Primary Health Care Strategy’

A sector reference group representing a cross section of key players within PHC paved the way in the development of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001). Providing health care services to match and improve health care need was, and still is, a major focus of the ‘Primary Health Care Strategy’. A change in emphasis was established towards population health, health promotion, local community involvement, preventative care and the quest for better alignment and integration of community services. For this to become a reality, health care professionals were required to work as a team that included allied health professionals (when available) and was to focus on population health. The ‘Primary Health Care Strategy’ (Ministry of Health, 2001) recognised that a strong PHC system would improve the health of all New Zealanders and would in particular, tackle inequalities in access to health care.
The vision of the ‘Primary Health Care Strategy’ ensured,

[p]eople will be a part of local primary health care services that improve their health, keep them well, are easy to get to and co-ordinate their ongoing care. Primary health care services will focus on better health for a population and actively work to reduce health inequalities between different groups.

(: vii)

The Labour-coalition government in 2002 identified that rural New Zealand had separate challenges from urban areas in terms of the provision of sustainable PHC. The ‘Primary Health Care Strategy’ (Ministry of Health, 2001) also recognized that rural New Zealanders needed appropriate access to essential PHC services. The Ministry of Health stated its commitment to developing “a coherent policy and package for assistance for rural communities” (Ministry of Health, 2001: 25) noting that the primary problems for the provision of health care were isolation, accessibility and affordability, appropriateness and availability of health professionals and health services (Litchfield, 2002). Additional support was needed for the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) to be implemented in rural New Zealand. This commitment in 2002 led to the establishment of the Rural Expert Advisory Group by the Ministry of Health, in which this group developed a report titled ‘Implementing the Primary Health Care Strategy in Rural New Zealand’ (Ministry of Health, 2002b). The following section is dedicated to discuss the particular issues associated with rural PHC in New Zealand.

iv. Rural primary health care

Rural PHC in New Zealand builds on the principles as discussed in the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) and is interrelated with the goals set out in ‘Implementing the Primary Health Care Strategy in Rural New Zealand’ (Ministry of Health, 2002b). These goals aimed to create a context where local rural solutions to local problems could be created to ensure accessible, affordable and appropriate health care services were provided locally or within acceptable travel distance and time, and that the retention and recruitment and availability of a skilled multidisciplinary collaborative rural health care team was maintained (as discussed in relation to the development of RCTs).
The ‘Primary Health Care Strategy’ (Ministry of Health, 2001) promoted the notion that for the effective and efficient delivery of PHC, a team approach was required (as discussed previously) including community partnership, which is now discussed below.

v. Teamwork for effective primary health care

The ability to improve health services reduces the fragmentation of care (Opie, 2005), especially when the team works within a defined population (Toop et al., 1996). Many important aspects of health care such as management of chronic health, maternity, and elderly care, to name but a few, require effective teamwork including the shared responsibility of care (Pritchard and Pritchard, 1994; Elwyn-Jones, et al., 1998; Opie, 2005). Katzenbach and Smith (1993) express that a team is a number of people who have a common purpose, collective goals and shared accountability.

A number of New Zealand government documents were developed during the 1990s and early 2000s which recognised that a diverse approach to the delivery of PHC would benefit from teamwork. These documents includes, ‘The Next Five Years in General Practice’ (Health Funding Authority, 1998); ‘Rural Health Policy: Meeting the Needs of Rural Communities’ (Ministry of Health, 1999b); ‘Locating Nursing in the Primary Health Care Sector’ (Carryer, et al., 1999); ‘The Future Shape of Primary Health Care’ (Ministry of Health, 2000c); ‘New Zealand Health Strategy’ (Ministry of Health, 2000a); ‘Summary of Responses to the Future Shape of Primary Health Care’ (Ministry of Health, 2000d); ‘Primary Health Care Strategy’ (Ministry of Health, 2001) and ‘Implementing the Primary Health Care Strategy in Rural New Zealand’ (Ministry of Health, 2002b).

The Ministry of Health’s emphasis in the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) was that a team approach was the most effective means available to address the complexity and variety of skills required to meet individuals’, groups’ or community’s health needs and reduce the determinants of health (Ministry of Health, 2001; Matheson and Neuwelt, 2013). The creation of a team of health professionals brings together different professions who can, in theory, provide a more complete health service (Opie, 2005). Teams are often complicated, dynamic and potentially
threatening to individual team members, so teams need to be understood and handled with care, respect and pride. It is however, the actual diversity of the various disciplines needed to provide effective and appropriate PHC, which is key to their operation (Toop et al., 1996; Blue, 2002).

To summarise, it could be suggested that health care teams are groups of health professionals from a variety of disciplines who understand and accept each-other’s complementary contributions, and who strive to achieve common goals with shared responsibilities (Blue, 2002). Katzenbach and Smith (1993) suggest that teamwork alone never makes a team, but that teamwork requires a set of values, which allow for shared listening, responding and support. These values, if accepted by all the members of the team, can assist in communication and collaboration, which are essential ingredients for successful teams. Similarly, teamwork is defined as the actions, processes, and behaviours, which contribute to a team’s ability to achieve specific, shared, and valued objectives. Teams are essential to sustain and maintain the provision of a dedicated rural health care service, which have further benefits for the retention and recruitment of rural health care practitioners (Toop, 1998; Ministry of Health, 2002b; Health Workforce Innovative Programme, 2009).

Effective teamwork in a rural setting, according to Strasser (1999) and Bourke et al. (2004), is enhanced when all rural health care practitioners from a number of disciplines work together collaboratively. When these PHC teams work effectively, they are in the position of meeting the health care requirements of rural communities’ health needs (Ross, 2001). Bourke, et al. (2004) explain that the success of meeting rural communities’ health needs, relates to adapting practice to meet individual needs rather than employing the notion that one health care model, fits all. This success is dependent on adapting health care to better address local rural issues, which includes providing patient-centred collaborative health care (Matheson and Neuwelt, 2013). Teams therefore are in a position to work within the principles set out in the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) while adapting their practice to meet the local rural residents’ health needs, including those of visitors and transient or seasonal workers (Fitzwater, 2008). Members of rural health care teams work together and with the community in the form of collaboration, which relates to the principles set out in the ‘Primary Health Care Strategy’ (Ministry of Health, 2001)
which helped to transform the practice of rural nurses into its contemporary form, as discussed in Chapters five and six.

vi. Community participation for effective primary health care

Community participation and community governance are interlinked in the planning, implementation and evaluation of PHC (Matheson and Neuwelt, 2013). Formal urban and rural community involvement commenced in the 1980s with the “development of non-governmental, not-for-profit primary health-care services” (Neuwelt and Crampton, 2006: 203), which have been successful in achieving their aims (National Health Committee, 2010). More recently, with the restructuring of PHC following the launch of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) in 2001 specified that community participation through the establishment of PHOs was a prerequisite noting that “services will then be more likely to reflect needs and priorities that are set by the people, not just the providers” (Ministry of Health, 2001: 7). Involving community members in setting their own health needs was a significant shift in philosophy, over and above what had ever been attempted previously. The overall aim was to reduce health disparities while being true to the principles of PHC, which encouraged the process of working from the bottom-up (at grass roots) and minimised a top-down approach (government directed) in the implementation of health care (Neuwelt and Crampton, 2005; Matheson and Neuwelt, 2013). Examples of this community participation are the RCTs established in the late 1980s and 1990s (discussed previously) which will be further elaborated on in this thesis as their formation helped construct the professional identity of the rural nurse in rural Otago.

Further initiatives over recent times have continued to improve the efficiency of health care, by promoting, a ‘better, sooner, more convenient’ approach which stresses, that health care services are, personalised and provided near to people’s homes (Matheson and Neuwelt, 2013). The aim is to reduce hospital admissions, focus on chronic disease management, in order to improve the health care, of the enrolled populations. In the process of achieving these aims, the ‘Integrated Family Health Centre’ concept has been created, in which various providers, including nurses, manage the health care of their clients (Matheson and Neuwelt, 2013). However, “[u]nlike the previous primary health care reform, these changes are taking
place in a period of constraint of health service spending” (Matheson and Neuwelt, 2013: 76) while, continuing to situate health care within a business model. This business model continues to hold back the practice nurses’ (as discussed previously) ability to offer health care that could meet the needs of the community and community residents (McMurray and Clendon, 2015).

2.8 Summary of Chapter

In this Chapter I have engaged with a contextual overview and explored the development of rural nursing in New Zealand throughout a one hundred year period. The aim has been to capture the diversity of the practice of the rural nurse in adapting and enhancing their occupational identity throughout the past century, while extending their professionalism within a myriad of changing health reforms, governance and funding structures. Situating the rural nurse within this historical period positions the contexts of their practice during New Zealand’s pioneering period 1840-1930s; the welfare state 1938-1980s period; the neo-liberal period 1980s-1990s and the more contemporary period of the 2000s associated with promoting the collaborative participative phase which were aligned with the ‘Primary Health Care Strategy’ (Ministry of Health, 2001).

The broader socio-political and professional contexts relating to both the urban and rural environments were highlighted and presented by engaging with the first component of the adapted ‘Funnel Model’ (Broman and Robèrt, 2015) termed the ‘contextual phase’ situated between the 1990-2000s which has highlighted the key contemporary issues associated with advancing nursing practice, education, regulation, and legislation during this time period. The health care reforms were linked to the significant changes of the delivery of health care in the rural Otago region, the study location. Alongside these changes was the focus on the development of RCTs established in the study location. The benefits of RCTs were that they became the funding structure that improved and supported collaboration, teamwork and community participation. A focus away from competition and towards collaboration and teamwork was the emphasis of the ‘Primary Health Care Strategy’ promoting that a team approach was needed to address the complexity and variety of skills required to meet the individual and/or community’s health needs (Ministry of
Health, 2001). The focus of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) laid the foundation in which to position nurses at the foreground of the delivery of PHC and improve nurses’ contribution to the delivery of health care, originally noted in the 1998 ‘Report of the Ministerial Taskforce on Nursing’ (Ministry of Health, 1998). This shift in focus has been beneficial for the advancement of PHC nurses and in particular rural nurses’ practice development and contribution to the delivery of sustainable health care. The following Chapter embraces the four essential concepts that underpin the foundations of this thesis in the conceptual framework which progresses this thesis onto the next stage of its development.
CHAPTER THREE: CONCEPTUAL FRAMEWORK GUIDING THIS RESEARCH

To care for... individuals in global populations, nursing must integrate knowledge about place experience, population health, and geography into nursing theory, research, and practice.

(Thomas, 2013: 3)

3.1 Introduction

In this Chapter I establish the conceptual framework that guides the structure of this study. To appreciate the identity and practice of rural nursing, this study draws on the disciplines of nursing and social geography (as discussed in Chapter one). Rural nurses are situated to provide health care within the rural context, and offering an appreciation of their professional identity, practice and contribution to the rural health care sector is the purpose of this research. This conceptual framework guiding this study comprises six key concepts. The first two concepts relate to identity construction and the theory of ‘place’, as related to nursing and equally, associated with social geography. The third key concept relates to aspects related with the ‘rural’ and in particular rural communities. The fourth key concept aligns with professional caring associated with nursing practice and the theoretical underpinnings of rural nursing aligned with ‘nursing core concepts of care’ (Torres and Yura, 1974). The fifth concept situates professional nursing and the delivery of health care within the concept of ‘govermentality’. The sixth key concept engages with Broman and Robèrt’s (2015) ‘Funnel Model’ or Framework for Strategic Sustainable Development (FSSD) in which to assist with positioning the analysis and presentation of the research findings. The rationale for the inclusion of each of these six concepts and their relationship with each other in the formation of this conceptual framework is the fundamental focus presented in this Chapter. Further, it is Thomas’s (2013) insightful quote above, which considers that the relationship between ‘place’, knowledge,
nursing and health are all fundamental relational components of nursing theory, which underpins nursing practice and which are key issues relayed within this Chapter.

3.2 Outline of Chapter

This Chapter consists of six sections. In the first section I introduce the key concepts in this conceptualisation as generated from social geography and nursing. The first key concept engages with the significance of identity construction as a noteworthy theory to this study, as discussed within social geography. The second section of this Chapter discusses the second key element of the conceptual framework which builds on the literature focused on the understanding of the significance of place, as it relates to both social geography’s and nursing’s engagement with this concept. The relational aspects associated with place and the rural including aspects associated with the progression of rural communities and the professional identity construction of the rural nurse lays the basis for the third and section of this Chapter. The fourth concept focuses on the particular qualities related to professional caring and the development of professional nursing practice, supported by theoretical understandings which are linked to the relational aspects associated with identity construction as discussed in section one. The fifth concept aligns with the notion of ‘governmentality’ associated with the provision of health care and nursing. In the final section of this Chapter Broman and Robért’s (2015) ‘Funnel Model’ or FSSD is introduced in which to provide structure to the conceptual framework and a vessel in which to position the contextual issues that are aligned with this study, the analysis and presentation of findings.

3.3 Establishing a platform in which to frame the conceptual framework

The study’s conceptual framework has been developed to give structure to this research. A conceptual framework includes either one or more concepts which are related and at the same time are stand-alone concepts which collectively frame the study, unlike a theoretical framework which comprises concepts related to each other and are associated with a specific field of knowledge (Orem, 1991; Schneider, 2016). To appreciate the identity construction and practice of rural nursing from the identified rural location, this study has taken a broader appreciation of identity and
how identity is ‘acted out’ or performed within the context of rural place. The six key concepts comprised within the conceptual framework and diagrammatically presented in Figure: 3.1 are introduced individually, as well as in terms of their relational aspects.

Figure: 3.1  
Relational concepts comprised within the conceptual framework
Source: Compiled by the author.

3.4  
Significance of identity construction in social geography

The concept of identity has been debated widely within international academic circles, leading to numerous discussions associated with developing identity theories (Rutherford, 1990; Panelli, 2004; Weedon, 2004; Jackson, 2005; England, 2011). Understanding the concept of identity has been used for interpreting social life experiences (Panelli, 2004; England, 2011); with understanding gender (Thompson, 2006); ethnicity and sexuality (Dwyer, 1999); class (Panelli, 2004) and community belonging (England, 2011; Nagel, 2011). Identity theories take numerous positions such as, identity beliefs is shaped by geographical context or is influenced by structures related to the person or the relevant profession (Thompson, 2006). Identity relates to individual, collective and multiple identities including identity related to
work and place in which the occupational identity is performed as comprised within the conceptual framework guiding this study.

In keeping with the interpretivist paradigm as methodology, my intention is not to derive a unified definition or identification of nurses, rather I seek to understand what led to the identity construction of the rural nurse and focus on their collective characteristics associated with their professional practice from the rural study location.

3.4.1. Identity construction

The performance of identity is interpreted through a socially constructed perspective. In practising nursing, identities are constituted through discourse, which shapes the identity as it is produced (performed) and becomes part of the lived subjectivity of the nurse and a sense of self cannot be fixed or certain, but instead is experienced in different ways through a variety of different subject positions (Hall, 1996; Panelli, 2004; England, 2011). Practices produce the discourses within which subjectivity is constituted. The construction of identities forces individuals to become subjects and the subjects have a relationship with their physical environment (Cloke, 2004). According to Panelli (2004) these meanings only make sense by representation of what to expect from the subjects’ practices and performance. In society there is an expectation of certain ways of representing behaviour, performance and talk, which is associated with a certain identity that presents a certain way of being in the world. When particular expectations are not met then resistance, difference and power issues may arise (Panelli, 2004; England, 2011; Woods, 2011). Difference in particular has been identified as a negative connotation and likened to being distinctive in comparison with something else. de Leeuw et al. (2011) suggest that difference becomes noticeable when an identity does not fit with the social norms or dominant ways of performing in society.

Woodward (1997) promotes the notion that identities are always constructed in relation to other identities, for example, in relation to what they are not. The question arises as to how do individuals become aware of their identity? Jackson (2005) explains that individuals become aware of their similarities and differences with
others, for example in terms of dress, language, values and beliefs associated with particular identities. Identities are therefore constructed in relation to similarities and at the same time differences can be observed. Identity is interpreted and formed in relation to others, rather than through self-identity, therefore identity becomes relational, and relational identity is subject to change and the notion of difference between people and places (Nagel, 2011).

3.4.2. Identity belonging

Identity is about belonging, about what individuals or groups have in common with some people and what differentiates each of them, from the other. Identity gives a sense of personal self. Each of us comprises a number of identities and these may either have a sense of belonging or be conflicting with the values individuals share together (Massey, 1994; Weeden, 2004; Nagel, 2011). Hetherington (2000) explains identity is formed as we position ourselves by creating boundaries. For rural nurses’ boundaries can be associated with being an, ‘insider’ or, as ‘outsider’ of the rural community (Bailey, 1998; Bushy, 2000; Lee and Winters, 2006). Boundaries create movement in that the self either identifies with or belongs and is therefore situated within an artificial boundary, or is unrelated and is on the outside of the ‘boundary’. According to Rutherford (1990) identity directs our world and relates to economic and political relationships (de Leeuw, 2011). In this study the data analysed also demonstrates that the economic and political changes of the time, did indeed relate to the changing identity of the nurse who practiced in the rural and will be further analysed in Chapter six. In the meantime it is timely to consider the second concept, namely ‘place’ in the following section. To understand ‘place’ is to consider it as having multiple layers, which combine together encapsulating the essence of what ‘place’, is. McKinnon (2011) notes that ‘place’ is also relational as indicated by Rutherford (1990) while comprising the physical, social, economic and political aspects of our society.

3.5 Significance of ‘place’ in this study

The intention in this section is to embrace the concept, ‘place’ that is a significant component of this study. Consideration is given to both social geography and
nursing’s interpretation of ‘place’. An overview of ‘place’ from both of these disciplines’ perspectives is offered, providing a background in which to situate this study. At the planning stage of this thesis I decided to include the concept of ‘place’ as one key element in the conceptual framework. My initial consideration of embracing the concept, ‘place’ assisted my engagement with the rural as the physical location in which the nurse, better identified as the rural nurse performs their practice.

The following discussion incorporates social geography and nursing’s theoretical interpretation of ‘place’. In geography, place is discussed within specialty areas, for example, humanist geography (Tuan, 1974; Vanclay, 2008), political geography (Agnew, 1987) social geography (Massey, 1994; 2005; Cresswell, 2004), rural geography (Woods, 2011) and health geography (Kearns and Moon, 2002; Andrews, 2002). Nursing is also concerned with conceptualising how place is understood within nursing and referred to as, context or situatedness (Jones and Ross, 2003; Carolan, et al., 2006; Lee and McDonagh, 2010). An overview from social geography in relation to place, place and space, and place and landscape is offered next followed by a discussion of nurses’ employment of the concept of place.

3.5.1 ‘Place’

In the first instance, place is a political issue involving the understanding of a sense of place, place identity, place and difference and place and power. While place is everywhere there is little understanding of the word place and interactions it can have with people (Cresswell, 2004). The English word ““place” is used in everyday life, while being associated with a number of meanings” (Cresswell, 2004: 1). Place is a familiar term and is assumed by the user and recipient that it has a meaning that is understood by both. In general terms place is considered a location or physical site, for example “this is my place is not your place… you and I come from different places” as discussed by Cresswell (2004: 2) who also acknowledges place is a way to understand the world. Place can be considered as a fixed location, which may be associated with a map, with the aim of finding a place or site associated with that location (Agnew, 1987; 2015; Cresswell, 2004).
3.5.2 ‘Place’ as defined in social geography

Social geographers note that ‘place’ occurs when meaning, naming or the feeling of connection occurs with that ‘place’, otherwise, what they are relating to is considered to be space (Cresswell, 2004) (further consideration of space will be discussed later on in this section). Agnew (1987) outlined three fundamental elements of ‘place’ as a meaningful location and he developed a framework (referred to as a ‘place framework’) in which to improve a deeper understanding of ‘place’ (presented in Chapters five, six and seven). Agnew’s (1987) three fundamental elements of ‘place’ include ‘location’, ‘locale’ and a ‘sense of place’ and is diagrammatically represented in Figure 3.2. This diagram also incorporates the ‘nursing core concepts of caring’ including, ‘environment’, ‘person and health’ and ‘nursing’ (Torres and Yura, 1974) presented diagrammatically in Figure 3.4 and discussed later on in this Chapter in which to engage and enhance the conceptual aspects supporting this study and the analysis in Chapters five, six and seven.
Figure: 3.2 ‘Place framework’
Source: Compiled by the author.
i. Introducing ‘location’

‘Location’, from Agnew’s (1987) perspective includes physical settings or structures and for the purposes of this research the sites of where rural nursing practice occurs. The physical environment in this study is considered as an important concept associated with the rural Otago location in which the construction of the professional identity of the rural nurse has occurred, and has been analysed from the data in Chapter five. Figure 3.2 makes up the three aspects of Agnew’s (1987) ‘place framework’. The three dotted circles are representative of the three elements of his framework. The green dotted circle represents movement in ‘place’ as ‘location’. Cresswell (2004) has indicated that the most understandable and “common definition of a place [is as] a meaningful location” (: 7). Meanings associated with ‘place’ become part of an individuals’ understanding of who they are in association with location, in which a sense of attachments, feelings and emotions may occur (Massey, 1995; Cresswell, 2002; McKinnon, 2011). An attachment to ‘place’ establishes a strong commitment to the physical location and a sense of place may develop (Nagel, 2011). In the interim the second of Agnew’s (1987) ‘place framework’, ‘locale’ and its relationship with ‘location’, is considered as an additional important component of the conceptual framework.

ii. Introducing ‘locale’

‘Locale’ is associated with the development and maintenance of social relationships as presented in Figure 3.2 (above) in which ‘place’, as ‘locale’ makes up the second aspect of Agnew’s (1987) ‘place framework’. This red dotted circle represents ‘place’ as ‘locale’ where social relations and the meaning of ‘place’ are made or developed both within and beyond the ‘location’, representative as the colour red as the second inner dotted circle. According to Agnew (1987) social relations are more complex than considering them only as interactions between people, what he terms human interaction. These relations are effectively between people, and their relationship to a specific geographical context. Relationships between geographical contexts and ‘locale’ are now discussed, demonstrating how identities are constructed where human activities occur in ‘place’ and where meaning is made. Meaningful places assist people to make connections and to develop a sense of who they are in
relation to a geographical location. As Hollaway and Hubbard (2001) explain “[t]hese meaningful relationships associate the formation or make up our identities” (: 71). Meaningful relationships can be further extended to encompass a ‘sense of place’ as represented by Agnew’s (1987) third element of his ‘place framework’, ‘sense of place’ discussed in the following section.

iii. Introducing a ‘sense of place’

According to Agnew (2004), ‘sense of place’ is about understanding meaning through subjectivity, belonging and attachments, which are identified and established as an emotional association that people have to ‘place’, as ‘location’. ‘Place’, as ‘sense of place’ is positioned diagrammatically in Figure 3.2 (above) and makes up the third inner aspect of Agnew’s (1987) ‘place framework’. This yellow inner dotted circle represents ‘place’ as ‘sense of place’ where attachments are being established, and a strong commitment to individuals’ location and there is a willingness on the part of people to contribute to their local place (Vanclay, 2008). A ‘sense of place’ usually involves or is associated with a community, which, according to Vanclay (2008) is termed ‘homeogeneity’ and refers to as belonging and cohesion. Individuals have an emotional need to identify with often personal and intimate places and hence ‘construct’ these places for themselves on the basis of repeated experiences. ‘Sense of place’, also includes the particular sounds, smells and sights related to specific locations that are represented as a nostalgic experience (McClinchey and Carmichael, 2010). Places are known and cared for from within ‘location’ as what Tuan (1974) calls ‘fields of care’ in which people demonstrate a love of place and an emotional attachment develops (England, 2011).

‘Sense of place’ helps explain how identities are established, which occurs through the attachments, performance and emotions, associated with place (Agnew, 1987; Butz and Eyles, 1997; Cresswell, 2004). According to Tuan (1974), to develop a ‘sense of place’ requires the ability to know the place personally and which the individual responds to emotionally. This intimate knowledge is gained over a long period of time through extended encounters with the ‘location’. These extended time periods invest the individual with a deep ‘sense of place’, which makes place an extension of the individual (Holloway and Hubbard, 2001). ‘Place’ therefore can be
viewed as a social and political resource with flows and movements Agnew (1987).
The political considerations are further explored in Chapters five, six and seven.

Whenever social geographers consider the notion of place, they tend to relate it with two other concepts associated with social geography, that of landscape and space. An ongoing debate continues within social geography whether there are similarities and differences between these two concepts. A brief overview of place and landscape and place and space, is now discussed in which to form a background account to which I come back to in the thesis discussion in Chapter eight.

iv. ‘Place and landscape’

Landscape is viewed similarly to a location and is referred to a section of the surface of the earth as viewed from a particular position (Cresswell, 2004). Defining landscape in this way “refers to the shape—the material topography–of a piece of land” (Cresswell, 2004: 11). Landscape is a way of looking at the land and dates back to the Renaissance when landscapes were painted and viewed from a distance (Cresswell, 2004). Landscape is generally viewed from the outside and is not a place where people reside; landscapes are a viewed experience and not a lived one. In this sense, this is how place and landscape are presented as being different. Place and space are now considered.

v. ‘Place and space’

The concept of space and how it is understood has been debated within geography over a period of time and there are different schools of thought about what makes up space and place, which have undergone recent transformations according to Agnew (2004; 2011). Space is not fixed and it undergoes constant dynamic and political change and neither is it a receptacle to be filled rather space has the ability to enhance change (Massey, 1999).

For the purposes of this thesis I do not intend to contribute to this space-place debate. However, I engage with the argument put forward by Agnew (2004) that when space and place work together, they are more dynamic than working separately. I consider
space and place meaningful, for as Thrift (1999) explains they weave together in order to maintain each other. Place is important because it is central to the social world. Places are what are made of spaces when linking the human interaction with the environment and this will be discussed as to their importance within this thesis in Chapters eight and nine. In this section a brief summary of the social geography debate associated with place and space together with my interpretation are now detailed.

The social geography literature associates ‘space and place’ as being relational (Agnew 2004; 2011). Space is viewed as abstract or general, modern and global, while ‘place’ is considered specific and local or traditional (Escobar, 2001; Agnew, 2004). Agnew (2004) considers ‘place’ from this traditional sense as nostalgic, but unlike space, which he considers as progressive and radical in which change occurs. Space is associated to a location, for example, having an address, while ‘place’ is about living at that address. As discussed above, in relation to place and landscape, ‘place’ becomes the lived experience.

Reflecting back to the seventeenth-century concepts related to Newtonian and Leibnizian thinking assists in understanding both space and place (Agnew, 2004). From this perspective, space is representative of movement, in opposition to the rootedness associated with place, which is where a Newtonian view of space becomes active. This is because according to this view, space is made up of places. In opposition to this view is the Leibnizian view, which considers the power of what occurs in place, and it is this that makes space appear active. Massey (2005) explains that space comprises a number of relational activities that are interrelated which occur from a global to a local sense. These relations in space are interactive and are never complete; space is always in motion and constantly being made, while engaging with openness towards the future. Agnew (2004) explains that space cannot exist without ‘place’ and he engages with subjectivities associated with that ‘place’. ‘Place’ as defined in nursing will now be discussed.
3.5.3. ‘Place’ as defined in nursing

As discussed above, the idea of ‘place’ is more than a physical or a geographical setting in which the nurse performs their practice. The literature associating ‘place’ and nursing practice was identified as far back as Florence Nightingale (Andrews, 2002; 2003) and will be further discussed within the section dedicated to the fourth key concept that of professional nursing practice. In 1859 Nightingale published the Notes on Nursing: What it is and what it is not (Nightingale, 1969) in which she discussed the requirements necessary to improve patient health care. Nightingale discussed the merits of cleanliness, the environmental necessities of clean air, effective ventilation, warmth and light, together with the nurses’ proximity to patients. She brought to light the potential for the environment to be a contributing factor to a person’s health and was one of the first nurses in the world to take notes on patient’s health issues and then to discern links between health and environment (Nightingale, 1969). Further research undertaken by Liaschenko (1996a) has explained the importance of understanding place in nursing research. Her argument revolves around the fact that nursing practice occurs in numerous sites and locations and so ‘place’ is important to nurses. The concept of space and the associated ideas of location and ‘place’ are central components of geography, which Liaschenko, considers as the geography of nursing. Liaschenko (1994; 1996a; 1996b; 1997) explains geography is a useful way through which to talk about the depth of the nurse-patient relationship in context. Context of practice has been further extended in Malone’s (2003) study that focused on the proximity of nurse-patient relationship in ‘place’ or location and was further extended as situatedness associated with nursing and ‘place’.

vi. ‘Place’ and situatedness

Carolan, et al. (2006) reviewed the nursing literature with the intent to understand how nurses conceptualised the term place compared to social geographies’ understanding of the term in relation to nursing practice. These authors indicate that there are four main categories emerging from the nursing literature associated with the dual concept of ‘place’ and nursing practice which all have a significant relevance with this thesis. The first category refers to ‘situatedness and is further discussed by
the authors as “being in and feeling place” (Carolan, et al., 2006: 204). The second category links situatedness with creating a healing environment. The third category is extended to conceptualise the nurses’ practice as disembodied or displaced and this in turn reflects the fourth category which focuses on nurses’ practice associated with ‘place’ involving issues of workplace, power and gender. The concepts revealed from these four categories expose nurses’ practice as comprising presence, co-presence, proximity, moral agency, and the therapeutic and interpersonal relationships with clients, families, work colleagues and communities. All these elements can be affiliated with the fundamental components comprised in nursing theories developed during the latter part of the twentieth century, exposing the caring elements that underpin nursing practice (Leininger, 1991) and related to tetralogy (Torres and Yura, 1974; Fawcett, 1984) (discussed later in this Chapter aligned with the fourth key concept, professional nursing practice and caring).

The literature associated with ‘place’ and nursing practice generally focuses on the site of practice, either in the hospital setting, or the client’s home. There is generally no differentiation as to whether these sites are urban or rural locations. Lee and McDonagh (2010) have recently connected the concept of situatedness in relation to the shaping of rural nursing practice which they have built on the initial work of Jones and Ross (2000). Situatedness extends the nurses’ proximity to the patient or client. Proximity associated with nursing practice and ‘place’ as discussed by Malone (2003) is now detailed.

Malone (2003) has reflected and built on Liaschenko’s (1994; 1996a; 1996b; 1997) arguments, which capture nursing practice as it occurs in certain physical and social spaces. Malone (2003) is interested in pursuing this notion of the spatial aspects of nursing practice which she refers to as proximity. Malone (2003) proposes that there are four areas to consider in relation to nurses’ proximity: physical proximity, narrative proximity, personal proximity and moral proximity. The first aspect, physical proximity is associated with the nurse practising in physical nearness to the client, including the concepts of touch (and physical caring). Narrative proximity engages the nurse and client together through effective communication and the facilitation of health care. Personal proximity focuses on understanding the client, and moral proximity refers to advocating on behalf of the client. Proximity with
patients can also be extended to the concept of nursing presence with patients or clients and extends the caring elements so important in nursing. Peter (2002) states that the presence of nurses has a profound effect on the experiences clients relate to, in conjunction with establishing place as the therapeutic essence of healing.

Furthermore Peter and Liaschenko (2004) have extended the work of Malone (2003) and Liaschenko (1994; 1996a; 1996b; 1997) and considered proximity as practising within the physical presence with patients. Physical presence benefits the development of the nurse-client relationship (a holistic move of health care and ‘new nursing’ which will be discussed later in this Chapter in relation to professionalism and caring). Relationships associated with nursing are twofold, firstly, nursing takes occurs in a physical location, and secondly, the development of a professional relationship is a necessary component of the work of nursing (Christensen, 1993; Liaschenko, 1997). The nurse-client relationship is a fundamental component of nursing and necessitates a nurse’s full, psychological and spiritual presence as explained by Osterman and Schwartz-Barcott (1996), whilst creating a specific ‘place’ of caring. Indeed for the nurse-client relationship to be effective the nurse is positioned physically to understand the client’s needs and to act on those needs. Proximity associated with the nurse-client/patient relationship, relates to nurses understanding of what their moral responsibilities are and how they enact their moral selves towards the client (Peter and Liaschenko, 2004).

Moral concerns for client care leads onto seeing the nurse as the moral agent and identifying nurses’ responsibilities and their response to these responsibilities. Proximity is also considered as the amount of time the nurse spends with the client, and therefore proximity becomes time dependent. Proximity also relates to relationships with the clients’ families, doctors, allied health professionals and community residents, which, in the case of nurses, is acknowledged by Peter and Liaschenko (2004) as signifying, “boundary workers in health-care” (: 222). The concept of nurses as boundary workers, connected to the notion of proximity, have entitled nurses to extend their practice into the domains of other health care professionals (Thompson, 2006). They do this to accommodate clients’ needs and requirements with the aim to provide some forms of treatments to avoid clients waiting for other health professionals’ attendance. Allen (1997) explains that nurses
extend their practice in such situations as a moral responsibility and a concern for the client. Peter’s (2002) argument that “[p]lace has the potential to limit and enhance the power of nurses” (: 65). Place therefore matters to rural nurses’ practise from the point of view of the physicality of place which is further discussed below.

Thomas (2013) has demonstrated the importance of place knowing, in which health and illness can be understood in relation to location. Understanding ‘place’ from Thomas’s perspective focuses on the knowledge generated by community residents about their own interpretation of factors that could affect their own health. This engagement builds on the work by health geographers Kearns and Moon (2002) who consider the importance of understanding place in relation to health, illness and the availability of health care services in local regional communities. From this analogy, place becomes a significant concept in which to consider the particular nuances associated with rural nursing practice. Benner and Wrubel (1989) state, caring is linked to the context in which that care occurs and indicate, “we must consider the caring context because the nature of the caring relationship is central to most nursing interventions” (: 4). Context is also referred to as an aspect of the interpretivist paradigm in which this thesis is situated, which will be discussed in the following Chapter.

The next section of this Chapter pays attention to and uncovers the particular nuances related to the rural in an attempt to further situate nursing practice within this thought-provoking and curious space. I offer a descriptive account of how the rural is represented, which leads on to a discussion of ‘knowing’ the rural and the interesting consideration of ‘performing’ in the rural. Engaging with the literature demonstrating the factors that are associated with performing in rural communities follows this descriptive account. This section concludes with reviewing the international literature aligned to defining the rural, and then moves on to defining the rural within New Zealand.

3.6 Significance of the rural and nursing practice

The third key concept, the rural, builds on the previous concept recognised as place, and is associated with the rural context and the engagements in which the majority of
the research participants live and work. The conceptual understanding of the rural is a key lens in this thesis, however the rural is not a simplistic concept as there is no one set of attributes that represent this complex space (Larson, 2002a; Woods, 2011). Instead, there are multiple ways of understanding the rural in which individuals and institutions, both within and beyond rural geographical boundaries construct their own understandings. These understandings fall into two categories, that the rural is both real (internal subjectivity) and imagined (external subjectivity). Halfacree (1996; 2006), studied the social constructions of the rural for many years and has noted a change in how the rural is represented and imagined, while also being associated with many diverse meanings. Diverse meanings reveals that the rural is a contested space, according to Woods (2011), who notes that a variety of different approaches are used to make sense of this space and describes these approaches as “imagination, representation, materialisation and contestation... taking on different forms in different contexts and from different perspectives” (: 30). These different and diverse understandings associated with the rural implies that there are multiple ways of knowing and understanding the rural for which it is necessary to critique the literature and this enhances a deeper understanding associated with this contested space. It is the essence of knowing the rural which is in question, as to how we can understand the rural, which requires the knower to have a sense of the rural. However, Woods (2011) cautions that,

[the rural is a messy and slippery idea that eludes easy definition and demarcation. We could probably all instinctively say whether any given place was rural to us, rather than urban, but explaining why it was rural, not urban, and drawing a boundary line between urban and rural space on a map are altogether more difficult tasks.

(30)

These multiple understandings hold similar, different and relational meanings for rural and non-rural people, organisations, policy-makers, educators and regulators, and are all important considerations in this thesis. Different meanings associated with the rural can lead to contesting what the rural space is and the practices which are performed in that space. The rural nurse performs their practice in this contested, dynamic and changeable space which forms the central theme associated with this thesis which seeks to uncover the rural nurses’ professional identity.
3.6.1 Urban-rural debate

In an attempt to uncover the particular nuances associated with the rural to better understand rural identity I have further engaged with the discipline of social geography in an attempted to define the rural and this has been achieved through recognising its division from the urban (de Leeuw et al., 2011). As noted in Chapter one, population density marks a point of difference, and in addition, population size, distance and access to health care and other services have been identified as some of the differences between rural and urban practices (Bidwell, 2001; Blue, 2002; Hutton, 2016). One important consideration is the dialogue attributed to the differentiation between the urban and rural in which Cloke (2006a) notes, “the distinction of rurality is significantly vested in its oppositional positioning to the urban” (:18). Urban-rural differences are associated with density of population in the urban regions which is in conflict to the isolation rural residents’ experience, resulting in differing social interactions which plays a significant part of the fabric of rural existence and communication (de Leeuw et al., 2011; Nagel, 2011). Defining the rural is an important concept which is now considered.

3.6.2 Defining the rural

Defining rural internationally particularly as it relates to health care plays an integral, but background element in this thesis. It is not however the intention of this thesis to add to the growing debate of defining rural (Cloke, 1997; Bushy, 2000; Francis and Chapman, 2014). Rural is identified as a worldwide concept, despite this, there is no one unified international definition encapsulating the rural (Cloke, 1997; Hugo, 2002). However, there are a number of core characteristics encompassing the rural, which fall into three main categories and include descriptions, typologies or continuums and indices (Bushy, 2000; Bidwell, 2001).

Descriptions of the rural are associated with population density and distance (Bidwell, 2001). Distance is measured by kilometres from urban centres (Bushy, 2000), which provide services such as tertiary health care and employment for rural residents who commute from their rural locations (Statistics New Zealand, 2006). Typologies or continuums, according to Halfacree (1993), have been in use since the 1940s to
measure the rural-urban divide. The aim of using a continuum is to measure the
differences in size, population and factors associated with the location from the
remote through to urban contexts. According to Hugo (2002), typologies or
continuums are valuable measures of defining rural. Measurements, whether
distance, the nature of the population base or access to health care, are associated in
defining the concept of the rural. Indices are linked with measuring specific rural
characteristics, which collectively, can have the aim of developing a rurality index. A
rurality index assists with the planning of health care, which takes into consideration
the nature of rural communities, and their health care needs (Kulig et al., 2008).

3.6.3 Defining rural New Zealand

Defining rural in New Zealand is understood as part of an urban/rural continuum,
which, according to Statistics New Zealand includes seven urban and rural settlement
rural groups, which categorises urban compared to rural New Zealand as highlighted
in Figure: 3.2 on the following page (Statistics New Zealand, 2006). These groupings
recognise a range of population size, residential address and place of employment as a
means to understand population characteristics rather than providing a specific
definition of rural. The rural categories include the degree of influence nearby urban
areas have on surrounding regions. Influences are recognised as being expressed
through employment, as many rural residents commute out of the rural region for
work. As residents work outside of their residential region they are able to use urban
services. These services may include health and recreational, shopping and banking
services. By contrast rural and more isolated regions tend to have less access to
services found in urban centres. In particular, as noted in ‘Defining Urban and Rural
New Zealand’ (Statistics New Zealand, n.d.) health services are defined as “a crucial
resource that is lacking in many rural areas” (no page number). This classification
also relates to a parallel report about remoteness and isolation as significant factors
that shape the health care services, the community and its residents (National Health
Committee, 2010). Rural areas have been defined into four categories as presented in
Figure: 3.3. These categories range from a rural area with a high urban influence to
the extreme where the rural area is highly rural or remote with minimal urban
influence on employment. Employment is the primary measure of defining rurality in
New Zealand (Statistics New Zealand, 2006) but in my opinion this does not take into
consideration the type of employment, neither is it a true representation of rural residents’ access to services.

![Diagram of Urban/Rural Profile Classification]

**Figure: 3.3 An Urban/Rural Profile Classification**  
Source: Statistics New Zealand (2006) and licensed by Statistics NZ for re-use under the Creative Commons Attribution 4.0 International License.

The Urban/Rural Profile Classification (Statistics New Zealand, 2006) in Figure: 3.3 (above) demonstrates the particular aspects of understanding the rural which are different to the urban context and from these descriptors the rural has its own culture, which is considered as ‘rurality’, a neutral term coined by academics to refer to the country (Woods, 2011). According to Cloke (2006) “it is [through] the social distinction of rurality that the significant differences between the rural and urban remain” (: 19). Rurality therefore, is related to the countryside or an isolated geographical location and includes traditional ways of living and being in the rural. The division of rural and urban is one of the oldest ideas in geography according to Woods (2011), which is now discussed in which a sense of difference between these two aspects is highlighted.

Rural residents are aware they identify themselves as different to urban people (Strasser, 2003). Rural community connectedness is one such factor (Hughes, 2009) in rural areas, everyone generally knows everyone (Hughes, 2009; England, 2011). Woods (2011) emphasises rural residents may feel a sense of belonging with each other, and a shared identity results, which is referred to as the traditional notion of Gemeinschaft. However, this social connection does not mean all rural residents
think and act in the same manner, residents do have differing rural values and views (England, 2011) as discussed previously in relation to ‘otherness’ and ‘marginalisation’. Rural identity is therefore an important aspect of understanding how the self identifies with the rural, which is now considered.

3.6.4 Rural identity

Attachment to place is understood to be important to rural peoples’ sense of identity, safety and life satisfaction (McMurray, 1999; McKinnon, 2011). A sense of identity can also be associated with a sense of belonging or feeling connected to a rural location and the rural people residing in that location (Nagel, 2011). Understanding the rural is taken further through the use of the concept of the insider/outsider, which is well documented, in rural nursing studies (Bailey, 1998; Lee 1998; Lee and Winert 2006). This is referred to as those rural people who are accepted as a part of the rural community and its members, while on the other hand referring to rural people who are either as of yet not accepted into the community or who remain physically outside of the community and its membership. Little (1999) advises for “greater sensitivity towards the complexity and fluidity of rural otherness and requires that we focus more directly on the meaning and construction of identity in a rural context” (: 438). This is an important factor in this thesis which is further expanded on below to consider what Cloke’s (1997; 2003) work focuses on, to reveal the characteristics of rural identity and how this is played out or performed in rural locations.

As noted previously the ‘rural’ has historically been identified with the countryside (Cloke, 2003) and with the notions of isolation, family connections and a small population, as well as a strong sense of community related to rural locations. The notion of rural communities is now engaged with.

3.6.5 Rural communities

A community is not necessarily associated with a physical location but can be a part of a global community (Ife, 2013; McMurray and Clendon, 2015). However, for the purposes of this thesis community refers to people who relate to each other within the context of an identified space, in this case a rural location. Hughes (2009) states
“[t]he very notion of ‘community’ sits rather more comfortably in a rural rather than urban framework. One does not often hear the term ‘urban community’ (p. 201). However, there has been a movement in New Zealand which attempts to engage urban community groups in planning to grow sustainable communities (Hayward, 2003). Communities are spaces of social networks where residents work, live and play and are associated with each other through shared connections, obligations and responsibilities (Hughes, 2009; England, 2011). Communities are also places where people, other than rural residents live; rural communities are places non-rural people visit for holidays and recreation. The concept of community in general terms is linked to people who align with similar values and beliefs, which bond them together with a common cause. Rural communities comprise rural people as a social collective. A social collective does not mean all people share the same values as a variety of views exist amongst rural people (as mentioned earlier).

Rural communities are identified as having both negative and positive connotations as discussed by Woods (2011) and Murray (2012), who reflect that the rural is sometimes considered as backward, in contrast to positive images related to the ‘rural idyll’, noting how the environment is an attractive and romanticized place to live in or visit. Liepins (2000) associates community cohesion, social collective and action with rural locations, and notes there is a greater sense of cohesion as rural communities become more remote from urban centres. Physical remoteness builds resilience amongst rural residents (Leipert and Reutter, 2005) and self-reliance (Bushy, 2000) and promotes community sustainability (Panelli, 2006; Dillon, 2008). Rural communities are constructed through their rural context, rural people, community meanings, community practice, and community space (Panelli, 2006). This is linked to expectations of social participation amongst rural residents who practice a sense of community through various social practices (Panelli, 2006). Instead of a community being considered a structural concept, community can be considered as a symbolic construct where meaning is made through the social relations within it. Meanings of community can be shared or contested. Liepins, (2000) contends that rural people feel a sense of belonging and social cohesion in relation to their communities based on where they live. Community and place are constantly intertwined (England, 2011). Communities involve and are based on social relations that occur continually in places and spaces as interactions develop and as
social relations are enhanced between people. Social relations are linked through family, friends, functionality, and loyalty to each other, as well as to community membership (Hughes 2009; England, 2011). Social relationships are based on personal bonds of friendship and kinship, inter-generational stability and a state of close proximity with associated beneficial interactions (Liepins, 2000) that are considered as a positive image associated with the rural. Rural images are now engaged with.

3.6.6 Rural images

Rural can create a range of images adding to the above list, such as wilderness, outback, village, bush, and open space (Halfacree, 2006). Rural places are understood as productive, for example for producing food, fuel and minerals. Rural places have also become recreational areas, holiday venues and a space to enjoy a slower pace of life (Woods, 2011; Central Otago a World of Difference, n.d.). Rural places are associated with wide-open spaces where, generally, activities are associated with production or recreation which are both associated with the land. These descriptors give substance to definitions of the rural for individual countries, which raises further concerns as rural definitions differ around the world. Difference is a particularly interesting phenomenon related to rural studies. It is useful to consider the links made from these images associated with geographical location, for example, the concept of a village as it relates to perceptions in Britain, and the concept of the Outback as it is conceived in Australia.

Rural nurses over the past century have used different terms to identify with their practice such as Bush nursing in Australia (Francis and Jacob, 2012) and in New Zealand the Native Nurse (Burgess, 1984); Backblock nursing and the Māori League nurses (Woods, 2008; 2009) in the early part of the twentieth century. The contemporary term used today is rural nurse or RNS, which associates nurses’ with their rural practice. Halfacree (2006) explains we must be able to describe practices which occur routinely in rural locations, it is therefore interesting to consider how rural locations are represented which construct the performance of individuals and groups within the rural.
3.6.7 Representations of the ‘rural’

There are numerous representations of the rural, and these include engaging with nature, farm life, including animals, farmed space, domesticated and wild space; agriculture and a simple healthy lifestyle which are positive aspects of rurality, clean air (Thurston and Meadows, 2003) and isolation (Lee, 1998; Bushy, 2012). Family is also an important focus, with family members living and working close to each other (Panelli, 2006) and maintaining family values (Bushy, 2000). Positive aspects associated with community include small populations, having a strong sense of community (Liepins, 2000; Cloke, 2003) and the availability of local meeting places, such as community market, and a slower pace of life (Bushy, 2000). Ideas of adventure, recreation and freedom are associated with the ‘rural’ and have come to be represented as adventure tourism (Woods, 2011). Adventure tourism includes a range of recreational activities, including more traditional activities such as rock climbing and mountain biking, while contemporary adventure tourism provides the individual with opportunities such as jet boating and four-wheel drive activities. In New Zealand, adventure tourism in rural locations has become fashionable and is considered a leading tourist industry (Woods, 2011) which is run by the locals, but not necessarily indulged by the locals. These representations of the rural are associated with the open spaces situated outside of cities (Bunce, 2003) and, are also identified with the term, ‘countryside’ (Cloke, 2003).

Further representation of the rural is associated with rurality. Rurality is a “social construct–that is as an imagined entity that is brought into being by particular discourses of rurality that are produced, reproduced and contested by academics, the media, policy-makers, rural lobby groups and ordinary individuals” (Woods, 2011: 9). For some people the rural is imagined, for others it is a lived reality, alternatively a place to visit. It is therefore evident that the concept of the rural is contested, depending on the individual’s construction of their understanding of rurality, which helps shape their own representation of the rural. An excellent example of the rural has been constructed by non-rural residents and is understood as the rural idyll.
3.6.8 The rural idyll

The rural idyll constructs rurality as anti-urbanism or counter-urbanism while maintaining a nostalgic and romanticised idea of the rural played out in social, economic and cultural structures with the intention to keep the rural image alive. Some people value and dream of the rural countryside, as a simpler way of life, which is lost in urban contexts and they “seek to construct rurality in a certain way rather than representing the rural that actually exists” (Woods, 2011: 22). The concept of the rural idyll can have strong influences on policy development by non-rural people (Cloke, 2003). Likewise, Liepins (2000) states that people from beyond a rural community may be powerful in constructing or constraining understandings about it, including the governance of policy-makers in core agencies who can shape resources, responsibilities and relations within and beyond the community. A representation associated with the rural is linked with the concept of knowing the rural.

3.6.9 Knowing the ‘rural’

Knowing the rural is concerned with how we come to know and understand the rural, as there is no one-way or means of positioning this understanding. There are however, a number of ways through which the rural is constructed. Understanding the construction of the rural is used in this thesis as a way of understanding the world, and of ensuring the visibility of certain relationships, practices and subjectivities through which we make our world visible. This visibility occurs through signs, symbols and practices, which represent what it means, what is accepted and how to perform in the rural (Woods, 2011). The interpretation of the rural by rural residents represents situational knowledge related to their lived experiences and assists in understanding how these people are constructed according to Woods (2011). Knowing and performing rural nursing practice is of particular importance in this thesis as it relates to the construction of nursing in rural contexts. Scharff (2006) considers the importance of the rural nurses’ knowledge associated with the rural culture, together with the knowledge the nurse is introduced to in practice and the knowledge generated from within the community. These three avenues of knowledge are imperative to know how to practise and perform in the rural.
3.6.10 Performing the ‘rural’

As rural residents come to know the rural, a sense of self and identity associated with this rural space develops (Woods, 2011). Edensor (2006) emphasises there is a way of performing within the rural, which can be considered an “unreflexivity habitus” (: 491). Unreflexivity habitus in this context refers to where everyday tasks are performed routinely and confidently in place and amongst rural residents, buildings and the countryside, including where non-human activities occur. Habitus is about everyday practice and an unconsciousness of performing in the everyday rural. What is interesting about this way of thinking is the notion that everyday habitual performances are constituted by an array of techniques which embody codes which guide what to do in particular settings as discussed by Edensor (2006).

Furthermore, as rural nurses come to know the rural the particular nuances associated with this thought provoking and curious space becomes uncovered, revealing how the rural nurse negotiates and performs their practice. For the purposes of this thesis, I consider whether rural space constructs the rural nurse to perform in a specific way, at the same time the nurse constructs this space and performs their practice, while accommodating rural residents’ health requirements and needs. How and why this occurs is discussed in the analysis Chapters five, six and seven. Performing in the rural is associated with knowing the rural, as discussed previously. According to Woods (2011), performing the rural is associated with living in the rural “which are about emotion, sense, instinct, intuition, habit and action” (: 201). Performing the rural takes on prescribed or constructed norms of behaviour, dress, language for the setting and engagement in community life, which develops to form a certain rural identity. As a rural identity emerges and the performance of rurality becomes natural, local discourses become habit and a natural way of performing the rural identity emerges which is connected in place, as discussed by Edensor (2006). Rural people measure their performance against the norms, expressed and demonstrated, as accepted within the rural community as everyday practice (Edensor, 2006). Failure to perform in an expected way can raise negative perceptions of the ‘rural’ resident behaviour by other members of the community as to their trustworthiness and the acceptance of embracing rural identity.
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The day-to-day activities performed in the rural have been well documented in the geographical and nursing literature (Lee, 1998; Bushy, 2000; Crooks, 2012) associated with rural communities in which the rural nurse engages with the particular contextual rural characteristics (Bushy, 2000; 2012). These characteristics make up and define rurality while positioning the rural nurse in an environment that necessitates them to embrace the unique contextual issues. Contextual issues include the population demographics, geographical features and the activities which occur in that rural location, while the rural nurse negotiates their practice in accordance with the communities’ diverse features. These features have been discussed previously and will be further engaged with as the analysis unfolds in Chapters five, six and seven. In the meantime it is timely to review the fourth key concept, professional caring and its significance in this thesis.

3.7 Significance of professional practice in nursing

In this section of the Chapter I introduce the fourth element of the conceptual framework commencing with a discussion based on the international literature related to the knowledge associated with professional nursing practice which builds on the introduction to the development of nursing practice in New Zealand in Chapter one. This section leads into a discussion of the important aspects associated with professional nursing practice, which forms the basis of nursing theories (Keleher, 2014). Nursing theories are further extended to encompass professional nursing practice and relevant theoretical developments situated within the concepts of place, including rural place.

3.7.1 Professional nursing practice

Caring is a principal concept related to professional nursing practice (Sherwood, 1991) and an important element in the conceptual framework guiding this study. For the purposes of this thesis, caring is discussed in the professional sense and is associated with the professional aspects of nursing practice. It is not my intention in this thesis to provide a detailed discussion related to caring, that in itself could be the focus of another thesis but rather, due to limited space it is my objective to only
introduce the professional elements of nursing practice associated with the notion of caring.

Aspects of caring have been a dominant component and discourse of nursing since the time of Florence Nightingale, when she wrote about the art of nursing, expressing that “care is the essence of nursing and the central, dominant, and unifying feature of nursing” (as cited in Leininger, 1988: 152). Despite this succinct quote by Nightingale, Benner (2000) contests that the concept of care is difficult to define and it’s equally difficult to express the caring elements of nursing. The main reason for this difficulty is because, traditionally, caring has been associated with women’s work and was not initially regarded as a professional activity (Tully and Mortlock, 2005). Witz (1994) argues, that as “care-giving is not recognized ‘as work’ there is an assumption that caring tasks are something that women simply do rather than skills that women and men might need to acquire” (: 39). Likewise Kitson (2003) cautions the nursing profession about the differences between caring concepts such as, ‘lay caring’ and ‘professional caring’. One overall difference between ‘lay’ and ‘professional’ caring is the relationship developed between the professional obligation between the patient and nurse, and initially identified by Benner and Wrubel (1989), which require professional presence, touch, communication, connection and concern for the patient or client and necessitates the RN to build a trusting partnership. The components identified above are further acknowledged by NCNZ, as compulsory elements of professional nursing practice.

Initially, partnership requires the nurse to be an active listener and engaged communicator in order for the nurse to assess clients health needs, plan and implement health care activities and evaluate the health care outcomes and is referred to as the ‘nursing process’ and will be discussed further in 3.7.2 below (Ryan, et al., 2005). The nurse expresses concern, compassion and commitment, providing a person-centred approach to health care, which includes the family members as well. In New Zealand the values underpinning nurse-client relationships, include trust, respect, partnership and integrity as reflected in the precepts of the Nursing Council of New Zealand’s, ‘Code of Conduct’, (Nursing Council New Zealand, 2012). How the nurse goes about performing their practice and the caring elements which make up their practice have been of interest to nurse theorists for the past three decades. The
theoretical base that informs and underpins nursing practice is now discussed in relation to professional caring, in the following part of this section.

3.7.2. Nursing’s theoretical base

During the 1970s a movement amongst nurse theorists emerged with two main aims. The first aim was to uncover a body of knowledge through which to demonstrate the unique features of nursing as a profession and to capture the concepts underpinning the caring and compassionate dimensions of nursing practice (Leininger, 1991; Sherwood, 1991). This new focus was seen as a way of moving away from the control of medicine related to the notion that health and illness were situated only within the field of medicine (i.e. under the oversight of doctors) (Tully and Mortlock, 2005) and, in so doing, promoted the discourse that nurses and their practice were led by or had delegated tasks (Turner, 1987) from medicine (Tully and Mortlock, 2005). The consequence of this ensured medicine dominance and nurse subordination (Papps, 2001) that according to Tully and Mortlock (2005) resulted in a focus on medicalization rather than a focus around the notion of professional caring. Moving away from the curative focus associated with the medical model to that of caring practice eventuated as these nurse theorists continued to study aspects of nursing care (Torres and Yura, 1974) with the aim of capturing the essence of nursing. Benner and Wrubel (1989), postulate that theories of nursing build the professional discipline and that theory informs real-world experience.

The professional aspects of caring is an art and a science, in which professional nurses’ combine both scientific knowledge with the caring aspects aligned with their practice. Caring is therefore a complex, multi-dimensional activity and as Sherwood (1991) expresses, professional caring considers the client as a “whole person, having regard for feelings, and paying attention to “little things” ” (84). Sherwood’s (1991) contribution assists in extending on one of the aims of this thesis, which is to seek further clarification as to why rural nurses practice the way they do, rather than what they do. One way this has been achieved has been through the efforts of a number of nurse theorists, who have studied the aspects of caring in relation to nursing. Nurse theorists noted the diversity and numerous experiences nurses acquire about nursing practice and the caring components related to their practice (Gaut and Leininger,
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One way through which nursing has begun to achieve its own professional status and knowledge began in the 1970’s when nursing firstly set out to redefine the caring aspect of their practice. What eventuated was a focus on the partnership between RNs and clients and what has come to be called new nursing (Ryan, et al., 2005; Tully and Mortlock, 2005). New nursing embraced a method in which nurses plan and implement nursing diagnosis, treatment planning, implement care and evaluate outcomes. This process is referred to as the ‘nursing process’ (Orem, 1991). The ‘nursing process’ is still current and involves a systematic and analytical model of nursing care that is concerned with problem solving, clinical reasoning and is person-centred (Dempsey et al., 2011).

The theoretical foundation that informs nursing practice is comprised within four main elements (Torres and Fawcett, 1991; Bushy, 2000; 2012). The first three of these elements include environment, person, and health and the fourth, caring (Fawcett 1984; Torres and Fawcett, 1991). The first three elements connect with the focus of nursing and are a good point from which to consider the theoretical aspects underpinning nursing practice aligned with professional caring (discussed in Chapters eight and nine). Meanwhile, the first of these three elements are introduced as related to nursing, commencing with environment. Environment has interested nurse researchers for many years, and was influenced by the initial work of Florence Nightingale in her first publication Notes on Nursing in 1859 (as introduced earlier). Nightingale brought to the attention of nurses the potential for the environment to be a contributing factor to a person’s health and identified the links between health and environment (Nightingale, 1969). During the 1960s and 1970s, nursing theories and models for practice were being developed to create a body of knowledge demonstrating the unique features of nursing as a profession. In the 1970s the concept of caring was included, and termed ‘nursing’, which refers to the practice of professional caring in different contexts, and the associated elements which make up that practice, for example ‘nursing’ as related to rural practice which aligns with the “[l]ack of anonymity, outsider versus insider… the nurse-client relationship… in a variety of social roles…” (Bushy, 2012: 13). The three core caring concepts, environment, person and health, when combined with the additional fourth concept, ‘nursing’ is referred to as ‘tetralogy’ (Torres and Yura, 1974) and are comprised in a variety of alternative nursing theories (Newman, 1989). The theory guiding rural
nursing practice by Long and Weinert (1989) and Winters and Lee (2010) is based on the four core nursing concepts or tetralogy (Torres and Yura, 1974).

vii. Rural nursing’s theoretical base

Rural nurse academics set out in the 1980s to develop a theory base which could capture the key caring aspects particular to rural nursing practice. These aspects include the special needs and health beliefs of rural populations and the particular nuances associated with individual rural communities’ geographical locations (Long and Weinert, 1989; Lee, 1998; Lee and Winters, 2006; Scharff, 2006; 2010; Bushy, 2010; Winters and Lee, 2010). Therefore the aim of uncovering the caring elements of rural nursing practice is necessary in order to practice effectively with rural residents. The rural nurse, by virtue of the complexity and dynamic nature of rural communities, has a responsibility to build up a complex and diverse knowledge base in order to aspire to be the best rural nurse she or he can be. As rural nurses’ become fully informed about the rural population’s attitudes and beliefs they are practising to their full potential (Bushy, 2012). As yet there is no comprehensive theory that integrates and underpins the practice of rural nurses and as Bushy (2012) implies, despite many years of work to develop a theory to guide rural nursing practice, instead what has been developed is still in the early stages. Bushy (2012) acknowledges the work of the Montana researchers their work was introduced in Chapter one. These researchers have examined the four relational concepts including, person; environment; health and nursing (Torres and Yura, 1974) are comprised in a nursing theory. These researchers have ‘proposed relational statements that are relevant to clients and nurses in rural environments’ (Bushy, 2012: 11), my interpretation of these four concepts are presented diagrammatically in Figure: 3.4 (on the following page).
**Nursing’s core concepts related to caring**

AS THEORISED THROUGH NURSING

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**Figure: 3.4  Nursing’s core concepts related to care**
Source: Adapted by the author from Torres and Yura (1994).
‘Person’, refers to rural people as self-reliant and independent in relation to accessing health care while preferring to have people they know rather than strangers caring for them. ‘Health’, is defined as the ability to work in which work and health are linked together and considered important by rural residents. ‘Environment’, refers to the isolation and distance people experience to access health care services and “often there is suspicion of outsiders and “government” authorities who the community perceives as historically providing short-term resources without an understanding of the rural way of life” (Bushy, 2012: 13). ‘Nursing’, aligns with the insider/outsider concept with a lack of anonymity while ‘knowing’ and caring for the majority of the community residents. The importance of gaining a trusting relationship with the community members is prefereable for the rural nurse to be in a position to offer effective and long-term health care. These ‘four nursing core concepts of care’ highlight the unique features that are linked to nursing in rural contexts. The ‘four versing core concepts’ (Torres and Yura, 1974) are further presented diagrammatically in association with Agnew’s (1987) ‘place framework’ and addressed in the analysis Chapters five, six and seven to further highlight the construction of the professional identity of the rural nurse. This theoretical framework and its rural characteristics will be presented in relation to the thesis discussion in Chapter eight.

Meanwhile the fifth concept ‘governmentality’, aligns with the governing structures in association with the previous concept, professional nursing practice and caring and is now discussed.

3.8 ‘Governmentality’

Governmentality stems from the work of the late Michel Foucault in which he provides a critical translation of governmentality in relation to power, initially related to disciplinary power and later bio-power (Foucault, 1990). Foucault considered human activities as a political affair in which power flows from the historical through to contemporary, social and economic events. Governmentality “describes the general mechanisms of society’s governance and does not refer specifically to the term, government, as commonly used” (Holmes and Gasteldo, 2006: 559). Since Foucault’s death in the 1980s, Gordon (1991) and Dean (1994) have further
developed the notion of governmentality which they draw on to offer a framework to interpret how a liberal state, or in other words, a ‘free’ society can be governed (Woods 2011). Danaher et al. (2000) discuss Foucault’s notion of governmentality as state and global politics and can be understood as the components associated with the governing of the state and the conduct of the individual. Foucault’s (1979) governmentality is considered as a matter of ‘body politics’, which he refers to as to how we relate our bodies to other bodies in a political society. Taken one step further, bodies are associated with discipline, for example the disciplinary knowledge and conduct the NCNZ expects RNs to adhere to, as they practise nursing (Holmes and Gastaldo, 2002). Gordon (1991) expresses that governmentality is understood as ‘the conduct of conduct’, which relates to the power to direct and guide self and others, the actions, behaviours and programmes on self and others through “which in our culture human beings are made subjects”(221). ‘Subject’ from Foucault’s perspective is an everyday modern person, constructed within political and personal contexts (Gordon, 1991).

The political context includes the notion of the subject as having certain rights, for example to vote, work, pay taxes and equally to abide by societies’ rules and, if they are broken, their peers test these individuals’ credibility. The personal context includes a person who lives and takes part in society, while at times contributing to that society, by using his or her own personal qualities, knowledge and expertise. It is this notion of being constructed within political and personal contexts, which is of importance as to how the self becomes ‘the subject’ (Danaher, et al., 2000). Governmentality assists in analysing the relations associated with governing structures, which are compared to as complex systems of power relations. Foucault, believed that power is not restricted or the property of one group of people or location (Fejes, 2008). Power is therefore, based on the ability of people to conform their own behaviour in which new forms of practice create new forms of subjectivity, and the potential, liberating form of identity (Fejes, 2008). The subject or subjectivity presents individual identity, and for the purposes of this thesis how the identity or subject position of the rural nurse was constructed.

The governing relations (noted above) according to Coyte and Holmes (2006) connect sovereignty-discipline-government as a three-way approach in which all three
techniques have forms of power. These forms of power are referred to as sovereign power (state power) where individuals are constructed within liberal rule “as sovereign subjects… within a self-governing political community under the conditions of liberal democracy” (Dean, 1994: 155). Disciplinary techniques (disciplinary power) are associated with authorities and organisations including disciplines that self-govern their practice. Self-governing ethics is how the self gets to act upon his or her own actions guided by their own moral integrity (Gordon, 1991; Dean, 1994; Coyte and Holmes, 2006; Darbyshire and Fleming, 2008). Numerous forms of power relations shape the ‘self’, for example nurses’ are governed by NCNZ as the governing discipline. Nurses are also governed by the state, through legislation and furthermore the self-governing activities the rural nurse engages with are analysed and these findings are presented in Chapters five, six and seven to reveal the identity construction, of the rural nurse. A variety of New Zealand studies have engaged with this notion of governmentality for example, in relation to health care and health professionals’ work (Thompson, 2006; Wilkinson, 2007), health care reforms (Prince, et al., 2006) and health geography (Kearns and Moon, 2002).

The sixth concept aligned with this conceptual framework, referred to as the ‘Funnel (Metaphor) Model’ designed by Broman and Robèrt (2015) is now considered in terms of its relationship with the previous five concepts and the rationale as to how I have engaged with this model in which to build up the analysis and presentation of the findings.

3.9 The ‘Funnel Model’

The ‘Funnel Model’ or FSSD is representative of a funnel in which to situate the sustainability challenges that either have occurred or are occurring in other words to highlight the situational activities that occur during a specified period and context. This model allows for backcasting, planning and redesign for sustainability ‘[a]n operational procedure for creative co-creation of strategic transitions towards sustainability’ (Broman and Robèrt, 2015: 4). The FSSD continues to be evolved and adapted from its initial development by Robèrt (2000) in the 1990s. Figure 3.5 provides a diagrammatic representation of the ‘Funnel Model’ and the sequence of its four procedures ABCD.
The ‘Funnel Model’ as representative in Figure 3.5 in section (A) offers a sustainable vision. Alternatively in section (B) the Model captures the challenges in relation to the vision. Section (C) is illustrative of the steps taken in an attempt for the vision to become successful which is further prioritised as a plan in section (D) which is presented in in Chapter eight in Figure 8.3. It is now timely to summarise the content of this Chapter.

3.10 Summary of Chapter

The six key elements comprised in the conceptual framework guiding this study have been presented in this Chapter. The first key element engaged with social geography’s interpretation of the construction of identity and aligns with the second key element related to the concept of ‘place’ and engaged with the international literature from the disciplines of both rural nursing and social geography. A wide variety of rural knowledge has been captured while attempting to connect the two
separate disciplines’ perspectives together, in the hope of offering a broader and richer understanding of place and the rural (concepts two and three, respectively). I have endeavoured to construct and demonstrate the advantage of positioning the knowledge from both rural nursing and social geography together, which potentially provides a strong interdisciplinary bond. An example of this is highlighted in Figure: 3.2 in which Agnew’s ‘place framework’ and the ‘nursing core concepts of caring’ (Torres and Yura, 1974) are connected and will be engaged with throughout the study. Further aims have been to share these two disciplines’ perspectives as a way to reveal the identity construction of the rural nurse in which the analysis and findings are exposed in Chapters five, six and seven. The six concepts that are comprised within the conceptual framework guiding this study, have been discussed individually and further consideration, has been applied to their relational aspects which will be highlighted throughout the remainder of this thesis.
4.1 Introduction

In this Chapter I provide a detailed account of the research process through which the study came to ‘know’ rural nursing. Rural nurses know what is required of them as they practise nursing in rural contexts and they know rural culture (Scharff, 1998; 2006; 2010). However, the above thought-provoking quote by Agar (1996) challenged me to consider how rural nurses have come to ‘know’ rural nursing which is a central focus of this thesis. Research therefore, aims to generate knowledge, based on underlying philosophical assumptions while aligning these assumptions together with the most appropriate research methods in which to further understand the topic investigated. This research is philosophically situated within the social sciences, and is guided by a qualitative methodology, associated with the interpretive paradigm which was deemed to be the most suitable theoretical approach through which to progress the research aims. I outline the stages and processes I undertook to establish the research design used in this study, the strategy for the data collection and the thematic analysis engaged with is discussed and this is also represented diagrammatically. Consideration is offered in relation to the study’s ethical issues. An overview as to how the research findings will be presented in the following analysis Chapters is provided alongside how I have attempted to maintain the rigour of this research. My reflexive position as it relates to this aspect of the research is also discussed and builds on the entries presented in the previous Chapters while adding to the discussion of my positionalty related to the research process, analysis, interpretation and presentation of findings, presented in the forthcoming Chapters.
4.2 Outline of Chapter

There are three sections in this Chapter. Section one offers a general descriptive account associated with research paradigms and includes an overview of the three dimensions included in the research process which defines the nature of inquiry through its ontological, epistemological and methodological dimensions. Section one further elaborates on the benefits of engaging with a qualitative research, and the interpretive paradigm which was drawn on to support and guide this study. Section two builds on the research background introduced in Chapter one and discusses the research design, research aims and research questions. Also in this section I discuss my reasoning for selecting two distinct participant groups, a national key informant group and a regional rural nurse Otago group. I discuss how I recruited and selected the participants for these groups. In section three of this Chapter I trace the steps I undertook from the initial planning and implementation of this study. The research methods are then discussed, presenting the key issues of data collection and the approach taken to identify the themes, categories and sub-categories analysed from the participants’ transcripts, by engaging with thematic analysis. The original planned generation of data, namely that of semi-structured interviews, focus group meetings and the employment of photo image are also included as part of the rationale of generating data. This section also discusses how I established ethical approval, including working in partnership with the regional iwi (tribe), Ngāi Tahu, a group of the tangata whenua. A brief introduction to the presentation of the analysis is included prior to concentrating on a discussion of the consistency and the credibility of this study, together with my reflexive position as a rural researcher, educator and RN and my engagement in this study that leads onto the summary of this Chapter.

4.3 Research paradigms

A paradigm is a specific view of the world or a philosophical position to which researchers align their research (Schneider, 2016). According to Weaver and Olson (2006) research paradigms are sets of beliefs, values and practices, which are

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17 The tangata whenua are referred to as the people of the land who have “special status in so far as they have the right to exercise control… offer hospitality and, importantly, to care for the land and for those who use it” (Durie, 2001: 79).
interrelated and which guide the research methodologically, its methods, analyses and
the presentation of the findings. The term paradigm was originally a concept devised
by the Greek, to mean ‘pattern’. Kuhn (1962) was the first philosopher to use this
concept, in which to represent a conceptual framework (a model in which to
investigate issues) with the intention of findings solutions within a structured system
approach. This approach was based on a group of scientific and academic ideas,
values and assumptions. These assumptions are shared by some researchers and at
the same time may be contested by others, depending on value and belief systems
(Francis et al., 2016). The paradigm a researcher implements “depends on a number
of factors, such as profession, ‘tradition’, understanding (knowledge-base), cultural
beliefs and hierarchy. No single theory, paradigm or framework alone can address all
aspects of… research nor is any superior to another.” (Whitehead, 2013: 22). A
research paradigm is an interrelated practice of thinking that define the nature of
enquiry along three dimensions and include, ontology; epistemology and
methodology (Francis, et al., 2016).

Ontology, is the study of existence, which seeks to understand the nature of ‘reality’
and the structure of the world and what can be known about it (Francis, et al., 2016).
Epistemology, refers to the search for knowledge and truth(s) and the relationship(s)
between various entities (Francis, et al., 2016). Methodology, is the the process of
gaining knowledge from the world through the process of engaging in a study
(Francis, et al., 2016).

Different types of inquiry (paradigms) are classified into three distant categories:
positivist, interpretive and critical (Willis, 2007) and are positioned as either
quantitative, qualitative or inquiry which incorporates both paradigms. I have
engaged with the qualitative paradigm in which to position this study which I discuss
in the following section.

4.4 Positioning this thesis within the qualitative paradigm

Qualitative researchers are particularly conscious of how their research connects with
social reality and understanding of the world. The social, political and cultural
aspects of reality influence and have progressed how qualitative research is
performed. The credibility of all research depends on ensuring that a sound research
design is shaped by the research question/s, while ensuring the data is interpreted
logically (Dwyer and Limb, 2001). Whitehead (2013) states qualitative research is
particularly beneficial for nurses who set out to study people’s relationships with
health, illness and the context this takes place in. Whitehead (2013) states,
“[q]ualitative research generally adopts an interpretive and naturalistic approach to
viewing the world and its phenomena” (: 105 emphasis maintained). Therefore
qualitative research assists the researcher to understand how participants experience
or view issues in society.

Qualitative social science research cuts across almost all the disciplines in the
field and borrows from almost everywhere, including the arts and the
humanities. Because qualitative researchers accept ways of knowing that go
well beyond the scientific methods, they have been open to the rich traditions
of many other disciplines.

(Willis, 2007: 191)

Willis, explains in the quote above that social researchers have access to a broad
spectrum of ways of engaging and discovering the social world. The social world is
experienced as being dynamic and changing, and always being constructed through
the intersection of cultural, economic, social and political processes. Engaging with a
qualitative method does not set out to uncover a world that holds existing knowledge
waiting to be discovered or measured (Dwyer and Limb, 2001). What qualitative
research does is to assist in exploring participants’ understandings, experiences and
phenomena in a variety of settings, which are related to “naturally occurring social
events” (Whitehead, 2013: 105). It is by engaging with a qualitative method that a
deeper level of analysis may be explored. Qualitative research is generally related to
the interpretive or critical paradigms (Willis, 2007). Qualitative research attempts to
discover knowledge related to the participants’ experiences and then interpret this
shared meaning of social reality in specific contexts (Whitehead, 2013). Denzin and
Lincoln (1994) emphasise qualitative research is creative, political, interpretive and is,

[m]ultimethod in focus, involving an interpretive, naturalistic approach to its
subject matter. This means that qualitative researchers study things in their
natural settings, attempting to make sense of, or interpret phenomena in terms
of the meaning people give to them.

( : 2)
In addition, the researcher’s philosophical position also informs the choices made as the researcher comes to understand their own interpretation of social reality (Dwyer and Limb, 2001). This thesis is no exception as I examined many of the numerous paradigms available to social scientists in determining my selection of the most appropriate approach to adopt. In so doing, I attempted to understand not only the methodological implications of each paradigm, but also its philosophical foundations. As I went about my examination I spent a considerable amount of time ensuring the paradigm would work effectively with the methods, analysis, my worldview and ethical principles deemed appropriate to conduct this research.

In conclusion researchers position and conduct their studies in a variety of ways. Regardless of this, all research is underpinned by certain standards. These standards are understood as a paradigm. Each qualitative method is interpretive and guided by the researcher’s beliefs and feelings about the world, including the questions the researcher asks and the interpretations brought to them (Weaver and Olson, 2006). I have engaged with the interpretive paradigm as the epistemological and methodological approach to conduct this research. The interpretive paradigm is discussed in-depth below, but first a brief introduction of the two alternative paradigms, positivist and critical are included while highlighting the rationale as to why I did not engage with either of these approaches.

4.4.1 The positivist paradigm

The positivist paradigm adopts a philosophical position situated within the scientific or quantitative methodology of generating objective generalizable knowledge which assumes that “certain investigated phenomena do not occur by chance. Instead, they have predisposing causes that are known to us” (Whitehead, 2013: 23). The positivist paradigm is deductive, where the researcher moves from the general or what is known, to the specific, or what can be measured or tested. The positivist paradigm was not appropriate for this study as I was not seeking to generate objective generalizable knowledge.
4.4.2 The critical paradigm

Alternatively, the critical paradigm is a qualitative methodology grounded on the undertaking of in-depth analysis, which provides an extended social understanding and direction for action (Willis, 2007). Traditionally, nurses have been “exploring the use of emancipatory inquiry, particularly feminist and critical theories, as philosophic bases for nursing practice and research” (Henderson, 1995: 58). In particular, nurses are interested in the dynamics of nursing within the socio-political contexts in which people live and work. The critical approach has been seen as a way of highlighting the oppression of people (Chinn and Kramer, 2000; Manias and Street, 2000) and, in the case of nurses, the clients they care for (Cheek, 2000). A critical approach points out to people in what way their ideas of themselves could be false and how the dominant group in society (for example medicine) has shaped them. It also informs people about the particular social conditions that are oppressive and considers this in the light of how they can change their circumstances. Identifying abuse of power is a key focus of this paradigm’s ideology which guides the research design and process (Fay, 1987). The aim is to work with the participants to understand and change the circumstances in which they become oppressed (Willis, 2007) and it is for this reason I did not engage with this paradigm as it did not suit the research aims which sought to strengthen the rural nurses’ awareness of their practice and to understand their changing professional identity. As this was a retrospective study there was no opportunity to rely on the participant’s involvement and to act on their newfound knowledge (enlightenment) while working in partnership with the researcher and to apply this knowledge in a practical approach in the real world (Fay, 1987). Critical research must always be adaptable to each and every individual situation and it is then that the critical theory may guide the people involved. However, it is the interpretive paradigm in which this study is situated, and is now considered.

4.4.3 The interpretive paradigm

Qualitative research in general is used to understand people’s individual experiences and the interpretive paradigm specifically extends this into associating the participants’ experiences within a particular context. Reeves and Hedberg (2003, p. 32) note that the “interpretivist” paradigm stresses the need to put analysis in context.
The meanings derived from the analysis which “are located in a particular context or situation and time and, generally, meanings emerge from the study process” (Francis, et al., 2016: 23). The interpretive paradigm is concerned with understanding the world as it is from subjective experiences of individuals. Methods, such as interviewing or participant observation, that rely on a subjective relationship between the researcher and participants are usually engaged with to generate data. Interpretive research does not predefine dependent and independent variables, but focuses on the full complexity of human sense making as the situation emerges (Kaplan and Maxwell, 1994). This is the interpretive approach, which aims to explain the subjective reasons and meanings that lie behind social action.

The interpretive paradigm can also be referred to as interpretivist research or the social constructivist or naturalistic approach. Willis (2007) states that this approach sets out to interpret peoples’ experience of social interaction in the world (Mackenzie and Knipe, 2006). What is important for the interpretive researcher is that reality consists of peoples’ subjective experiences of life and being in the world and that there is no one ‘truth’ to be discovered. This knowledge is subjective and, in keeping with the interpretive paradigm, people establish their own subjective and inter-subjective values of being and interacting in the world. There are therefore numerous ‘truths’ and many different realities (Willis, 2007). The interpretive approach allows for a clearer and more open understanding of the phenomenon being studied. This interpretation is informed as a result of accessing reality through language, consciousness and shared meanings. Interpretive researchers believe knowledge and meaning come about from interpretation and therefore, there is no objective knowledge and that subjective meaning lies behind social action; interpretive research, therefore responds to human interaction (Willis, 2007).

According to Weaver and Olson (2006) the interpretive paradigm is compatible with the discipline of nursing, as its focus relates to the ‘context’ and the contextual issues relating to nursing practice and client’s health care. Willis (2007) states the goal of the interpretive paradigm is to understand the context in which the research is situated. In response to aligning this study within the ‘context’, this promotes the notion that all evidence is comprised of a variety of situational information which are linked with the current situation. Understanding the context is a multidimensional
process through which to totally engage in the research, while providing an opportunity for the participants’ voice and practice to be understood within the actual setting which they are engaged. The interpretations of ‘context’ are helpful in planning the content in which to embrace the contextualized features, presented throughout this thesis.

In response to the need to align this thesis within the study context I have engaged with Molinari’s (2012a) description of context to capture and present this research. Context, from this perspective ranges from the typical geographical locations to including members of those locations and organisations. Related knowledge, resources and information are also included. As the ‘context’ is a significant part of this research process, the engagement with the study ‘context’ has been offered throughout each of the previous and the following Chapters, which provide a link to the content and which is in keeping with the interpretive approach. A research study’s location and ‘context’ can be further understood by engaging with nursing’s concepts of caring (Torres and Yura, 1974) and Bushy’s (2012) rural nursing concepts together with a social geography approach, focusing on the rural interrelations between nature and society, which includes human and non-human connections (Woods, 2011). Socially constructed knowledge reflects the contextual aspects associated with practice relations, which in turn constructs meaning, according to Panelli (2004). For the interpretive researcher meaning is derived from interpreting data from interviews and observation, together with the subjective relationship between the researcher and participants.

The aim of this research enquiry had a profound influence on my decision to position this qualitative design within the interpretive paradigm because it offered a broad approach which enabled me to collect data from a small group of participants and then to analyse this data by engaging with thematic analyses.

4.5 Research design

In this section I describe the research design, including the research aims and research questions and introduce the national and regional research locations in which I undertook the data collection. In this section I also explain how I went about
recruiting and selecting the key informants and regional rural Otago nurse participants.

Qualitative research according to Willis (2007) is “recursive and fuzzy” (: 203) which implies the researcher has the authority and responsibility to be present in the research design. The research design has involved maintaining congruence between the methodology which was chosen to frame the study, and how this in turn has informed the methods, which are linked to the research questions (Munhall, 2007).

Qualitative research assumes numerous approaches to data collection and data analysis, in line with this consideration are, the diverse range of epistemological, theoretical, and disciplinary perspectives. The theoretical or philosophical foundation provides a framework for inquiry but it is the data collection, analysis undertaken and the outcome of those processes that are important components of the study (Agar, 1996). Further, Denzin and Lincoln (2008) indicate that,

\[\text{Qualitative research is a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that makes the world visible. These practices transform the world. They turn the world into a series of representations, including field notes, interviews, conversations, photographs, recordings, and memos to the self. At this level, qualitative research involves an interpretive, naturalistic approach to the world. This means that qualitative researchers study things in their natural settings, attempting to make sense of, or interpret, phenomena in terms of the meanings people bring to them.}\]

(4)

This quote by Denzin and Lincoln (2008) leads on to detailing the research process commencing with the research aims which are now presented.

4.5.1 Research aims

The research aims associated with this thesis were developed in response to the significant regional (rural Otago) health care changes aligned with the delivery and funding of health care (discussed in Chapter two). The first research aim aligned with this research has taken into consideration the reality that some nurses practising in this
rural region referred to themselves as a practice nurse, district nurse, Plunket nurse or public health nurse (refer back to Table: 1.1 in Chapter one for a more detailed description of these occupational titles). The occupational titles mentioned above were also used to describe the practice of urban nurses, however these titles did not capture the unique aspects of nursing practice within this rural context. In fact the more recent contemporary occupation title associated with nursing practice in rural contexts that of the ‘rural nurse’ similarly in my view, is not an adequate portrayal of rural nurses’ practice. Drawing on existing literature the identity associated with the practice of rural nurses has tended to focus on what they do (Litchfield, 2001; O’Connor, 2003a; 2003b; 2003c; Thompson, 2005; O’Malley et al., 2009) including a description of their practice (Scharff, 1998; 2006) rather than determining their identity and defining their practice more clearly. Defining their practice related to social rural community encounters, including the ‘situatedness’ of their practice (Jones and Ross, 2003; Lee and McDonagh, 2010) would benefit from a more thorough definition. To a large extent these accounts acknowledge that the practice of rural nursing is diverse and fragmented (Ross, 1996; Litchfield and Ross, 2000; Dawson, 2000; Jones and Ross, 2002; 2003; Fitzgerald, 2004; Armstrong, 2008).

My curiosity and previous research relating to understanding the development of rural nursing practice (Ross, 1996; Ross, 1999; Ross, Litchfield and Jones, 2000; Jones and Ross, 2002; 2003) commenced during my work with the NCRH and was further stimulated by the challenge presented by the nursing profession as to why rural nursing was different and misunderstood when compared to that of urban nursing (Ross, 2008). In addition, Thompson (2006) has also recognised that there is a difference between primary health care rural and urban nursing models of practice. This challenge is not unique to New Zealand as internationally rural nurses and their practice is also questioned (Scharff, 2010; Bushy, 2012) as discussed in Chapter one.

At the onset of this study the initial aim was to strengthen rural nurses’ awareness of their practice. This aim has been designed to increase rural nurses understanding and articulation of their changing and adapting professional identity and, furthermore the second aim, offers the rural nurses’ an appreciation of their contribution to the delivery of rural health care. If this is the case then rural nurses could be in a position in which they have the ability to dialogue, participate and contribute locally,
regionally, nationally and internationally with respect to the significance and impact that their practice has within the rural health care sector. This is extremely pertinent at a time of difficulty experienced in recruiting and retaining nurses to rural areas (O’Malley et al., 2009). Moreover, further dialogue with the national nursing sector, politicians, policy-makers, employers and researchers to name but a few, could have a number of positive influencing factors where non-rural people and organisations begin to contribute to rural nurses’ discourses aligned with their practice. Building a strong self-awareness is necessary for rural nurses’ in a complex and changing socio-political, cultural and economic context, where the influence of ‘others’ shapes nurses’ practice (Thompson, 2006). Thus, this study’s aims are to investigate the identity of the rural nurse from the regional rural Otago location at a time when the identity and practice of nursing associated with rural locations was being constructed in an especially dynamic, discursive context and time period (Jacobs, 1998; Jacobs and Boddy, 2008). In determining these aims, three research questions were posed:

4.5.2 Research questions

Q.1 What constitutes being a rural nurse, and where do rural nurses work?

The first question takes a broad overview of the meaning of what constitutes being a rural nurse in context and seeks to provide an account of where they work. In answering this question, this explanation moves on from the descriptive accounts of rural nurses’ work found in the literature (refer back to Chapters one and two) to position the occupational identity of the rural nurse in relation to place as defined by Agnew (1987) and Massey (2005), and the rural, as defined by Woods (2011) and Panelli (2003; 2006) in seeking to uncover the particular nuances associated with nurses who practice in rural locations.

Q.2 How do rural nurses practice, and what is their contribution to the rural health sector?

The second question seeks to ascertain a deeper level of meaning and understanding related to the practice of rural nurses, moving on from the previous question. Practice becomes the focus associated with rural and professional discourses. The contribution
rural nurses offer to the wider rural health care sector is also examined. The analyses associated with these questions relate to the neo-liberal changes which impacted on the focus of the provision of health care as discussed in Chapter two and which are interrelated with the notion of governmentality. Governmentality has been separated into three main aspects of governance and includes the state, discipline and governance of the self that are examined in relation to this thesis in Chapters five, six and seven and which are key aspects of the study’s findings.

Q.3 How can rural nurses advance their practice and contribution to the rural delivery of health care, leadership, policy development, nurse education and research?

The third question elaborates on the potential for rural nurses to advance their practice and to contribute to the health sector, as well as advancing the practice competencies set down by Nursing Council of New Zealand (2001). The New Zealand socio-economic climate at the time of developing these questions in 2005, was dominated by national discussions associated with nurses’ advancing practice and defining the scope of practice as stated by the Health Practitioner Competence Assurance Act 2003 (HPCAA). Further discussions led into the domains of national nursing leadership, policy development, nurse education, research and their contribution to the health care sector, including clinical practice. These discussions dominated the way the profession considered the value placed on nurses who wished to progress their careers into the advanced scope of practice, namely the NP. NPs were required to demonstrate they could perform all of the activities highlighted in question three above in conjunction with their advanced clinical practice. The majority of the rural nurse participants hesitated to answer this third question, as they expressed a difficulty in envisaging how rural nurses could indeed contribute to the broader aspects related to nursing’s contribution to leadership, policy development, research and education outside of their geographical rural locations. Data aligned with the third research question was generated and through the process of the thematic analysis the findings demonstrated that the majority of the participants expressed that the potential for rural nurses to contribute further to the areas mentioned above was out of the reach for the majority of these nurses. The reason articulated by the participants’ expressed that because of rural nurses’ isolation and on call commitments, it was
recognised that to attend national meetings was problematic and therefore this question did not proceed. It is now timely to introduce the research locations.

4.5.3 Research locations

A brief description of the geographical, demographic and cultural aspects associated with the contextual landscape of New Zealand was presented in the Preface and in Chapter two. Particular emphasis was placed on rural New Zealand and rural Otago as the study’s context, together with an overview of the diverse demographics associated with rural populations in New Zealand. I have come to understand rural New Zealand as a clinical practitioner and academic and not through the social construction of growing up in this country, therefore my knowledge base is as an ‘outsider’ looking in. The research locations related to this thesis include both a national focus and more specifically a regional focus related to the rural Otago region (refer back to Figure: 1.1 in Chapter one) which are now introduced.

i. National location

The contextual factors related to the national study location were presented in the Preface, and in Chapters one and two. The national location was chosen with the aim of engaging with selected participants, whom I refer to as national key informants. The key informant participants were members of national and regional informant clusters, who were in key positions at the time of the data gathering, and were experienced in rural affairs, including some nurses who had a connection between rural policy development and the profession of nursing. The analysed data from these key informant participants are presented in Chapter six. The regional study location and the selection of how I went about recruiting potential rural nurse participants is presented next.

ii. Regional rural Otago location

This study is focused in one regional location, namely rural Otago of the South Island of New Zealand. An introduction of the geography and demographics of this region was provided in the Preface. This location was chosen for three main reasons.
Firstly, this region is my place of residence and is in close proximity to my place of employment as an academic at the School of Nursing at Otago Polytechnic, which is situated in Dunedin, Otago, New Zealand. Secondly, the institution, in which I am enrolled, as a PhD student, situated at the University of Otago is also situated in Dunedin. The Otago region is also a location where I work, live and holiday. Thirdly, I was also associated with this region in my capacity as co-director of the NCRH and the convener of the postgraduate diploma of primary rural health care and co-ordinator of the RNNN which established my relationships with rural nurses between 1994-2003. These factors are a potential problem as well as strengthening this research. Previously I had worked alongside these nurses, facilitating professional support, education and involving them in rural projects which led me to become aware of the rural health care challenges and opportunities rural practitioners, including nurses, were faced with, for example personal and professional isolation. I was particularly interested to investigate if these challenges and opportunities influenced the identity construction of the rural nurse.

In the process of the recruitment of participants I ensured that I remained objective related to the context in which I had known the regional and national participants given my previous regional and national engagement. This is discussed further in the section dedicated to the credibility of this research and my reflexive positionality, later on in this Chapter. An account as to how the participants were selected is now presented.

4.6 Selecting participants

Potential participants were specifically selected by myself to contribute to this research and through what is termed ‘convenience’ or ‘purposeful sampling’ (Schneider and Fisher, 2013). Purposeful sampling is intended to identify particular participants who possess a set of criteria relevant to the research (set by the researchers that are related to the research aims) who are invited to participate in a study (Lopez and Whitehead, 2013). The participants recruited were in a position in which they could offer the research rich in-depth information based on their knowledge and experience. I engaged with what Lopez and Whitehead (2013) explain as “[m]aximum phenomena variation sampling [which] is sometimes used to
ensure that the full range and extent of the phenomena are represented” (: 125 emphasis maintained). Two separate participant groups were identified as providing valuable insights in which to generate data that could potentially answer the research questions and meet the research aims. These two participant groups include, national key informants and regional rural nurse participants which are now presented.

4.6.1 National key informant participants

The national key informant participant group was invited to contribute from New Zealand and were either in or had previously been in a position (within the identified study time period 1990-2000s) in one or more of the following areas associated with rural nursing practice; rural affairs; development; planning; funding; policy; research; education; rural general practice or leaders of nursing either nationally or regionally. These key informant participants were members of informant clusters, including national or regional government departments, DHBs, PHOs or RCTs, academic institutions, and national professional networks including nursing bodies and organisations related to rural development. Contact lists containing potential key informant details were generated from national telephone directories, websites and through professional networks who referred me on to additional key informants. A total of twenty one key informant participants were invited to participate, one potential participant declined, due to significant workload issues. In total twenty key informants were recruited and will be discussed in the sub-section 4.6.2 and further illustrated in Table 4.1.

4.6.2 Regional rural nurse Otago participants

The regional rural Otago location participant group comprised RNs and NPs. Additional criteria for participating in this study included, either currently or previously practicing RN or NP from the rural Otago region during the 1990-2000s time period. The participants either practised in the community or in the community as well as the local rural hospital and were all employed in various roles including PHOs, RCTs, Plunket (refer back to Table: 1.1 in Chapter one for a brief description of nurses occupational titles) and through the Otago District Health Board (ODHB). The ODHB extended its geographical boundaries in 2010 to include the Southland
District Health Board population and health service facilities. As from 2012 this DHB has been referred to as the Southern District Health Board (SDHB). This study has not extended its boundaries to include additional participants from the SDHB as all data had been previously collected and analysed prior to this amalgamation in 2012. Contact lists containing details of potential participants were generated from Otago regional directories where contact details for health services were available. I also searched websites and professional networks using a purposeful sample method (Lopez and Whitehead, 2013). A total of seventeen regional rural nurse participants were recruited and will be discussed in detail in the sub-section 4.6.3.

4.6.3 Recruiting participants in my professional capacity

In consideration of my professional relationships with both the national key informant and regional rural Otago participants I considered that my position as an academic could potentially influence the research outcomes of this study. In my capacity as an academic I have taught in both the Bachelor and Masters of Nursing courses and have been a supervisor of students in their capacity as a RN working on their Masters theses. I considered the power imbalances between myself as the postgraduate supervisor, and the student (who was also employed as a rural nurse from this region) as inappropriate, to recruit them for this research during the time of their studies. For this reason I set out a number of criteria excluding potential participants from being recruited. These criteria included any current work colleagues in clinical practice, education or other rural projects and RNs during the time of generating the data that were studying at postgraduate level in the educational institution in which I was an academic. There was one former postgraduate student who had completed her study from this educational institution, who agreed to participate. Equally, all RNs or NPs who had not practised in the rural Otago location were not recruited.

All potential participants were contacted by letter (Appendix: 1 dated 2007, a similar letter was sent out in 2006, dated 2006 to the potential key informants) and invited to contribute to this study and participate in a semi-structured interview. In addition, there was a possibility that a selected number of participants from the regional rural Otago location could be invited at a later date, to attend a focus group meeting (this aspect of the research was not included in the key informant letter) to progress the
analysis of the study. The purpose of the letter was to provide information about the research and to inform the participants of their potential involvement. The content of the letter included the research aims, the research process requirements of participants, and ethical considerations. Enclosed with the letter was an information sheet (Appendix: 2) and consent form (Appendix: 3) regarding ethical procedures. A follow up phone call or email was made within seven days of the letter being posted out to seek the potential participant’s involvement and to answer any questions. At this time a fuller explanation of the purpose of the study and research design was offered.

4.6.4 Recruiting participants and gaining consent

The participants who agreed to be involved were invited to complete the written consent form which was posted back to me in the stamped addressed envelope, provided with my initial letter. The participants also indicated their preference for either a face to face, or telephone interview, including a suitable date and time for the interview to take place. In addition, I offered participants an alternative medium in which to participate (as I was particularly aware of participants’ time constraints and the logistics of visiting participants to interview them as well as travelling over a large geographical location). Participants had an alternative opportunity to either write or email their response to the three research questions posed (in the information sheet, Appendix: 2) and post them or email them, back to me (examined in section 4.6.5). My aim was to reach the largest possible target audience and get participants’ involvement and participation in this study. I was trying to avoid as much as possible the difficulties of planning interview times and appropriate venues with people who had a variety of professional demands on their time. I understood the complexities of rural practice (having lived and worked in rural practice as a nurse, educator and researcher) for health professionals to set aside their valuable time to participate in research projects.

This study did not seek to address particularly sensitive issues. During the planning phase of this research, I acknowledged that it was my responsibility to make sure participants did not become distressed during the interview, following the interview or through the distribution and reporting of the research findings. I also ensured that
the potential participants understood their voluntary nature of participation and withdrawal options. All participants were guaranteed confidentiality with respect to the content of their transcripts and that all identifying features would be removed, for example their names and information associating them to a particular location or person. I also guaranteed that any material made available in the public domain would not identify individual participants or their confidential details. The written consent also gave me permission to include participants’ contributions from the analysed data at conference presentations and in subsequent journal publications (Appendices: 2 and 3).

In response to gaining participant consent I have taken into consideration that New Zealand comprises a small population and the rural community is even smaller (Statistics New Zealand, 2006) and issues of confidentiality may become problematic in this context. Firstly, identification may arise with participants associated with a close knit community or associated with rural activities including rural practice, education, policy development and research. Secondly, participants could be identified by former colleagues, external to this study. I was also aware the participants might be known to each other, I therefore took into consideration how I was going to maintain participant anonymity. I also needed to ensure that any issues relating to the confidentiality of information were treated with the utmost respect and participants’ details were not revealed in the analysis phase. This led me to consider how I included participants’ contributions in Chapters five, six and seven. I decided I did not want to attach pseudonyms to individual participants’ quotations or to only follow one participant’s contribution throughout the analysis phase, as this could identify that participant. Participants’ data includes a confidential code which corresponds to their individual contributions.

4.6.5 Participants engaged in this study

The participants engaged in this study were affiliated into two distinct groups, the national key informant group and the rural regional Otago rural nurse group. All of the participants firstly consented in writing and were assured of the study’s commitment to maintain confidentiality. Demographic details of all of the participants were obtained during the interview, by inviting participants to provide
their details on the written form (Appendix: 4). Personal information was gathered and included the participants’ names, postal details and national held positions. This information was required, for the purposes of later thanking the participants for their contribution and giving of their time with a letter, which was posted to each participant following each interview. Each participant was also invited to indicate if they wished to receive a summary of the research findings at the completion of the study.

iii. National key informant participants

There were twenty national key informants who consented to participate in a semi-structured interview lasting between forty-five minutes and three hours. These interviews occurred over a three-month period in 2006. The aim was to capture the participants’ contributions within a relatively short time period, in order to avoid new developments clouding the participants’ interpretation of rural nursing between the 1990s and the 2000s which was the focus of the questioning. Out of the twenty national key informants, a total of sixteen of these participants were interviewed face to face. I arranged to meet these participants over a one-month period, during the winter of 2006. I travelled to the participant’s locations throughout the rural and urban regions of the North and South Islands of New Zealand. The interviews took place at the discretion of the participant either at their place of work, in their home or at my rental accommodation. Three participants were interviewed by telephone at a later date during 2007 and 2008. The one remaining participant contributed in writing, which was later sent onto me by email. The key informant participants were both female and male and their experiences relating to rural affairs ranged from three months to fifteen years. All of the key informant participants knew me in a professional capacity. I had previously collaborated with them or their organisations by invitation on a variety of national and regional working parties, on contracts and through research associated with rural issues (as introduced previously in Chapter one).

The majority of the key informants were particularly interested in this study topic. When I interviewed them, they said they had reflected on the topic that they initially thought they did not have a lot to contribute, but as we progressed with the interviews
they were quite impressed with their own understanding of rural nursing and the particular complexities associated with their practice. The key informant participants’ contributions are presented in Chapter six in the form of anonymised quotations (in italics) from their interview transcripts, included as primary data in support of the findings generated from the rural nurse participants’ themed analysis. The following Table 4.1 introduces the key informant participant details:

<table>
<thead>
<tr>
<th>Key Informant</th>
<th>Gender</th>
<th>Organisation</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Male</td>
<td>Government representative</td>
<td>National</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>Independent</td>
<td>National</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>Ministry of Health representative</td>
<td>National</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>Ministry of Health representative</td>
<td>National</td>
</tr>
<tr>
<td>5</td>
<td>Male</td>
<td>Ministry of Health representative</td>
<td>National</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>Independent</td>
<td>National</td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>Rural organisation representative</td>
<td>North Island</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>Educational Institution representative</td>
<td>North Island</td>
</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>Nursing organisation representative</td>
<td>National</td>
</tr>
<tr>
<td>10</td>
<td>Female</td>
<td>PHO representative</td>
<td>North Island</td>
</tr>
<tr>
<td>11</td>
<td>Female</td>
<td>DHB representative</td>
<td>South Island</td>
</tr>
<tr>
<td>12</td>
<td>Female</td>
<td>Nursing organisation representative</td>
<td>National</td>
</tr>
<tr>
<td>13</td>
<td>Female</td>
<td>Rural organisation representative</td>
<td>National</td>
</tr>
<tr>
<td>14</td>
<td>Female</td>
<td>Nursing organisation representative</td>
<td>National</td>
</tr>
<tr>
<td>15</td>
<td>Male</td>
<td>Independent</td>
<td>South Island</td>
</tr>
<tr>
<td>16</td>
<td>Female</td>
<td>Nursing organisation representative</td>
<td>National</td>
</tr>
<tr>
<td>17</td>
<td>Male</td>
<td>Government representative</td>
<td>National</td>
</tr>
<tr>
<td>18</td>
<td>Female</td>
<td>Rural PHO Organisation</td>
<td>Lower South Island</td>
</tr>
<tr>
<td>19</td>
<td>Male</td>
<td>Rural PHO Organisation</td>
<td>Lower South Island</td>
</tr>
<tr>
<td>20</td>
<td>Male</td>
<td>Rural PHO Organisation</td>
<td>Lower South Island</td>
</tr>
</tbody>
</table>

Table 4.1  Key informant participant details

The key informant participant (informants) details, reflects that a broad array of national and regional organisations that were represented. These organisations have been grouped together for the purposes of presenting a synopsis of this data. The majority (four representatives) are from national nursing organisations and equally, PHO organisations. Ministry of Health representatives (totally three) are equal in number with the independent representatives who participated. To a lesser extent were the government officials and rural organisation representatives, which both had
two representatives each. The lowest level of representation was one informant from a DHB and the other informant from an educational institution. There were twelve informants representing national organisations, while there were three informants representing North Island organisations and two informants from South Island organisations. An additional three informants represented the lower South Island PHO. There was a broad spread of representations in particular the majority of informants are from national organisations.

iv. Regional rural nurse participants

The rural nurse participants formed a more defined group than the key informant participants as they were confined to the rural Otago region (the study location). Seventeen regional rural nurse participants agreed to participate and consented (in writing) to be interviewed. I noted the participant’s preferences and timetabled the interviews with the participants. These semi-structured interviews occurred in rural Otago over a three-week period in April/May 2007 when I travelled around the rural Otago region and visited and interviewed thirteen participants face to face. These interviews ranged from forty-five minutes to two and a half hours in duration. The interviews took place at the discretion of the participant at their place of work, or at their home. The remaining seven participants were subsequently interviewed over the telephone, during 2007 and 2008. Three participants who responded to the letter inviting them to contribute to this study were all new to rural nursing in the Otago region. These participants were also all under 30 years of age and were not aware of my previous involvement with rural nurses. What was encouraging and slightly more challenging with this group of participants was their intrigue as to who would be interested to study rural nursing. These participants questioned me as the researcher, as to why a PhD student from geography (thinking I was a geographer from the letter-head on the letter of invitation) would be interested in a study related to rural nurses. Table 4.2 (on the following page) provides the regional rural nurse participants’ details:
The rural Otago regional nurse participants’ details indicate that all participants were female and their ages ranged between 20-60 plus years at the time of data collection. There were two participants in the 20-29 year group who had experienced rural practice between three months and 1.5 years, at the time of data collection. Two participants were aged between 30-39 years and had experienced rural practice between two and six years. There were five participants whose ages ranged between 40-49 years and had experienced rural practice between three and twenty five years, Equally the age ranges of the rural nurse participants’ between the years of 50-59 had experienced rural practice between four and seventeen years. Additionally, there were three participants who identified as 60 years plus and had experienced rural practice between eighteen and twenty years. This study represented a broad spectrum

<table>
<thead>
<tr>
<th>Regional rural nurse participant</th>
<th>Gender</th>
<th>Age</th>
<th>Experience as a rural nurse</th>
<th>Organisation</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Female</td>
<td>40-49</td>
<td>3 years</td>
<td>Community Trust</td>
<td>Rural farming Otago</td>
</tr>
<tr>
<td>2</td>
<td>Female</td>
<td>20-29</td>
<td>1.5 years</td>
<td>Community Trust</td>
<td>Rural farming Otago</td>
</tr>
<tr>
<td>3</td>
<td>Female</td>
<td>20-29</td>
<td>3 months</td>
<td>Community Trust</td>
<td>Rural Otago community</td>
</tr>
<tr>
<td>4</td>
<td>Female</td>
<td>30-39</td>
<td>2 years</td>
<td>Community Trust</td>
<td>Rural Otago community</td>
</tr>
<tr>
<td>5</td>
<td>Female</td>
<td>40-49</td>
<td>25 years</td>
<td>Community Trust</td>
<td>Rural Otago district</td>
</tr>
<tr>
<td>6</td>
<td>Female</td>
<td>40-49</td>
<td>10 years</td>
<td>Community Trust</td>
<td>Rural Otago district</td>
</tr>
<tr>
<td>7</td>
<td>Female</td>
<td>50-59</td>
<td>17 years</td>
<td>Community Trust</td>
<td>Rural Otago district</td>
</tr>
<tr>
<td>8</td>
<td>Female</td>
<td>30-39</td>
<td>6 years</td>
<td>Community Trust</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>9</td>
<td>Female</td>
<td>40-49</td>
<td>5 years</td>
<td>Community Trust</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>10</td>
<td>Female</td>
<td>60+</td>
<td>20 years</td>
<td>DHB</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>11</td>
<td>Female</td>
<td>50-59</td>
<td>5 years</td>
<td>Community Trust</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>12</td>
<td>Female</td>
<td>50-59</td>
<td>6 years</td>
<td>Community Trust</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>13</td>
<td>Female</td>
<td>50-59</td>
<td>15 years</td>
<td>PHO</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>14</td>
<td>Female</td>
<td>60+</td>
<td>20 years</td>
<td>Community Trust</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>15</td>
<td>Female</td>
<td>40-49</td>
<td>3 years</td>
<td>PHO</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>16</td>
<td>Female</td>
<td>60+</td>
<td>18 years</td>
<td>DHB</td>
<td>Rural Otago</td>
</tr>
<tr>
<td>17</td>
<td>Female</td>
<td>50-59</td>
<td>4 years</td>
<td>PHO</td>
<td>Rural Otago</td>
</tr>
</tbody>
</table>

Table 4.2 Regional rural nurse participant details

The rural Otago regional nurse participants’ details indicate that all participants were female and their ages ranged between 20-60 plus years at the time of data collection. There were two participants in the 20-29 year group who had experienced rural practice between three months and 1.5 years, at the time of data collection. Two participants were aged between 30-39 years and had experienced rural practice between two and six years. There were five participants whose ages ranged between 40-49 years and had experienced rural practice between three and twenty five years, Equally the age ranges of the rural nurse participants’ between the years of 50-59 had experienced rural practice between four and seventeen years. Additionally, there were three participants who identified as 60 years plus and had experienced rural practice between eighteen and twenty years. This study represented a broad spectrum
of regional rural nurse participants ranging from a minimum of three months practice to twenty five years and a number of years in between these minimum and maximum ranges. The age ranges of the rural nurse participants were representative of the years of experience however, there was one exception as one participant representative of the 40-49 year range who had been the longest in rural practice, in total, twenty-five years at the time of data collection.

The data from these interviews were themed, leading to insightful findings which will be discussed further in the analysis Chapters five, six and seven. Ethical considerations considered in undertaking this research are now discussed.

4.7 Ethical considerations relating to this study

An ethical consideration related to this study was to obtain informed consent from the participants to engage in the data collection in the form of semi-structured interviews. The University of Otago Human Ethics Committee granted ethical approval in November 2005 when the proposal was approved provisionally to include an amended statement in the information sheet which related to the anonymity of participants. I was required to include the following statement in the information sheet “[t]he results of this project may be published and will be available in the library but every attempt will be made to preserve my anonymity” (Letter from Mr Gary Witte, 2005) (Appendix: 5) before I could proceed with the data collection.

In addition to gaining ethical approval through the University of Otago Human Ethics Committee in November 2005 I completed a further ethical application in 2006 with the Ngāi Tahu Research Consultation Committee through the Research Māori, Research Division, Te Whare Wananga o Otago. This engagement was a result of an application for a number of research grants and scholarships I made to support the fieldwork. In the process of submitting applications I applied to the New Zealand Nursing Organisation, Nursing Education Research Foundation (NERF) and Gretta Harry Hamblin Trust Research Scholarships. This Scholarship Review Committee asked me for additional information to support my funding application and to engage with the questions they posed for me to complete, for example Te Tiriti o Waitangi, safe collection and storage of data and whether the findings could improve outcomes
for Maori (Appendix: 6). Te Tiriti o Waitangi and its association with New Zealand was introduced in the Preface to this thesis and is expanded on in the following section.

4.7.1. Te Tiriti o Waitangi

Recognition of and the importance of Te Tiriti o Waitangi to New Zealand engages with the three principles associated with Te Tiriti are defined as partnership, participation and protection, which provide a framework to address Māori rights under Te Tiriti. This research embraces these three principles in relation to gaining ethical approval and researching in partnership with Ngāi Tahu (the local iwi), which are discussed further in this section.

v. Partnership with Ngāi Tahu

I approached the Māori Student Advisor at the University of Otago and requested advice regarding the appropriate 'path' for addressing the posed questions from the Scholarship Review Committee. I was aware these questions addressed cultural responsibilities in relation to Māori and non-Māori rural nurses who care for Māori people who could potentially participate in this study. I progressed my consultation with the Kaitakawaenga Rangahau Māori, Facilitator Research Māori Research Division, Te Whare Wānanga o Otāgo. The ethical application was submitted to the Ngāi Tahu Research Consultation Committee in 2006 in which I expressed my wish to gain their support to undertake this research with the local iwi (Ngāi Tahu). The Ngāi Tahu Research Consultation Committee agreed with the reviews from the Scholarship Committee indicating that this research could be of interest and importance to Māori health and encouraged me to proceed in collaboration with themselves (refer to Appendix: 7). I was persuaded by the Ngāi Tahu Research Consultation Committee to gather ethnicity data as they considered this could add to their growing understanding of Māori access to rural health care services in rural Otago. To achieve this I included an additional question in the demographic information sheet which the regional study participants were invited to complete. This additional question was derived from the 2006 Statistics New Zealand Census
Questionnaire which is designed to establish Maori ethnicity (Question 11) (Statistics New Zealand, 2006).

This Ngāi Tahu Research Consultation Committee also suggested I work alongside a Māori co-researcher when collecting and analysing data related to Māori information, and to ensure that all Māori participants would have access to appropriate support if requested when participating in the research as well as that all data related to Māori would be protected and handed back to the local iwi when the research had been completed, and is discussed later on in this Chapter. Data recorded would be transcribed and stored with the personal details removed and given a code. Information relating to Māori was protected on the advice and direction of the Kaitakawaenga Rangahau Māori, Facilitator. This advice was in accordance with the University of Otago’s Policy for Research Consultation with Māori (Research Consultation with Maori Policy, 2003). This was a requirement specified by the Review Committee following the Māori consultation process which allowed me to include data belonging to Māori in this thesis.

There was a high probability that rural nurses caring for Māori people within some parts of rural Otago could potentially be participants of this study. I was aware the identity of a rural nurse could have insight into Māori ways of life and therefore the Second Article of Te Tiriti o Waitangi highlights that the rights of Māori customs, knowledge, and property are to be respected. Therefore it was necessary that Māori participants be fully informed as to how, where and what would occur to the information relating to Māori. In addition I was aware it would be necessary to ensure all participants were fully informed and there might be a need to provide translation to Māori and from Māori to English for some participants. In the course of interviews if a participant identified as Māori I planned to ask the individual if they were comfortable in carrying on with the interview. A future date could be set to continue the interview with an identified support person. I also planned to discuss the interview process with the Māori advisor, to gain insight and ensure I had protected the process correctly. This process included data collection and analysis while guiding me throughout the stages associated with this research. My aim was to seek further advice specifically related to Māori health outcomes and disparity. This did not eventuate, because not one of the regional participants’ identified as Māori either
prior to, or during the interview. However, I am indebted to the Research Division, Te Whare Wānanga o Otāgo and the Ngāi Tahu Research Consultation Committee for their support and advice in the ethical application associated with Māori.

4.8 Research methods and analysis

This research has employed a qualitative design situated within three main sources of data that took into consideration the relationships and engagement participants have with their contexts (Willis, 2007). These data sources included semi-structured interviews with national key informant participants and the regional rural nurse Otago participants. I had initially intended to hold two focus group meetings with selected regional Otago rural nurse participants, the rationale for this, and the reason why I did not engage with this method is discussed below following a detailed account of the semi-structured interviews I engaged with.

4.8.1 Semi-structured interviews

A qualitative design was employed to gather data from the participants through the use of semi-structured interviews. Interviews are considered as a leading method employed to generate data in qualitative research (Lopez and Whitehead, 2013). Semi-structured interviews contain both elements from structured and unstructured interviews and are less controlled than structured interviews. Semi-structured interviews utilise both open and closed ended questions (Munhall, 2007). Engaging with this style of interview the researcher or interviewer can guide, within reason, how the pre-planned primary questions are presented to individual interviewees. An interview guide sets out the pre-determined research questions, which are pre-planned at the time of developing the research investigation and are designed with the goal of contributing to the aims of the study. Pre-planned questions provided guidance and consistency with the interview process, and each participant was invited to develop their answers around the core questions (Lopez and Whitehead, 2013). The following list (on the following page) is an outline of the types of questions presented to the participants:
What constitutes being a rural nurse?
Where do rural nurses practice?
How do rural nurses practice?
What is their contribution to the rural health care sector?
How can rural nurses advance their practice?
How can rural nurses contribute to the rural delivery of health care through:
   Leadership?
   Policy development?
   Education?
   Research?

Prior to interviewing the participants I conducted a pilot interview with an experienced colleague whom I asked to help refine the pre-planned research questions. The aim of this exercise was to ensure the research questions were answerable and that my technique of conducting the interview was suitable. On completion of this pilot phase we reflected on the interview process and the research questions were deemed to be satisfactory. However, we agreed that holding the interview in a quiet location at a conference we were both attending at the time, on reflection, was not a suitable method (because of noise disturbance). From this experience I made it a priority that the venue for future interviews needed to be private, quiet and comfortable. I was also mindful of the time limitations some participants could be under as they went about their daily practice. I made sure I adapted the interview according to their demands while picking up on their cues when it was time to terminate the interview. There was only one occasion when I needed to reschedule the interview to accommodate a participant’s changed workload requirements at the time of the original interview that had been planned. We met the following morning at her request, at her private residence.

Each interview addressed the three broad questions that had previously been made available to each participant in the information sheet (Appendix: 2) that had been distributed to each potential participant included with the original letter of invitation to participate (Appendix: 1). Consent to participate had been sought prior to the interview taking place (as discussed previously). Unless otherwise discussed between the participant and myself the data collection was through an interview conducted
either in person, or over the telephone, and all were audio taped and later transcribed by a professional typist who signed a confidentiality agreement (Appendix: 8). All of the transcripts were analysed using a thematic approach; data generated from the telephone interviews were also transcribed, however the email contribution from one key informant was not transcribed but analysed as per its content.

At the commencement of each of the semi-structured interviews I invited the participant to introduce themselves, and to provide a brief overview of their experience and relationship to rural matters. The aim of this introduction assisted in ensuring the tape recorder was running correctly and it could pick up on the participant’s voice. It also acted as an ice breaker and encouraged participants to converse as openly as possible while the tape recorder was running. I ensured the participant was comfortable and interruptions were minimalized. I attempted not to hurry the interview ensuring there was sufficient time to allow the participant to cover the issues they wanted to. Lopez and Whitehead (2013) recommend interviews should run one to two hours and should not proceed longer than this as both the interviewee and interviewer can potentially tire and this can affect the richness of the data collected. I was aware throughout the study of my prior relationship with the majority of the participants (as discussed previously) and of my aim for undertaking this research was always at the foreground of my mind, namely to capture the nature of rural nursing. I therefore listened intently to the participants’ contribution and engaged only to clarify and extend the interview. I was aware of not asking any leading questions or to provide factual information which could bias the data collection.

As I progressed with the rural nurse participants’ interviews they became more of a conversation as I dipped in and out of the pre-planned interview questions and sought further clarification, or probed for further elaboration and checked the interpretations. This is what Lopez and Whitehead (2013) argue when they state that “semi-structured interviews steer the interviews yet allow for flexibility” (: 128). Although the interviews were planned to be semi-structured in nature, listening to the interview tape recordings and reading the transcripts I realised that there was less structure than I originally intended, which meant the interviews turned into more of a conversation and a partially unstructured research enquiry. Participants voluntarily included
examples of what they were saying and this information provided me with a fuller depth of understanding of rural nurses and their practice.

At the completion of each interview I thanked the participants for contributing. I later followed up each interview with a letter of my appreciation for their contribution and giving up their time. In addition the participants were reminded that if they had a personal or professional issue related to the research questions or practice issue which arose from the interview, then they might like to consider making contact with me to arrange further professional assistance if necessary. It was made clear to each of the participants that they were free to withdraw from the study at any stage. Also, if they did withdraw (which did not occur) it was clarified that such a move would have no effect on the participant’s future relationship with myself. I also stressed that once data from their transcript had been categorised and themes developed, I would be unable to prevent their individual contribution from being made available in the analysis.

Following the conclusion of the interviews I reflected on them and the time they took. I wrote up my field notes and noted down insights and important developments that occurred around the interview in my reflective journal. This proved critical on one occasion when the tape recording was muffled due the recorder failing to record the dialogue. This was an interview I undertook over the telephone and as the interview progressed I made written notes to assist and remind me of the interview. At the completion of this interview I went back to listen to the recording and realised the interview had not been recorded. I immediately continued to extend the written notes that I had been making, although I was unable to quote from this participants’ contribution I was however able to include content in the categories which were later used to confirm the themes uncovered in the analysis. At the completion of each interview I wrote up my field notes (which I wrote up throughout this study) and my reflexive journal, which included entries following each, completed interview. A summary of each interview was included in my journal noting any particular insights that emerged at the time and assists in my reflective study journey which is discussed in the last section of this Chapter.
I debriefed after the overall interview process with my supervisors. This debriefing exercise included a review of the conversations (from the semi-structured interviews) and how I was going to proceed with the analysis of data. My reflective journal was also used to discuss my thoughts of the interviews and the themes, which were beginning to be generated with my supervisors as an excellent resource to be used in the analysis and writing up phases. Reflecting back on this content took me straight back to the time and place of the interviews, which further assisted in completing the analysis. I could recall the interview, the conversation, the location and the weather which all added to the richness of the analysis. Willis (2007) emphasises that reflection improves the relationship between the data, the context and the researcher’s subjective association with the research. Further reflection revealed that the participants appeared to be relaxed and enjoyed talking about rural nursing. I became even more encouraged about pursuing this research as participants also saw this study as important, indicating they would be interested in the results and wished me good luck for its completion. Some of the regional rural Otago nurse participants did question and ask for further clarification about the definition of a ‘rural nurse’ and wondered whether they were categorised as such, or even if they identified as one. In this instance I did prompt these participants to reconsider their own understanding to this research question, as I was particularly interested in searching for the meaning of ‘what constitutes being a rural nurse?’ as part of my research questions. Likewise, some of the key informants asked for further clarification of the definition ‘rural’ and again I encouraged these participants to explore their own understandings and interpretations (discussed previously in Chapter two and further explored in Chapters five and six).

The semi-structured interviews were the main overall method of generating data, however I did also consider and received ethical approval to hold focus group meetings to extend the analysis. The rationale for considering focus group meetings and the reason why I did not proceed with this method is now discussed.

4.8.2 Focus group meetings

At the onset of the research I had intended to hold two focus group meetings with selected regional Otago rural nurse participants, following their contributions and the
preliminary analysis of the data collected, at the semi-structured interviews. It was my anticipation this would give the participants time to reflect on their original contribution and to consider the preliminary analysis, which I would provide for them, prior to attending these meetings. The aim of the focus group meetings was to assist in enhancing the credibility of the study and to progress the analysis with other rural nurse participants and myself. Focus group meetings aim to unite people in which to discuss a particular topic of which they each have an understanding (Kruger, 1994). However, despite my initial planning to hold two focus groups this did not eventuate. The reason was that trying to organize meetings with six to eight rural nurse participants from the extensive rural Otago region to attend a face-to-face focus group meeting in a suitable rural location became problematic. I did consider holding a focus group meeting by telephone however on reflection I realised discussing the ‘analytical place-based matrix’ over the telephone could be an ineffective way of engaging with this line of inquiry. Likewise, I discussed my concerns with my supervisor and we agreed not to progress this line of enquiry. We were however satisfied I had progressed the analysis to a satisfactory level and had received external feedback on the data though discussions at conferences when I presented the analysis and findings in the form of this ‘matrix’ and received feedback from delegates who attended my presentations and will be discussed later on in this Chapter relating to the credibility of this research section now leads conveniently onto the analysis of this research.

4.8.3 Analysis

Analysis is a key feature of the research design and process. In this thesis I commenced with the preliminary analysis, which occurred as data collection was taking place (Speziale and Carpenter, 2011). This helped to ensure the research questions I was asking the participants did actually make sense and that, as I progressed with the data collection. I was beginning to make connections between the participants’ contributions. As data collection was completed I then progressed onto analysing the complete set of data to gain a sense of the ‘whole’ and then progressed into the interpretation stage as I engaged with a thematic analysis method (Harding and Whitehead, 2013). How I went about organizing this analysis process is now
discussed commencing with transcription of the interview tape recordings and then engaging with thematic analysis.

vi Transcription

All the interviews were recorded and then transcribed by a professional typist who signed a confidentiality agreement not to divulge the information from the tape recordings or transcripts to a third party as discussed previously (Appendix: 8). I have differentiated the national key informant and the regional Otago rural participants by identifying them as either, key informant interview or rural nurse participant. All of the names and contact details of each of the participants’ have been removed and given a code, the full details of which is only known by my supervisors and myself. The interview recorded on the audiotapes and the paper transcripts, email correspondence and the diagrammatic models are securely stored in a locked cabinet and will be stored for seven years as per the University of Otago’s ethical guidelines (University of Otago Human Ethics Committee Application Form: Category A). It was agreed that all participants could receive a copy of their transcript if they requested it at the time of the interview. Two participants requested copies of their full transcripts which they have kept. As the transcripts became available to me I commenced with the more formal analysis and engaged with thematic analysis.

4.8.4. Thematic Analysis

Thematic analysis, according to Bryman (2012), is the formal examination of data. The relevance of engaging with qualitative research and the method of thematic analysis is associated with the “application of inductive reasoning, which generates ideas from the collected data” (Harding and Whitehead, 2013: 142 emphasis included). The advantage of engaging with thematic analysis is its flexible approach which does not imply that the researcher can do what they want, it is imperative that a systematic approach is pursued to demonstrate as to how the method has been applied. As discussed previously, the method of thematic analysis was appropriate when the researcher sought to engage with the rich data generated from a small number of participants and to seek how social reality is constructed (Whitehead,
2013). Connecting this analysis with the participants’ context is in keeping with the interpretive approach.

A systematic approach was used in this study to firstly generate data from the participant interviews which were audio-recorded and then transcribed verbatim. I read each of the transcripts separately while listening to the recorded interviews from the related recorded audiotape interviews. The aim of revisiting the audiotapes was to familiarise myself with each of the participants’ contributions and also to immerse myself in the data. It is necessary to re-read the transcripts and re-listen to the recordings to get a better feel for the nuances or emphases, particularly the hesitations about some of the questions, which were not picked up on in the transcript (Harding and Whitehead, 2013). I noted down initial ideas, which according to Morse (2011) is necessary in the process of conceptualizing and mapping qualitative analysis. As I continued reading I placed words and ideas of interest in the margins of the transcripts. This assisted me as I collated the codes into concepts. I later grouped these concepts together using coloured sticky notelets highlighting the written concepts on them, which were then placed on large sheets of butcher’s paper. I then sorted these concepts into categories and sub-categories, a diagrammatic representation (in Figure: 4.1) illustrates how I analysed the data, developing codes, categories and identifying the key themes, resulting in a systematic approach (Jackson, 2001).
Figure: 4.1  Diagrammatic representation of the thematic analysis process
Source: Compiled by the author.
Through the process of the analysis I found I had many concepts to deal with, and in the end I made a selection of a number of the most prominent ones, which I further analysed assisted by Jackson’s (2001) explanation that concepts refer to the initial stages where the data are cautiously explored by the researcher while reflecting on the aims of the study. To make sense of this data I made a number of mind maps consisting of the words; ideas; concepts; categories and sub-categories, which led to the identification and development of the overall key themes.

Jackson (2001) explains that concepts assist in the analysis process ensuring it is systematic and may build up an interpretation through a series of stages. The credibility of the research rests with a thorough description about how the data were collected and the categories interpreted. A theme is broader than a category running back and forth, within the data (Jackson 2001). When searching for themes I was looking for repetition of categories, which recur throughout the collective data (Bryman, 2012). Themes interpreted were examined for their relevance across the whole data set. These themes were then analysed against the context in which the participants were situated.

At the commencement of the formal analysis phase I analysed three separate interview transcripts using the research questions as a guide to highlight and identify issues and ideas. This exercise was discussed with my supervisor who validated my approach. I then developed a template that allowed for data to be collated into cells associated with the categories identified and the participant’s quoted data (Bryman, 2012). This approach assisted in the analysis as a way of managing all the data. Themes were easy to be identified (once I was experiencing recurring codes and categories) and were referred back to the analysis of corresponding transcripts and participants’ quotations, which backed up and further validated the identified key themes (Willis, 2007). I have interpreted what the participants collectively experienced directed by the research questions in the process of the analysis and eventually revealing the key themes and subsequent sub-themes. The identified key themes include a ‘sense of difference’, a ‘sense of change’ and a ‘sense of self’ and are presented in Chapters five, six and seven (respectively). This approach best acknowledges how the rural nurse’s professional identity is constructed (as analysed from the data) as well as where and how they practice, which also allows for a
discussion on their contribution to the rural health care sector which enabled me to answer and make sense of the findings in relation to the research questions. Furthermore, I have engaged with a selection of photographs (represented as photo image) in which to further the written presentation of the analysis and findings, introduced in the following section.

4.8.5 The photo image

I decided to present images, through the medium of photographs, to further illustrate the written analysis and findings of this study. According to Richardson and MacLeod (2010) photographs can convey a strong sense of meaning, which can be significantly more dynamic than the written word. I have been drawn to the fact that “it is vital to consider that photographs, when united with descriptions, have the potential to be much more powerful and expressive than the written word alone” (Burke and Evans, 2011: 174). It is for this reason I built up a bank of photographs that were randomly chosen. These photographs were representative of the rural Otago region and were derived from a catalogue of collections of images produced by professional photographers, who gave me permission to use and reproduce the images. I invited a small selection of the participants, on an individual and confidential basis, at a RGPN conference to consider if any of the photographs (images) were representative of the identity construction of the rural nurse from the region, in relation to Agnew’s (1987) three elements of his ‘place framework’; namely ‘location’, ‘locale’ and ‘sense of place’. The benefit of this aspect of the study was to offer the participants’ an opportunity to provide their own insights into their perceptions of ‘location’, ‘locale’ and ‘sense of place’ through the medium of these photographs. The photographs that were chosen (from the bank of photographs) by the participants are presented (together with a brief indication as to what they wished to communicate as to what they saw in each of the photographs, as they reflected on their individual understandings (Mader, et al., 2016). These reflections are included in the following three analysis Chapters. Harding and Whitehead (2013) explain that the images presented in photographs assist with the interpretation presented from the analysis, in the case of this, the thesis from the written dialogue. The participants’ reflection aligned with the photo images have been engaged with minimally, as the intention was to give prominence to the participants’ quotations and
written dialogue, with the support of photographs to enhance the research understandings and to forge future dialogue with the nursing profession and health care planners. The intention was to reconstruct the rural nurses’ reality while providing a visual representation that speaks to the observer (non-rural colleague) through illustrating an alternative medium (Richardson and MacLeod, 2010). As photographs trigger multiple meanings for the viewers, as what is significant to one viewer may not be to another, leading to unexpected revelations (Thom, 2000) and further meaningful dialogue in which to depth the understanding of the rural nurse identity. This aspect of the study never set out to generate additional data, the commentary generated from the participants’ is minimal, as the intention was to focus on the photographs in support of the three aspects of Agnew’s (1987) ‘place framework’ and aid future dialogue. I have also included a selection of additional photographs to further support the written dialogue and the analysis which are also presented throughout this thesis, followed by my brief commentary as to why they have been included.

4.9 Framing of the analyses and findings

The presentation of the findings in this thesis offers a diverse range of approaches and has been separated into three main sections in the following three Chapters. The analyses and findings are presented by engaging with Agnew’s (1987) ‘place framework’ which was introduced in Chapter three comprising ‘location’, ‘locale’ and ‘sense of place’ which opens up the possibilities of understanding rural nursing as a ‘place-based practice’ constructed from within a location, as well as from beyond. Agnew’s (1987) ‘place framework’ is engaged together with the notion of governmentality (Gordon, 1991) as related to the neo-liberal change associated with the early 1990s as initially discussed in Chapter two and three. It was in Chapter two that I aligned the contextual events and the changes that took place which had an effect on the health care system during the 1990s and 2000s. These events are presented diagrammatically which adds a further dimension to the presentation of the findings in all three phases of the adapted version of the ‘Funnel Model’ by Broman and Robèrt (2015) in the ‘analytical place-based matrix’ which is presented in Figure: 8.3 in Chapter eight. The ‘contextual phase’ (was presented in Figure: 2.1 in Chapter two) is the first phase of the matrix. A further two phases completes this matrix.
presenting additional analysis and findings represented in the ‘performance phase’ and the ‘transformational phase’ (in Figures: 8.1 and 8.2 respectively, in Chapter eight). Finally, when these three phases are affiliated together they are referred to as the ‘analytical place-based matrix’ and presented in Chapter eight in Figure: 8.3. Agnew’s (1987) ‘place framework’ also sets the foundation in which to further analyse nursing’s core concept of caring aligned with ‘environment’, ‘person and health’ and ‘nursing’ and will be discussed in the following five Chapters. Likewise, a small selection of photographs, as mentioned in 4.8.5 have also been engaged with to enhance and support the written analysis and findings (Burke and Evans, 2011).

The analytical techniques together with the generation of data, the research design and methodology, are appraised throughout this thesis in order to judge the trustworthiness of the research (Willis 2007) including the following criteria, credibility, fittingness, auditability and confirmability, and are examined in the following section.

4.10 Process of rigour

Ensuring credibility and rigour are critical in research. Aligning the research paradigm with the appropriate evaluation criteria is essential, as this gives further credibility to the research. Criteria associated with quantitative research associates ‘validity, reliability and objectivity’ (Harding and Whitehead, 2013) to evaluate and present the findings from scientific and experimental studies. Quantitative research focuses on the generalizability of the results and tries to ensure that the research design is replicable, while the research findings can discover ‘truth’, as stated by Lopez and Whitehead (2013). In contrast qualitative research does not set out to discover a one ‘truth’ as qualitative researchers do not believe there is one ‘truth’ waiting out there to be discovered. Therefore, qualitative research is less clear-cut to evaluate (Harding and Whitehead, 2013). Silverman (2005) explains it is the qualitative research design and methods employed which are aligned with the research paradigm and analysis that guides the congruence of the research’s credibility. Congruent methodology and methods ensures the credibility of the research (Willis, 2007; Chapman and Francis, 2014).
The concepts of ‘credibility’ and ‘trustworthiness’ are more suitable standards to evaluate interpretive research as discussed by Baxter and Eyles (1997). Guba and Lincoln (1989) have set criteria for evaluating the trustworthiness of qualitative research comprising credibility, auditability, fittingness or transferability and confirmability. A key purpose of this Chapter has been to address the questions of the consistency and credibility of this research. The qualitative criteria are now discussed with examples as to how this study demonstrates the credibility of the research.

4.10.1 Credibility

Credibility, according to Baxter and Eyles (1997) is the most significant component of qualitative research. Credibility can be enhanced when the interpretation of the data represents accurate descriptions and experiences that the participants could recognise as their own (Guba and Lincoln, 1981). Inviting participants to validate the accuracy (or member checking) of the content of their transcripts before the analysis commences is one form of establishing the credibility of the research however, how reliable this process is, may be questionable. Smith (1995) notes whether to do this or not rests with the aim of the research process. My aims were not to represent individual participants’ transcripts so I did not invite participants to validate their transcripts or the themes generated from the collective data. The themes were my interpretation of the collective data. A theme or category is never a finished version of analysis rather the analysis is concerned with offering meaning to the participants. This analysis is a snapshot of something that is dynamic and contextual. Likewise gaining feedback on the findings and conclusions is also considered to enhance credibility, although this is debatable as stated by Thorne, et al. (1997),

[i]n our view, taking the raw data (such as transcripts) back to participants for a credibility check is generally insufficient for the purposes and may as Sandelowski (1993) points out, create contradictions within the process of developing knowledge. Instead, it is our view that beginning conceptualizations, representing the entire sample rather than the individual research subject, are more usefully brought to individual research participants for their critical consideration.

( : 175)
Credibility is developed when the participant reads the whole document and can see themselves in the quotations where the participants are in a position to judge the findings as credible (Harding and Whitehead, 2013). Credibility, therefore includes the process of choosing the participants, equally the methods engaged with and the analysis strategy employed. A descriptive account of all the themes, ideas and conclusions were used as a basis for the overall analysis of the information about the phenomenon being studied. This process has contributed to the credibility of the dialogue by some of the participants who have attended a number of conference presentations from 2011 onwards when I have shared aspects of the research analysis.

Additionally I have presented a detailed analysis of the findings at two international conferences in 2011 in August and October (respectively) the Royal Geographical Society Conference in London and at the International Rural Nurse Conference in Binghamton, New York. It was at these conferences I presented a draft version of the ‘analytical place-based matrix’. I received interest from some of the delegates who attended my presentation at the Royal Geographical Society Conference about the potential of adapting this matrix for non-health professionals in rural communities with agencies, such as the police and clergy. Equally, feedback from the international delegates who attended my presentation was gratifying, it validated my conclusions and it has allowed me to further interpret the concept ‘place’ in relation to analysing rural nursing practice. Both presentations provided me with feedback validating that the theoretical medium through which I was presenting the analysis offered members of both the audiences a more informed understanding of rural practice. For delegates who were not rural practitioners the verbal feedback at the conference supported the theoretical approach I was using to demonstrate my argument. Likewise, these delegates emphasised the analyses was believable, therefore maintaining the credibility of this study.

4.10.2 Auditability

Auditability is concerned with the believability or trustworthiness of the detailed account of the analysis of the study. This commences with the methodology and methods are in alignment with the research aims and research questions which were previously discussed in this Chapter. Furthermore, auditability centres on the method
of undertaking the analysis and extracting the findings from the raw data (which will be presented in Chapters five, six and seven) while ensuring the intent of the interpretive paradigm (chosen in this thesis) is maintained. This alignment allows the reader to critique the approaches chosen and to question the methodological assumptions made.

What is important to present is the trustworthiness of the research. The trustworthiness relates not only to the results of the study, but also how the process of the research was recorded and the planning which took place to create and proceed with the research process. The way a research study is legitimised depends on the “exploration of conditions, philosophical underpinnings and assumptions within the research work” as argued by Koch and Harrington (1998: 335).

4.10.3 Fittingness

Fittingness refers to whether the research findings can in fact be transferred to other contexts. This idea of fittingness of findings is always questionable as qualitative studies’ design, this study in particular, takes into consideration the background and the physical locality or environment in which the participants’ experience their setting, which is meaningful to them (Baxter and Eyles, 1997). The paradigm I engaged with, namely the interpretive approach emphasizes the importance of ‘context’ in relation to the study being undertaken. ‘Context’ associated with this study has been presented in the Preface and in Chapters one and two. Therefore qualitative research does not lay any claims that the findings will be transferable (or generalizable). One of the stated aims of this research was to explore the themes interpreted from the participants, rather than providing generalizable results. Sandelowski (1986) explains that the duplication of qualitative research results is inappropriate and that the uniqueness of the variety of results demonstrates the complexity of both human experience and research.

What is meaningful and experienced by one group of people may be shared or compared with another group, despite their context being different (Baxter and Eyles, 1997). The important aspect associated with fittingness is the responsibility the researcher has to provide the reader with a detailed account of the context of the study
and the methodology and methods employed (Harding and Whitehead, 2013). In terms of fittingness, the research design may be transferred to other contexts and findings may be compared (discussed further in Chapter nine). However, as a qualitative researcher I am more concerned with the credibility of the findings of the research rather than the findings being transferable to other settings.

4.10.4 Confirmability

When the research design and research process are examined this can confirm the dependability of the research. Once the findings, analysis and interpretation are supported by the data, the confirmability of the research is established. To ensure this is successful Lincoln and Guba (1985) suggest an audit or inquiry trail should be clearly written. An inquiry trail examines both the process and the development of data from the research, which assures the reader that the research is dependable by affirming that the research process supports the findings, analysis and interpretations, and then its conformability, can be established. The research process described within this Chapter and throughout this thesis assists in tracking the research steps and audit trail I undertook. When documenting the process of this research, all of the steps have been identified to clearly detail the research process and this has provided transparency for the reader into the research process that was undertaken. Qualitative research acknowledges the data can never be completely free from the researcher’s own position (Willis, 2007). Wherever possible, I have acknowledged my own opinions and values in the description and interpretation of the research data and findings, which are presented in the following three analysis Chapters.

4.11 Positionality

In this section of the Chapter I offer my reflection on my positionality in relation to this study, which is an important aspect of qualitative research (Bourke, 2014). The researcher, in all qualitative studies, leaves their own essence as a component of the study and their own subjectivity forms a part of the research. The researcher is positioned within the study in which the '[p]ositionality represents a space in which objectivism and subjectivism meet' (Bourke, 2014: 3) and subjectivity therefore becomes the position of the researcher. I am cognisant it is impossible for me to
stand outside and be totally separate from this study as qualitative researchers are unable to divorce themselves from the research, but instead the aim is to create a space in which the voices of the participants are heard and this is what I have sought to achieve as presented in Chapters five, six and seven.

My positionality was at the forefront of my mind from the planning stage of this research and serves as a reminder of its potential effects on the research process as well as on the participants and myself as the researcher. 'Reflexivity involves a self-sorting on the part of the researcher; a self-conscious awareness of the relationship between the researcher and the “other”' (Bourke, 2014: 2). The “other”, is related to the participants who contributed to this study and is an important consideration as I have experienced relationships with some of the participants, both as an insider and outsider. Positioning myself as both insider and outsider are a significant component aligned with this study which was discussed in detail in section 1.8 in Chapter one. This aspect of the Chapter builds on the previous discussion with the aim to discuss the issues, the assumptions I made and the lessons I continue to learn and apply regarding my positionality.

As insider and prior to this study, I am a RN who has practiced in the rural Canterbury region of New Zealand, in addition to being the co-director of the National CRH. Both of these roles led me to work alongside some of the rural nurse participants in a professional capacity. This work included setting up professional networks, and providing ongoing and postgraduate education and was further supported by the development of a number of research studies. More than ten years of working in this capacity led to my interest in conducting this study and to learn more about rural nursing from the rural Otago region and how and why this professional identity was constructed. My aim was to further understand the rural nurses’ changing and adapting identity, I was equally interested whether ‘place’, does shape this identity. Being so involved over a number of years prompted my desire to share these findings with the rural nurses and for them to articulate the significance and contribution of their practice, to the rural health care and national nursing sectors. As this study has progressed I have reflected on my positionality as a nurse, educator and researcher and visitor to the region. These four positions are interconnected and I have continued to take an interest in the region, with rural
community and health service developments from the point of view of student education and access to clinical placements. Equally, with my ongoing relationships with the rural nurses from the region and my connections with friends who reside there as I have travelled through on business and pleasure.

I have noted that I had a lack of awareness during the 1990s onwards as to the importance of the rural nurses’ contribution as they adapted their practice to accommodate the changing delivery of health care in the rural sector. Through the research process I can now answer some of the research questions that are highlighted in the analysis Chapters five, six and seven and in the thesis discussion, posed in Chapter eight. Further, I have reflected on how I positioned myself on the interactions that I had with the rural nurse participants and the key informant participants. First, are the participants that I had had a previous relationship with as colleagues in clinical practice and second, was those participants whilst in my position as co-director of the NCRH. I have considered how I went about building a rapport and gaining trust and how I interacted with the participants both during the research data collection process, whilst in the rural Otago region and at rural conferences. I am also positioned as an, ‘outsider’ in that I had never practiced as a rural nurse in the rural Otago region and had not developed a relationship with some of the rural nurse participants. Equally, I have remained as an ‘outsider’ with all of the key informant participants’ group members, as a result of not being employed by any of the national organisations (which the key informant participants were employed by) despite knowing each of the key informant participants, in a professional capacity. These relationships were a strength to this study, despite being an, ‘outsider’ I was able to gain ‘inside’ information which is presented in Chapter six.

Throughout the process of this study I have positioned myself as the researcher with an enquiring mind, to further understand how the identity of the rural nurse was constructed during the 1990 and early 2000s. I have treated the method of data collection and analysis with respect and ensured to the best of my ability I have respected the anonymity and confidentiality of the participants’. I was mindful of the relationships I had previously developed with some of the potential participants and it was for this reason I excluded those from participating who were at the time of the
study, a student or work colleague from the School of Nursing situated at Otago Polytechnic, Dunedin. I strove for objectivity at all times which did not to my prior knowledge colour my interpretations or the way in which I engaged with the research participants.

4.11 Summary of Chapter

This Chapter has provided a detailed account of the research paradigm, design and methodology employed in this study. The interpretive paradigm has provided the theoretical position which guided this research, offering a well-developed structure in which to situate this study. The interpretive paradigm associated with qualitative research and thematic analysis has proven to be a consistent and compatible research design. Ethical considerations were discussed including why I sought and established ethical approval including working in partnership with Ngāi Tahu. A semi-structured interview was the preferred medium for data collection. Semi-structured interviews provided an opportunity for the participants to contribute and discuss their understandings and experiences related to the phenomenon studied, namely rural nursing from the identified study location which. A detailed account of how the analysis and findings will be presented was included. The study’s credibility, transferability, fittingness and conformability have been identified and my reflexive position discussed which leads into the diverse range of themes I employed to analyse the findings in Chapters five, six and seven. It is in these Chapters that rural nurses’ voice comes to the foreground.
CHAPTER FIVE: PRESENTING THE ANALYSES AND FINDINGS, FROM THE RURAL NURSES ‘SENSE OF DIFFERENCE’ IN ‘LOCATION’

[Place] has provided a significant lens through which everyday life is investigated…

(Agnew, 2004: 84).

5.1 Introduction

This Chapter is the first of the three analysis Chapters in which each Chapter presents different but complementary aspects of the study’s written analyses, findings and the engagement with the photo images. Through answering the research questions (presented in the previous Chapter) exposes how place constructs the identity of the rural nurse, where the rural nurse works, how the rural nurse practices and further, how these nurses contributed to the rural health care sector during the identified study period, 1990-2000s from the rural Otago region. The concept and interpretation of place makes a significant contribution to the analysis in this thesis. Place constructs our identities, performances and behaviours, and this is why I have engaged with Agnew’s (2004) quote at the commencement of this Chapter. Agnew’s quote offers guidance about how to proceed with the analysis of the findings. I engage with both the theoretical and practical positions associated with place, by engaging with Agnew’s (1987) ‘place framework’, ‘location, in this Chapter. The further two aspects aligned with his framework, ‘locale’ and ‘sense of place’, are also engaged with when I analyse and present the identity of the rural nurse in the following two Chapters, six and seven (respectively).

To further understand how the professional identity of the rural nurse was constructed, it is essential to understand the meaning of how the nurses’ identify themselves. In framing the analysis and findings, ‘place’ as a concept, has provided a
lens through which to analyse and present the professional identity of the rural nurse. In order to make sense of how this identity is constructed the personal, professional and place-specific aspects of rural nursing are identified as key variables. The rural nurses’ identity in this Chapter is understood as the outcome of having a ‘sense of difference’ as analysed from the data and is presented by engaging with Agnew’s (1987) ‘place framework’, ‘location’ in addition to aligning the analysis with nursing core concepts of caring associated with the ‘environment’ (Torres and Yura, 1974).

5.2 Outline of Chapter

This Chapter comprises two sections and discusses the analysis and findings associated with the establishment of the changing professional identity of the rural nurse as it evolved over the research phase of this investigation. In section one I demonstrate the approach I have engaged with to present the analysis and findings in which to understand how the professional identity of the rural nurse from this region was constructed. This thesis draws on the theory of place and the notion of governmentality to report on the analysis and findings in section two. These two approaches include the first aspect of Agnew’s (1987) ‘place framework’ that incorporates, ‘location’, which is further framed around the components associated with the governing by the state compared to the governing of the individual (the rural nurse), which are linked to the concept of ‘governmentality’ (previously examined in Chapter three as concepts aligned with the conceptual framework guiding this thesis). ‘Place’ as ‘location’ as discussed by Agnew (1987) is further supported by a subsidiary method of using a selection of photographs (plates) in this Chapter to capture visually evocative expressions of ‘location’, as reflected upon by some of the participants including my interpretation which further frame up the analysis and findings (Sontag, 1977; Rich, et al., 2000; Mader, et al., 2016). The first section of this Chapter is now presented.

5.3 Engaging with the analysis and findings

The analysis and the findings presented in this Chapter were guided by the first research question, what constitutes being a rural nurse, and where do rural nurses work? that was initially posed at the commencement and the planning stage of the
research investigation in Chapter one and which was further discussed in Chapter four. This analysis engages with the concepts of place and governmentality to frame up the findings of this research. A more explicit account of place was discussed in Chapter three where it is argued that ‘place was one of the six chosen key concepts underlying the conceptual framework which guides this research. ‘Place’ is considered as a dynamic, fluid and a relational construct which is never static and is always becoming rather than being (Agnew, 2011). Understanding ‘place’ from this standpoint provides this analysis with an approach from which to present the unique relationships rural nurses engage with in their everyday performance, as they practice in rural locations (Crooks, 2012). Relational aspects associate ‘place’ within the broader realm of the socio-political, economic and cultural contexts that are positioned locally, regionally, nationally and globally (Agnew, 2011). These contexts are also considered important aspects in relation to rural nursing practice as highlighted previously in Chapter two, which presented the contextual events related to the evolving rural nursing practice within the socio-political and economic periods leading up to and including the major health care reforms, between the 1980 and 2000s (Gauld, 2001; McMurray and Clendon, 2015). The analysis of how the identity of the rural nurse was constructed during this time period and context is now presented, as I engage with Agnew’s (1987) first element of his ‘place framework’, ‘location’ (initially presented in Chapter three) and diagrammatically presented in Figure: 5.1. ‘Location’, includes the physical settings or the sites where rural nursing practice occurs (Agnew, 1987). The green dotted (representing movement) circle represents ‘place’ as ‘location’ in Figure: 5.1 and is positioned against a green rectangle which is representative of the first of the four core concepts that make up ‘nursing core concepts of caring’ (Torras and Yura, 1994) the ‘environment’ and was initially presented in Figure: 3.4 in Chapter three. Engaging with ‘location’ as understood in social geography and ‘environment’ from nursing adds to a more detailed understanding of rural nurses’ identity construction, the ‘place framework’ diagram will be further developed throughout this, and the following two analysis Chapters.
Figure: 5.1  ‘Place Framework’ depicting ‘location and sites of practice’
Source: Compiled by the author.
5.4 **Rural nurses’ identity, constructed through ‘location’**

The first of the three core key themes interpreted from the data is presented in this Chapter and analysed to convey a ‘sense of difference’ which further constructs the rural nurses’ professional nursing identity as discussed in this Chapter and is associated with the rural nurses’ shared encounters of rural practice compared with the imaginative accounts of the rural by non-rural nurses, which is now explored.

5.5 **The first key theme a ‘sense of difference’**

This section of the Chapter provides a discussion related to the analysed themes and subthemes generated from the participants’ contributions, supported with excerpts from the rural nurse participants. During the course of the semi-structured interviews I invited the participants to consider the first research question; *what constitutes being a rural nurse and where do they practice?* Posing this question stopped the interview conversation for some of the participants, the majority of whom were long-term, experienced rural nurses and who considered this question to be too difficult a concept to elaborate on. These participants wished to discuss rural versus urban difference, associated with the way in which the rural nurse is exposed to the particular nuances associated with the rural. A brief encounter with the development of defining the ‘rural’ in New Zealand is offered in the following section in which to help elaborate on the participants’ limited understanding of the ‘rural’.

i. **Rural definition**

At the time of commencing this thesis in mid-2005 there was no formal rural definition associated with New Zealand, as this was a time of transition in definitional terms. In 2006 Statistics New Zealand (2006) published an urban-rural classification profile describing the degrees of urban influence on rural populations (refer back to Chapter three for further information). This definition was further developed in 2010 and referred to as an, ‘experimental’ urban/rural classification profile (Statistics New Zealand, 2010). The lack of a formal definition of ‘rural’ caused some concern for the participants during the interview, when they asked for further clarification and referred to the rural definition (Statistics New Zealand, 2006) in negative terms (if at
all). The participants expressed this definition was not referred to in decision making or understanding rural New Zealand because of its simplistic approach and its reliance on the urban comparison.

As I progressed with the analysis I became aware of a number of developing themes through which the participants’ were identifying themselves in relation to urban nurses. This theme arose through numerous interviews with the rural nurse participants as they further expressed that urban nurses’ were dismissive of rural nurses’ practice and emphasised that they (urban nurses) understood rural practice, as not being too dissimilar to their own practice. I had not set out to specifically focus on or include a discussion related to this notion of a ‘sense of difference’, however the rural nurse participants themselves certainly expressed a variety of perceptions associated with the notion of difference. In the process of discussing their identity the rural nurses’ became aware of the differences between their own identity and that of urban nurses. In particular how the rural environment and the community expectations shaped the nurses’ practice developed as a core key feature. Likewise, the relationships which developed in the rural community prompted the rural nurses to engage both in a social and professional capacity with rural people, which was described as both having a positive and negative effect on the nurse’s own personal and professional life.

As I considered this potential dichotomy between knowing the reality of the rural identified by the rural nurses and the imagined aspects of understanding the rural from the perspective of the rural nurses’ associated with understanding rural reality by non-rural nurses’, I considered Woods’s (2011) work on the notion of the imaginative rurality. According to him, for some people, the rural is imagined and romanticised and lacks the everyday reality experienced by those people who live this reality. Generally, imaginative rurality is experienced by non-rural people, who may be situated in state and discipline governing positions (for example, NCNZ governing rural nurses’ practice) such as policy-makers who do not automatically know the rural, but consider they do (Woods, 2011). Policy-makers may also base their interpretation of the information used to govern rural practice on urban reality, rather than the rural nurses’ reality which may result in negative consequences for rural policy development (McMurray and Clendon, 2015). The potential for engaging with
and recognising these interpretations has the potential to lay the basis for a different and more positive conversation than what is currently occurring with non-rural colleagues, nursing organizations, educators and policy-makers. These conversations may lead to an informed understanding of the practice of the rural nurse and their connection with ‘place’ (discussed further in Chapters eight and nine).

Identifying a ‘sense of difference’ was an interesting juxtaposed position from which rural nurses interpreted their own identity in relation to others, in this case urban nurses. A ‘sense of difference’ is encountered in our everyday social experiences, which is in opposition to those whom we identify with, such as people, groups and places (Panelli, 2004; de Leeuw et al., 2011). Participants from this study identified, a significant ‘sense of difference’ contrasted with urban nurses’ and their contexts of practice and also with outsiders such as state agencies and policy-makers. ‘Sense of difference’ therefore associates affiliating with an identity that ‘others’ contest (Panelli, 2004). Contesting an identity is about the differences ‘others’ perceive or imagine about how an identity is constructed and recognise the visible signs that are believed to relate to that identity. In contesting an identity it is the shared meanings, which are in conflict, which normally stem from association with difference, opposition, boundaries and power relations (de Leeuw et al., 2011). By contrast, shared meanings associated with identities become realised in relation to what they are not (Panelli, 2004) and include self-recognition, belonging and a distinction from ‘others’ (Spinaze, 2008; de Leeuw et al., 2011; Crooks, 2012). Through these encounters, a deeper understanding was revealed as to how the rural nurses’ adapted both personally and professionally to accommodate others requirements. The notion of others in relation to identity construction will be discussed in Chapter seven. Meanwhile a ‘sense of difference’ has been captured from the rural nurses’ contributions and corresponding sub-themes, the first which I have identified was shared practice encounters in opposition with the imagination of the rural.

5.5.1 Shared practice encounters in opposition to the imaginative rurality

The following excerpt as expressed by one participant who reflected on her contribution as a rural nurse as she was preparing her answers prior to the interview
(the research questions were provided to the participants on an information sheet, in Appendix 2 prior to the interview):

I was thinking about it last night. I thought that’s a really hard one isn’t it? You know what is rural? And I thought right, well trying to be really definitive about it and you think that rural must be anywhere that I would think is an hours drive from a tertiary centre and then I thought… that excludes [place name removed]… I think that anyone who considers themselves to be rural, is rural and for a particular reason according to their context.

(Rural nurse participant 5)

Likewise, the subsequent excerpt also demonstrates the difficulty some nurses’ experienced in answering this question and in doing so also recognised aspects of difference and the importance of the context when considering what constructed the professional identity of a rural nurse:

I almost got stuck on the first bit about what is a rural nurse. It’s probably the hardest bit really… it’s so different I mean it’s so contextual. And it’s as different as rural areas are different… we’ve got to have a definition of rural? You could say that the rural nurse, a nurse that identifies with some of the things that are commonly thought of as being part of rural practice as living and working in a rural community… professional and geographical isolation.

(Rural nurse participant 16)

The previous two excerpts recognise that rural nurses regard themselves as being different, while acknowledging that the rural context plays a unique component in constructing their identity. There is also a perceived need to have a distinctive definition encompassing all that is rural. A rural definition would be useful for strengthening the general understanding of rurality with regard to the challenges for the rural health practitioners living and working within such physical and professional isolation and will be discussed further in Chapters eight and nine.

It was never the intention of this research to study rurality, however out of respect for these participants’ considered opinions I believe it would be worthy to reconsider New Zealand’s classification of rural (introduced in Chapter three and further discussed in Chapter nine). A revised rural definition that engages with the established international core characteristics defining rural and which understands
rurality as a phenomenon, is socially and culturally constructed (Cloke and Little, 1997) would be beneficial to apply, to help understand the identity of the rural nurse (Bushy, 2000; Hutton, 2016). At the time of gathering data a New Zealand rural classification had been published, however some of the participants may not have engaged with this publication (Statistics New Zealand, 2006) and therefore found it difficult to provide an informed response to this research question.

It was evident from the continued discussion that rural nurses’ experience a ‘sense of difference’ and that there are a number of collective descriptions and shared encounters amongst the participants. Shared encounters were demonstrated through their nursing experience in which they shared their awareness of what it means to practice in a rural location. The rural nurses’ in these rural locations perceive that they are challenged by non-rural nurses who emphasis that there are no differences between rural and non-rural practice (Hutton, 2016). Thompson (2004) acknowledges nurses’ who practice in rural contexts are identified as being different and nurses are regularly challenged as to why they consider themselves as being different from non-rural colleagues. Woods (2011) recognises that there is a distinction between the ‘us’ and ‘them’ way of thinking in terms of the insider and outsider understanding which is evidenced in the excerpt below in which the participant speaks on behalf of other rural nurses when she indicates that, in her view, urban nurses do not appreciate the distinctiveness of living and working rurally. Despite rural nurses explaining different aspects of their practice, they believe that their explanations are not acknowledged and are brushed aside, as urban nurses’ responded that their practice was also similar to that of rural nurses. Participants, viewed outsiders with a disregard of their practise leaving them feeling unheard and with the perception that their practice is unworthy of being acknowledged as different. The following excerpt highlights these raised concerns and is displayed in the first photo plate in this section identified as plate two which is used to illustrate and exemplify further, the written analysis:

[…] us rural nurses believe that we know what we mean and we understand [the rural] because we live this world. It might sound a bit petty and political but we believe the urban [nurses] don’t really understand what it is like to be rural although we try and explain it, they say things like we do that too, we’ve got that too because we go to outlying areas but there is a difference... They don’t listen and one of us made a comment to [name removed] that they don’t
get it… We try and tell them and they say, oh yes but [name removed] said they will never understand what it means to be a rural practitioner. The isolation and the extra things…

(Rural nurse participant 10)

Plate two from the bank of photographs I used supports the textual analyses, by representing ‘location’ and also depicts a ‘sense of difference’ and a ‘sense of place’ which was reflected by some of the rural nurse participants as being associated with a barren location they operate in as is mirrored in plate two below and which reflects the rural nurses’ perception of the reality of their practice, which they do not believe that urban nurses’ understand.

Plate Two: Represents Rural Isolation
Source: Printed with permission from Brian Scantlebury.

Plate two is regarded as reflecting a situation in which “the location is isolated and stark and it does not have anything in it, there is very little to support the work we do, there are numerous obstacles to get to where we practice” (expressed by a rural nurse participant from the bank of photographs) and was selected out of several options by the participants, as typifying a particular theme. Isolation and distance are key dimensions of working in this environment and have been recognised by Bushy (2009) and Hutton (2016) as being associated with ethical concerns associated with
rural nurses’ practising in professional isolation which will be discussed further later on in this Chapter.

These findings are in alignment with Bushy’s (2000) interpretations that there is a distinction between the ‘them and us’ way of thinking and about the ‘insider/outsider’ phenomenon, which is related to the identification of the importance of having a distinctive rural geographical location. This distinction is further explained by Woods (2011) as an imagined distinction between the rural and urban of which each has an ordered way of being. The relationships between local people (insiders) compared to others (outsiders as discussed by) and the relationship with place is further considered here. Insider and outsiders concepts are well documented in rural nursing research (Lee, 1998; Bushy, 2000; Lee and Winert, 2006). Holloway and Hubbard (2001) recognise that people may understand and experience place in different ways. Understanding place in different ways is related to peoples’ knowledge of how places function, with their social and political composition as well as the boundaries surrounding place.

The following excerpts illustrate the significance of understanding the reality of rural place, which is associated with rural nurses’ ability to practice in the most effective ways by reducing barriers to accessing health care. Barriers to access may include transport, either public or private, and travelling long distances both within and external to the rural community (Bushy, 2009). Rural nurses’ practice encompasses a vast array of knowledge, skill and expertise, the challenges of which are compounded by limited resources, education and training (Ross, 1999; Molinari, 2012b). The majority of the rural nurse participants’ explain they are relying on themselves and have to adapt to numerous circumstances, and in doing so, they are demonstrating that they are managing their own practice in the rural contexts in a unique and distinctive fashion. In these contexts it is necessary for the rural nurse to be knowledgeable and self-sufficient and to be in a position to function effectively in an array of situations, for example, being able to change a car-tyre when travelling to client’s homes whether remote, isolated or rural location and adapt to the physical environment including, non-human encounters. These encounters are recognised as creating a further ‘sense of difference’ from their urban colleagues as is highlighted in the following excerpts:
[...] when you’re working in a rural environment all you’ve got to go on is your own experience and your own knowledge base and at the time you’re at a, in a situation you’ve only got yourself to draw on. You don’t have hospital equipment or resources, you don’t have other colleagues with you there so I’ve found that the biggest difference also being only qualified for five or six years or whatever it is, I’ve found that the biggest hurdle to have to trust my own instincts and make sure I’ve got the knowledge that I can feel safe in those environments when I’ve only got myself to rely on.

(Rural nurse participant 2)

Well the training is just learned from people who have experienced working out there before you, they pass on that information. There’s no formal training for district nursing, particularly not in rural areas. You have to learn how to change your own tyre, you know that sort of thing. I can learn how to open farm gates and you know go up ski field roads sometimes, remote places… you need to know how to handle, dogs, cattle, sheep, all sorts of things.

(Rural nurse participant 6)

Building on from these excerpts, plate three, represents and highlights the non-human encounters, in the rural environment that are an everyday aspect and part of the landscape rural nurses operate in. Plate three (below) represents an additional contrast, between rural nurses and non-rural nurses practice, this is my interpretation.

Plate Three: Represents Navigating Nursing Practice with Non-human Encounters
Source: Printed with permission from Brian Scantlebury.
Rural nurses have identified their own distinctiveness associated with a number of differences between their own professional identity and that of non-rural nurses (urban nurses). This identification demonstrates congruency amongst these participants who are in a position to identify that the professional identity associated with urban nurses’ is different to their own professional identity associated with rural nursing. In reference to Jackson (2005) and du Leeuw et al.’s (2011) work who acknowledge that differences occur as identity becomes acknowledged with similarities as well as dissimilarities. While, McKinnon (2011) promotes the notion that identities are constructed in relation to other identities, for example to what they are not. This description leads into the next sub-theme namely a ‘sense of difference’ associated with the rural location as the rural nurse engages with the ‘rural environment’.

5.5.2. Engaging with the ‘rural’ environment, distance and isolation

Physical location emerged as one of the main categories of difference generated from several of the participants’ data and the relevance of this concept was further extended through focusing on how the rural nurses’ professional identity was constructed through engaging with the rural physical environment. Most of the participants made reference to the physical attributes of the local rural environment and described the physical geographical place and specific characteristics associated with their practice. These characteristics included the effects of climate, seasonal changes and terrain, which impact upon the performance of the rural nurses’ practice and their relationship with the rural context. These characteristics became significant in the way in which the rural nurse participants interpreted their identity. As discussed elsewhere, local discourses associate rural people with their environment, giving dominance to this theme as discussed by Goodrich and Sampson (2008) whose research explored what it means to be a local rural resident on the West Coast of the South Island of New Zealand (highlighted in the map in the Preface to refer to these New Zealand geographical locations mentioned above). Within these rural regions local people associate with their rural environments and describe the beauty of rural locations, as well as revealing an understanding of, or note of the complexity of the physical terrain, a theme which is detailed in the following section.
ii. Rural environment

A significant number of the participants were happy to reflect on their relationship with their rural environment in which they associated and referred to their practice as being in the ‘rural context’, rather than being defined as ‘remote’ nursing practice as is often associated with international definitions including that in Australia (Bushy, 2000; Thompson, 2005). These reflections included the environment, location, climate, terrain, distance and isolation from other communities, which have also been identified in the international literature as a component associated with rural nursing (Bushy, 2009; McMurray and Clendon, 2015). The rural environment comprises a wide range of attributes associated with the physical location, which is broadly identified as place.

Place is a central feature of this research and connects all the relational aspects within the social world, the relations between humans and non-humans (as depicted in plate three above), and the social interactions which occur in place (Agnew, 2011; Woods, 2011). The rural environment also includes how people relate in place, what attachments they have and what it means to identify with a ‘location’ or sites of practice as a ‘sense of place’ (discussed in Chapter seven). Attachments and the relational values are associated with a location and include the people, their joint values, physicality including the geography, and their emotional connections with place (Agnew, 2011), which is borne out in the following quotation by Panelli (2004: 140) who states that,

[…] identity involves the meanings and expressions of self… and others… and places… that appear relatively stable and singular but are likely to be multiple and unstable, and may be challenged or renegotiated in a range of ways.

‘Place’, therefore becomes central to identity construction and to community engagement. The geography and climate of rural Otago was a touchstone, which the participants’ spoke about with respect to the nature of their practice. In the interviews most of the participants talked about their physical location, although this was not a main focus in the overall conversation regarding what constructs the professional identity of the rural nurse. The weather was identified as a symbolic concept
associated with the professional identity formation of the rural nurse. By associating with the physical location the following excerpts have identified the importance of the seasonal climate in shaping where and how rural nurses work and their identity construction. The weather has a positive influence on how the nurse relates to that physical environment in terms of both living and working in a beautiful location as is illustrated in the following excerpts:

I think a little bit is the weather. It sounds a silly thing to say but I mean the climate is just so lovely here.

    (Rural nurse participant 4)

It’s a cold place in the winter... but it’s a dry cold. It’s not a wet cold.

    (Rural nurse participant 16)

It’s a beautiful area and rural Otago is one way of the largest rural areas in the country I believe, well Central Otago anyway. People come here because they like the lifestyle, it affords beautiful scenery and great recreational activities.

    (Rural nurse participant 15)

The following two plates (four and five) I have selected to further illustrate the written data analysis that is representative of the responses of the rural nurse participants’ who noted ‘location’, as a place they associated with including the climate and, terrain, in general, in which the physicality of where they practice frames, how they practice. Plate four represents the beauty of the regional location in the winter months.
Plate Four: Represents the Beautiful Landscape of Rural Central Otago
Source: Printed with permission from Brian Scantlebury.

Plate four is in contrast to the starkness and extreme frost represented in plate five (on the following page). Plate five represents the location of rural Central Otago in the frosty winter months showing the terrain, climate, season and isolation in which the rural nurse negotiates their practice which is illustrative of my personal interpretation exemplifying the contrasting and juxtaposed position of the weather and climate, as compared with plate four.
The second theme, which cannot be separated from the environment, but which does stand as a unique element, is associated with movement within location, and the related sub-themes of travel and distance. Movement comprises all of the concepts of what constructs a rural nurse in location as highlighted by Massey (2005) who considers place as being associated with flows and movement. There is a sheer degree of physical and geographical isolation including reduced cell phone coverage, which exists in these areas and which is represented in the following excerpts. The participants highlighted the dominant characteristics of distance and isolation that define the rural location and the lives of the people who live ruraly. Traditionally, rural people have responded to this isolation by developing self-reliance, hardiness and becoming a close-knit community (Cloke, 2006b; Bushy, 2009). Distance can be classified by actual distance measured by kilometres, time taken to travel and the perceived time and distance to services (Bushy, 2000; Bidwell, 2001). Plate six from the portfolio of photographs is representative of the physical location and symbolises
“movement, the nurse moving in, the patient moving out” (expressed by one regional rural nurse participant) as knowing “who lives up the track and who farms the land” (this view was reflected by two of the rural nurse participants’). Plate six (below) also reflects the reality of rural nurses’ practice and how they navigate their practice within this terrain.

Plate Six: Represents Movement within Rural Place
Source: Printed with permission from Brian Scantlebury.

Rural nurses identified a number of aspects which identify them with the rural region, such as being aware of the particular nuances of distance and the time taken when travelling around the region to provide health care. More specifically rural nurses noted they were aware of being responsive to the particularities associated with the physical terrain, long distances travelled and the factors which promote isolation. This means they are required to become as resourceful as possible as they practise within these contexts. Isolation can compromise the rural nurses’ practice, often resulting in ethical dilemmas (Bushy, 2009; Hutton, 2016) that were highlighted previously as to the choices and decisions the rural nurse makes related to the context of their practice. The rural characteristics of hardiness, autonomy, diligence and perseverance are seen to foster self-reliance (Lee, 1998; Bushy, 2000) and further
characterised as a result of distance and isolation as, expressed in the following excerpts:

[…] you are working alone with no, with no immediate backup if something goes wrong although they have cell phones there is very limited reception out there.

(Rural nurse participant 6)

Probably the differences are, when you’re working in a rural environment all you’ve got to go on is your own experience and your own knowledge base and at the time you’re… in a situation you’ve only got yourself to draw on.

(Rural nurse participant 2)

Working alone in a situation of physical isolation, as highlighted in the above excerpts, is recognised as an attribute associated with rural nursing practice. Further, rural nurses’ recognised their rural practice as being different to urban nursing practice. The following excerpts illustrates both of these considerations:

Travel time, and knowing the distance and the terrain, the geography and the climate, is very much part of how the rural nurse is constituted… we have a huge amount of nursing hours in travel… travelling time to people… we have to organise our loads really well.

(Rural nurse participant 6)

Travel means that there is a large geographical area that nurses are part of… and perhaps a larger ratio of rural nurses in rural communities compared to other areas.

(Rural nurse participant 10)

You could say that the rural nurse that identifies with some of the things that are commonly thought of as being part of rural practice as living and working in a rural community, the sort of professional and geographical isolation, some of those common factors are common to all rural nurses.

(Rural nurse participant 16)

Where rural nursing practice occurs rather than what rural nurses do, was the rationale for including this aspect as a component of the first research question in which to assist in understanding further what constructs the professional identity of the rural nurse other than their daily practice from the rural Otago region. However, the majority of the rural nurse participants did discuss their practice relating it to their
skill base, which ranges from health promotion activities such as immunizations, health education incorporating dietary advice, chronic illness rehabilitation and lifestyle instruction, to the management of chronic and acute wounds as well as the provision of emergency contact at accidents. These are all small but a diverse selection of components of their practice. The following section addresses the issues associated with where rural nurses practise.

5.5.3 Performing practice in-between various locations and sites

The second aspect of the first research question I posed to the participants related to where do rural nurses’ practice? This question was a further component from which to build-up an understanding of how the professional identity of the rural nurse has been constructed. As I engaged with the data I identified that rural nursing practice occurs within a number of sites situated within the physical rural location of the rural Otago region. The sites and the composition of rural nurses’ practice is an overriding subtheme that has been analysed from the data generated from the participants’ contributions and these findings demonstrate the complexity of rural nurses’ practice, in-between these sites. The complexity of this in-between practice indicates that what has been identified from this analysis has determined that rural nursing practice is performed in numerous sites, which may include, the rural community hospital (unlike tertiary hospitals which is typically associated with urban and city locations) and residential care (older adult residential facilities), in general practice clinics, rural schools and in client’s homes.

iii. Performing rural nursing practice in response to community need

One interesting factor that relates to rural nurses’ performance can be associated with the expectations which either come from community members or from the way in which rural nurses wish to govern their own practice in which they are in a position to accommodate clients’ health requirements. The following two excerpts illustrate how the majority of rural nurses’ respond to community health needs. Rural nurses respond to patient’s requests to either stay at home or get back to their local community hospital (from a tertiary hospital) to continue their health care and rehabilitation care as illustrated by the following two participants:
They [rural nurses] are prepared to put themselves out there and to go that extra distance and the common understanding is that you want to make, you want it to work for people who are at home so you do your utmost to do that and often sacrificing your own time… we want it to work for them [client’s] so we do our best to make it work for them out there.

(Rural nurse participant 6)

The rural nurse participants’ have taken into consideration that resident’s recovery could be improved significantly, if they were cared for nearer to their home. This is an aspect associated with a beneficial component of nursing theory as expressed by Carolan, et al. (2006). In respect of this request the rural nurse “goes the extra distance” and expands her knowledge and learns new technical skills to accommodate the clients’ health needs. In the second excerpt the experienced rural nurse explains that to adequately care for this client she needs to became competent to perform the care required for the maintenance of a Hickman Line (a central intravenous line) and the administration of Total Parenteral Nutrition (total supportive feeding via a central intravenous line (Crisp and Taylor, 2010)) in order to be confident to manage the complexity of this specialist area of practice. The nurse is aware of the physiological complications that could occur, including the potential for cross-infection, if she was not competent to perform this aspect of practice. This rural nurse takes into consideration community members’ requests and health needs as discussed in the excerpt:

[…] they [community members] say can I come back to your hospital and they’ve got a Hickman line in and you’ve never dealt with it or you’ve only very rarely dealt with a Hickman and you think holly heck, how am I going to bring this patient back, who’s got a Hickman line and having TPN but I know that she really wants to get home for Christmas to be with her family so therefore [nursing position removed] I have to make sure that I know how to do it and that I train the nurses like in three days, so that they can care for it…

(Rural nurse participant 5)

In practice settings, such as described above, rural nurses advanced their practice to provide a health care service specific to the needs of the community members in a particular ‘location’. Rural nurses practice in an autonomous capacity, as explained by the nurse (in the excerpts below) which they practice, both in a general practice clinic and the in client’s homes, which is another identified site of practice. The following excerpt is reflective of practicing in a rural general practice clinic, and
highlights the requirements to be a competent rural nurse working in an isolated context. Isolated contexts require the rural nurse to have a broad nursing knowledge base, while also having sufficient nursing experience in order to practice competently and confidently in isolated locations and sites.

The following excerpts are also illustrative of a fairly new rural nurse to rural nursing practice who highlights the difference between urban and rural nursing. It can be deduced from this excerpt that rural nursing is viewed in a positive light within this site of practice (i.e. general practice clinic). For the rural nurse to provide the health care service it is necessary for this practitioner to have an advanced scope of practice (a more detailed account of scope of practice will be discussed in relation to a ‘sense of change’ presented in Chapter six) that requires a broad knowledge base and effective decision-making skills. Experience and knowledge have normally been acquired through experience gained over a number of years:

I’ve certainly felt that I’ve got more of a responsibility here than I did have at [urban general practice, place name removed]. I was a nurse there and there was eight other nurses so at any time there’s always six nurses on per day. So if you’ve got like a wound and you needed a second opinion, there’s always a nurse floating around… Here [rural general practice] it’s pretty much you’re it. Like you have to know a lot more, you know like, I don’t think I could have done this job if I hadn’t had two years previous practice nurse experience.

and

[…] you don’t have the support of another nurse right there to help you or if you’ve got a sick child and you want a second opinion to look at a rash or a spot or something, you have to be able to make a decision, you have to make a lot more decisions on your own which for me I’ve found really good, really awesome, really good for my practice but something I couldn’t have done [in urban general practice] without sort of three year’s experience. So for me this is a really cool job…

(Rural nurse participant 3)

The majority of the rural nurse participants’ practice is constructed routinely within one site as discussed above, whether in general practice, the client’s home, residential care or the local rural hospital. However the rural nurse often finds that their practice is constructed within numerous locations as referred to in the following sub-section as diverse practice locations.
iv. Diverse practice locations

An example of rural nurses’ diverse practice refers to when tending to emergency call-outs. Emergency call-outs occur in client’s homes, in community facilities such as the local school, workplaces and at the roadside. The rural nurse as the PRIME provider (PRIME was introduced in Chapter two and is further analysed in the following Chapter) is the lead emergency health care provider in emergency situations and this further defines the professional identity of the rural nurse with a ‘sense of difference’ which is not performed in the urban contexts as emergency health services are provided by an array of providers (Ministry of Health, 1999a; Horner, 2008).

This ‘sense of difference’ is further associated with the moral responsibilities associated with rural cultural values and professional accountability as the rural nurses’ identity is constructed as a component of the rural culture she/he is part of. The rural nurse creates a healing environment within various rural sites and structures as this occurs a nurse-client-community proximity is established which has entitled this nurse to advance their practice. Examples of their practice includes working in partnership with clients and community members and establishing PRIME access which has benefitted the health care of the clients in these rural communities. This is especially visible in the Nursing Council of New Zealand (2012) ‘Guidelines: Professional Boundaries’ document and presented to the rural nurse delegates’ who attended the ‘Rural Nurse Workshop’ at the 2013 National Rural General Practice Conference, in Rotorua, challenged the presenter. The delegates expressed that the scenarios representative of rural nurses’ practice exemplified in this document are not fully appreciative of the reality of rural nursing practice (discussed further in Chapter eight). The following section illustrates the rural nurse participants’ rural reality.

iv. Moving in-between practice localities

The rural nurses’ practice associated with location enables the rural nurse to practice with autonomy, confidence and flexibility in order to support community health needs. Some rural nurses’ practice is also constructed through moving between practice sites. The ability to move between sites and practice in a number of these sites has numerous benefits for the community members and the rural nurse, which I
have referred to as practicing ‘in-between’ locations. In-between practice locations provides an opportunity for the rural nurse to care for the same clients in numerous sites of practice in the same rural community, as illustrated in the following excerpt by one of the rural nurse participants who had cared for an older person in her own home. The nurse assesses the person’s breathing and determines a nursing diagnosis that this client requires oxygen. The nearest facility that has the ability to provide oxygen therapy in this scenario is the local rural hospital where there are two medical beds, which are usually used for local residents when there is a need, for either respite care or medical observation. In this scenario the rural nurse decides the most effective way of ensuring this person gets the treatment required is to take her to the local rural hospital in the nurses’ work related vehicle as expressed in the following excerpt:

"[...] we have patients who sometimes require oxygen and we can just if we’re out visiting them and we feel they need it, we can just bring them back with us and put the oxygen on and the doctor will come and visit them."

(Rural nurse participant 2)

This excerpt illustrates the autonomous nature of rural nursing practice, through the assessment of a client’s health status, the management of the case and local treatments as well as carrying out the necessary action to ensure clients receive appropriate health care in a timely manner. In the rural context, regardless of which site or sites the rural nurse is practising within, there is an overall theme of responsibility and expectations of the nurses’ practice by ‘others’ as well as by themselves, to perform in a certain way. Adapting and broadening the scope of the registered nurses’ practice and performing in isolation from other nurses is a further point of difference from urban nurses, which is raised in the following excerpts. These excerpts highlight the unique insight of the rural nurses’ practice which are aligned with ‘location and the physical sites of where and how practice occurs, for example within the patients’ home and in the general practice clinic. The following excerpts demonstrate the ability of the rural nurse to practice autonomously. Nurses are in a position to self-govern their own practice, while considering the best use which can be made of available resources, including minimising as much as possible disruption for the patients/clients. Autonomous and diverse practice is a theme which is highlighted as the rural nurses express the importance of getting to know the clients and their living
situations, as this way of practicing better accommodates the comfort of the client when they are in their own home (McMurray and Clendon, 2015). The following example has been highlighted as to how some people feel uncomfortable in the doctor’s clinic or have difficulty getting to the clinic and so the nurse visits the resident on her way to work or during work time. The nurses are accommodating and adapt their practice, which improves the quality of health care for residents. In the following Chapter I will further illustrate how the rural nurse performs and further governs their practice, but before doing so, the following excerpts demonstrate the flexibility, responsibility and community spirit, which underpins rural nurses’ practice of providing health care in-between locations and sites:

Starting off with a home visit to a chap who can’t come into the Medical Centre because of his [condition removed] so he’s on my way to work and because it’s a local, rural area and you know people in town, you just pop in on your way and you know everybody by their first name and his caregiver […] was there and he knew it was me that come in the door even though he’s [disability removed] and took his bloods and carried onto work.

(Rural nurse participant 17)

I think to be fair that some people don’t like coming to the doctor, let alone having to sit out in the waiting room and there might be a lot of other people there and there’s people coming and going. I mean we do our best I suppose, to make people feel comfortable and things but there’s nothing like seeing people in their home. And it’s on their terms... I love it when I have to go out, I’ll often shoot out and do bloods and things. The district nurses here… doesn’t do bloods… I’ll often pop out in the car and go [place name removed] I like getting out and seeing people in their home, in their environment, on their terms.

(Rural nurse participant 4)

Unlike formal models of practice there are also informal models; by informal I refer to practice being performed in non-state governed sites or locations, the following section illustrates the informal models of rural nursing practice.

v. Informal models of practice

Informal models of practice are representative, for example, of the local supermarket and social and recreational sites such as tennis and badminton courts and the golf course. It is within these informal sites that the majority of the participants expressed
a discontent at being interrupted in their non-professional work capacity as residents ask them for health information, for example their blood test results as illustrated in the following excerpts. These participants noted they responded to clients politely as they do not wish to appear to be rude to the person asking for information, however it is inconvenient for the nurses. The following excerpts highlight these concerns:

 [...] you go to the supermarket to do your shopping and somebody wants to ask you a question, that’s okay up to a point… So I think that boundary setting is important and being quite clear about it and saying no, we’ll talk about this on Monday if it's clearly not important. If it is urgent, say I think you better contact the on-call person and talk about this with them and not try to do things all of the time because you just wear yourself out and you don’t do a good job.

 (Rural nurse participant 7)

 [...] people… in the community, they expect a lot of you – you’ll be down the street getting the groceries and if you worked in the hospital and that I mean I wouldn’t imagine that happens in urban areas that often that a patient would come up to you and say, now you know the other day when you did my blood… I think you’ve got to be a really level headed.

 (Rural nurse participant 4)

 [...] without being rude, you feel like it, you can’t because you know, you know you’ve got to see them at tennis or badminton the next day.

 (Rural nurse participant 17)

All rural nurse participants are aware of their own behaviour, presence and attitude to local residents in ‘place’ and in the case of the analysis associated with the theme represented in this Chapter, as the ‘location’ aligns with the first element of the nursing’s core concepts related to caring, ‘environment’, which refers to the isolation and distance rural people experience as they access and wngae in the rural health care services (Bushy, 2012). In addition it has been highlighted in this Chapter the nurses aspects aligned with a ‘sense of place’ (which has been analysed and presented in Chapter seven aligned with the nursing core concepts related to caring) and the rural nurses’ need to navigate their position in a way which ensures their practice is not compromised and the resident is respectful of how the rural nurse has handled their request. If the rural nurse does not handle this situation professionally it could result in the nurse experiencing moral distress and their integrity could be called into
question and potentially reduce the nurses’ relationship and integrity within the community which progresses the analysis in this thesis on to the second key theme ‘sense of change’ which is the focus of the following Chapter. In the meantime this Chapter will now be summarised.

5.6 Summary of Chapter

In this Chapter I have presented three key core themes and corresponding sub-themes analysed from the data which focused on how the professional identity of the rural nurse was constructed and how it has been analysed through applying Agnew’s (1987) first aspect of his ‘place framework’, ‘location’. Massey (1995) argues people and places have a relationship as people construct places, at the same time places construct human and non-human identity, behaviours and performances. Consequently people and places derive their identities from each other to a significant extent. Relationships between people and places are always in a state of becoming rather than of simply ‘being’. Therefore, identity is never static or singular but is always in a state of movement. One example of a relational identity was a ‘sense of difference’, which refers to the identity of rural nurse as being contested and associated with more complex power relations. What is meaningful to the rural nurse may be meaningless to others and, as demonstrated, contested as being different, which has led to presenting the analysis as a ‘sense of difference’ which is an imaginative response to identity construction. A short summary of key insights gained from participants were a ‘sense of difference’ aligned with the sub-themes; shared encounters in opposition with the imaginative rurality, and engaging with the rural environment including the associated issues related to rurality such as isolation and distance. The ability of the rural nurse to practice ‘in-between’ various locations and sites referred to as one of the nursing core concepts related to caring as ‘environment’, which benefits the community members and offers the rural nurse a flexible PHC practice which is discussed in detail in the following analysis Chapter referred to as ‘sense of change’ where social encounters emerge and are reflected by engaging with Agnew’s (1987) second aspect of his ‘place framework’, ‘locale’.
CHAPTER SIX: PRESENTING THE ANALYSES AND FINDINGS, FROM THE RURAL NURSES ‘SENSE OF CHANGE’ IN ‘LOCALE’

What community means is subjective. …community is a concept, process, and effect. It can lead to both social harmony and social discord. It is difficult to define, to see and to study. It can be both exclusionary and inclusionary at the same time.

(England, 2011: 103)

6.1 Introduction

This Chapter is the second of the three analysis Chapters that presents the analysis, and findings. It is in this Chapter that the second aspect of Agnew’s (1987) ‘place framework’, ‘locale’, becomes a focal point which is used to present the analysis and findings. The data presented in this Chapter are representative of both the regional rural nurse and national key informant participants’ and associated with the identified key theme ‘sense of change’ through answering the second research question (identified previously in Chapter four and later in this Chapter). This study has engaged closely with the regional rural Otago rural nurse participants and the data analysed has brought to the foreground the rural nurses’ motivations to adapt their practice and provide a health care model which demonstrates their commitment to sustain the health care needs of the local residents. This evolving model embraces concepts of community development and principles of social justice, which include self-direction, self-reliance and sustainability (Ife, 2013). These rural nurses needed to shift their thinking from a reliance on receiving direction from a traditional ‘top-down’ approach to one of local community control (Barnett and Barnett, 2001). On first impressions this change process was initially an approach directed by the National government in the late 1980s and was state controlled, which in this study has been further corroborated with the presentation of the national key informant participants’ responses. The national key informant participant contributions reflect the contextual issues and associated changes that occurred during the identified study
time period 1990-2000s, which may have contributed to the rural nurses’ professional identity construction. Likewise, excerpts from the rural nurse participants’ are also included as representative of those rural nurses’ who were a part of the restructuring as well as those who have taken up employment in more recent times. However, it is apparent that change was not solely ‘top down’ and in a radical rethink about how health care services could best meet the needs of the rural community residents, the local members of the rural communities and the local health care professionals also engaged with a partnership model and approached the planning and delivery of health care from a ‘bottom-up’ approach. This approach enabled the local residents and the rural nurses to utilise community knowledge (Ife, 2013) in an attempt to create a health care service aligned with providing a radical shift to the provision of rural health care, that met the community health needs and which reduced health disparities (one aim of the health care restructuring as discussed in Chapter two). These evolving models of rural nursing practice demonstrate working in collaboration with community residents and health care professionals. Once again a selection of photographs are engaged with to capture visually evocative expressions of place (Sontag, 1977; Madar et al., 2016) as representative of Agnew’s (1987) second element of his ‘place framework’, ‘locale’ which also includes nursing concepts of caring as related to ‘person and health’ (Torres and Yura, 1974) which further helps to frame up the analysis and findings throughout this Chapter.

6.2 Outline of Chapter

In section one of this Chapter I demonstrate the approach I have engaged with through the analysis and presentation of the findings, in which to understand how the professional identity of the rural nurse from the study location was constructed. The analysis and findings presented in this Chapter are guided by the second research question. The second core theme analysed from the data is illustrative of a ‘sense of change’ which is further framed around the components associated with the governing of the state, aligned with the neo-liberal changes (as introduced in Chapter two). The neo-liberal changes relate to the notion of a government that has a broader viewpoint than simply considering government as recognised as ‘the state’ and the regularity authority (Holmes and Gastello, 2002) but which also introduces an understanding of the management of society and the way in which individuals are governed at the
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‘micro-level’ and constituted into subject positions (Larner, 2000). Section one now engages with the approach I took to uncover the analysis and findings.

6.3 Engaging with the analysis and findings

Engaging with the analysis and findings in this Chapter has been guided by the second research question that sought to present the analysis and findings relating to how do rural nurses practice, and what is their contribution to the rural health sector? This question was discussed in Chapter four in which I debated the justifications as to the reason why the research questions were posed and the associated aims of the study.

As I progressed through the analysis phase the categories and sub-categories of analyses which were being developed, revealed that my original intention of examining the identity of rural nurses associated with their physical rural location (discussed in Chapters one and four) did not fully capture all that constitutes the professional identity of the rural nurse within the regional study location. This led me to further investigate how place was conceptualised in social geography. During this progression in the investigation I began to understand place as having multiple layers that combine together, encapsulating the essence of how place is understood. Place is relational, it comprises the physical, social, economic and political aspects of our society and is not a simple geography located on a map (Agnew, 2011). Considering place from this multidimensional position therefore becomes a social and political resource with flows and movements (Massey, 2005).

Initially, I connected with Cresswell’s (2004) work related to place in which he cites Agnew’s (1987) work. This led me to seek Agnew’s (1987) original meaning of place, which was published in “The Geographical Mediation of State and Society” I engaged with Agnew’s work seeking further clarification (by email) from Professor John Agnew whom I asked to clarify for me, his meaning of the association he was making between his use of the term place as ‘locale’ where social relationships are developed, both from within and beyond ‘location’. In response he stressed the connection social relationships have within and beyond ‘locale’ and related this to the substantive ties, which he aligns with ‘locale’. The substantive ties as expressed by
Agnew in his response to me, are associated “between people... and the rules governing their routine interactions [which] develop in specific physical locations and locales”. Agnew’s (pers. comm., 2008) reply assisted in my ongoing interpretation of the data specifically associated with the governing structures aligned with the rural nurse participants’ practice.

This Chapter also includes the key informant responses which are included as quotations in italics to differentiate them from the rural nurse participants’ contributions. These quotations are aligned in support of the contextual issues which occurred during the identified study time period 1990-2000s and provide further insight as to how the rural nurses’ professional identity was constructed. In the meantime a descriptive account of ‘locale’, as defined by Agnew (1987) is now presented in an attempt to further present the analysis associated with the identity construction of the rural nurse aligned with ‘locale’.

6.4 Rural nurses’ identity constructed through ‘locale’

I analysed a number of categories generated from the regional rural nurses’ data, which I identified through the relationships which exist between the rural nurse and place including the social relations which develop and constitute the identity of the rural nurse, attributed to ‘locale’ as defined by Agnew (1987). Figure 6.1 below is representative of the ongoing process of building up the diagrammatical ‘matrix’ aligned with Figure: 8.1 in the ‘performance phase’ and Figure: 8.3 in which to complete the ‘place based-analytical matrix’ in Chapter eight. Equally, Figure: 6.1 the ‘Place Framework’ denates ‘where local social relations develop both within and beyond location’ and is also representative of the nursing concepts of care (Torras and Yura, 1994) which is pictorially represented as ‘person and health’ associated with the red rectangle in this diagram. The second of the three key core themes is interpreted from the data and analysed and presented in this section of the Chapter to convey a ‘sense of change’ associated with the rural nurses’ evolving models of nursing practice and community development. Working in partnership with community members and health care professionals both within and beyond ‘locale’ is discussed in relation to a restructuring of a health care system and is supported with data from the participants’.
Figure: 6.1 ‘Place Framework’ depicting ‘locale’- where social relations develop within and beyond location
Source: Compiled by the author
6.5. The second key theme a ‘sense of change’

The second key theme, a ‘sense of change’ has been identified as a core theme from the data collected and relates to the participants’ awareness of a number of changes, which occurred during the study period. A sense of change connected with the rural nurses’ practice and their professional identity emerged in response to developments within the rural study location’s community and the parallel advances that took place in national nursing practice. These relationships are developed both within and beyond the rural community while drawing on the analytical insight offered by the second part of Agnew’s (1987) ‘place framework’, ‘locale’.

The concept of change in any situation is a contentious concept and can be met with a number of diverse responses from different people in which Bozak (2005) contends that change is inevitable and is occurring all of the time, and it is noted that nothing is static. There are degrees of change, which may occur at the micro-level and which can extend through to the macro-meso and nano-levels. Associated with these changes is the response from those individuals who are affected by the change process who conventionally ask why a change is necessary? And, furthermore, ask about who is instigating the change process? These questions posed by individuals are typical responses and are recognised as part of the change process (Jones, 2012). Individuals and groups can associate change with both negative or positive attitudes and concerns as to how the future may transpire. Likewise, change may be resisted and considered as difficult and unnecessary (Jones, 2012). Alternatively, change may be embraced as essential, dynamic and necessary for future success and the sustainability of the organization or practice and, in the case of this research, the rural nurses’ practice as a community health care sustainable model.

The implementation of change may result in resistance from people as a result of a fear of the unknown or they could be afraid of failure. Using Lewin’s force field or change theory as a point of reference is a useful framework that can assist understanding of the change process. Lewin’s model comprises three stages: the unfreezing, moving and refreezing stages (Lewin, 1952; Bozak, 2003; Burnes, 2004; Jones, 2010). The intention of the model is to identify factors that can impede change from occurring and to take note of the driving forces necessary for successful change.
to occur. In this process open communication is required as well as participation in recognizing and responding to the change process and equally as individuals become involved their commitment to the process will benefit the success of the planned change (Jones, 2012).

In this retrospective interpretive study some of the rural nurse participants from the study location were actively involved in the change process which was aligned with the restructuring of the health care system, during the 1990s. This change process can be attributed to the first of three of Lewin’s stages associated with his change model, the ‘unfreezing’ stage (Lewin, 1952; Bozak, 2005; Jones, 2012). The ‘unfreezing’ stage associated with this study initially occurred during the late 1980s with the restructuring of rural healthcare (as identified diagrammatically in Figure: 2.1 in Chapter two). Examples represented from the ‘unfreezing stage’ include, changes to the funding and overall practice of rural nursing in the community, in client’s homes and the provision of ‘24 hour’ health care, including emergency care. This in turn led to the ‘moving’ stage (which will be presented in the ‘performance phase’ in Figure: 8.1 in Chapter eight) during the latter part of the 1990s and early 2000s and then into the ‘refreezing’ stage which commenced from the mid-2000s onwards which is further discussed and diagrammatically represented in Figures: 8.2 and 8.3 (respectively) in Chapter eight.

Over time innovative models of practice were developed by some of the rural nurse participants. However, not all of the rural nurse participants’ were a part of this change process. Some of these participants entered employment in this regional location in more recent times and presented alternative experiences and backgrounds to the rural nurses’ who were employed during the changing and at times controversial time period (discussed later in this Chapter). Initially these changes where recognized as a result of the establishment of the neo-liberal transformation in the country which brought about by the restructuring of the health care system led by the Labour-Coalition government in the late 1980s. In the early 1990s the National led government continued with these reforms (Barnett and Barnett, 2006). Further restructuring of the health care system in 2001, was dominated by the ‘Primary Health Care Strategy’ (Ministry of Health, 2001). First, I will present how the change process occurred by engaging with the participants’ who were part of the healthcare
restructuring process during the 1990s and the early part of the 2000s. In bringing to
the foreground the original rural nurses’ experiences I am able to demonstrate how
they went about adapting their practice from that advocated by the more traditional
practice models, while contributing and developing new approaches through which to
provide contemporary rural health care services.

The following categories were analysed from the data, and make-up the subthemes
associated with a ‘sense of change’, and include; evolving models of rural nursing
practice and the identification of the rural nurse with the local rural community.
These models of practice provided an opportunity for the rural nurse to further adapt
and advance their practice in accordance with the rural communities’ vision and
direction that met their health care needs. These opportunities were initially aligned
with RCTs (Barnett and Barnett, 2001) in the early part of the 1990s, PRIME in the
latter part of the 1990s and the ‘Primary Health Care Strategy’ (Ministry of Health,
2001) in the early part of the 2000s. These categories also include the rural nurses’
awareness of a particular community’s social and cultural characteristics, as well as
the social and professional collaborative relationships which occur both within and
beyond ‘locale’. These subthemes are now engaged with, commencing with a
presentation of evolving models of rural nursing practice.

6.5.1 Evolving models of practice aligned with Rural Community Trusts

The analysis and findings associated with this subtheme demonstrates that rural
nursing practice is performed in numerous sites of practice. These nurses are
positioned to practice in one or more of these sites, referred to as formal models of
practice. The data analysis suggests nurses actually present and practice within other
sites as well, as an everyday occurrence, for example within client’s homes, general
practice clinics, and in the local rural hospital. Informal models of practice have also
been discussed (in Chapter five) within a range of locations in the community, for
example in the local shop, and at sporting events which highlights an opportunity for
rural nurses’ to practice in diverse ways. Further themes analysed from the data
illustrate that the rural nurses’ practice was evolving into new models as they engaged
and worked in partnership, initially aligned with RCTs (Gauld, 2000; Barnett and
Barnett, 2001) following the philosophical shift from state welfare to a neo-liberal
approach to the delivery of PHC (Ministry of Health, 2001) as illustrated throughout the remaining parts of this section of the Chapter.

The rural nurses’ practice evolved in response to international, national and regional changes. The global economic downturn of the 1980s and 1990s resulted in major health care restructuring in New Zealand (National Health Committee, 2010). A shift of ideological thinking was a result of these changes from one of a state welfare approach (which had been the dominant ideology since the late 1930s) to a neo-liberalist ideology (Oliver, 1988; Dalziel and Saunders, 2014). This shift in thinking began to influence government policy and the provisions of health care funding from the 1980s (Ife, 2013). Detailed accounts of the health care restructuring in New Zealand and in particular the study location was introduced in Chapter two and are further analysed and elaborated on in this section of the Chapter.

A ‘sense of change’ became evident from the data, which was indicated by the participants’ who had been a part of the ‘change process’. Both the rural nurse and key informant participants were aware of the changes associated with this shifting ideological drive that changed the delivery and funding of rural health care, from one of state and GP control to local community control and effectively self-governance (Barnet and Barnett, 2009). Local control was shared between the state and locally self-managed institutions in a response to a call to provide community health care, initially through the establishment of RCTs (Gauld, 2000; Barnett and Barnett, 2001) in the 1990s. The RCTs were representative of the local rural community residents and consisted of a number of the health care professionals who practiced in these communities (Barnett and Barnett, 2001). The intentions of the RCTs were to identify the health needs of their community residents’ and to plan and manage health services and evaluate the outcomes (Barnett and Barnett, 2001; National Health Committee, 2010). Instead of these services being governed nationally the governance of these services, was transferred to that of community control. This governance was directed from the state to the community and became the responsibility of the community residents’ to decide on what services were needed and how services would be delivered and by whom, subject to regulation, legislation and professional obligations. For example RCTs could be found operating within the rural Otago region (identified in Figure: 2.2 in Chapter two).
The intention of transferring the governance to a partnership arrangement between the rural community residents and the rural nurse aimed to develop a health care service tailor-made to accommodate local residents’ new acceptance and engagement with the health care service. Health care professionals then become responsible to the local community in which they recognized the value of local knowledge, wisdom and expertise and understood that universal knowledge cannot simply be applied to the rural community, as their context needs to be included. Health care professionals and policy-makers often undervalue local knowledge (Ife, 2013). However, in New Zealand, some rural communities from the regional study location were successful in maintaining local access to a range of health care services which when combined with strong community leadership and committed local professionals, have aided in the retention of local facilities and led in some cases to improved community satisfaction.

Initially, as this change process was taking place, community residents and the health care practitioners did not have a lot of say in the implementation of the change process, as this was directed by the state. However, over time, this change process shifted the balance of power with the state and discipline governing from a distance, while the local community residents’ were placed in a position to govern their own health care services as discussed by Barnett and Barnett (2001). These themes were highlighted by some of the participants, especially those who had been in rural practice at the time of the actual health care restructuring and had experienced variations to their practice in which they responded to the changes.

A reflective process helped identify how participants expressed and articulated their understanding of the development of their practice, while revealing how their professional identity was being (re)-constructed. Nurses have often, in the past, been forced to change their practice to accommodate organizational requirements without having the opportunity to give input, which may have eroded nurses’ trust in organisations (Bozak, 2003). However, some of the rural nurse participants from the study location were in fact associated with the changing delivery of community health care with the development of RCTs during the 1990s.

The following participant and I engaged in an interesting dialogue when I asked how do rural nurses’ practice? (associated with the first part of the second research
question). I was interested in how their practice had evolved given the health care restructuring and the consequence of these changes. Her response was:

[...] because the hospital closed and poof, there’s nothing there. The few of us left that wanted to carry on working... we didn’t know what we were supposed to do, we didn’t know what we shouldn’t do so we did what we thought we should do rather than being based on, this is the way it is.

(Rural nurse participant 7)

I was attracted to learn more about the development of the rural health care services and asked her to further expand how the health services developed during the time of the healthcare restructuring. The participant’s response signalled that the evolving models of nursing practice was driven by having local knowledge of the community and the way in which this knowledge was assessed through being a local member of that community. The evolving models were driven by a ‘can do it’ attitude rather than by putting boundaries around traditional practice models, such as practice nursing associated with the general practice clinic or typically district nursing in which the nurse’s practice relates to clients in their home. The evolving models of practice aimed to offer and maintain a quality health care service identified from this analysis as being based on the flexible nature of rural nursing practice, by acknowledging community residents’ health needs and providing a health care service that was responsive to the local community. Identifying with a local community was also noted as a key change by one national key informant representative associated with a national nursing organisation. This key informant noted that the philosophy underpinning the rural nurses’ practice resembeled what would become the focus of PHC years later. This key informant emphasised that community involvement in the planning and delivery of health care was aligned with nurses and in particular rural nurses’ contribution to the delivery of this health care in the community which is further affiliated with ‘locale’ as discussed by Agnew (1987):

*I think a lot of that’s [working towards community involvement in health care] got to do with the fact that we were looking at a primary healthcare strategy which had it’s basis on communities, population, health the very thing rural nurses are sitting ducks for really, it’s exactly what their work is...*

(Key informant interview 14)
A discussion of the findings relating to how the rural nurses’ identity was constructed in ‘location’ through formal and informal models of practice was presented in Chapter five and this has been further elaborated on in this Chapter with reference to RCTs. The sense of change and the evolving models of rural nursing practice are now further built on in this section, which now considers community engagement.

The focus on community has been recognized in this research as an important element in the redesign of rural nursing practice and further identity construction. This association with community was further revealed as I worked through the analyses and this is examined in this section dedicated to community engagement. The term community in its fullest sense is characterized as being geographical and functional, including engagement with on-line communities (Ife, 2013; McMurray and Clendon, 2015). What is interesting about the relationships between people in all types of communities is that they are involved in human interaction and a sense of belonging and a commitment to contribute, which binds community residents together while recognizing the,

unique characteristics associated with that community, which will enable people to become active producers of that culture rather than passive consumers, and which will thus encourage both diversity among communities and broad-based participation.

(Ife, 2013: 114)

Therefore, for successful change to occur, the members of a rural community need an understanding of the particular environmental, social, political and economic aspects associated with the community and its sustainable existence (England, 2011). Members of the community need to be engaged and in a position to fully participate, collaborate and communicate with residents and non-residents. Ife (2013) notes that community development can be more effective and straightforward in rural communities. The rationale for this is that the rural community have a small and generally constant and committed population that have definite connections with their community. Rural community cohesion is recognized as one main feature in times of crisis and residents ‘pull’ together, “where new alternative community structures will more readily emerge, because such structures are not greatly different from people’s experience” (Ife, 2013: 117). Successful rural community cohesion aligned with the
provision of health care in New Zealand necessitates a sense of commitment and involvement from the local residents and health care professionals who have the ability to offer a flexible, integrated model of service, under the direction of local community leadership (Barnett and Barnett, 2001; Bidwell, 2001). However, it is important to note that not all residents from a rural community will agree with all of the decisions made by its members in relation, to how to progress and plan future community development.

The study participants demonstrated that, at times, they responded by adapting their practice with the changing delivery of rural health care services. Community health care evolved in response to the changing health care system over this period. These changes highlighted a greater awareness of how best nurses were positioned to nurse the community, and required nurses to offer a healthcare service that was innovative, appropriate and collaborative. The following key informant continues with this line of thought and noted that rural nursing was fundamentally founded on the principles of PHC and a model which could be duplicated in urban regions which associates with ‘locale’, as discussed by Agnew (1987) in relation to enhancing social relationships both within and beyond community:

_I see now in terms of where we are going with primary healthcare, that rural nursing really has become I believe the blueprint for how we should be delivering nursing to communities and populations as a whole._

(Key informant interview 14)

To achieve these outcomes rural nurses adapted and advanced their knowledge and clinical skills to meet the rural community’s health needs and their circumstances in which evolving models of practice emerged.

6.5.2 Evolving models of practice aligned with PRIME

Participants’ identified evolving models of rural nursing practice during the restructuring of the health care service such as the provision of ‘24 hour’ on-call
health care. The provision of on-call health care may range from palliative care\(^{18}\); wound management to acute presentations, emergencies including accidents, such as, motor vehicle accidents involving local community people, visitors and tourists. On-call rural nursing practice also includes, for some rural nurses, practising as a PRIME provider (discussed in Chapter two) and responder for medical emergencies. This provision of emergency health care ranges from trauma, to medical, mental health and maternity emergencies. Horner (2008) explains that PRIME includes health care provided by the rural nurse over a ‘24 hour’ period, seven days a week (related to an out of normal work hours situation, traditionally related to being on-call).

The PRIME model relates specifically to rural practice and is identified as specific knowledge related to emergency and on-call events that occur in rural locations. PRIME training is not discipline specific, both rural nurses and rural GPs are educated together and receive the same training (Ministry of Health, 1999a; 2002a; Horner, 2008). There is no difference between medicine and nurses’ expected practice, outcome and demonstration of competencies as a designated PRIME provider. This on-call provision of health care is a component of some rural nurses’ practice while offering the rural nurse another point of difference to urban nursing practice highlighted in the previous Chapter. The aim of PRIME has been to develop a structure around the provision of an emergency after-hours health care system in rural New Zealand, with the aim to improve health care outcomes. The health care practitioners who provide PRIME are required to initially complete a specific training schedule, which was commissioned by the SRHA in the mid-1990s.

The significance of the establishment of the PRIME training and the rural nurse is that PRIME training was initially trailled with fifteen rural nurses, as a component of their postgraduate rural educational course through the University of Otago (discussed in Chapter two) in 1998. Initially PRIME was provided in the SRHA region in 1998 and then in 1999 was rolled out nationally to rural New Zealand (Horner, 2008; Howie, 2008). PRIME is still, to this day, an ongoing significant delivery mechanism of emergency health care in rural New Zealand which is provided by both GPs and rural nurses, including some of the study participants.

\(^{18}\)Palliative care is concerned with the delivery of the best possible health care to a person who is experiencing an end-life situation (McMurry and Clendon, 2015)
The introduction of the provision of PRIME has been met with some resistance by some of the participants typically the more recently employed rural nurses to the regional study location. Concerns were raised by some of the participants as they become aware that there was an expectation made by their employers and GPs that PRIME is or should be a component of the rural nurses’ routine practice. Therefore on-call is provided by all rural nurses as a norm, rather than an exception, as highlighted in the following excerpts. Working as a PRIME provider has enormous consequences for the rural nurse and just because some participants have undergone the PRIME training and successfully completed it, does not ensure they feel competent to practice these skills in isolation in rural locations. Ensuring they are competent and can maintain competencies in emergency care is essential (Horner, 2008).

Those of the participants, who discussed PRIME also considered that additional and ongoing training including opportunities with face-to-face education is required to improve their competence level as PRIME providers. It is because of these considerations that several participants decided not to be involved and do the PRIME training, because they were either, not interested, did not feel competent or felt the legislation did not support them to practice to the intense degree required. The participants responded to this aspect of their practice differently from each other as is illustrated by the following excerpts:

I’ve done the PRIME training for a week and I think that’s really good but I also think that, like while I was doing the PRIME course I kept saying to everyone, you know everyone kept saying, now you can decompress the chest and now you can intubate someone and I kept saying, no, no you can’t. This is like a tiny little, the first step into being able to learn to do those things but I think there needs to be heaps more, heaps more training. Like they’re thinking of, we’re allowed to do on-call. As soon as you’ve done your PRIME you pretty much get your certificate and now you’re allowed to do on-call but really I don’t think it should just be a, it’s not necessarily a license to just go and do on-call.

and

[…] sometimes during the week we’re left here and we’re given the on-call pager and the St John’s pager and like a few times the doctors just gone off sort of an hour away and he’s like okay, I’m just going for the afternoon, you’re it and you have to stay here and the whole time you just sit here, cross
your fingers and I think, okay, please nothing happen because it’s pretty much you. You’re the only person.

(Rural nurse participant 3)

Yep. I’m happy to do it [PRIME] but I’ve also been told its kind of part of the job as well.

(Rural nurse participant 2)

The following national key informant participants representing a national organization associated with policy development knew only too well of the implications national policy or strategy could have when developed to accommodate both the provision of urban and rural primary health care. The inside knowledge is in complete contrast to the rural nurse participants’ contributions as discussed previously and yet again is representative of ‘locale’ as discussed by Agnew (1987):

[…] we expect rural healthcare providers to be able to take part in emergency responses and instantly... PRIME is a pretty neat thing.... I think for nurses and doctors to be trained to do that and play that part is quite interesting... that’s another example of that, of how they work in a different way to those nurses working in urban environments.

(Key informant interview 5)

They’ve [rural nurses’ have] been particularly important in more recently involved in after hours services so that’s also been an important area for them to play an increasing role... and this is the after hours primary healthcare working party report it does mention there a particular comment on the place of nurses and the need to be part of a planned service and part of a team’s backup rather than be left to work in isolation.

(Key informant interview 8)

As the practice of rural nurses evolved into new models so did their recognition of their changing professional identity associated with their traditional occupational title and this is now introduced.

6.5.3 Rural nurses’ professional identity associated their occupational titles

Rural nurses traditionally were associated with the traditional titles representing community nursing practice, including the more recent development in the late 1980s of the occupational identity of the practice nurse that is associated with community
nursing in the general practice clinic alongside the GP. The community nursing role is associated with district nursing, whose practice is aligned with nursing within the patients’ or clients’ own home and public health nursing specifically relates to health education and promotion in the community and in schools. What became evident throughout the analysis was that several participants identified themselves as the RNS rather than with the traditional titles of practice nurse, district nurse or public health nurse. The significance of rural nurses’ identifying as a RNS demonstrates that in their considered opinion, they are associating their practice in relation to specific rural encounters in the specialist aspects of their practice.

i. Rural nurse specialist

A specialist is viewed as being an expert in a particular field (Jones and Ross, 2003) for example urology nursing\(^ {19} \), or a focus on the older person (Nursing Council of New Zealand, 2001) and considered as a specialty aspect of nursing practice. In the case of rural nursing the location is the focus which highlights the specialist aspect of the rural nurses’ practice as defined by the research associated with Litchfield (2001); Jones and Ross (2002); Barber (2007) and O’Malley et al. (2009). Defining what this specialist area of practice comprises is debated within nursing as highlighted in the following participant excerpt:

[...] you’re expected by your urban colleagues to be specialists in everything, to the same level that they’ve obtained. And at times they can be very critical of you if you don’t achieve that… that criticism in itself can be very wearying and it can be very destructive to your professional self-worth and you have to constantly tell yourself that the work you do is valued and it’s good and that you don’t have to be a specialist in every single aspect of the care that you do as long as you know how to access the more advanced knowledge.

   (Rural nurse participant 5)

Rural nurses perceive that urban nurses consider they should know everything associated with their specialty practice to the same degree as nurses who specialise in one aspect of nursing for example, pain management in which “the dimensions of specialist practice as narrow and deep” (Jones and Ross, 2003: 7). When rural nurses fall short of this knowledge, urban nurses criticise them as is highlighted in this

\(^ {19} \)Urology nursing is concerned with nursing people experiencing urinary symptoms.
excerpt. In contrast the rural nurses justify that their practice does not have to be specialist in all aspects in fact they consider their practice as a generalist/specialist in that the generalist component of this practice represents a broad scope of knowledge, skill and competence (O’Malley and Fearnley, 2007; O’Malley, et al., 2009). Rural nurses’ practice is associated with the population from birth to death including the promotion of health, acute and emergency care, chronic, rehabilitative, and palliative care (Jones and Ross, 2003). In this context, the specialist aspect is seen, by them, as being associated with the knowledge associated with the rural location:

We’re not specialised which can limit you if you are doing a specialised sort of course and you know working in a particular ward in a hospital they could call you an expert or whatever.

(Rural nurse participant 2)

Rural nursing was identified as a specialist domain of nursing practice and some rural nurses and their employers refer them as the RNS. It has not, however, been an easy task to understand this specialty area of practice. Appreciating the development of the role and how its contribution could improve the delivery of rural health care has been a core focus of this research. There has been significant discussion both within the profession and between rural nurses and the NCNZ and the national nursing organisations (which are related to the social relations that are developed beyond the ‘location’ and represented as ‘locale’ as representative in the following key informants’ contribution) associated with recognising rural nursing as a ‘specialty’ area of nursing practice while highlighting the particular competencies which underpin this area of practice (Jones and Ross, 2002; 2003). One key informant representative of a national nurses’ organisation, expressed that:

The words around primary healthcare were sitting there but then nobody really understood that. In the middle of that transition between a nurse who had worked in rural practice for many years and then wanted postgraduate qualifications whether it was on a framework as a nurse practitioner or not, there was that huge missing gap that required a transitional time, a transitional period and I don’t think primary healthcare in its real sense really became a part of that.

(Key informant interview 14)
In the study region the rural nurses’ role was established to accommodate the needs of individual communities as illustrated above in the time period from the 1990-2000s. Rural nurses have raised their concerns that this specialist role was developed in an ad-hoc manner and was seen by some as an add-on to the traditional roles of community nursing practice, including district nursing and practice nursing. The concept of the RNS role was developed during the time when the new evolving models of rural nursing practice were developed to accommodate changing rural health care and funding structures, including the community residents’ involvement in the form of RCTs and PRIME.

The overall concern associated with employers or policy-makers is with the notion that these rural nurses extended their practice to accommodate practice areas that were not being attended to, mainly because of difficulties associated with the retention and recruitment of other health care professionals, including medicine. Despite rural nurses accommodating these demands which were included as a component of their practice, it is demonstrated that the real work of rural nurses was overlooked when external agents sought to address the gap in the availability of some aspects of the provision of health care, for example providing after hours health care and emergency service (as discussed previously in relation to PRIME). These challenges impacted on the further development of rural nursing, and several rural nurses were concerned that the true value of rural nursing was misrepresented to fill a gap in the health care system, as highlighted by the following excerpt:

It’s [development of rural nurse specialist] grown differently in different areas in response to the needs of different areas. Some areas have looked at like in Otago most of the areas are looking at rural nurse specialists, as add-ons to the practice… I think that those employing rural nurse specialists are likely to just see them as somebody who they can just ask to do more and more and more without looking at the whole complexity of the role... it’s so easy for I think, people who are employing them, whether they be trusts or DHBs, just to land another thing on top of them because you know, well after all they’re just an extension of the district nurse so they can do this as well but they don’t see the whole role and the whole depth of the role… which match the competencies for advanced practice and I think if you’re going to call somebody a rural nurse specialist, they need to meet those type of competencies.

(Rural nurse participant 16)
The majority of participants’ bore out the earlier assertion “that rural nursing is a ‘specialty’ in that there is a specific focus, body of knowledge and practice” (Jones and Ross, 2003: 7). The specific aspects are associated with this body of knowledge that links to rurality (previously discussed in Chapter three). The rural physical location is a prominent feature of the rural nurses’ understanding of their practice, coupled with living and working in close proximity with community residents which defines and unites their practice as rural nurses. It is the rural context that allows the rural nurse to come to terms with practicing in this unique environment (Jones and Ross, 2002) and recognizes their practice as a ‘specialty’, which according to NCNZ is situated at level three and four of the ‘Framework for Post-Registration Nursing Education’ (Nursing Council of New Zealand, 1999).

There are four levels of practice in which level one includes the beginner level of practice, level two is referred to as a competent practitioner in which the rural nurse is beginning to build on nursing knowledge in maintaining and improving health care of clients’ in the rural context. Levels three and four are established as specialty nursing practice and are recognized as a proficient practitioner who is in a position where the person is expected to manage complex client care and who “demonstrates experience and confidence in clinical skill and autonomy, they require minimal guidance, and undertake increasing responsibility for complex patient care… within the primary healthcare team” (Jones and Ross, 2002: opposite page 10). Level four acknowledges expert practice and is aligned with advanced nursing practice. A tension exists between how rural nurses define, describe and perform their practice and the intent of NCNZ levels of practice in the ‘Framework for Post-Registration Nursing Education’ (Nursing Council of New Zealand, 1999). This framework articulates specialty and advanced practice as different practice levels, which include different competencies and educational requirements to attain these practice levels. To practice at levels three and four, is a judgment call (by NCNZ), indicating whether a nurse practices at one level or another, and if they have acquired sufficient education (at postgraduate level) and if the nurse can demonstrate the competencies related to this level. Although some rural nurses use the term ‘specialty’ to describe their practice, they may not actually meet the NCNZ’s educational requirements or preparation to practice at this level.
Some of the participants discussed their engagement with postgraduate education in which they mentioned that they had been confronted by some community residents as to how they would apply their new knowledge in the community and whether this education would allow them to be either a ‘doctor’ as expressed in the following excerpt, or a ‘mini-doctor’ as highlighted by one rural nurse participant as she encountered other rural nurses who expressed their concern over the level of their practice. What is interesting about these two excerpts is the link between postgraduate education and ‘specialty’ practice, which comprises the ongoing development of clinical skills in which to practice rurally, at an advanced or specialist level (Maw, 2008). In parallel with the clinical content of postgraduate education is the theoretical knowledge, which supports and further advances the development of nursing knowledge. Participant’s reflected on their advancing practice, which is demonstrated in the following two excerpts, in which they interpret that by engaging with this level of education they are now able to provide deeper and more holistic health care as discussed in the following excerpts. Advancing practice leads to an enhanced understanding of the professional identity associated with the rural nurses’ evolving models of practice:

I am asked by my patients are you a doctor now? No, I’m not a doctor. Well what’s the difference do you get more money? No I don’t get more money. I just give deeper care.

and

I think I just sound like a mini doctor, they’re [community members] just going to turn around and say I sound like a mini doctor and you know, I’ve been able to turn around and say, hey, come on, you’re into advanced practice. You [the rural nurse] of all people bring with you that holistic, caring stuff where you look after not only the patients but the family and the aunts and the uncles.

(Rural nurse participant 16)

Evolving models of rural nursing practice led to an, awareness, that rural nurses from this location had received a national political recognition from within the profession of nursing, NCNZ, politicians, and educators and locally with the community members and health care practitioners. This in turn provided rural nurses with the opportunity and ability to articulate within local, regional and national forums, the significance of their practice and contribution to the rural health care sector and of the
importance of the rural perspective. Rural nurses’ were identifying themselves as a defined specialty and their professional relationships in ‘locale’ were becoming more visible during the latter part of the 1990s and early part of 2000s, both within and beyond the rural community as their practice became more self-governed, which was in alignment with the philosophy underpinning the ‘Primary Health Care Strategy’ (Ministry of Health, 2001).

The following key informant participant representing a national organisation associated with policy development summarised that the health care reforms and rural nursing are succinctly entwined as one has benefited from the other:

[…] being a participant in this [research study] has really made me think for the first time in all seriousness about the unique situation of rural nurses. …through this [research] process I can actually learn about the actual extremes of rurality that nurses are facing is a bit of an eye opener really so for me... working on and they’re generally sort of macro policy issues around our primary healthcare strategy I’m kind of grateful for that ability to reflect on this a bit more.

(Key informant interview 5)

This key informant identified that there are situations in which the rural nurse experiences a level of difference between urban and rural practice and the development of PHC in which nurses’ contribution would benefit the success of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001). However, the key informant participants suggest otherwise suggesting that what resulted in the early part of the twenty-first century was a move away from this thinking which signalled rural nurses as specialist and ultimately built up the demise of the concept of the rural nurse in support of one PHC model fits all (including both rural and urban practice) resulting in the dominance of urban practice and the decline of the professional support of rural nursing as a speciality. This line of enquiry is discussed further in Chapter eight. In the meantime the evolving model of rural nursing practice aligned with the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) is now discussed.
ii. Provision of rural primary health care nursing

The following key informant, who was attached to the development of health policy, gave the impression that the provision of rural PHC was meeting the needs of the community residents, in models that were flexible and less bound by rules and regulations in comparison to urban PHC. While in the second excerpt from the same key informant, the participant considered that a flexible approach to providing health care was a successful model in which health needs of the local population were met, which aligned with the previous three key informants’ considerations:

[…] a greater freedom and there are less kinds of rules and regulations or proper ways, you know they don’t have to be bound by ways of doing things.

and

I think people in rural areas they’re leading the development of the primary health care strategy and have been, I mean anticipated in lots of ways simply because that’s been the best way of working and it makes sense… It’s much more conducive to the sort of the philosophy of the primary health care strategy which is very much about community based, community development, … rather than … being described or prescribed… from outside… I think the sort of sense of control and sense of empowerment that rural communities often have, because people have to do things for themselves and they’re less reliant on sort of government in many respects and they’re more used to taking their own course...

(Key informant interview 3)

The following key informant was a rural practitioner and representative from a national organisation knew only too well of the implications national policy or strategy could have when developed to accommodate both the provision of urban and rural primary health care. The inside knowledge is in complete contrast to the next key informant’s contribution who challenges urban dominance and again aligns with ‘locale’ as discussed by Agnew (1987):

[…] they [the Ministry] had the primary care strategy that was coming out but when you open any of these documents, where does rural sit? Is it in your face? No it is not. Is it something that everybody wants to forget because it’s in the too hard basket or it doesn’t have, what’s that business language, it doesn’t have the volume. The mass volume I can’t remember the fancy language off the top of my head. It doesn’t have that to fit the business framework. You know it doesn’t make sense. The people that are there doing
the work, given the opportunity to talk about what it means to be a nurse in a rural community, what does that mean to me, I live here I’m part of it.

(Key informant interview 10)

The following key informant participant who was representing a national organisation expressed an understanding of the contribution rural nurses made to their rural communities in relation to the PHC philosophy as follows:

[...] rural nursing has really been the beginnings of practice nursing in New Zealand and really what I see now in terms of where we are going with Primary Health Care, that rural nursing really has become I believe the blueprint for how we should be delivering nursing to communities and populations as a whole.

(Key informant interview 6)

This key informant illustrates that rural nurses, in their attempt to offer a community health care service, they have developed a beneficial model which should be drawn on by non-rural nurses. Further discussion related to the ongoing evolving models of practice is now presented.

6.5.4 Evolving models of practice aligned with the ‘Primary Health Care Strategy’

The continued evolving models of rural nursing practice described by these participants further evolved during the 2000s with the establishment of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001; Litchfield, 2001). The following national key informant who was aligned with the development of health policy, understood rural nurses as having a less traditional focus to their practice in which they have flexibility and practice within governance structures that are less rigid with:

[...] fewer barriers to doing things differently if you’re [the rural nurses] in a rural area... it’s because there aren’t alternatives you know and you have to be creative and you have to think how...what makes sense here, what’s the most efficient and effective way to serve a population that might be dispersed or home bound... you don’t have the sort of either the [name removed] bureaucrats or your sort of district health board saying that it must be done this way and we’re sending out people to make sure that you know, you’re filling the terms of your contract or your scope of practice. I mean I think a lot of the creativity comes from the fact that you’re not having to meet or confine yourselves to you know traditional ways of doing things.

(Key informant interview 3)
The changing ideology of the New Zealand Labour government in the 2000s reinforced the ongoing evolving models of rural nursing practice that originated in the 1990s and led on from the more traditional models of practice. These evolving models of rural nursing practice was necessary in which to support “a strong primary health care system… [which was] central to improving the health of New Zealanders and, in particular, tackling inequalities in health” (Ministry of Health, 2001: vii). In the early part of the 2000s this belief led to a significant change nationally in how health care was to be planned, delivered and funded in all community settings.

The New Zealand Public Health and Disability Act 2000 gave DHBs responsibility to ensure the provision of health care within their region was appropriate, accessible and affordable for their population’s health needs (Matheson and Neuwelt, 2013). In doing so, each DHB were to assess the health and disability needs of their defined populations. It was believed that the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) would guide all (at that time) 21 DHBs in New Zealand to achieve health gains by identifying inequalities in health and establishing appropriate health care services to manage health needs so as to reduce health inequalities. The government expected that implementation of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) would ‘evolve’ over five to ten years and within this time frame a flexible approach to developing new initiatives, and models of practice were to be expected. Despite this, certain criteria for early success were set and included, reducing financial and access barriers for population groups with high levels of health care needs and supporting new initiatives for health delivery, including multi-disciplinary health care, which characterized this phase.

From the early 2000s to the current day, planning, funding and governance has shifted from the state to the regions as a component of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) and the associated development of PHOs (Mackay, 2008). In this context, support of PHOs and the enrolment of populations were necessary for success. PHOs were and still are responsible for providing health care services in the community which meet the health care needs of the population in which they serve, the ‘enrolled population’ (Ministry of Health, 2001). ‘Enrolled populations’ are linked to the PHO via a general practice health centre or clinic. Individuals enrol with
a general practice clinic and receive subsidised health care, via government funding through the administration and responsibility of a PHO (discussed in Chapter two).

Further changes to the delivery of community health care, guided by the principles set down in the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) from the 2000s onwards, has required community residents and local health care practitioners, including rural nurses to be a part of this change process (Mackay, 2008; Matheson and Neuwelt, 2013). Ultimately the changes associated with these governing structures provided rural nurses’ with an opportunity to develop and govern their own innovative models of practice (Mackay, 2008; McMurray and Clendon, 2015). Innovative models of practice will be demonstrated in this section of the Chapter and supported with data from the participants. Throughout this time period there was little guidance or direction, professional support, career development and education from the profession resulting in a lack of collaboration amongst rural nurses themselves, both nationally and internationally (Mackay, 2008). Also, at this time, development of the rural nurse’s role and their professional identity was an evolving process moving into an unknown territory and could be considered as an ad hoc development of innovative models of practice, which were aligned with community development.

The following areas were identified from the data collected and illustrate the most dominant sub-themes and include community partnership and adapting practice and professional teamwork, which all relate to the broader key theme ‘sense of change’. These subthemes are all identified by the participants in the study as necessary to ensure the successful outcomes for the delivery of rural community health care. The following excerpts analysed from the data, highlight the views of nurse participants’ who were part of the changes of the restructuring of the health care system, they became aware of adapting their practice to accommodate the diversity of community requirements and health needs, including supporting their colleagues workload, patients requests, funding for health services, lifestyle and work philosophies. The evidence gathered implies that evolving models of rural nursing practice were associated with the collaborative relationships the nurse had developed with the members of the community and local health care professionals:
I think it’s coming from being local in your own community and understanding your community. I don’t think it was nursing driven. I really don’t. I mean it’s hard to say because it just happened. It’s pretty hard to really analyse why it happened the way it did but there’s always been a very close relationship with the general practitioner and the district nurses. Like for example, you’re out on district and you suddenly get a ring on the cell phone look so and so has rung in and we can’t get an appointment, can you pop and check whether they really need one? And you go in, oh yes, you don’t look too good, right, do the observations. Ring up, yes I’m actually calling the ambulance...

(Rural nurse participant 7)

I think it’s… working together to develop systems that work for the community… I think nursing, I think communities, the older parts of the communities think it was the doctor but I think in a lot of the community-based decisions, nursing has as valuable input.

(Rural nurse participant 5)

[...] we definitely adapt the way we work to the needs of the job and especially the community as well as being associated with the development of the ‘new health system’.

(Rural nurse participant 2)

This new health system changed the philosophy of how health care was to be delivered in communities. The stimulus for this was the acknowledgment from the government that there were inequalities in health care provision for some population groups (National Health Committee, 2010). The cost of health care and or treatment and the difficulty of accessing health care providers, as well as the appropriateness of these providers, were recognised as barriers preventing health care provision. However, as identified from the data analysis the collaborative rural community relationships rural nurses were engaged with assisted nurses to adapt their practice which improved the provision of health care.

The following excerpt is revealing of one participant’s reflective approach (which is also representative of most of the participants’ responses) to the second question indicating that the rural nurses did indeed adapt their practice to meet the needs of the rural community. However, as a result, this participant contemplates the notion that there are possibly others, such as employers and policy-makers and even nurses within the wider profession of nursing, distant to the rural nurse and her practice in
location, that are deciding how the rural nurse could contribute to the health care service:

[…] is it because we see ourselves as meeting the need in an area? Or is it because we’ve never been strong enough or vocal enough to stand up and say, this is what I can do. We let other people decide for us what it is we do. I’ve never thought about that but we do. What a nurse does is more decided by other professionals, by employing bodies than it is by nursing. It’s a bit of worry, isn’t it?

(Rural nurse participant 16)

This experienced nurse participant demonstrates her concern that the full nursing response to health care is not being totally developed and recognized. As she advances on these ponderings she further recognizes that as rural nurses adapt their practice to accommodate rural community’s health needs (as well as accommodating changing government policy, discussed in this section), there are some common themes which bind the practice of rural nurses together, namely the community focus, isolation, inadequate resources, limited transport, lack of anonymity and the restricted availability of health care practitioners.

Likewise, the point being made in the following excerpt is that practice is dependent on the degree of physical isolation and the availability or lack of availability of health professionals and it is the rural nurse who adjusts and adapts their practice. This style of practice relies on the rural nurse using initiative, being innovative and flexible, rather than relying on one practice model which fits all rural communities. The analogy of ‘sliding into’ and ‘filling the gap’ can be related with adaptable rural nursing practice. However, this participant highlights more of a concern about rural nurses not practicing ‘nursing’, but instead is responding to a need or a gap in service provision. This is debatable as the rural nurse is demonstrating that they are ‘sliding into’, rather than constructing their practice which could potentially restrict the evolving practice models. While these nurses are working to the full potential of their scope of practice, what they are doing is not fully constructed by themselves but constructed or governed from outside of the ‘locale’:

There will always be some common things but what the nurse will be doing will be influenced by what the area is that what the nurses were doing was
very different from area to area. And while there were always some common things right across, what happened in the rural area... what other professionals were there all influenced greatly what the nurse did so it seemed rather than nursing going out and influencing and establishing its claim to a certain type of practice like medicine does, nurses are more, what’s the word I’m trying to say, were more adaptable so we kind of slide into where the need is. And so the practice reflects the need in the area, it’s not, or the gaps in the area, the nurses are sliding in and filling the gaps rather than establishing an area that they’re saying is nursing.

(Rural nurse participant 16)

Likewise, a strong sentiment is highlighted by the following participant as she reflects on nursing and in particular on nursing leaders’ (at the time between 1990s and 2000s) ability or commitment to lead nursing and understand rural nursing as a specialist area situated within the generalist field of nursing practice. In this process of reflection this participant highlights that rural nursing is not that complicated, in fact what rural nursing is, is ‘nursing’ in its unspoiled form:

I have the feeling that there are a lot of nurses who are so busy trying to be something that they’re not terribly sure what that is and I think a lot of the nursing leaders could be actually put in that category whereby they actually haven’t worked in a broad enough spectrum of nursing to understand what nursing does so they’re trying to make up a complicated explanation of what the profession is, instead of just letting it be nursing which does have a lot of valuable input and most people know when they’ve been nursed.

(Rural nurse participant 5)

Rural nursing practice is flexible in that rural nurses’ have adapted their practice to accommodate a changing health care environment. Rural nurses have developed a clinical skill set that extends or expands their practice to accommodate the lack of or limited availability of other health care professionals, particularly medicine. Rural nurses fill the gaps or ‘step up’ and meet the needs of the community that would otherwise go unmet (Jones and Ross, 2003). In doing so most rural nurses’ contribute and perform to their highest standards guided by the professions’ ‘Code of Conduct’ as well as using their professional judgment to provide competent nursing care in a range of areas of practice and clinical settings (Nursing Council of New Zealand, 2012).
In 2004 the HPCA Act 2003 came into effect and the concept of a ‘scope’ of nursing practice became a legal entity with the view that all health professionals’ practice should become state governed with delegated authority being given to their disciplinary bodies. This further change, lead to the state and discipline governing nursing practice of which the rural nurses’ are comprised from within and beyond the ‘locale’. The following section relates to relationships, which are developed both within and beyond ‘locale’.

6.5.5 Professional relationships developed both within and beyond ‘locale’

Professional relationships between the rural nurses and community residents were occurring within ‘locale’ as discussed previously, however simultaneously, relationships were developed beyond the ‘locale’ also constructing the rural nurse’s professional identity. National relationships between the rural nurse and the discipline of nursing, policy-makers and employers and others are key themes discussed in this section.

Social relations are developed in location or sites of practice, as well as beyond the site. Massey’s (2005) notions of flows and movement provides a more thorough and deeper explanation as to how the rural nurses’ practice is constructed from both within ‘location’ and ‘beyond location’. Place unites the natural, the physical and the human social worlds and this is noteworthy to understand human life, as place constructs people and at the same time people construct place (Tuan, 1974). Places and the meanings, which are attached to them, are always contested.

The analyses and findings in which I commence this section with the following photo image, as depicted in, plate seven representing, ‘locale’ which was reflected by one rural nurse participant who acknowledges that ‘locale’ is associated with community activity, which is represented, for her, in plate seven (on the following page).
Plate seven depicts old buildings, which signified for the rural nurse participant, as social meeting places localised in a rural township. This photo image further represents a positive attitude to local activity where residents of the community participate together, indicating a strong sense of community membership. Through participating together in various activities, community members should be able to determine their own health care needs and how they will be met, while valuing local community knowledge and culture. One of the main reason for this was the significant change to the delivery of health care restructuring, engaging with a ‘bottom-up’ approach to sustain a local healthcare service, which was locally governed and which links well with ‘locale’ as discussed by Agnew (1987) in association with his, ‘place framework’.

Likewise, identities are constructed where human-to-human and human-to-location interaction takes place, which is understood through ‘meaning’. Meaningful places assist people to make connections and create a sense of who they are in relation to place, for as Hollaway and Hubbard (2001) explain “[t]hese meaningful relationships associate the formation or make up our identities” (:71). Social relations develop in
‘locale’ in a number of locations or sites of practice while ‘substantive ties’ are developed amongst rural nurses and between rural nurses, health professionals and community members, within the broader rural Otago region and the broader rural community. The nature of the relationship developed within ‘locale’ has demonstrated the need for an understanding of relationships based on partnership and teamwork with community members and is representative of the quote by England (2011) at the commencement of this Chapter.

There is a lack of anonymity and associated factors related to the nurses’ presence in the community in which personal and professional boundaries are encountered as the rural nurse goes about their daily practise. The personal and professional relationships developed between the rural nurse and local people from the same rural location (as part of the concept of community), have been identified as creating a sense of rural identity which is associated with the concept of a ‘sense of belonging’ in ‘place’. The professional identity of the rural nurse is constructed in the local rural community in alignment with local community values and knowledge associated with the physical and transcendent presence, affiliated with their practice. Holloway and Hubbard (2001) discuss the notion of territoriality whereby people develop an understanding that certain spaces ‘belong’ to particular people. This can be linked to the rural nurses sense of belonging and ‘knowing’ a rural community which can potentially exclude others from that particular community and can ultimately have negative consequences and will be discussed in detail in the following third analysis Chapter.

Relationships associated with ‘locale’ highlight the challenges the rural nurses’ experience between their personal and the professional self in which they have the opportunity to govern their own practice. The personal self belongs in and with the community, as the majority of the participants’ tend to live within the rural community and become associated with local rural culture and knowledge. By contrast, the professional self is associated with the professional discourses associated with professional nursing and employment systems and a tension exists between these two juxtaposed positions. The following excerpts illustrate the nature of rural nurses’ community engagement, with the differing responses reflecting the varying length of time these rural nurses had been in rural practice for:
It’s a role that is much more than just a job. I think because it is part of your life when you’re working, and when you’re not working.

(Rural nurse participant 4)

The people that you treat, or your clients tend to become friends, and you build such a strong relationship with them that they become more than just your clients, they end up as part of your social circle, or you know their families, or their families know you, and you end up seeing them in your social life as well as your work.

(Rural nurse participant 21)

It’s a job full of very blurred boundaries.

(Rural nurse participant 16)

I’ll often say to people, what have you been up to and just take a general interest and that’s I guess how you get to know them and they get to know you. It is really special. I mean I’ve never worked in town so I guess apart from in the hospitals but I think, you know and it can be very difficult with confidentiality and things, you’ve got to be very, very careful…

(Rural nurse participant 2)

The knowledge the rural nurse acquires whilst living and practicing in the same rural community relates to their understanding of the person or client within their own context. The rural nurse acquires information while working in partnership with the client and their family and utilises ways of knowing the rural, which can be attuned to “emotion, sense, instinct, intuition, habit and action” (Woods, 2011: 201). The rural nurses achieve this in anticipation that the best outcomes for the delivery of health care can be achieved, as illustrated previously, through the discussion of the evolving models of practice. Rural nurses’ identity is constructed to establish relations in ‘locale’, and this is expressed as ‘being known’ in the community and this is identified in both negative and positive response from various participants’, as revealed in the following excerpts:

Being known in the community, known of being a nurse and the expectation of community, to be able to support as and when required the community members.

(Rural nurse participant 2)

[...] developing a relationship with people, about knowing people, knowing their home, knowing their family, knowing their expectations…

(Rural nurse participant 17)
[...] knowing and getting a person home to their family, and to their place...

(Rural nurse participant 5)

The following plate eight (below) is representative of the establishment and maintenance of social relationships in ‘locale’.

Plate Eight: Represents Knowing Community Residents in Context
Source: Printed with permission from Brian Scantlebury.

Plate eight was selected by some of the rural nurse participants’ to represent ‘locale’ where social relations’ emerge between the rural nurse in their professional capacity and the community residents. The hat in this plate represents “knowing the person and the whole context in which this person fits into the community” (referred to by two of the rural nurse participants) while a further participant acknowledged that ‘locale’ is associated with relationships that develop in a community. The image from plate eight is further represented as a positive attitude to developing and maintaining ‘substantive ties’ within ‘locale’ as discussed by Agnew (1987).

By contrast the following excerpts highlight the disadvantages rural nurses experience of being known in the community, which further illustrates the complex nature of
community relationships as reflected in the views from the experienced rural nurse participants:

[…] there are huge benefits as well of course with being known as well as the down side…

(Rural nurse participant 2)

[…] although it can be a pain getting rung up [from community members at home for health and emergency advice], it doesn’t happen so much now as it used to, a few years ago.

(Rural nurse participant 10)

[…] it is quite hard being a nurse in a rural community, often because there is a lot of expectation placed on you by those people, and you never get away from it

(Rural nurse participant 3)

The following example demonstrates that the nurse is not only aware of herself being known, she is also aware of the reality that community members are also known to each other in the community. The lack of anonymity which rural nurses experience is not a new concept and has been well-recognised in the international and national nursing literature in which the value associated with the concept of ‘locale’ and social relationships are acknowledged (Lee, 1998; Bushy, 2000; England, 2011). The following excerpt offers an interesting consideration of the participant’s awareness of how a lack of anonymity not only affects herself, but also members of the community in which she adapts her practice to avoid negative consequences from occurring:

He’s a businessman and because he’s known in the community, it was difficult for him… you know because he had expectations of him because he’s known in the community. Whereas perhaps if he was in the city, he wouldn’t, he would have more anonymity because, there would still be people that knew him but it wouldn’t have been so difficult for him…

(Rural nurse participant 10)

The lack of anonymity is something expressed by a number of participants as they discussed their practice:
Something that you ache for, anonymity, sometimes but then the pluses of living in a rural community far outweigh that, so you don’t sort of worry about it too much.

(Rural nurse participant 5)

It’s just you feel quite wrapped up in your community. You feel quite surrounded by it, and you don’t feel anonymous.

(Rural nurse participant 10)

Associating the construction of the professional identity of the rural nurse with ‘locale’ can be understood and experienced through local relationships, of being known, and engaging with the local rural knowledge and values, while adapting nursing practice to accommodate communities’ needs and responses. According to Edensor (2006) this is termed the ‘habitual performances’ of the rural nurse, which are influenced by their rural environment.

The first two of the following excerpts are included to highlight a number of experienced participants’ consideration of conflicts, which they are aware of, between local and professional discourses, associated with being in a rural community. The rural nurse negotiates their practice ensuring they have set workable boundaries in which the personal and professional ‘self’ becomes safe and manageable within ‘locale’ as these boundaries potentially can be challenged on a regular basis by local residents’. The third excerpt continues with these considerations however, from a less experienced rural nurse participant demonstrating she may not be as vocal in her development of professional boundaries through which to protect her own personal and professional self in ‘locale’:

I think you need to be quite clear who you are, you need to protect yourself, you need to look after your community. You can’t be all things to all people, and you need to have mechanisms whereby you have boundaries, and you have space for you and your family and that it isn’t impinged on by the community’s requirements of you.

(Rural nurse participant 7)

Rural nurses are aware of boundaries, but also expectations from the community and being level headed is being part of ensuring one’s professional and personal life is protected.

(Rural nurse participant 16)
 [...] the rural supermarket is a point of contention. Where community members think they can ask you questions about themselves or other residents. (Rural nurse participant 4)

As the rural nurse engages with the rural community residents, social relationships develop, however the rural nurse is characteristically a member of the community in a professional basis. How the rural nurse negotiates their practice becomes reliant on his or her own self-governance, which also forms a component of what constructs the rural nurses’ professional identity. This contemporary approach of governing promotes individuals to take responsibility for their own actions and furthermore the outcomes of these actions. Individuals conduct and govern their own practice, by enhancing a certain form of freedom translated between a complex flow of sets of relation between different groups and organisations, which changes with circumstances over time and is reflected through power relations according to Danaher, et al. (2000). Communities comprise social places where people can identify with and interrelate with other community members as illustrated by the rural nurse participants as previously demonstrated, and a shared sense of identity develops in location (England, 2011). Identifying with likeminded people, groups and places, a number of shared meanings, attachments and feelings are held to describe how people develop this shared identity (England, 2011; McKinnon, 2011). Identity in this respect attracts a number of related values and beliefs, including the emergence of an expected form of behaviour and performance (Goodrich and Sampson, 2008) and the resultant emergence of a ‘sense of belonging’ and is discussed in the following Chapter.

Presenting the concept of a ‘sense of change’ highlights the involvement of the rural nurse participants’ and was supported by the national key informant participants’ contributions who were either in a position of governance at the time of the restructuring of the regional healthcare delivery system, during the 1990s and 2000s or were currently in a position of national influence at the time of this study was being conducted. The majority of the key informants were particularly interested in this study topic, as I interviewed them they said they had reflected on the topic and in fact thought they did not have a lot to contribute, but as we progressed with the interview they were quite impressed with their understanding of rural nursing and the particular
complexity of their practice, as stated by a national member of the profession of nursing who noted that:

[...] it’s given me a bit of a jolt start... I would suggest that sitting down and being a participant in this, has really made me think for the first time in all seriousness about the unique situation of rural nurses. I’ve had ideas in my mind about the nurse practitioner scope and how it’s quite restrictive and how that might impact on rural nursing but if I’m honest, the fact that through this process I can actually learn about the actual extremes of rurality that nurses are facing is a bit of an eye opener really...

(Key informant interview 5)

Likewise a member of the government enquired:

When will this be concluded? When will this great advice come back to government?

(Key informant interview 1)

The responses from both of these national informants as highlighted above, led me to consider that they were interested in rural nursing and as new knowledge was developed they were willing and interested in utilising this information to inform policy and nursing practice. New ways of thinking about rural nursing practice was being reflected by members of national organisations, coupled with a ‘sense of change’ as analysed from the rural nurse participants’ and the key informants’ data. The analysis presented in this Chapter aligns with the nursing core concepts related to care as the concepts of ‘person and health’, which refers to rural people as self-reliant and independent in relation to accessing health care while preferring to have people they know rather than strangers caring for them. While health, is defined as the ability to work in which work and health are linked together and considered important by rural residents’ self-determination as determined in this Chapter.

6.6 Summary of Chapter

This Chapter has focused on presenting the analysis and findings, which informs the second research question and presents the key theme, a ‘sense of change’. Themes analysed from the data have revealed in Chapter five that rural nurses are engaged in formal and informal models of practice. In this Chapter I have illustrated that rural
nurses’ practice was evolving into new models with the restructuring of the health care system. These evolving models of practice permitted the rural nurse to engage and work in partnership with the members of the RCTs, including rural health care team members, which offered the rural nurse a way in which to meet the health needs of the rural residents. This change process is noteworthy factor and was anchored in the evolving models of rural nursing practice, as the change of the governance structures from state to the local community occurred during the 1990s. The health care restructuring, combined with the national changes led to the releasing of nursing’s full potential and contribution to the health care delivery which was a key factor in the emergence of rural nurses’ professional identity, which some of the participants referred to as the RNS. This emerging identity is coupled with the reality that the rural nurse does indeed engage with a ‘sense of community’ which was analysed and presented by engaging with Agnew’s (1987) ‘place framework’, ‘locale’. The third aspect of the analysis is presented in the following Chapter seven which now builds on the final aspect of Agnew’s ‘place framework’ and presents how the professional identity of the rural nurse was constructed through the lens of a ‘sense of place’.
CHAPTER SEVEN: PRESENTING THE ANALYSES AND FINDINGS, FROM THE RURAL NURSES ‘SENSE OF SELF’ IN RELATION TO ‘SENSE OF PLACE’

Environments can be socially constructed, and how they contribute to the making of place and identity. …attachment to place is a significant contributor to how individuals develop sense of place, and that community is a place in which identity construction can occur.

(Goodrich and Sampson, 2008: 261)

7.1 Introduction

This Chapter is the third of the three analysis Chapters in which I present the analysis and findings that are in alignment with both of the first and second research questions (discussed in Chapters five and six, respectively). Likewise in this Chapter I continue to engage with Agnew’s (1987) ‘place framework’, in which a ‘sense of place’ is connected with. A ‘sense of place’, does not fit discretely into its own individual category in relation to the analysed data, as ‘location’ and ‘locale’ did, as was presented in the previous two Chapters, five and six, respectively. A ‘sense of place’ as discussed by Agnew (1987), involves a connection and an emotional attachment within ‘location’ and ‘locale’. A ‘sense of self’, aligns with how the rural nurse participants’ become aware of aspects of the ‘self’ in the rural context as a ‘sense of place’ develops. It is this notion of developing a ‘sense of place’ which takes precedence in this Chapter, in order to uncover how the rural nurses’ professional identity was constructed, which is a vital focal element identified from the analysis of the data. A ‘sense of place’, is about understanding meaning through subjectivity, emotion and attachments or identification and a way of ‘being and performing’ practice in place, which merges with the analysis of the data that was presented in the previous two Chapters. This Chapter advances on this analysis and presents how a ‘sense of place’, has become established as an emotional attachment and a sense of belonging is experienced by the rural nurse and occurs in reference to ‘location’ and ‘locale’. These attachments establish a strong commitment and willingness on the
part of participants to continue to contribute to their community (Vanclay, 2008; McMurray and Clendon, 2015). The presentation of the analysis once again engages with a selection of photographs which are included in this Chapter and which continue with this theme, a ‘sense of place’. It is in this Chapter (unlike the previous two analysis Chapters) the photographs presented are not representative of a shared reflection between the rural nurse participants’. Rather they are chosen based on individual reflections from the rural nurse participants’ own personal and professional engagement as representative of their practice and illustrative as a ‘sense of place’ through which a ‘sense of self’ is established.

7.2 Outline of Chapter

This Chapter is comprised of two sections, and is presented in a similar fashion to the previous two analysis Chapters, five and six. However, because aspects of the data analysis associated with a ‘sense of place and a ‘sense of self’ have been identified in Chapters five and six the analysis and findings presented in this Chapter, although significant in providing an understanding how the rural nurses’ identity is constructed, is shorter in length compared to the other two Chapters’ content. In the first section I demonstrate the approach I have taken through which to engage with the analysis and findings aligned with Agnew’s (1987) third aspect of his ‘place framework’, ‘sense of place’. In section two I consider how the rural nurses’ identity was constructed through a ‘sense of place’, as associated with a ‘sense of self’ and analysed from the data as the third core theme from the data. This analysis is also aligned with a sense of belonging and an emotional attachment to the rural location, in which a ‘sense of place’, is revealed and the emphasis on caring for the self (the rural nurse) is highlighted as a unique aspect aligned with nursing practice in general. Section one is now presented.

A ‘sense of place’ is critical in maintaining the rural nurse’s professional identity as a meaningful member in rural communities and the nursing profession as a whole. The exploration of this meaningful role helps one engage in a more robust dialogue. Meaning is made in ‘locale’ (as discussed in Chapter six) but understood through a ‘sense of place’ as discussed by Agnew (1987) as the third fundamental aspect of his ‘place framework’ which is considered below in relation to this study.
A sense of place is associated with a location in which the members of a community are generally willing to contribute to that community which develops a sense of belonging and cohesion, referred to as omeogeneality according to Vanclay (2008). A person’s awareness of self is linked to place where a sense of belonging as a personal or equally professional ‘sense of belonging’ are congruent with the communities’ expectations to respond to their expectations (Vanclay, 2008; Nagel, 2011). Tuan (1974) argues that the social interaction and the experiences people have with place forms a deeper understanding of attachments to place, and what he has termed ‘topophilia’ (: 4). Massey (1995) also refers to this concept as explaining why many geographers regard sense of place as having a significant contribution to the attachments and emotions people have with locations (Del Casino et al., 2011). Sense of place is a very important aspect of engaging with the concept of place and rural nursing which is a key component of the analysis undertaken in this thesis and which is discussed in Chapter seven.

A sense of place can be associated with regional, national and international feelings of attachment and belonging. While this may be the case, a reactionary response could occur to maintain as Massey (1994) argues “fixity” (: 151). Fixity ensures the identity remains unchanged, this is despite a shifting world in which adapting identity may be more beneficial to the success of an individual or group rather than remaining stagnant. Massey (1995) acknowledges a need to hold onto a sense of who we are, in other words our identities associated with place identities “actively make places, both in imagination (the ‘olde worlde’ village) and in material practice (perhaps by keeping out things and people whom we argue do not belong)” (: 48). By keeping others out of place, different ways of thinking may surface between, people and groups and those who belong and those who do not. Notions of difference may eventuate, leading to conflict and resistance, instead of understanding place as dynamic and complex (Massey, 2005; England, 2011) where multiple experiences and connections are played out.

7.3 Engaging with the analysis and findings

This section of the Chapter is designed to present a more explicit account of place as representative of the rural nurse participants’ identity construction denoted as a ‘sense
of place’, in relation to Agnew’s (1987) third element of his ‘place framework’. The analysis and findings presented in the previous two Chapters are further built on in this Chapter.

7.4 Rural nurses’ identity constructed through a ‘sense of place’

Place, associated with a ‘sense of place’, is positioned as the third dotted circle in Figure: 7.1 (on the following page) as representative of Agnew’s (1987) third element of his ‘place framework’. This dotted circle (in yellow) represents place as ‘sense of place’ where the emotional attachments and a feeling of belonging in ‘location’, as depicted previously in Figure: 5.1 in Chapter five, and ‘locale’ in Figure: 6.1 in Chapter six. These representations are expressed, as a component of the rural nurses’ practice in the rural context and Figure: 7.1 is the third and final aspect of the ongoing process aligned with place and ‘nursing core concepts of care’ (Torres and Yura, 1974). ‘Nursing’, aligns with the insider/outsider concept noting there is a lack of anonymity while ‘knowing’ and caring for the majority of the community residents. The importance of gaining a trusting relationship with the community members is prefereable for the rural nurse to be in a position to offer effective and long-term health care. These ‘four nursing core concepts of care’ highlight the unique features that are linked to nursing in rural contexts and when aligned with Agnew’s (1987) ‘place framework’ offers a detailed understanding as to how the rural nurses’ identity was constructed in rural Otago. This analysis further builds up the ‘analytical base-place matrix’, which accumulates in Figures: 8.1 and 8.3 in Chapter eight.
Figure: 7.1 ‘Place Framework’ depicting ‘sense of place’ and belonging
Source: Compiled by the author.
The analysis of the rural nurse participants’ data led to a ‘sense of self’ (i.e. of the rural nurse) being revealed, in relation to a ‘sense of place’ and is now introduced.

7.5 Introducing a ‘sense of self’

A number of related aspects, associated with the identified third core key theme, ‘sense of self’ includes the notion of belonging to a community, and the associated presence and a sense of ‘other’ in relation to those that do not belong or associate themselves with the rural community. The following subthemes, identified from the analyses linked with a ‘sense of place’, are associated with the participants’ ‘sense of self’, which have developed from becoming a community member; engaging socially in the community, experiencing the notions of accommodating, and performing their practice to fit into the community values and norms; while a parallel lack of anonymity has also been identified (as discussed in Chapter six). These subthemes led on to how the ‘sense of self’ becomes aware of the different contexts in which these numerous roles are performed.

In order to become aware of a ‘sense of self’ this section has built on the previous analysis and finding (in Chapters five and six) where the professional identity of the rural nurse was portrayed and which was illustrated with reference to a ‘sense of difference’ and ‘sense of change’. Rural engagement results with the rural nurses’ acceptance of the local rural knowledge and culture, which, over time, informs and guides their practice through the notion of self-governance as represented through aspects of governmentality as discussed by Foucault (1988), while the nurses’ practice is furthermore also state and discipline governed. It is how the rural nurse negotiates and performs their practice in-between these three governance sources that is a key focus and discussion in Chapter eight. This section of this Chapter now engages with and presents the findings embedded in a ‘sense of place’ aligned with a ‘sense of self’ and self-governing practice and commences by engaging with a ‘sense of place’. A ‘sense of self’ is contextually dependent and associated with a ‘sense of place’.

This section of the analysis and discussion provides a selection of excerpts specifically focused on a ‘sense of place’. Social geographies’ theoretical stance on
place, as discussed by Agnew (1987), Tuan (1974) Massey (1995) and Holloway and Hubbard (2001) and Cresswell (2004), provided me with a more consolidated understanding of place which is associated with identity construction. Through this analysis it became obvious that place is not a thing, place is always a way of seeing, knowing and understanding the world, through attachments. Place is about meaning and experience and how we make sense of the world and the way we experience it as meaningful. Attributes aligned with a ‘sense of place’ are characterized and embedded within a sense of belonging, and a sense of presence is embedded in the professional ethical obligations aligned with a rural community (Bushy, 2009; Francis, et al., 2014) which are discussed in the following sections.

7.5.1 Belonging in rural place

A ‘sense of place’ occurs when attachments and belonging to a place, understood as a location, become a lived experience and an individual or collective identity is constructed, through shared meanings. The attachment of meaning brings place into human understanding and makes a place ‘belong’ to us. Meaningful places became part of who we are and the way we understand ourselves and our place in the world (Holloway and Hubbard, 2001). Meanings associated with place become part of an individuals’ understanding of who they are in association with place and can help to make sense of attachments, feelings and emotions (Massey, 1995). Therefore, meaningful relationships play a part in the formation of identities (Holloway and Hubbard, 2001) and a person’s awareness of self is linked to place where a sense of belonging occurs. Goodrich and Sampson (2008) argue, “community is crucial (and specific) in relation to the set of cultural boundaries individuals draw upon in the creation of identity…” (: 267). Belonging embodies and is based on members of a community, who engage with shared meanings and acknowledge local values, behaviours and actions, which are congruent with the community. The following excerpts highlight the way in which the rural nurses’ professional identity is associated with ‘sense of place’:

Well I think the community is just so good and I enjoy it. I enjoy the patients and that’s a really big thing I think.

(Rural nurse participant 4)
[...] belonging [to the rural community] ... takes a long time to belong.

(Rural nurse participant 2)

For the participants, place is characterised as more than its physical setting, it is composed of human and social interaction, as well as the interaction with place as place becomes symbiotic and relational. It became clear from the analyses that this study demonstrates that identity, place and belonging to a rural community, constructs the rural nurse identity, and that the idea of community is central to identity construction, maintenance and attachment associated with a ‘sense of place’. Membership of a community is also essential to understand identity, as discussed by Goodrich and Sampson (2008), and assists with the validating the notion of belonging to the community, where members of a community are willing to contribute (as discussed in Chapter three). When one belongs to a community, accepting the values and beliefs of that community develop (Ife, 2013) and the ‘self’ becomes concerned about what other people think about individual community members’ performance, in this case, nurses’ practice. This performance focuses on how members of the community interpret other members’ engagement and, so for the ‘self’ to maintain respect and to build up a trusting relationship in the community, Elliot (2008) states, “we learn to view ourselves as other people see us, adjusting and transforming our self-understanding in light of ongoing social interaction and dialogue…” (: 32). The ‘other’ is a concept related to the identity of difference that is discussed within some works of anthropology where the characteristic of the ‘other’, is noted as being different from the identity of the ‘self’. Identity difference refers to who and what is distinct or separate from the identity and from the ‘self’ (Elliot, 2008; England, 2011).

The succeeding excerpts illustrate the notion of a ‘sense of self’ in the community. The positioning of this ‘sense of self’ results in blurred boundaries, as discussed previously (in Chapters five and six) and relates to issues of knowing and being known in the community which is further experienced by the rural nurse as a feeling of being owned by the community. As the rural nurse becomes known in the community she/he experiences a lack of anonymity (Bushy, 2008; Winters and Lee, 2010). How the rural nurse negotiates their personal and professional ‘self’ in these rural settings, relies on their own moral integrity and performance as they go about their everyday practice, a negotiation which is further compounded by the reality that
the rural nurse has a personal as well as their professional sense of belonging in the community and ultimately the ‘location’ and ‘locale’. The following participant, who was fairly new to rural nursing practice, when interviewed expressed that she enjoyed:

[…] being seen as a nurse by everyone I meet, and that rural, being a part of not just my job but who I am. Just the way you end up living and everybody recognises you as The Nurse.

(Rural nurse participant 2)

I reflected on this participants’ contribution associated with the visibility of the rural nurse in this community, and I further asked this participant, how she cared for herself given her public domain? This participant further responded with her solution to my question:

I’m happy to take on that responsibility of the role but I do adapt so that I can have space from it as well… I live out on a farm and so when I’m not working I tend to stay at home and I’m not really in contact with people… I do find that discussing [health care] in the supermarket comes up quite a lot so I tend to do my supermarket shopping somewhere else.

(Rural nurse participant 2)

Further, this participant indicated that she took breaks away from the rural community on a regular basis to get away from the constant, intense level of personal contact. This participant adjusted her lifestyle to fit the needs of the community and their expectations of how one ought to be a rural nurse, while also ensuring her own personal needs were met. The professional identity of the rural nurse was constructed by, and through the community expectations related to rural culture, including aspects of belonging and engaging with community members. Rural nurses have adapted and accommodated community members’ health needs and social expectations, as illustrated above in the previous excerpts. However, through belonging and engaging in a rural community, at a professional and social level, provides the rural nurse with a ‘sense of place’, as illustrated in the following excerpts:

[…] because I work seven days on/seven days off, we [my partner and I] go away a lot in my week off so I’m away from town on a regular basis so I get that space from it.

(Rural nurse participant 2)
It’s just you feel quite wrapped up in your community. You feel quite surrounded by it…

(Rural nurse participant 16)

The elements are connecting, as to other, basically to the community as the people that live in it. The institutions that are in it, it’s a connectedness, community appears to be the hub, as well as understood by the community people.

(Rural nurse participant 2)

Agnew (1987) has conceptualised that a ‘sense of place’ is about subjectivity, emotion and attachments. Whether these are positive or negative interpretations, they are still associated notions with the concept of the ‘sense of place’. The different experiences rural nurses encounter with ‘sense of place’ are worth considering as to whether they feel a sense of belonging and how relevant this is to their personal and professional self. The differing views are demonstrated within this section through personal reflections and analysis, both positively and negatively, as illustrated in the previous excerpts. ‘Sense of place’ occurs when attachments and belonging to a location becomes a lived experience, and where individual and collective identity is constructed through these shared meanings, including values, behaviours and actions, which construct community members’ actions in place (Butz and Eyles, 1997).

A person’s identity is linked to location as discussed by Vanclay (2008), when a sense of belonging transpires through adapting behaviour, such as taking on the communities’ ways while participating in local activities, for example on the sports grounds and at the local store. Identifying and becoming aware of the communities’ local ways acknowledges and promotes identity with the knowledge or local discourses specific to that location. Knowledge is built up over time through many activities within the local place and with its people. A deep ‘sense of place’ is developed with individuals and place becomes an extension of the ‘self’. Having a ‘sense of place’ usually involves a connection with the community and gives individuals’ life meaning and contributes to well-being and life satisfaction (Vanclay, 2008). A sense of physical and mental/emotional well being and feeling ‘in place’ or ‘at home’ can then be regarded as a sign that an individual has an emotional tie to a location. Attachment to place is important to people’s sense of identity and life satisfaction (McMurray, 1999). Goodrich and Sampson’s (2008) research on local
people of the West Coast of the South Island of New Zealand, indicates that it is not just the case if you have “birth right and lineage that matter, but also the kinds of behaviours one might engage in…” (: 263).

Community–minded behaviours are considered essential and evoke the kind of resourcefulness needed in isolated, rugged circumstances that dictate the lives and behaviour of local residents. Those who do not belong by birthright belong in a different sense as they contribute to the rural community and a sense of belonging eventuates (Goodrich and Sampson, 2008). For example the rural nurse provides a much-needed health care service dedicated to the rural community. Bringing skills such as nursing practice into a rural community aids the newcomer’s acceptance in the community as highlighted in the quote above by Goodrich and Sampson (2008). This example can be likened to adapting nursing practice to meet the needs of the rural community’s health requirements relative to the availability of resources. A ‘sense of place’ becomes paramount to identity construction and Jackson (2005) argues that identity is interpreted and formed in relation to others, rather than the ‘self’. The participants discussed their practice relative to that of urban nurses, which was discussed and related to the first core theme presented in Chapter five, as a ‘sense of difference’.

Plate nine (on the following page) is representative of how a deep ‘sense of place’ is associated with a ‘sense of self’. Having a ‘sense of place’ usually involves a connection with ‘locale’ and gives individuals’ lives meaning and contributes to life satisfaction. This plate represents ‘sense of place’ and a ‘sense of self’ once again simultaneously’, which was reflected by one rural nurse participant and associated with a particular local landmark. A response from the participant which identified with this image emphasised as to why it was significant in representing a ‘sense of place’, expressing that the historical relationship she had with “this local landmark ties me to the location, the community, the people and to the land, while offering me a ‘sense of place’ and belonging” (rural nurse participant in which the code has not been included in support of the participants’ anonymity). Therefore local landmarks in rural locations, however barren, represent a sense of belonging.
Plate Nine: Represents Sense of Place, Belonging and Identity
Source: Printed with permission from Brian Scantlebury

Plate nine reflects the personal aspects associated with the emotional attachment to this rural location while offering this participant a ‘sense of self’ and identity. The identity of the rural nurse comprises both professional and personal elements and it is because of this I became interested in investigating further how rural nurses cared for themselves as they engage with a ‘sense of place’, which is presented below.

7.5.2 Caring for ‘self’ in rural ‘place’

I was interested in considering how and by what means do rural nurses care for themselves as they equally care for community members. Given the demands that rural nurses experience related to accommodating the community’s values and beliefs and aligning their performance in a suitable manner that is acceptable within the rural community. The following excerpts emphasise the approaches these rural nurses take to retain privacy and ‘self’ care in their personal lives. The following excerpt from a less experienced participant shows the importance of ensuring she has space away from the pressures of being the rural nurse either when physically in the role, or when she is not. This excerpt highlights the relationship between the professional and
personal self in ‘place’ or in a particular location, where the professional self (the rural nurse) is visible in non-health care settings and is routinely viewed by the members of the community and is identified as ‘the nurse’. This is despite the fact that rural nurses are not always in their professional capacity, but in their personal role as members of the community:

[…] there’s a lot of crossover between your individual place in a community and your job in serving the community. It’s a role that is much more than just a job I think because it is part of your life when you’re working and when you’re not working and also the people that you treat or your clients tend to become friends and you build such a strong relationship with them that they become more than just your clients. They end up as part of your social circle or you know their families or their families know you and you end up seeing them in your social life as well as your work life. It’s a job full of very blurred boundaries.

(Rural nurse participant 2)

In contrast a more experienced in participant in clinical rural practice provides a deeper understanding as to the reasons why this juxtaposed position occurs as she reflects on her personal and professional ‘self’, and how that ‘self’ becomes subject which is associated with blurred boundaries which in turn governs her own practice:

It is very community orientated, there is nothing for me to be standing in the supermarket and then someone will come up to you. People they know about you, you’re very much part of them… people feel they belong, you kind of belong to them because you’re rural.

(Rural nurse participant 4)

The majority of the participants in this study actually lived in the community (location) they worked in, while one participant lived outside of the community. As illustrated in the following excerpts, the participants adjusted their lifestyle to fit the needs and expectations of the community. The nurses understood that the community has a kind of ownership of them and an expectation of a particular standard of behaviour, as highlighted by several participants who identified their professional responsibility (of always being the rural nurse in the rural community with the notion of either being on or off duty). The participants offered sound reflections on their coping strategies as highlighted in the following excerpt:
I think you need to be quite clear who you are, you need to protect yourself… You can’t be all things to all people and you need to have mechanisms whereby you have boundaries and you have space for you and your family and that isn’t impinged on by the community’s requirements of you.

(Rural nurse participant 7)

[…] no matter if you’re on duty or off duty, because it is kind of expected of you and I think that’s how we all feel. You kind of behave yourself wherever you are.

(Rural nurse participant 4)

[…] you’ve got to have a certain standard of behaviour…

(Rural nurse participant 7)

Community expectations, as discussed above are further elaborated on by Edensor (2006) who states, that in the rural, there is a “normative etiquette” (: 492) which forms a particular, accepted conduct and behaviour. Participants mention the local shop, public house and sports grounds as associated with their practice in which appropriate behaviour in these places were expected by community members which has required the rural nurse to act suitably in ways acceptable, not only within the rural culture but also within the professional culture of nursing. Cresswell (1996) suggests this implies a moral dimension which further constructs rural nurses’ performance as expressed by Bushy (2009) and Francis, et al. (2014). Rural nurses understand this is important and part of a local discourse in relation to rural community and the culture associated with rural living, as illustrated in the following excerpts:

The focus here is on doing the best by the person, the person is central within the community…

(Rural nurse participant 5)

Being knowledgeable about the location is essential for the nurse to be comfortable in responding to the community…

(Rural nurse participant 16)

In a small rural place like the [place name removed] here we have a great relationship with our community.

(Rural nurse participant 15)
Plate ten (below) is representative of ‘sense of place’ and a ‘sense of self’ simultaneously and was reflected on by one participant who acknowledged that a ‘sense of place’ is associated with local community activity, which is signified in plate ten, as social relationships have traditionally taken place in this railway station.

Plate Ten: Represents Rural Community Social Cohesion
Source: Printed with permission from Brian Scantlebury.

However, in this contemporary space the railway station is no longer active but is represented as a tourist attraction with the establishment of the popular local Central Otago cycle rail trail (Central Otago Rail Trail, n.d.). Plate ten is a personal (by the author) illustration as to exemplify a positive expression associated with local activity, which is shared with visitors and illustrates a strong sense of community membership and pride. Once again this analysis can be further aligned with nursing’s core concept aligned with caring and engages with the insider/outsider aspects of practice associated with a lack of anonymity while ‘knowing’ the majority of the community residents and at the same time engaging with non-community residents, these concepts will be presented further and discussed in Chapter eight. It is now timely to summarise the content of this Chapter.
7.6 Summary of Chapter

A ‘sense of self’ has been identified as one of the three core themes in the thesis analysis. A ‘sense of self’ as a form of subjectivity has been made visible in all aspects of the ‘place framework’ but is typically focused in alignment with ‘sense of place’ discussed within this Chapter. The characteristics of a particular environment and the way in which the ‘locale’ and rural nurses’ connect within that physical setting are shaped by the manner in which they were able to construct their understanding and practice a ‘sense of place’, which in turn has shaped their professional identity. Place is about meaning and experience and how the world is made meaningful. Places become special to people and the rural nurse, is not immune to this connection which has a meaningful association. Tuan (1974) notes, places are multidimensional and exist in a range of meanings and significances, resulting in meaningful relationships. The rural nurses’ professional identity is constructed by and through community expectations related to rural culture and local knowledge, including aspects of belonging and engaging with community members. Rural nurses adapt as they accommodate community members’ health needs and social expectations. However, as the rural nurse associates with a sense of belonging to a rural community and engages professionally and personally at the social level with that community, this provides the rural nurse with a ‘sense of place’. In the following Chapter the research discussion is presented and supported, diagrammatically by the ‘place-based analytical matrix’.
CHAPTER EIGHT: DISCUSSION REVEALING RURAL NURSES’ PROFESSIONAL IDENTITY

Focusing on place therefore attends to how we are in the world-how we relate to our environment and make it into place.
(Cresswell, 2008: 136)

8.1 Introduction

In this Chapter I reflect on the degree to which the research aims have been met in this study, and overview the rationale for undertaking this investigation. The main argument aligned with this study focuses on how the professional identity of the rural nurse from the rural Otago region of New Zealand was constructed in the period 1990-2000s. This time period was chosen in which to undertake the research because of the significant changes to the delivery and funding of rural health care that took place in this period which redefined the role of the rural nurse who practiced in the rural location. The restructuring of the health care system initially changed the practice of nursing from this rural location and, over time, led to nurses’ identifying as being different from the conventional professional identity aligned with national understanding of what constituted a nurses’ identity. The rural nurses’ professional identity unfolded as the investigation took place, and, in so doing, it became necessary to appreciate the significance ‘place’ has in the construction of rural nurses’ identity, performance and behavior. ‘Place’, as defined by Agnew (1987), makes a significant contribution in this thesis as discussed in the previous three analysis Chapters which revealed rural nurses’ relationship and connection with ‘place’ as ‘location, ‘locale’ and ‘sense of place’. Furthermore, identity is considered a dynamic, fluid, a relational and contested construct which is performed in place, as highlighted in Cresswell’s quote, at the commencement of this Chapter while considering place from this perspective guided the data analyses and presentation of findings. These findings are a component of the historical and contextual
examination (discussed in Chapter two) which provided the foundation from which to engage with the impacts and effects of the socio-political and economic changes in the periods leading up to and including the major health care reforms, between 1980s and the 2000s time periods (Gauld, 2001; Dalziel and Saunders, 2014).

The identity construction of the rural nurse has been further enhanced by engaging with the four ‘nursing core concepts of care’ as discussed by Torres and Yura (1974) in conjunction with Agnew’s three elements of his ‘place framework’ to offer a deeper and more meaningful analysis. It is in this Chapter the three key core themes identified from the analysed data presented in Chapters five, six and seven are discussed. These three key themes include the changes that occurred throughout the 1990-2000s time period for the provision and development of the rural health care services within the study location; the effects that a number of aspects of difference associated with rural nursing practice have had, and the advent of a new specialty of practice role within nursing, namely the rural nurse or RNS. These themes are analysed, synthesized and aligned with the changes that occurred during this time period including the prevailing governance structures. These structures occurred and altered the delivery of health care as a result of the neo-liberal reforms of the 1990s which shaped and constructed the rural nurses’ professional identity in the rural location, which is linked to the development of social relations and a ‘sense of place’ which is developed as the rural nurse performs their practice and a further ‘sense of belonging’ transpires, as shown in the previous Chapter which is further elaborated on in this Chapter.

8.2 Outline of Chapter

This Chapter is comprised of four sections, which present the core argument of the thesis and demonstrate how the professional identity of the rural nurse from the identified study location was established. Section one reflects on the research aims and rationale of this thesis. Section two introduces the approach I have used to engage the reader as to how I have presented the thesis argument in the written and diagrammatic forms, in Figures: 8.1, 8.2 and 8.3 which has built on the analysis and findings which were presented in the previous three Chapters. Section two dovetails into section three of this Chapter and advances on the thesis argument which
discusses how the professional identity of the rural nurse from the study location emerged, to reveal the contextual issues which position the nurses’ practice at the local levels and embeds these with the elements structured around ‘place’, which incorporate the three aspects of Agnew’s (1987) ‘place framework’, ‘location’, ‘locale’ and ‘sense of place’. Agnew’s ‘place framework’ together with ‘nursing core concepts of care’ (Torres and Yura, 1974) are further framed around the components associated with governmentality, as it relates to the neo-liberal changes which includes three aspects of governance; state governance, discipline governance and self-governance (Gordon, 1991). These aspects of ‘place’, ‘care’ and ‘governmentality’ lead into a detailed argument demonstrating how the professional identity of the rural nurse was established as the neo-liberal changes progressed.

Section four, highlights how this study has contributed to knowledge generation within both the disciplines of nursing and social geography. It is in this section that I argue that understanding ‘place matters’ to rural nursing practice, and that rural nursing and rural place are mutually constitutive. To further demonstrate and elaborate on this argument, I present a diagrammatic representation which incorporates and synthesizes the components of the adapted ‘Funnel Model’ (Broman and Robèrt, 2015) initially presented in the ‘contextual phase’ in Chapter two (Figure: 2.1) and is further advanced on in Chapter three and this Chapter to provide a visual representation referred to as the ‘analytical place-based matrix’ in the completed form in Figure: 8.3.

The intention of the ‘analytical place-based matrix’ frames up the thesis argument, in this way provides a unique presentation which can capture interest from rural nurses’, the discipline of nursing and others including policy-makers and, in so doing, initiate ongoing critical dialogue of the range of governance structures associated with rural nursing practice and the three elements of place through which to further enhance the understanding of how and why the rural nurses’ professional identity became established between 1990 and 2000s. Figure: 8.1 the ‘performance phase’ and Figure: 8.2 the ‘transformational phase’ are the two additional phases which together with Figure: 2.1 the ‘contextual phase’ (presented in Chapter two) complete all three phases of the ‘analytical place-based matrix’ (Figure: 8.3).
The conclusion of this Chapter provides a summary of how the research discussion unfolds, and leads onto Chapter nine in which the research conclusion, and future research possibilities, as well as the limitations of the study are discussed. In the meantime the research aims and rationale are reflected upon.

8.3 Reflecting on the research aims and rationale for the research

The purpose of this research was to discover how the professional identity of the rural nurse from the study location was established during the 1990s and the early part of the 2000s. This time period covered a complex, dynamic and changing socio-political and economic context in which the delivery of rural health care changed significantly and rural nurses from the rural Otago region responded by adapting their practice to accommodate these trends. Therefore this research was undertaken to investigate what were the factors constructing the evolving professional identity of this nurse. Similarly, the advancement of national nursing aspirations (identified in Chapter two) aimed to realise the full potential of nursing practice and advance nurses contribution to the delivery of health care, as discussed in the ‘Ministerial Taskforce on Nursing Report’ (Ministry of Health, 1998; Jacobs, 1998; Jacobs and Boddy, 2008) which also influenced the professional identity formation of rural nursing. During the 1990s and 2000s the nurses in rural areas adapted their practice to accommodate these changes and communities’ health needs and, in so doing, the rural nurse emerged as a distinct specialist. This research has captured how and why the professional identity of the rural nurse was forged at this time. The unique aspects and particular attributes that contribute to the professional identity of the rural nurse were recognised regionally while revealing that rural nursing practice is distinctive, relational and contextual. Additionally, the rural nurses’ contribution to the rural health care sector has also been exposed.

The intention of this research has been to raise the awareness of the role played by various factors related to the changes made from the traditional occupational titles associated with community nursing practice for example, practice nursing and district nursing and the establishment of the occupational title rural nurse or RNS, during the 1990s. I have argued that the title rural nurse is not an adequate portrayal of the rural nurses’ professional identity from this study location, as there are a range of key
differences, as discussed below, which distinguish rural nurses from their urban colleagues in respect to defining their practice which is directly associated with their rural physical locations. The concept rural conjures up images of rurality or ‘rural idyll’, which may be different from the lived and performed reality, experienced by rural nurses who participate in the rural context. Therefore, by relying on this notion of rural, as defined by the occupational title rural nurse, is an inadequate description of their professional identity, and the findings linked to this research is discussed throughout this Chapter.

The motivation for this research originated in response to regional and national challenges which emerged during the 2000s from non-rural nurses who wished to understand why rural nurses considered their practice as different to that of urban nurses (as introduced in Chapter one). The rural nurses, in their defence, responded to this challenge by highlighting the following aspects of their practice as different, for example, physical and professional isolation and lack of anonymity, rural community membership, caring for community residents, a broad scope of generalist, autonomous and holistic practice, and a practice that overlaps with other health disciplines (O’Connor, 2015, 2016a, 2016b) (also analysed from the data presented in Chapters five-seven). There is also a strong emphasis on teamwork and working in collaboration with community members. This explanation did not satisfy non-rural colleagues and instead they commented that their practice could also include these distinctive aspects (which was presented in Chapter five). Following on from these encounters misunderstandings have been associated between nurses and have revealed NCNZ’s lack of recognition that rural nursing is considered a ‘specialty’ area of nursing practice. This aspect is further discussed in relation to this thesis later in this Chapter. Also, misunderstandings by health care planners (identified in this study as national key informants has shed some light on their limited understandings of rural nursing practice, as analysed from the data, in Chapter six) who direct rural policy development, and who typically have a predominantly urban focus emerged. Equally, the unequal distribution of resources that disadvantage rural health care services, as discussed by the National Health Committee (2010) became an issue of concern. The identified challenges has provided the incentive for this study to investigate, generate data and strengthen the rural nurses’ awareness of their emerging professional identity and to align this awareness with the knowledge and understanding as to what was/is
unique about their practice. Long and Weinert (1989) and Bushy (2012), have proposed there is no suitable model encapsulating the unique aspects of rural nursing practice. This study, adds to the growing rural nursing knowledge base with insights about identity formation, in respect to rural nursing practice in New Zealand.

8.4 A synthesis of the how the thesis argument is presented

This research has focused on enhancing how the professional identity of the rural nurse was constructed during the 1990s and early 2000s. The formation of identity is not made, but instead is discovered (McKinnon, 2011). In the process of this discovery, the importance of connecting identity with ‘place’ has been revealed. Therefore, to determine how identity is constructed, is to understand ‘place’. ‘Place’, for the purposes of this research, helps to understand how the identity of the rural nurse was established, initially, attuned to the rural physical context. However, relying on the physical context (‘location’) alone to understand identity formation is insufficient (analysed in Chapters five-seven). What is necessary is to understand ‘place’ as connecting and developing social relationships in which attachments and belonging may transpire and a ‘sense of place’ develops which further constructs identity formation (Nagel, 2011). The presentation of the thesis argument and contributing to the rural nursing knowledge base, I have adapted Broman and Robért’s (2015) ‘Funnel Model’ which includes three phases. The first phase was initially presented in Chapter two (Figure: 2.1) and will be further advanced on in this Chapter in Figure: 8.3 in the ‘analytical place-based matrix’, which incorporates and synthesizes all three components together. The additional two components include the ‘performance phase, in Figure: 8.1 and the ‘transformational phase’ in Figure: 8.2. The ‘performance phase’ of the matrix builds on the first phase the ‘contextual phase’, of the matrix and is now discussed.

8.5 The ‘performance phase’

The ‘performance phase’ presented in Figure: 8.1 and engages with both Agnew’s (1987) ‘place framework’ and the notion of governmentality (Foucault, 1979; Gordon, 1991). Place is a “means to understand the world, and while doing so, people are engaged in place” (Cresswell, 2004: 4). ‘Places’ have a relationship with
humans and as this relationship develops, ‘place’ is understood as a meaningful location, as individuals connect with it. Therefore, ‘place’ takes on a far greater significance than that simply assigned to a physical location. Associating the rural nurses’ professional identity with location only (as considered in my original engagement with place at the commencement of this thesis) is insufficient and ‘place’ needs to be engaged with as discussed by Agnew (1987) to incorporate the three elements ‘location’, ‘locale’ and ‘sense of place’. Identity is expressed through place, and place, for the purposes of this thesis, comprises the three elements as mentioned above (Agnew, 1987). The professional identity of the rural nurse has been recognised in all three of these place elements (engaged with in Chapters five, six and seven and identified diagrammatically in Figures: 5.1, 6.1 and 7.1, respectively). The three place elements that are displayed vertically in the ‘performance phase’, are signified by three dotted individual circles which further characterise that the space between each of them, are representative of, a lack of fixity, movement and fluidity, which is illustrative of the dynamic nature of rural nursing practice aligned with place.

In Figure 8.1 the ‘performance phase’ comprises three elements associated with ‘place’ and are further combined with the notion of governmentality in the three corresponding columns that are presented along a continuum. Affiliating place and governmentality together has created a deeper understanding of rural nurses’ practice and identity construction, revealing the levels of governance structures, comprising state, discipline and the self, which all govern the nurses’ practice and conduct. According the Gordon (1991) Foucault considers individuals have the ability to be governed and at the same time govern others, while simultaneously governing the ‘self’. In this case of rural nurses’ agencies, authorities and organisations have shaped the rural nurses’ performance and conduct of their practice and this reveals how the professional identity of the rural nurse has been constructed and can once again can be associated with Lewin’s change process but this time aligned with the ‘moving’ phase (Jones, 2012) with the implementation of the changes to the restructuring of the health care system and national nursing advancement. Furthermore the four relational concepts including, person; environment; health and nursing (Torres and Yura, 1974) are comprised in a nursing theory and are included in Figure 8.1 which builds on my
interpretation of these four concepts which were presented diagrammatically in Figure: 3.4 (in Chapter three).

In Chapters five, six and seven the construction of the professional identity of the rural nurse was analysed and highlights how the concept ‘person’, refers to rural people as self-reliant and independent in relation to accessing health care while preferring to have people they know rather than strangers caring for them. ‘Health’, is defined as the ability to work in which work and health are linked together and considered important by rural residents. ‘Environment’, refers to the isolation and distance rural people experience to access health care services and “often there is suspicion of outsiders and “government” authorities who the community perceives as historically providing short-term resources without an understanding of the rural way of life” (Bushy, 2012: 13). ‘Nursing’, aligns with the insider/outsider concept with a lack of anonymity while ‘knowing’ and caring for the majority of the community residents. The importance of gaining a trusting relationship with the community members is preferable for the rural nurse to be in a position to offer effective and long-term health care. These ‘four nursing core concepts of care’ highlight the unique features that are linked to nursing in rural contexts. These ‘four nursing core concepts’ (Torres and Yura, 1974) are further presented in the ‘performance phase’ in Figure: 8.1 is presented (on the following page).
Available from the author

**Figure: 8.1 ‘Performance phase’**
Source: Compiled by the author.
Figure: 8.1 is representative of the ‘performance phase’ and identity construction. The rural nurses’ identity can be understood by engaging with the three aspects associated with Agnew’s (1987) ‘place framework’. The rural nurse is situated at the centre of these three elements aligned with this concept ‘place’. Situating the rural nurse in the centre is representative of the rural nurse as being at the heart of ‘place’ and is further bounded by the identified governance structures. The ‘place’ elements are discussed in relation to how the rural nurse negotiates and transforms their evolving models of practice, within these different governance structures, health care restructuring and national nursing developments. This articulation is needed to promote the importance of acknowledging and defining the occupational title, of the ‘rural nurse’, and to ensure that there is an adequate portrayal of their professional identity which is understood amongst rural nurses and accepted within the profession of nursing and the wider health care environment. Ultimately, the necessity for nurses that practice in rural contexts to articulate the distinctive components that define and construct the way in which they practice is discussed by engaging with the diagrammatic representation in Figure 8.1 and supported with the following written dialogue. Issues of engaging with place, as defined by Agnew (1987; 2011) as ‘location’ and the governance structures including state, discipline and self-governance, are now considered to demonstrate how the establishment of the rural nurses’ professional identity was established, in location.

8.5.1 ‘Location’ and governance structures

The location or the sites where rural nursing practice happens “relates to other sites or locations because of interaction, movement and diffusion between them” (Agnew, 2011: 23) as exemplified by state legislation and discipline knowledge which directs and informs nurses’ in their everyday practice and conduct. These governing structures guide the performance of nurses’ practice in accordance with state regulation and discipline expectations. ‘Place’ defined by Agnew (1987; 2011) as ‘location’ opens up the possibilities of understanding nursing in which nurses’ practice occurs within numerous physical geographical sites, underpinned by different models of practice. Nurses’ practice is governed through state legislation, primarily the HPCA Act 2003 (Goodwin, 2003). The intention of this Act is to provide a more flexible approach to meet the changing roles and scope of health care practitioners
practice, including nurses, to accommodate the diversity of the population’s health needs. The HPCA Act 2003 aligns with the governance of nurses via the NCNZ who developed ‘scopes of practice’. The RN’s scope of practice, which came into effect in 2004, was a new entity in which all RNs were and still are required to adhere to and practice within this stated scope (Nursing Council of New Zealand, 2007).

Further governance structures are affiliated with the NCNZ and its oversight of the conduct of nurses’ practice. The governance structures aligned with the NCNZ changed the lines of direct authority to delegated authority by the New Zealand Ministry of Health which requires the NCNZ to ensure protection of the publics’ health and safety while monitoring the disciplines’ educational framework for entry to the profession, including the ongoing professional competence of all RNs’ (Nursing Council of New Zealand, 2007). One such mechanism the NCNZ engages with is to maintain the conduct of the profession to achieve this in 2012, NCNZ updated the professions’ ‘Code of Conduct’ (Nursing Council of New Zealand, 2012) which complements the legal professional obligations found in the HPCA Act, 2003, the ‘Health Information Privacy Code’ (1994) as well as the ‘Health and Disability Commissioner Regulations’ (1996).

The ‘Code of Conduct’ (Nursing Council of New Zealand, 2012) details the criteria of behaviour, expected that all nurses’ to comply with. This ‘Code of Conduct’ can be used as a point of reference in which nurses, employers, the public and the Council can refer to if a nurses’ practice is in question. An important emphasis in the ‘Code’ relates to the behaviour or conduct of the nurse in their professional and non-professional capacities, which is a particular important consideration for rural nurses as the majority of whom, both live and work in the same location resulting in a lack of personal and professional boundaries. The main emphasis is that the nurse maintains public trust and upholds professional status (Nursing Council of New Zealand, 2012). This ‘Code of Conduct’ is an excellent document that can serve as a yardstick against which the rural nurses’ professional identity and conduct can be reflected, relative to the profession’s expectations of conduct. I refer to this ‘Code’ as it focuses on rural nursing in the contemporary context. At the Rural General Practice conference in 2013, I became aware of some of the rural nurse delegates who attended a presentation/workshop held by NCNZ, of their disappointment with NCNZ’s
interpretation of the rural clinical scenarios showcased within the ‘Code of Conduct’ (Nursing Council of New Zealand, 2012) and exemplified by NCNZ’s statements as to the appropriate performance and behaviour expected of a RN. The rural nurses who attended this workshop thought these scenarios were not an accurate representation of their everyday clinical practice. The delegates indicated to the NCNZ representative that they would have appreciated been invited to contribute to the rural clinical scenarios and offer solutions to what at times are complicated situations, that arise in their everyday practice. In this thesis I argue that the concerns that have been highlighted by the rural nurse participants in this study have expressed a number of issues in regard to maintaining their own professional identity, which I refer to within this Chapter alongside the current ‘Code of Conduct’ (Nursing Council of New Zealand, 2012).

The changing health care reforms and different funding structures which emerged during the 1990s and 2000s and which are situated within the neo-liberal paradigm warranted a different form of governance and practice development from that which had gone before. Rural nurses were discursively positioned within various governing structures, which shaped and constructed their subjectivity. Governmentality offers a way of understanding the rural nurses’ identity as intermeshed between the ‘location’, or as one of the four nursing core concepts of caring, the ‘environment’, where practice is performed between national and local governance structures, in this case the rural values that also govern the nurses’ practice. These governance structures are further enhanced by engaging with the concepts of ‘place’ as defined by Agnew (1987), with the intention to illustrate how both the place and power of the state, discipline and the ‘self’ constructed the professional identity of the rural nurse. Rural nursing practice became more visible and was questioned during the restructuring of the health care reforms as to how and why these nurses’ practice the way in which they do; in parallel as national nurses’ raised their concerns that their full potential was not being realised. Situating rural nursing practice within the domain of these regulatory and legal structures and rural values that are aligned with the national and regional socio-political and economic issues. These issues contributed to the significant changes to the delivery of health care that has shaped the practice of nurses within the confines of an array of governance structures associated with ‘locale’. Issues related to ‘locale’ are now discussed.
8.5.2 ‘Locale’ and governance structures

‘Place’ as ‘locale’ provides the space where social relations emerge (Agnew, 1987) and rural nurses’ practice is built on developing these relations and a shared identity develops as “social interaction helps forge values, attitudes and behaviours” (Agnew, 2011: 23). This study found that the models of rural nursing practice identified, were attributed to ‘locale’ developed both from within the rural community in collaboration with community residents, local health care professionals and beyond the community in alignment with state governance structures, and this further uncovers how the professional identity of the rural nurse was constructed.

In Figure: 8.1 the governing structures associated in ‘location’ are represented with the colour green. As further analysed from the data the rural nurses’ are also associated with ‘locale’, as defined by Agnew (1987), and their practice is also governed by both the state and discipline as highlighted previously in alignment with ‘place’ as ‘location’. The RCTs established a ‘locale’ governance model, including community members and health professionals who had a goal to improve local health care. The ongoing developments associated with the changes to the models of practice during the policy and neo-liberal reforms undertaken during the 1990s and 2000s, provided these rural nurses with an opportunity to construct new models of practice. New funding structures, in the form of a trust employing the health professionals including the GPs (Barrett and Barrett, 2005), provided the opportunity for the rural nurses’ role to expand which offered them a chance to self-govern as they went about meeting the needs of the rural communities’ health requirements. Examples of self-governing practice have been identified as providing holistic, emergency and on-call (in the form of PRIME discussed in Chapters five and six) health care. These evolving models of practice permitted these nurses to engage with colleagues, including rural nurses, practice nurses, public health nurses and district nurses as well as GPs leading to effective teamwork. The ability of the rural nurse to practice ‘in-between’ various locations and sites which was identified and analysed from the data in Chapter six, which had benefits for the host communities and offered the rural nurse a flexible (self-governing) PHC practice. Once again it is interesting to note that the second and third elements of the nursing core concepts of caring can also be aligned with ‘place’ as ‘locale’.
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PHC is usually the first point of contact that patients have with the health care system (Ministry of Health, 2001). The activities provided by PHC practitioners promote the health of the population they care for, manage episodes of illness, including acute and chronic presentations of disease management, end of life care as well as providing emergency care (Horner, 2008; McMurray and Clendon, 2015). Rural health care practitioners care for all ages of the rural residents, visitors, and transient and seasonal workers when they require health care (Fitzwater, 2008). Health care is provided by a number of formal, informal and evolving health care models to ensure residents can access health care ‘24 hours’ a day (as analysed from the thesis data and presented in Chapters five and six). In 1999 the Labour-led Coalition government came into office moving away from a National-led Coalition government and a change in focus enhanced the contribution nurses could make in relation to the reduction of health inequalities by increasing access to health care (Ministry of Health, 2001; McMurray and Clendon, 2015). Rural nurses experienced a number of opportunities as they become involved in the community and with its residents while developing a long term relationship with patients and their families and performing their practice in a flexible, adaptable and autonomous way which further enhances partnership and trust with rural residents as supported by the work of Joseph and Chalmers (1995).

Equally, challenges have also been recognized from the data and these include personal and professional isolation, limited on-going education and lack of anonymity. A lack of anonymity associated with nursing in the rural community has been particularly well recognised in the international literature (Bushy, 2000; Winters and Lee, 2010) in which the rural nurse identifies and becomes familiar with both the positive and negative experiences simultaneously of being a rural nurse and a community resident. As the rural nurse engages with the host rural community residents, social relationships develop, however the rural nurse is typically a member of the community on a professional basis. Rural nurses have to negotiate their practice and this becomes reliant on his or her, own self-governance, which also forms a component of what constructs the professional identity of the rural nurse. This contemporary approach of governing encourages individuals to take responsibility for their own actions and furthermore the outcomes of these actions. Individuals conduct and govern their own practice, by enhancing forms of freedom which are mediated through a complex flow of relations between different groups and
organisations, which changes with evolving circumstances overtime. What can be inferred from these examples is that the rural nurse takes up this self-governing RN scope of practice and adapts to the changing contexts in order to continue to provide a sustainable health care service.

This study has exposed a strong sense of professionalism, and includes the way in which the rural nurse connects with the local community residents, as they engage in the health care system. These participants’ demonstrated that they value the relationships developed within ‘locale’ and that this further constructs their professional identity as they perform their practice in the rural. The rural nurses’ professional identity has been constructed as social relationships form within the rural community. This study has demonstrated that the rural nurse encounters, develops and maintains numerous relationships, as they go about their daily practice in the capacity as a RN, engaging with local community residents, co-workers, clients their families and social networks. For nurses in rural practice, this concept of community membership with rural community residents differentiates the personal and professional boundaries associated with their dual relationship, which occurs within a rural community noted by O’Malley, et al. (2009) and likewise within this study.

In the meantime, it is worth considering additional relationships that are external to a rural community which often support a nurses’ professional and personal development as discussed previously with reference to the governing structures such as the state and the discipline of nursing. These relations develop both within and external to the ‘location’ and ‘locale’ as discussed by Massey (2005) as ‘flows and movement’, which capture ‘the other’, difference, boundaries and power relations. As ‘place’ becomes a meaningful location, this once basic notion associated with the physical geographical setting has become understood as a complex relational and a reactionary concept, which is understood from both within the rural location and beyond (non-rural) locations. Relational aspects associate place within the broader realm of the socio-political, economic and cultural contexts that they are positioned in locally; regionally; nationally and globally (Agniew, 2011). Massey (2005) argues that space is linked with interrelations associated as embedded practices, which can occur in the global or local contexts. Embedded practices in this sense refer to being rooted or entrenched which has been referred to as ‘location’ as discussed previously.
by Agnew (1987). The rural nurse identifies with and connects with rural community members and a shared sense of belonging develops in ‘location’. ‘Location’ in this sense connects the rural nurse with a ‘sense of belonging’ and being connected with the ‘rural cultural norms which further constructs and governs the rural nurses’ practice which will be presented as the third element linked with Agnew’s (1987) ‘place framework’, a ‘sense of place’ and the associated governance structures within the ‘rural’ that further construct the rural nurses’ identity which is now considered.

8.5.3 ‘Sense of place’ and governance

‘Sense of place’ situated in Figure: 7.1 and 8.1, displayed in yellow is associated with the emotional attachment rural nurses experience with the ‘location’ and ‘locale’ where a strong sense of attachment and belonging and community engagement are established. Agnew (1987) describes ‘sense of place’ as the space in which meaning emerges for an individual through emotional and attachments of belonging with a location. A “sense of place… is a necessary prerequisite for social solidarity and collective action” (Agnew, 2011: 24) ‘sense of place’ has been identified in this study as the rural nurses’ experienced and developed emotional attachments associated with a rural community, in which the rural nurse worked and generally resided in as well. Attachments are accompanied in general with a willingness on the part of local residents, including rural nurses, to contribute to the community. In the case of rural nurses, their contribution has been identified with a strong commitment providing individualised holistic models of care for community members and their families. Long-term relationships have been developed through which the rural nurse cares for residents providing continuing care in numerous localised settings and structures. The rural nurse participants’ demonstrated a commitment in their responses that helps to ensure clients had a positive experience when engaging with the nurse in either formal health care services or informal models and were well cared for.

The rural nurses’ ‘sense of place’ has shaped their practice. Examples, from Chapters five, six and seven reveal how rural nurses went about practising to support the rural community residents and to improve access to health care. Further, there is evidence to support that rural nurses’ take into consideration local community values in the form of caring for community members, being available to offer advice and health
care while on and off duty and being ‘known’ in the community as the locale nurse which results in the development of personal and professional connections being made together within the rural location. In rural communities this study shows the residents know each other as well as the rural nurse and have developed a community connectedness, which makes a difference in how people interact together and with the rural nurses. It is this unique, dual relationship rural nurses have with rural residents, in which they manage both professional and personal obligations. These relationships associate the rural nurse in a professional relationship with a community member and at the same time this community member is also the nurse’s neighbour and/or friend (Hughes, 2009). What is clear from this study is that rural nurses experience this dual relationship as both an opportunity and as a challenge. Professional isolation is one example, which has been identified with both a positive and a negative response. Geographical and professional isolation has provided these nurses with an opportunity to forge new models of practice which are true to the essence of nursing while caring for the whole person, family and community. In doing so there is a lack of peer support and clinical supervision and their practice may span far beyond the RNs scope of practice.

People develop a shared identity by identifying with likeminded people, groups and places where a number of shared meanings; attachments and feelings are held (Goodrich and Sampson, 2008). Identity, in this respect, attracts a number of related values and beliefs, including an expected form of behaviour and performance (Goodrich and Sampson, 2008) and the resultant emergence of a ‘sense of belonging’. A person’s awareness of self is linked to the location in which a sense of belonging evolves, demonstrated in this thesis as the rural nurses being aware of the need to maintain appropriate behaviour connected with the rural cultural norms whilst in their professional capacity, as well as being a resident member of the community referred to as rural knowledge. Dedicated rural knowledge and values governs the rural nurses’ practice, which further guides their conduct and practice in which the individual rural nurse self-governs and decides how they will perform their practice in accordance with state and discipline governing structures and has been referred to in this thesis as the rural values that govern practice. It is this notion of identifying with likeminded people and recognising at the same time, that the rural nurse is positioned ‘in-between’, being a member of the rural community at the same time as the rural
nurse is a member of the profession of nursing in which the rural nurse manages these positions. Once again it is pertinent to reflect on nursing core concepts of caring while aligning the ‘sense of place’ with the fourth concept, ‘nursing’. It is now timely to discuss how the professional identity of the rural nurse from the study location has evolved.

8.6 **The rural nurse’s evolving professional identity**

The ‘rural nurses’ evolving professional identity was established in the 1990s and was initially constructed by the nurses themselves as they engaged with their rural locations in the Otago region and the West Coast of New Zealand (Ross, 1999, 2008). These nurses have identified with either the occupational title ‘rural nurse’ or ‘RNS’. The concept of the RNS was introduced in Chapter one and discussed in association with the contextual issues analysed and presented in Chapter five, and as detailed with respect to the RNS’s role in Chapter six. As the delivery of rural health care was being transformed, predominantly in response to emerging rural community governance and the provision of the communities’ own health care structures in the form of RCTs, the nurse’s practice in this context, was referred to as a ‘generalist specialist’ area of nursing practice (O’Malley, et al., 2009). As the rural nurses’ practice became more extensive and varied the nurses became aware that the existing occupational titles associated with community nursing practice, including practice nurse, public health nurse or district nurse did not embody all of the rural nurses’ unique aspects to their practice as discussed in this study. It was therefore appropriate to move away from those traditional titles and take up the occupational title, ‘rural nurse’ which represented the particular nuances aligned with nursing in a rural context, for example, their advancing, adaptable and flexible evolving models of practice.

The nurse participants in this study noted that the changes brought about by the health care reforms did indeed result in them adapting their practice to accommodate this ideological shift from one of the welfare state to the neo-liberal movement which changed their practice models. These models identified rural nursing as a ‘specialist’ or ‘specialty’ practice, and initially occurred in response to a change or acknowledgment that indeed these nurses were practising in a ‘generalist’ role
constructed in the ‘rural’ (O’Malley, et al., 2009). The way these nurses practiced in rural locations was becoming more noticeable in the 1990s and the rural nurses’ themselves were identifying as a collective group of nurses with specific educational requirements and the need for support to reduce their personal and professional isolation (Ross, 1996; O’Malley and Fearnley, 2007).

‘Specialty’ practice, rather than ‘specialist practice’ was a new term connected with during the 1990s within nursing at a national level rather than within regional settings. From the national perspective ‘specialty practice’ was situated alongside an educational framework which differentiated nursing practice as a ‘specialty’ compared to advanced practice educational programmes (Jacob and Boddy, 2008). The development of this educational framework was formed around the bases of post-registration and postgraduate education, which also included the concept of ‘specialty’ nursing practice and the evolving role and development of the NP (established in New Zealand in 2001). It is the terminology used concerning ‘specialty’ and ‘specialist’ aspects of practice which has been exemplified as a component of the thesis argument as it aligns with how some of the rural nurses from the study region identified themselves as a RNS which has been in my opinion, in opposition to the NCNZ education framework in which the perception of ‘specialty’ is the preferred term, rather than ‘specialist’ area of nursing expertise (Nursing Council of New Zealand, 1999). This inadequate view and the lack of acknowledgment of the RNS by NCNZ has persisted throughout the developments of advanced nursing practice in New Zealand during the latter part of the 1990 and early 2000s (O’Malley, et al., 2009).

The occupational title rural nurse or RNS has still not, by 2016, been formalised by the NCNZ as an identified specialty of nursing practice, as exemplified in the content of the application for nurses’ annual practicing certificate registration. However, in 2012 some headway was made when the NCNZ introduced an additional code related to the employment location (and not dedicated to nursing specialty associated with rural practice) termed the employment code ‘24 Rural’ and added this to the RN annual practicing certificate registration form. Each nurse requesting a current practising certificate on the basis of which demographic and statistical information is generated completes the registration form on a yearly basis. The Ministry of Health
asked NCNZ to collect, on its behalf, statistical and demographic information from nurses who practise in rural locations (Nursing Council of New Zealand, pers. comm. February 2015). From 2012 NCNZ added to the Annual Practising Certificate Registration Form (Appendix: 9) an additional question (referred to as ‘rural setting’) which is aligned to the category related to the nurses’ “employment setting” in an attempt to generate additional data from RNs. Equally, question 14 on the same form invites the RN to nominate an identified area of nursing practice as their preferred specialty (discussed in Chapter two) referred as the RNs most recent nursing practice, in which there are 28 practice codes that distinguish various aspects of nursing practice, for example emergency and trauma, nursing research, primary health care, and cancer, and there is one further code dedicated to “Other (specify)”. However, there is not a practice code identifying nursing practice within the realm of ‘rural nursing’ or RNS and even at this stage, rural nurses question whether they can qualify as a rural nurse (analysed from the data and presented in Chapter five).

An interesting juxtaposed position between the governing body (NCNZ) associated with the discipline of nursing and a group of nurses who identify with the professional title RNS or ‘rural nurse’ has developed. In consideration of this dilemma NCNZ link rural nursing with a geographical or employment location associated with where the nurse works or is employed and not with a specialised field of practice, which leads to an inadequate recognition of the speciality practice of the rural nurse by NCNZ. And, ultimately, leads to whether the nurse identifies with this criteria as a ‘rural nurse’. In addition, there is no definition or guidance stipulated on the annual practicing certificate information sheet about how the NCNZ identifies and defines ‘rural’. These issues may limit the ability of rural nurses to identify with the rural environment. In order for nurses to practice rural nursing it is imperative that they understand the ‘rural’ (discussed in Chapter three). The NCNZ has not yet recognised rural nursing as a distinct area of nursing practice, and this inattention has resulted in the lack of the generation of statistical data, for example, how many rural nurses there are in practice, or where they are physically located. In parallel there is no realistic workforce planning, education and professional support even the Health Workforce Innovative Programme (2009) has limited statistical data in support of its cause.
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This study has demonstrated that the professional identity of the rural nurse was established during the 1990-2000s with the restructuring of the health care system and the advancement of nursing nationally. Therefore, it is important to recognise rural nursing as a specialty area of practice, of which the distinctive aspects of this practice are understood and essential educational preparation and professional support can be developed and provided (O’Malley, et al., 2009). The identity construction of the rural nurse develops in a rural place while it is only by being in place that the identity formation of the study participants from rural Otago can be revealed and not just imagined. Diverse meanings associated with the rural can lead to contesting the meaning of rural space and the practices, which are performed in that space. The rural nurse performs their practice in this contested rural space, which is associated with multiple understandings allied with rural and non-rural individuals, organisations, policy-makers, educators and regulators. The rural, according to Mormont (1990), is a ‘category of thought’ (: 40) in which the rural is considered in the first instance as an imagined concept before it is transposed into a material form discussed by Woods (2011) as,

[…] places, landscapes and ways of life shaped to conform to the expectations that the idea of the ‘rural’ embodied. Experiences of these ‘rural’ places and lifestyles are fed back into the collective imagination, refining and modifying the idea and thus contributing to a dynamic process through which the ‘rural’ is produced and reproduced.

(: 16)

Identity formation is socially constructed and equally the rural is constructed, and over time, understanding the rural has changed, especially as urban growth has exerted increased population and economic control (Woods, 2011). It is important when considering how the formation of the professional identity of the study participants was established to reflect on relying on their perceived reality that offers insight into this professional identity. In contrast, non-rural policy-makers and organisations’ interpretations of rural nursing practice are based on their own imagined rural understandings and this needs further examination to determine the accuracy of these interpretations. The way in which the rural is experienced is different from the imaginary knowing, which is contrasted with rural reality. Rural reality, and the sharing of this reality are considered in the ‘analytical place-based
matrix’ (in Figure: 8.3 on page 261). In the interim the third component, the ‘transitional phase’ of the ‘analytical place-based matrix’ is introduced in the following sub-section.

8.6.1 The ‘transformational phase’

The ‘transformational phase’ is responsive of the change and reaction to the period associated with the 2000s and recognises that a new nursing identity and models of practice were being developed while being anchored in the rural. The ‘transformational phase’ can be associated with Lewin’s final component of his interpretation of the change process, the ‘refreezing phase’. I acknowledge this ‘refreezing phase’ as the phase in which there are new ways of performing and I look to Massey’s (1999) conceptualisation of space to present this discussion in which activities occur. Space, provides the opportunities for fresh insights to develop in which the transformational activities aligned with the establishment of the evolving models of rural nursing and their professional identity was developing. Space, for the purposes of this thesis, is not a fixed entity, or a receptacle that can be filled (Rose, 1999) but in contrast it is in constant dynamic and political movement or action (Massey, 1999). Space co-exists as multiple or as a plural activity in Massey’s (2005) words “as the sphere of the possibility of existence” (: 9). Where plural activity occurs then, equally, there will be either relations, embodied through difference, or sameness which are displayed as a component of the ‘transformational phase’ in Figure: 8.2 on the following page.
Figure: 8.2  'Transformational phase'
Source: Compiled by the author.
The ‘transformational phase’, comprises a pair of branches that are representative of openness providing an opportunity in which I have been able to reflect and consider the transformational activities associated with the 1990s and 2000s time period. The pair of branches represents the increasing regional developments and the decreasing state authority and structures illustrative of the neo-liberal period. This neo-liberal period resulted in the development of a change to the way health care was funded and ultimately delivered, which included transforming the models of health care and effectively the local and national governance structures including state, discipline and self-governance which have been demonstrated in this thesis as constructing and shaping the rural nurses’ professional identity (refer back to Figure: 8.1). To achieve a deeper understanding of the changes which occurred, the theories of place from social geography and nursing were simultaneously engaged with in the process of positioning the rural nurses’ identity, as transformational while revealing their contribution for the delivery of rural health care from the rural Otago region.

It is in this final section of this Chapter that the professional identity of the rural nurse is revealed when space and place work together, a notion of difference is embraced and the transformational aspects as identified associated with this discovery, are exposed. A ‘sense of difference and a ‘sense of change’ was exposed from the analysed data, in which a ‘sense of self’, of the rural nurse, has emerged. Foucault (1990) explained that a sense of ‘self’ could only be experienced in numerous ways as subject positions. When individuals are looking after themselves they are able, through an ethic of the self, to make changes to themselves, which introduces the possibility to practice in a more freeway. New forms of practice create new forms of subjectivity and a liberating form of identity (Fejes, 2008).

8.6.2 Embracing difference

The aim of this section of the Chapter is to acknowledge rural nursing as ‘different’, having identified professional requirements that are unlike those of urban nurses, as rural nurses have unique aspects associated with practising and negotiating the rural. Aspects of practising and negotiating the rural have been identified in this thesis and are associated with requiring specific regulation, educational and professional needs. The rural nurses’ consideration of the establishment of their professional identity as
analysed and identified (in Chapter five) as a ‘sense of difference’ is further associated with distinctive differences between rural nurses and non-rural nurses. While de Leeuw et al. (2011) defines identity formation as relational, and argues that relational identity is subject to change and difference is experienced between people and places. This is, in particular, reflected in how the rural nurse goes about their practice and engagement with clients associated with rural communities that have emerged as an important characteristic in the search to establish what constitutes the professional identity of the rural nurse.

In consideration of how the professional identity of the rural nurse was constituted in this study, it is necessary to acknowledge the relations, which formed together in this process. This thinking resonates with the key core themes (presented in Chapters five, six and seven) and this opens up the political, governance and power structures governing rural nurses’ practice and promotes the professional identity of the rural nurse. The purpose of engaging with Massey’s (2005) proposition of space allows for a constructive approach through which to engage with the thesis argument presented in this section. The concept of space (initially introduced in Chapter three) was associated with the relational aspects aligned with place and landscape. Space has taken on different meanings within social geography (Agnew, 2011) and there are different schools of thought about what makes up space and its relationships with place (Agnew, 2011). I have engaged with the suggestion put forward by Agnew (2011) whose thinking guides the thesis argument as it highlights the reality that place and space can work together and maintain and support each other. Space, according to Massey (2005), does not exist prior to identity formation but instead identities and the relations between them are co-constitutive, which indicates the world is made through relations, relations that are either connected together or display aspects of difference, which exhibit issues of boundary settings and power relations.

Space therefore offers the opportunity to accept that difference is a part of identity existence and instead of placing boundaries around identities, which Massey (2005) refers to as ‘turf guarding’, there is a need to rather acknowledge and accept difference. As the profession of nursing accepts rural nursing as different in terms of the way in which rural nurses practice within formal, informal and evolving models, which at times are in opposition to the dominant practice models of nursing. By
engaging with the concept ‘space’, this permits the profession to become creative and to understand and accept rural nursing practice is not the same as urban nursing practice and to celebrate these differences. The following and final section of this Chapter advances on this argument which is presented diagrammatically in the ‘analytical place-based matrix’ (in Figure: 8.3) which aligns together all three phases of the ‘matrix’ which reflects on the research argument.

8.7 The ‘analytical place-based matrix’

This ‘analytical place-based matrix’ (presented in Figure: 8.3) provides a distinctive presentation through which to potentially capture the interest of the profession, including both rural nurses and non-rural nurses. Further, presenting this ‘matrix’ aims to open up and stimulate constructive dialogue between rural nurses and the broader nursing profession as a whole through which to appreciate the aspects of nursing that align together and to demonstrate features that are different.

Additionally, there is an opportunity for those in governing structures to dialogue with rural nurses, prior to developing policies and guidelines that could in effect support rural nurses’ practice and further enhance the delivery and access of rural health care. This diagrammatic representation is in keeping with the intent that a visual interpretation can further assist any written dialogue, as discussed in relation to the photo images introduced in Chapter four.
Available from the author

Figure: 8.3  'Analytical place-based matrix'
Source: Compiled by the author.
The ‘analytical place-based matrix’ (Figure: 8.3) frames up the thesis argument which is a central component of the thesis aims which have sought to present how the relational aspects associated with the professional identity of the rural nurse from the study location were established in the 1990s-2000s. The ‘analytical place-based matrix’ is composed of three phases: including the ‘contextual phase’, the ‘performance phase’ and the ‘transformational phase’. The ‘contextual and the transformational phases’ (Figures: 2.1 and 8.2, respectively) comprise separate branches of the ‘analytical place-based matrix’ in Figure: 8.3 (adapted version of the ‘Funnel Model’ by Broman and Robèrt, 2015). These branches are in opposition to each other, and are positioned specifically to present the influences of the contextual issues and the events which occurred during 1990-2000s, which impacted on the professional practice of the rural nurses situated in rural Otago.

The branches of the ‘contextual phase’ have been designed to project inwards to visually reflect the build-up of a sense of pressure (or squeeze, as emphasised by Robèrt, 2000) which was experienced, and how a crisis was averted given the events which took place in the ‘performance phase’ in Figure: 8.1.

In contrast the second pair of branches are associated with the third component of the ‘matrix’ and are represented in the ‘transformational phase’ which offers an ‘openness’ depicted in this phase as space and offers the opportunity through which to reflect and consider the transformational (and relational) activities that contributed to the construction of the rural nurse. These activities involved the change to the health care reforms and the advancement of nursing, the movement and flows which took place during this time period as represented locally, regionally, nationally and internationally, and reveals the professional identity of the rural nurse. Equally their contribution to the delivery of health care in the rural context is also exposed. The construction of the rural nurse is not finished and will never be complete as the rural space in which this identity is constructed is never closed and always in a state of ‘becoming’.

These two sets of branches represent a juxtaposed position associated with the changing health care system and the practice of national nursing practice from decreasing national or state resources, identified in the first phase of the ‘matrix’ the
The professional identity of the rural nurse is not a fixed expression of how the rural nurse is constructed. The construction of identity involves a number of circumstances, which came together and are associated with specific periods of time. The development of nursing practice in rural locations in New Zealand has taken place within a changing socio-political economic and legislative background over the previous century. Despite these changes, nurses have contributed to the delivery of health care to rural New Zealanders. Nurses who have and continue to practice in rural New Zealand throughout the twentieth and twenty-first centuries have adapted and changed their practice to accommodate the various state reforms, policy developments and the evolving discipline of nursing as a result of professional developments, regulatory changes and educational advancements. The professional identity of the rural nurse was significantly reshaped following the national economic policy changes in the 1980s, which had a dramatic effect on the New Zealand economy and in particular on the rural sector. The progressive development of the rural nurse identity has been revealed by drawing on the theories of identity and place associated with social geography and the notion of governmentality.

The national health care reforms and the significant changes of the delivery of health care occurred in both the rural study location and the national setting and are both referred to as the thesis argument progresses and influenced the construction of the
professional identity of the rural nurse from the study location. The thesis argument advances on from the historical and contextual analyses (discussed in Chapter two) that provided the foundation from which to engage with the socio-political and economic periods leading up to and including the major health care reforms, throughout the 1980s and 2000s (Gauld, 2001). The restructuring and funding of the changes in the health care system were initially driven by the National government in the late 1980s and took effect in the early 1990s. A change in this political ideology during this time period was influenced by neo-liberalism and this relates to the economic changes from the late 1980s in New Zealand (Oliver, 1988). Neo-liberalism, encourages individuals to take responsibility for their own actions and furthermore the outcomes of those actions. Individuals are expected (by state authorities) to conduct and govern their own practice, this occurs by enhancing a certain form of freedom. During the 1990s neo-liberalism reduced the responsibility of the state and the welfare sector, while transferring responsibility to the individual or organisations. As responsibility was relocated, so too was the funding structures which made way for the HFA to enter into contracts with a number of different health care providers. These providers offered a range of health care services which eventually led to a competitive health care delivery model (Hornblow, 1997) and increasing competition amongst health professionals. This resulted in health professionals, the funders and health care groups having a wider appreciation of the determinants of ill-health than ever before and the importance of providing cost-effective health care (McMurray and Clendon, 2015).

The restructuring and the change of funding for the delivery of health care, resulted in health care professionals becoming accountable to a number of different organisations with a variety of funding structures, each with their own goals and visions. This led to a situation in which the system came under tremendous strain. For example, in the provision of community health care, the independent contracting status and the differing employment status of GPs, practice nurses, and other PHC providers led to tensions within the health care team (Toop et al., 1996). The funding for general practice and in particular that of practice nurses has been an ongoing controversial aspect of the delivery of health care (Docherty, 1998; McMurray and Clendon, 2015). These numerous contracts affected community nurses’ practice in that their practice
could potentially be comprised of three or more contracts with each of them associated with different occupational titles (Litchfield, 2001).

In the rural Otago region a neo-liberal focus was played out, through engaging with the development of RCTs in the 1990s. For RCTs to be effective required partnerships to develop between rural health care professionals and community members who together designed and managed the local health care services, which Gauld (2000) explains was one positive outcome of the major health care reforms of the 1980s-1990s. The model of RCTs shifted the governance of health care from one of state welfare to local community control (Barnett and Barnett, 2001) and the benefits that resulted were that they became the funding structure for the delivery of local rural community health care, which in effect improved and supported community participation.

Further restructuring was extended by the Labour government in the early 2000s, with the creation of the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) in 2001. The ‘Primary Health Care Strategy’ broadened the focus of health care to include a collaborative approach and teamwork amongst the rural health care practitioners, and the improved delivery of health care, which included easier access for community residents (McMurray and Clendon, 2015). A team approach was needed to address the complexity and variety of skills required to meet the individual and/or community’s health needs. This approach was designed to promote and maintain the health of the population with an emphasis on community partnership, teamwork and positioning nurses at the centre of the delivery of community health care (Ministry of Health, 2001). Parallel to these changes was the motivation from the profession to reposition nursing, with the aim of advancing nurses’ practice so that their full potential could be harnessed, to improve and reduce inequalities in the provision of health care (Ministry of Health, 2001). All of these contextual and relational aspects have contributed to and been a part of the construction of the professional identity of the rural nurse from the rural Otago region. It is now timely to summarise this Chapter.
8.8 Summary of Chapter

This Chapter has presented the thesis argument, initially reflecting on the research aims and rationale for undertaking this study to establish how the professional identity of the rural nurse from the rural Otago location was constructed during the identified study period. The 1990 and 2000s was chosen as the appropriate time period for the research phase of this investigation, because of the significant changes to the delivery and funding of rural health care, which occurred at that time. The restructuring of the health care system initially changed the practice of nursing in this rural location and over time led to these nurses identifying as being different from the conventional professional identity aligned with national nursing’s identity. The professional identity of the ‘rural nurse’ as discussed within this thesis has been revealed as being constructed from both within and beyond the rural physical location.

This Chapter has identified that space and place are important concepts engaged with individually, however it has been further shown in this thesis that when space and place work together they form a powerful analytical lens (Agnew, 2004) and this relates to how the world is made meaningful and in which social relationships develop. The emerging rural nurse identity is coupled with the reality that the rural nurse does indeed engage with a ‘sense of belonging’ analysed and presented by engaging with Agnew’s (1987) ‘place framework’, and with ‘locale’ which is used in reference to a setting or settings in which every-day social life takes place. Further, there is development and maintenance of relationships, both internal and external to the location, where relationships are developed both within and beyond the immediate setting, including the connection with a variety of governance structures. Building and sustaining effective relationships by a nurse with local residents is a distinctive feature of rural nursing practice. Social relations are more complex than simply an interaction between humans; rather, these include dynamic political movements among those who are in the relationship and who reside in the same shared space is important that the rural nurse learns to understand the political tensions (local, regional and national) as this ability facilitates the nurse in their professional practice and community engagement.
Three elements associated with Agnew’s (1987) ‘place framework’, ‘location’, ‘locale’ and a ‘sense of place’ were used as a platform from which to present the analyses in the previous three Chapters which has been developed further in this Chapter through aligning the analysis with the notion of governmentality. Engaging with governmentality and the concept of place (Agnew, 1987) has demonstrated how the health care restructuring progressed from state welfare governance through to the neo-liberal reforms and self-governance, by engaging with RCTs in the 1990s and then the ‘Primary Health Care Strategy’ (Ministry of Health, 2001) in the early 2000s. It was during this period that rural nurses adapted their practice to accommodate these changes and communities’ health needs, and in so doing the current, distinctive and self-identified identity of the rural nurse emerged.

The diagrammatic ‘analytical place-based analytical matrix’ (Figure: 8.3) based on an adapted version of the ‘Funnel Model’ (Broman and Robèrt, 2015) has been used to provide a visual representation of the combination of a myriad of relational and governance structures associated with establishing the professional identity of the rural nurse. This diagrammatic representation is in keeping with the intent that a visual interpretation can further assist the written dialogue. Framing up the thesis argument in this way provides a distinctive and unique theoretical, conceptual and visual presentation through which to reflect the voices of rural nurses and to potentially capture interest from the profession, organisations and policy-makers. The aim of enhancing and furthering the critical dialogue stresses the importance of the contextual analyses associated with the considerations, which have had a major effect on the construction of the professional identity of the rural nurse. The final Chapter of this thesis provides the conclusion, reflections and potential new directions.
The rural is not a pre-determined and discrete geographical territory, and neither is it a fantasy of the imagination. Rather, viewed from a relational perspective, the rural comprises millions of dynamic meeting-points, where different networks, and flows and processes are knotted together in unique ways…

(Woods, 2011: 291)

9.1 Introduction

In this Chapter I provide a summary of the major findings of this study and present the research recommendations for potential new and ongoing research projects and reflect on the thesis limitations. The concluding comments and reflections on these are related to the overall aims of the thesis. The objective of undertaking this thesis is considered in the first section of this Chapter in which I reflect on and reconsider the purpose of the thesis and its contributions to the wider disciplines of nursing and social geography. The second section of this Chapter reflects on my core contribution to the literature and theory development. In the process of achieving this, the question of identity construction and in particular the formation of the identity of the rural nurse are understood by engaging with the theory of place from social geography and relevant nursing literature. Identity construction of the rural nurse has been presented diagrammatically in the ‘analytical place-based matrix’ (in Figure: 8.3). This ‘matrix’ attempted to position the particular features constructing rural nurses’ practice and ultimately, professional identity, which adds to the growing body of discipline knowledge. Similarly, this ‘matrix’ demonstrates the contrast between the identified differences, similarities and relational activities experienced by rural nurses’ as exemplified in above quote by Woods (2011) in which there are different ways in which rural and non–rural nurses’ practice and governance structures exist. The study’s limitations are discussed in the third part of this Chapter and in the fourth part the implications for future research and potential opportunities are highlighted, in
an attempt to extend this research further, into the domains of the two disciplines mentioned above.

9.2 The aims this thesis

This thesis had two main aims. The overall aim has been to capture why and how the professional identity of the rural nurse was established during the 1990s and the early part of the 2000s from the rural Otago region of the South Island of New Zealand. In answering the why question what follows is the “how did this occur?” A secondary aim has been to recognise the rural nurses’ contribution to the rural health care sector. This study has shown that the 1990-2000s were aligned with a specific, complex, dynamic and changing socio-political and economic context. This changing context occurred during a particularly volatile period associated with the restructuring of the health care system resulting in a substantial change to the national and local governance structures. The changing governance structures, employment, models of nursing practice, and community engagement in the development of their own health care in the form of RCTs and the ‘Primary Health Care Strategy’ (Ministry of Health, 2001), have all contributed to the establishment of a new professional identity, which is recognised as the ‘rural nurse’. Traditional occupational titles, for example district nurse and practice nurse, were no longer adequate in defining the practice of nursing in the rural associated with the conditions and environment as highlighted above.

To this effect rural nurses collectively recognised a ‘sense of difference’ between their practice and that of urban nurses. Difference has been attributed to the rural nurse’s practice as it advanced to accommodate the particular health needs and requirements of the rural community members as the nurses’ practice flowed in-between community settings, for example the hospital, the home and the community, creating a dynamic model of health care, which helped to improve access to health care and reduce health disparities. The notion of difference was equally associated with the nurses’ specific requirements related to their professional support and the need for adequate and appropriate postgraduate education, aligned with their rural context, legislation in support of their practice and recognition of ongoing policy development. These requirements were supported by national nursing endeavours in response to releasing the full potential of nursing practice through which to improve
the delivery of health care (Jacobs, 1998; Jacobs and Boddy, 2008; McMurray and Clendon, 2015).

The restructuring of the health care environment was originally met with opposition from rural community members and health care professionals as the erosion of the state welfare governance through to one influenced by the new neo-liberal context (Barnett and Barnett, 2001). Neo-liberalism introduced a free market ideology concept aligned with the new forms of the delivery of health care, in an attempt to create competition between health care providers and reduce cost (Woods, 2011), which impacted on health policy and health professionals’ practice, including that of nurses (Litchfield, 2001; Duncan, et al., 2014). As the neo-liberal changes occurred, self-governance structures evolved and, for the rural nurse participants in this research, an opportunity arose to advocate for social justice, which meant developing partnerships with rural community members through which to enhance health care decisions and actions and improve the social determinants of health, in particular access to ‘24 hour’ health care provision and health promoting behaviours (McMurray and Clendon, 2015). These changes were primarily made manifest through the establishment of RCTs in the 1990s and from the early part of the 2000s the health care system came under the influence of and was shaped by the ‘Primary Health Care Strategy’ (Ministry of Health, 2001). During this restructuring the delivery of rural health care changed significantly as identified by the national key informant participants’ responses in comparison with the rural nurse participants’, who responded by adapting their practice to accommodate these trends and to contribute suitably to the health care environment. Contributing to the improved delivery of health care was a vision driven by national nursing aspirations in the latter part of the 1990s with the expectation of realising the full potential of nursing practice through which to improve the delivery of health care (Ministry of Health, 1998; Jacobs, 1998; Jacobs and Boddy, 2008; McMurray and Clendon, 2015). Such aspirations were further supported with the work, initially by the CRH from 1995, and later the NCRH between 1999-2002.

The restructuring of the health care system and the advancement of national nursing practice initially changed nursing practice in the rural Otago region and, over time, led to these nurses’ identifying as being different from the conventional and uniform
professional identity aligned with national nursing’s professional identity. Social geographers, including Valentine (2001), Panelli (2004) and de Leeuw et al. (2011) have acknowledged that difference occurs between those who identify with each other and those who do not. Identities are constructed in relation to other identities, and Jackson (2005) explains that individuals become aware of similarities and differences, for example rural nurses are aware of different practice values and beliefs, from their urban peers that are associated with their particular identity. Jackson (2005) advances on this argument, explaining that identities are therefore constructed in relation to similarities, and at the same time differences are observed and formed in relation to others, rather than the self. While de Leeuw et al. (2011) defines identity formation as relational, and argues that relational identity is subject to change and difference is experienced between people and places. It has therefore been fitting to engage with the discipline of social geography where difference is typically experienced within geographical spaces and between rural nursing practice and non-rural practice, the latter characteristically referred to as urban practice or urban nursing.

The rationale and motivation for this research originated in response to regional and national challenges which emerged during the 2000s from non-rural nurses who wished to understand why rural nurses’ considered their practice as different to that of urban nurses (discussed previously in Chapters one and five). Examples of the unique aspects associated with the rural nurses’ practice include their physical and professional isolation, a lack of anonymity whilst becoming and being a member of the rural community and, at the same time, offering professional health care services to those members of that community (considered as a dual-relationship as a result).

The rural nurse’s practice is broad in its scope while being generalist and holistic in nature and it overlaps with the practice of other health disciplines. Establishing rural nurses as different is not unique to New Zealand, as internationally rural nurses and their practice are challenged and misunderstood from non-rural colleagues (Scharff, 1998; 2010; Bushy, 2012). Following on from these encounters, misunderstandings have been linked between nurses and have revealed NCNZ’s lack of recognition that rural nursing is considered a ‘specialty’ area of nursing practice. Equally, misunderstandings relate to health care planners who oversee rural policy development, who generally have a predominantly urban focus, resulting in the
unequal distribution of resources, which disadvantages rural health care services, while overlooking individual rural communities’ health needs and the associated barriers existing in such areas, as rural residents seek access to health care (National Health Committee, 2010; McMurray and Clendon, 2015).

This research was undertaken in response to these challenges (as discussed above) and also sparked my desire, through this thesis, to establish and strengthen rural nurses’ awareness of their professional identity. My intention and focus has always been for rural nurses to be in a position to debate, with sufficient evidence, the role and the contribution they make in the rural health care context. The aim has been to elaborate on what constitutes the uniqueness of rural nurses’ practice, their emerging professional identity and to align this awareness with international debates regarding rural nursing, how their practice is conceptualised and how it relates to the relevant theoretical knowledge base. This awareness distinguishes rural nurses from their urban colleagues, in respect to defining their practice which is directly associated with their rural locations. Therefore the question arises as to how the professional identity, ‘rural nurse’, was constructed during the identified time period 1990-2000s? It is now timely to reflect on the said question.

9.3 The question of identity construction of the ‘rural nurse’

The professional identity of the rural nurse analysed in this thesis has been revealed as having being constructed from both within the rural Otago region and beyond this rural physical location. To understand how the professional identity of the rural nurse was established during the 1990s and 2000s, this study has undertaken a broad appreciation of identity and how identity is acted out within a rural physical context. It is in recognition of the changes during this time period that the identity of the rural nurse, (as currently referred) was established. It was in the initial development phase of the research that I was interested to investigate if there was a link between the physical location, associated with the rural Otago region and the occupational title rural nurse attributed to the nurse who performed their practice in the rural. I was therefore drawn to social geography’s approach of understanding the world and the relational activities that developed between people and places. Engaging with social geography’ concepts of place, identity and the rural together with professional caring
which is further aligned with the four concepts that make up a theory of nursing, as well as governmentality and the ‘Funnel Model’ are comprised in the conceptual framework guiding this study. These six concepts have benefitted this study’s investigation and helped in the achievement of the thesis aims. This research has captured how and why the professional identity of the rural nurse was forged during this time period and has revealed the unique aspects and particular attributes which are associated with rural nursing practice, as identified from the key conceptual analytical lens, as a ‘sense of difference’, a ‘sense of change’ and a ‘sense of self.’ There have been a variety of relational activities which have constructed the professional identity of the rural nurse which have been identified by engaging in this study, represented diagrammatically in Figure: 9.1 in the following sub-section.

### 9.3.1 Relational activities

The rural nurses associated with this thesis (the participants) have been identified as being discursively positioned within a number of relational aspects, including governance structures, community involvement and the knowledge underpinning nurses’ practice, which are affiliated with place and rural contexts which have been shown in this thesis to construct the subjective position of the rural nurses’ identity as represented diagrammatically in Figure: 9.1 below.

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**Figure: 9.1  Relational activities constructing the rural nurses’ identity**

Source: Compiled by the author.
The rural nurses’ practice is situated within a context specifically reflects the rural physical location and their practice identifies with a ‘sense of difference’ in which the physical location is one aspect that constructs the practice of the rural nurse. Distance between the various health care sites and settings in which the nurse provides health care and seasonal and climatic occurrences all play a significant part in the construction of the rural nurses’ professional identity. The rural, in which, the nurse performs their practice is recognised as a contested space (Woods, 2011). This contested space is associated with multiple understandings connected with rural and non-rural individuals, organisations, policy-makers, educators and regulators (Woods, 2011; McMurray and Clendon, 2015). Social geographers recognise that the rural is an imagined concept, as a result of a romanticised view of the countryside, which has been relayed through the media, through film, poetry and art and is understood as an urban-interpretation, correlated with the ‘rural idyll’. The inferences connected with the ‘rural idyll’ associate the rural as a peaceful location, with idyllic ideas of the countryside, in contrast with the faster pace of life linked with the urban location, which are densely populated (Woods, 2011). Non-rural residents from outside rural locations have imposed the idea of the rural from this perspective and this does not necessarily connect with the people who reside in the rural community (Woods, 2011). Given this perspective, this thesis has recognised that, in order to be in the position of understanding how the professional identity of the rural nurse was constructed, it has been necessary to depend on the participants’ understandings to reveal how their identity was established, while demonstrating that the imagined or romanticised views associated with the ‘rural idyll’ contrasts with the rural nurses’ lived experiences.

i. Engaging with ‘place’

Traditionally, the profession of nursing has not routinely engaged with the discipline of social geography in undertaking its research. This thesis has however engaged with social geography’s concepts of place and identity that have proved valuable in helping provide an understanding of the relationship between the rural nurses’ professional identity construction and place. However, it has been necessary to note that despite the profession of nursing’s lack of engagement with place, as defined by social geography, nursing does connect with this concept in other ways (Carolan, et
Place associated with nursing practice has generally focused on the site of practice, which bears a resemblance to either a hospital setting, or the client’s home (Liaschenko, 1996) and generally has limited differentiation as to whether these sites are urban or rural locations.

The notion of place and nursing practice was initially recognised by Florence Nightingale in 1859 (Nightingale, 1969) that referred to nursing sites of practice as the ‘environment’ in which patients’ experienced and received health care. The environment has continued to be of interest in nursing as discussed in Chapter three when the concept of tetralogy was introduced to demonstrate the four core caring elements related to nursing. The core elements are represented as environment, person, health and nursing (Torres and Yura, 1974) and these assist to further understand the relational aspects associated with rural nursing practice (Bushy, 2012). However, more recently, Lee and McDonagh (2010) have raised the concept of situatedness as a suitable alternative concept to the ‘environment’ linked with rural nursing. Situatedness has been engaged with in relation to the shaping of rural nursing practice, and is associated with the notion of creating a healing environment within various sites and locations. Situatedness extends the nurses’ relationship and partnership between the patient, client or community which are associated with place, and which can be considered as the nurse/client proximity as suggested by Peter and Liaschenko (2004). Proximity relates to how rural nurses’ enact their practice and their moral selves with respect to their clients and community residents.

The participants reported making professional decisions related to individual clients’ circumstances on a day-to-day basis, which extends their practice in such situations as a moral responsibility, which further informs how they go about their everyday nursing practice. Rural nurses’ are connected to the notion of proximity which has entitled these nurses to extend their practice into the domains of other health care professionals, for example within the traditional domain of ‘24 hour’ of health care provision including PRIME access. Rural nurses practice in partnership, for example visiting clients’ in their own home and adapting their practice to accommodate clients’ needs. Benefitting the health care of these clients is a result of the rural nurses’ autonomous practice, which can be in concurrence with rural nurses’ moral responsibilities allied to rural cultural values, beliefs and professional accountabilities.
Rural nurses often do this to prevent clients needing to wait for some forms of treatment, and while the appropriateness of this may be debated amongst the profession as appropriate. This is generally done with the best of intention and in the interest of the client in mind. This study has shown that the rural nurses’ professional identity was constructed as a component of rural cultural issues aligned with ‘location’, ‘locale’ and ‘sense of place’ as discussed in Agnew’s (1987) ‘place framework’ including rural and non-rural governance structures which are now considered.

ii. Governance structures

Governance structures, including the state or authority governance, which legislates the practice and employment of RNs are acknowledged and their role is in accordance with the identity construction of the rural nurse. The profession of nursing also governs nurses’ practice and develops and shapes nurses’ conduct and the discipline knowledge base. Establishing and maintaining a rural health care service demands governing in-between these structures mentioned above. This research has exposed that the rural nurse governs their own practice, which is influenced by the regulation of the rural and the knowledge, which underpins rural culture, rural values and rural behaviour. These governance structures remain as dominant features in contemporary rural locations and continue to influence the power structures within the health care system (Bushy, 2000). Each of these governance structures has been presented diagrammatically in the ‘analytical place-based matrix’ (Figures: 8.1 and 8.3) which frames up the thesis argument. It also presents how the relational aspects, related with the professional identity of the rural nurse identified in this thesis were established during the 1990s and 2000s associated with the restructuring of the health care system. Combining place and governance is now considered.

iii. Combining ‘place’ and governance structures

Place and governance structures have been analysed in this thesis by engaging with the notion of governmentality which relates to multiple governing relationships. These relationships associate with self to self, to group, to populations and to wider forms of government. The ‘self’, for the purposes of this thesis, has been associated
with an ethic of the self and how the rural nurses’ have gone about and made changes to their behaviour and ultimately how they practice in the rural. This is what Foucault (1988) terms ‘technologies of the self’ which focuses on the rural nurse and how the nurse performs and governs his or her self. These governance activities are played out in rural place, which has been considered earlier as their moral responsibilities which are aligned with the rural cultural values, and further constructs their professional identity, as discussed as a ‘sense of place’ through which a sense of belonging develops and an emotional attachment occurs. In order to achieve a sense of belonging rural nurses have established insights and a knowledge base while understanding the particular attitudes associated with the community and its members. The notion of belonging is expressed by engaging with Agnew’s (1987) ‘place framework’ and in particular the third element a ‘sense of place’. Place, consequently becomes an important aspect for understanding how the professional identity of rural nurses’ associated with this study as a valuable concept in this thesis, which adds to the growing theory base, which captures the key aspects particular to rural nursing practice, and is presented in the next sub-section.

iv. Theoretical contributions

This study has made the following theoretical contribution by situating this research within the interpretive paradigm and it embeds this retrospective study within the discipline of social geography and nursing. This study engages with the theories of place which was deemed a critical variable in explaining how rural nursing practice has evolved as understood by social geographers Agnew’s (1987); Cresswell (2004) and Massey (2004). When blended together with nursing’s engagement with place as understood by Torres and Yura (1974); Liaschenko (1996a; 1996b); Peter and Liaschenko (2004) and Lee and McDonagh (2010) these concepts have contributed to a significant degree to the generation of understanding how the professional identity of the rural nurses was established in the identified study location. The rural place experience is multidimensional in which meaning is made by engaging with Agnew’s (1987) ‘place framework’ and simultaneously drawing together nursing’s comprehension of place originally equated to tetralogy (Torres and Yura, 1974). Agnew’s (1987) ‘place framework’ comprises ‘location’, ‘locale’ and ‘sense of place’ which when combined with the professional elements of nursing practice
‘environment, person and health and nursing’ as discussed by Torres and Yura (1974) and comprises these elements together. ‘Environment’ can be allied with Agnew’s (1987) ‘place framework’ as ‘location’, while ‘locale’ (where social relations develop) is compared with ‘person and health’ and ‘sense of place’ relates to nursing in particular rural nursing which is distinctive to this thesis.

The professional identity of the rural nurse has been constructed as social relations developed in ‘location’ while simultaneously social relations were developed beyond the immediate rural location, defined by Massey (2004) as the flows and movements, which provide a more thorough and deeper explanation as to how the rural nurses’ practice is constructed from both within and ‘beyond location’. As social relations developed between different groups connected with the identified numerous locations and settings of practice have also been acknowledged in this thesis by engaging with Foucault’s notion of governmentality (Gordon, 1991). Engaging with place and the theoretical contributions as understood in nursing, when combined together with governmentality has provided insight into how the professional identity of the rural nurse was established. This insight was initially discussed and diagrammatically presented in Chapter eight in the ‘analytical place-based matrix’ (Figure: 8.3) which has validated the identification of the unique professional identity of the rural nurse. As rural nurses’ engage with the significance of the theory of place this can allow them to be in the inevitable position to participate within the international rural nurse community to further develop the foundations of rural nursing theory and its knowledge base. Equally important with the generation of knowledge, is the methodology employed, which has generated the analyses and findings which reveal the relevance of this thesis, which is now reflected upon in the following section.

9.4 The complementary use of the interpretivist paradigm and context

This thesis has engaged in a qualitative study positioned within the social sciences, and has adopted an interpretive approach. I engaged with this methodology with the aim of generating knowledge relating to the participants’ experiences within a particular context (Willis, 2007). The interpretive approach sets out to understand peoples’ experience of social interaction in the world (Mackenzie and Knipe, 2006). Socially constructed knowledge reflects the contextual aspects associated with
practice relations, which in turn, constructs meaning. The physical context associated with this research has been situated in the rural Otago region of the South Island of New Zealand and this has been shared throughout this thesis in the form of a number of different textual formats. The context associated with this thesis has been a particularly important aspect of the research methodology engaged with in this study. Factors associated with the regional context, in addition to the national context, including both urban and rural New Zealand have been engaged with in this thesis in an attempt to involve the reader with the factors associated with constructing the rural nurses’ professional identity. Stemming from this engagement some limitations with the study have become apparent, which will now be reflected on.

9.5 Limitations to the study

This qualitative study was based within an identified location, the rural Otago region of the South Island of New Zealand. This study was situated within a particular historical time period (1990-2000s) which focused on a retrospective understanding of how the rural nurses’ professional identity was constructed during a significant period of change. The findings presented in this study are not generalizable and are related only to the present study being offered in this thesis. If similar studies were conducted focusing on a different historical period or geographical location while engaging with the same methodology, it may reveal findings with different interpretations and meanings through which the rural nurses’ professional identity associated with that particular context, was constructed.

The following section identifies that there is an opportunity for future research and replication of the ‘analytical place-based matrix’ (Figure: 8.3) in other studies that aim to focus on professional identity construction. In Chapter four I noted the interest that was shown by delegates when I presented a draft version of the ‘analytical place-based matrix’ at national and international conferences. Interest was made known to me from professional groups allied with rural nurses including rural police and rural clergy, as conversations progressed following my conference presentations. I could have proceeded with this line of investigation and explored the identity construction of other rural professional’s identity construction, with the view of contrasting these findings with the identity construction aligned with the rural nurses. However,
tempting though this was, it was not the intention of this thesis to pursue this line of enquiry, nonetheless, further research with other professional groups could be taken up in the future and the ‘analytical place-based matrix’ could be adapted for this purpose. However I noted and respected all of the delegates’ feedback to me and considered this as I reworked the original ‘matrix’.

Likewise, I had intended to engage with focus group meetings in an attempt to further work up the analyses with the rural nurse participants’, following the semi-structured interviews. However, due to limited time constraints and a difficulty of getting the rural nurse participants to meet together at a convenient time and venue, given the geographical distance between each of the participants, this method of data generation did not proceed.

The findings from this research could have opened up an opportunity for rural nurses who identified as Māori to further the rural nurses’ research knowledge. There was also a potential in this thesis to investigate those nurses caring for Māori, and recognise the health disparities amongst the Māori, population. In addition, this study had the potential to further identify how these rural nurses’ self-govern their practice with Māori clients, through which to improve health care access. Further limitations associated with this thesis have been acknowledged because there were no participants who identified as Māori, so a potential line of inquiry related to Māori health concerns, could not proceed.

Further reflections with the first and second research questions have revealed that these questions were very detailed and each comprised two parts combined together. Both of these questions could have been further divided into more definitive single questions, which would have benefitted the data collection and the analyses and the presentation of the findings (refer back to Chapter four). The third research question aimed to elaborate on the potential for rural nurses to advance their practice and to contribute to the rural health sector in the areas of national nursing leadership, policy development, nurse education and research which in 2006 (when I was developing the research questions) were topical national issues of concern and dominated the way the profession considered the value placed on nurses who wished to progress their careers into the advanced scope of practice. I therefore included these questions in the study
at that time, however on further reflection the majority of the participants hesitated when they attempted to answer this question as they considered the difficulties rural nurses could experience in contributing to national nursing developments in the areas mentioned above, because of their geographical rural isolated locations being often a considerable distance from major urban centres where national meetings took place.

9.6 **Implications for future research and opportunities**

This thesis is a founding piece of research. Further, studies within the realm of rural nursing could be conducted with a larger group of rural nurses, regionally, nationally and internationally. Additional research studies could provide further evidence as to the unique aspects that construct rural nursing practice as discussed in this thesis. The ‘analytical place-based matrix’ (Figure: 8.3) could be used to provide a space in which non-rural and rural nurses reflect on their own practice in accordance with their ‘place’ and the numerous governance structures constructing their practice. As rural nurses and non-rural nurses position their practice in contrast to this ‘matrix’, this may offer a focal point through which to further understand and debate the particular nuances associated with different specialty areas of nursing practice. In particular, the focus of this research was associated with rural nursing practice and how this specialty is understood.

Others associated with rural nursing practice and concerned about the health outcomes of rural Māori and non-Māori population groups could engage in future research studies, building on an awareness of the rural nurses’ professional identity and the work they undertake to improve the health care of rural communities. There is a high proportion of Māori who live in rural New Zealand, therefore by inviting nurses to describe their practice often results in engaging with the Māori community. Additionally, future work could focus on viewing the North Island and South Island separately to study the differences between the Islands’ demographics which could point to further potential disparities, differential management and funding of health services and how rural nurses’ models of practice occurs within these contexts, while taking into account the acceptance that all research related to Māori requires engagement as a consultative process with key Māori advisors.
Rural nurse academics, including Long and Weinert (1989) and Bushy (2012) from the USA, have said there is no suitable model encapsulating the unique aspects of rural nursing practice. Therefore, adding to the global rural nursing knowledge base with insights generated from this thesis may capture key aspects and issues related to identity formation, in respect to rural nursing practice from New Zealand. This knowledge can contribute to the growing body of knowledge associated with the theoretical base established previously by rural academics and rural nurses. The knowledge generated from researching nursing associated with rural nursing concepts, theory and practice acknowledges the particular issues associated with the provision of health care for rural residents. It is important to recognise this knowledge is different to urban knowledge and urban models of nursing practice and that, as policies, guidelines and legislation are being developed, the knowledge pertaining to the rural needs to be considered along with the assignment of appropriate rural personnel to add to the debate. It is essential this research and knowledge be translated into practice legislation, policy and education which guides and funds rural practice and those rural nurses are at the forefront of this endeavour. To this effect it is fundamental that nursing from a national level needs to encompass regional and local rural nurses’ experiences that can influence the policy process at governmental levels and share their experiences associated with the changes related to the neo-liberal movement and, in particular, how rural nurses’ have advanced their practice in the process associated with this approach.

The particular nuances related to the rural have been revealed in contrast to the urban in this thesis. Relying on an urban-rural classification through which to understand the rural more clearly may not be as straight forward as initially considered in New Zealand in 2006 (Statistics New Zealand, 2006). This classification was further updated in 2010 (Statistics New Zealand, 2010) to include one further classification on the urban-rural spectrum which is identified as the area outside the urban/rural profile and relates to the highly rural and remote areas in which it is acknowledged that the rural populations who reside in these areas, are less dependent or influenced on urban employment and amenities (National Health Committee, 2010). Further clarification is necessary to engage in meaningful dialogue between rural residents, rural health care practitioners and rural planners and funders. An opportunity could arise to trace the emergence and divergence of how social geographers and nursing
specialists understand the terms associated with place and the rural. Further, social geographers may consider engaging with the knowledge identified from this thesis while acknowledging there may be a wider field of evidence available through which to study rural issues. Likewise, nurses may consider engaging with the discipline of social geography in an attempt to broaden the discipline of nursing’s knowledge base. Additionally, there may be an opportunity for future collaborative research between rural nurses and social geographers emphasising further potential for knowledge generation.

9.7 Concluding comments

The exploration throughout this research has been to understand the experiences of rural nurses’ from the rural Otago region of the South Island of New Zealand encountered between the 1990s and 2000s as to how their professional identity was constituted, as well as where and how they performed their practice in the rural. The aim of the thesis has been to investigate the rural nurses' emerging practice and professional identity and their contribution to the delivery of rural health care. The health care reforms of the early 1990s created opportunities for rural nurses and the larger body of the nursing profession to address population health inequities and simultaneously advance the growth of nursing knowledge. The rural communities affiliated with this study benefitted from these changes, as the rural nurses’ adapted their practice to accommodate the rural communities’ health needs and, in so doing, the identity of the rural nurse emerged. The identity associated with the rural nurse has been constructed by three governance structures; state, discipline and self-governance. This identity is performed through the three aspects of ‘place’ as identified by Agnew (1987) ‘location, ‘locale’ and ‘sense of place’ and the notion of the caring elements and nurses’ theoretical foundation which informs nursing practice. Combining the governance structures, the concept of place and the caring elements of nursing, reveals how the identity construction of the rural nurse was established, and this has been presented diagrammatically in the ‘analytical place-based matrix’. This research has analysed rural nurses’ professional identity through the concept of a ‘sense of difference’, in which practising nursing in the rural is unlike practising nursing in the urban context. Likewise a ‘sense of change’ was analysed as associated with the major health care restructuring and national nursing’s contribution
to the delivery of health care. The expectations placed on the rural nurse by the members of the rural communities’, in addition to the rural cultural norms necessitates that the rural nurse practice with moral integrity and demonstrate moral concern for their clients and the rural community, identified from the analysis as a ‘sense of self’. It is for this very reason the professional identity of the rural nurse needs to be understood by rural nurses and likewise by the profession of nursing. This thesis provides a starting point from which to initiate a robust debate together, and embrace this sense of difference between rural and non-rural nursing practice in which rural nurses can be acknowledged and recognized with the integrity they so deserve.

This thesis concludes with a poem by Brian Turner who was introduced at the commencement of this thesis in the Preface. The purpose of including this poem draws together how the three elements associated with place ‘location’, ‘locale’ and ‘sense of place’ as presented within this thesis impacts on individuals ‘sense of self’ and distinctive relationship with the rural Otago context. As expressed by Turner (2012: 169):

From Afar

A friend asks what I miss most.
aside from friends and foes,
and I say, Most is hard to answer,
but try this: the saurian backs
of high country lands; real rivers
and mountains; ice and snow
and winds that know how to blow;
high, crusty white clouds by day
and orange and red and gold
and green lenticulars above the ranges
in the evenings. And even more
the sounds of brisk running water
and clear, hard, sharp light
in the grandest blue skies of all.

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APPENDIX: 1 Letter of invitation to contribute
Appendix Two

APPENDIX: 2 Information sheet
APPENDIX: 3 Research consent form
APPENDIX: 4 Demographic form
APPENDIX: 5 Ethical approval letter from Mr Gary Witte (2005)
APPENDIX: 6 Scholarship Review Committee Questions
APPENDIX: 7 Research Consultation Committee (approval)
APPENDIX: 8 Confidentiality agreement transcriber
APPENDIX: 9 NCNZ Annual Practising Certificate Application