Published in final edited form as:

J Rural Health. 2011 ; 27(1): 122–130. doi:10.1111/j.1748-0361.2010.00314.x.

“If Only Someone Had Told Me...”: Lessons From Rural Providers

Cody Chipp, PhD¹, Sarah Dewane, MS¹, Christiane Brems, PhD, ABPP¹, Mark E. Johnson, PhD¹, Teddy D. Warner, PhD², and Laura W. Roberts, MD³

¹Center for Behavioral Health Research and Services, University of Alaska Anchorage, Anchorage, Alaska

²Department of Family and Community Medicine, University of New Mexico School of Medicine, Albuquerque, New Mexico

³Department of Psychiatry and Behavioral Medicine, Medical College of Wisconsin, Milwaukee, Wisconsin

Abstract

Purpose—Health care providers face challenges in rural service delivery due to the unique circumstances of rural living. The intersection of rural living and health care challenges can create barriers to care that providers may not be trained to navigate, resulting in burnout and high turnover. Through the exploration of experienced rural providers’ knowledge and lessons learned, this study sought to inform future practitioners, educators, and policy makers in avenues through which to enhance training, recruiting, and maintaining a rural workforce across multiple health care domains.

Methods—Using a qualitative study design, 18 focus groups were conducted, with a total of 127 health care providers from Alaska and New Mexico. Transcribed responses from the question, “What are the 3 things you wish someone would have told you about delivering health care in rural areas?” were thematically coded.

Findings—Emergent themes coalesced into 3 overarching themes addressing practice-related factors surrounding the challenges, adaptations, and rewards of being a rural practitioner.

Conclusion—Based on the themes, a series of recommendations are offered to future rural practitioners related to community engagement, service delivery, and burnout prevention. The recommendations offered may help practitioners enter communities more respectfully and competently. They can also be used by training programs and communities to develop supportive programs for new practitioners, enabling them to retain their services and help practitioners integrate into the community. Moving toward an integrative paradigm of health care delivery wherein practitioners and communities collaborate in service delivery will be the key to enhancing rural health care and reducing disparities.

Keywords

access to care; allied health; health disparities; qualitative research; rural health care providers

According to the United States Department of Agriculture (USDA) Economic Research Service (ERS), rural and frontier America consists of approximately 80% of the US

landmass and is inhabited by 50 million people (<http://www.ers.usda.gov>). Rural America is increasingly more culturally diverse with approximately 20% of rural residents indicating their heritage as Hispanic, African American, Native America/Alaska Native, Asian, or multi-race.¹ Although rich with diversity, rural and frontier areas often have limited economic resources. Rural regions report limited economic growth, lower median income, and higher rates of poverty than their urban counterparts. These economic disparities are even greater in rural areas with concentrations of racial and ethnic minorities.²

Given the unique and complex features of rural America, many challenges arise in the provision of effective and ethical health care.³ One major challenge is related to geographic and travel barriers that rural residents and health care providers encounter.^{4–6} Due to these geographic challenges, some rural residents make trade-offs between their safe travel in inclement weather and accessing health care in a timely manner. Rural residents incur more expense to travel to regional centers to receive care that may not exist in their local community. Additionally, due to distance and access restrictions, rural residents with a chronic illness may not receive updated information regarding new treatment strategies.⁶ Residents and providers have limited access to specialized providers, consultants (ie, cardiologists, oncologists, psychiatrists), and additional resources due to the rural geography.^{7–10}

Additional impediments to effective and ethical rural health care come in many forms including economic disparities,^{11,12} navigating multiple relationships,^{3,7,13,14} cultural and communication differences,^{15–18} and regularly encountering ethical dilemmas.^{18–20} Adding to the complexity of rural practice, providers are often working in demanding environments, with heavy caseloads, high patient acuity, and limited time for vacations.^{12,13,21} Over the last decade, efforts have attempted to address these issues through the development of various rurally tailored education and training programs designed to prepare health care providers for service in rural communities.^{22,23} Although a worthy endeavor, these efforts have been marginal in their success due to the very challenges experienced by rural health care systems, including complications in recruitment, retention, and training of rural health care professionals.^{22,24}

Rural providers confront challenges related to too few continuing education opportunities²⁵ and insufficient supervision, training, and preparation for the uniqueness of providing care in rural and remote settings.^{13,26} The difficulty of practicing in rural settings with limited training opportunities, or being ill-prepared for rural practice at the onset, inhibits retention and recruitment of a rural workforce.^{27–29} These factors result in high rates of depression, burnout, and turnover among rural providers.³⁰ To develop and maintain a rural workforce and to avoid the pitfalls experienced by many rural practitioners and residents, it is vital to adequately train and prepare providers interested in rural health care. The intersection of rural living and health care challenges can create barriers to care that health care providers may not be trained to navigate, resulting in burnout and high turnover.

The purpose of this study is to enhance knowledge and understanding of the preparatory needs of professionals embarking on careers in rural health care settings. More specifically, this qualitative study provides a comprehensive analysis of what experienced rural health care providers wish they had known prior to embarking on their own careers. Through the exploration of experienced rural providers' knowledge and lessons learned, the ultimate aim of the study is to help inform future practitioners, educators, and policy makers in training, recruiting, and maintaining a rural workforce across multiple health care domains. Findings such as these are crucial in the development and maintenance of a sustainable rural workforce.

Method

Participants

Data were collected through a series of 18 (12 in Alaska, 6 in New Mexico) 90-minute focus groups of practitioners who reported having provided extensive mental or physical health care and related services in rural communities in Alaska and New Mexico. The 18 focus groups included a total of 127 participants, with 85 participants in Alaska and 42 in New Mexico. Sixteen of the 18 focus groups were conducted in non-metropolitan communities, as designated by the USDA Economic Research Service.³¹ The other 2 focus groups were conducted with individuals who reside in metropolitan centers but provide itinerant care in non-metropolitan communities. Focus group size ranged from 5 to 10, with an approximate average of 8 participants per group. Each group was composed of individuals with varying professional training (eg, physicians, physician assistants, nurse practitioners, nurses, psychologists, social workers, substance abuse counselors, licensed behavioral health counselors). Table 1 provides participants' demographic information.

Instruments

The focus group protocol consisted of 6 questions eliciting practitioners' opinions about their experience with rural practice, unique issues that influence care of patients with potentially stigmatizing illnesses, and advantages and disadvantages that arise from providing health care in rural areas. For the purpose of this study, the following question pertaining to lessons learned about rural services provision was chosen: *"What are the 3 things you wish someone would have told you about delivering health care in rural areas."* A copy of the focus group protocol is available from the corresponding author.

Procedures

Institutional Review Boards at the University of Alaska Anchorage and the University of New Mexico School of Medicine reviewed and approved this study. Participants were recruited in both states through rural health organization staff members who provided names of experienced rural health care professionals. Recruitment letters were sent to identified professionals, and arrangements were made for participation by those who responded to the recruitment letter.

Focus groups in Alaska and New Mexico used the same procedures and protocol, but they had different group leaders. Both focus group facilitators had a master's degree, and both were trained in and had considerable experience with conducting focus groups. The facilitators' role in this particular study was limited to the focus group facilitation. These focus group facilitators were supervised by doctoral-level researchers who were responsible for analyzing and interpreting the data. Once participants read, understood, and signed the informed consent, the focus group facilitator introduced the study's purpose, explaining its interest in understanding complexity of issues faced by professionals providing care in rural communities. Following the introduction, questions were asked consecutively, with each question being fully processed before asking the next question. Once a content area was thoroughly covered, the facilitator summarized the information, providing an opportunity for clarification and additional comments. Each focus group lasted approximately 90 minutes. Participants received a \$100 gift certificate for their time and effort. Focus groups were audiotaped with permission from the respondents, and they were transcribed and imported into NVivo Version 8 (QSR International Pty Ltd, Melbourne, Australia) software for qualitative analysis.

Data Analysis

To best summarize the findings, qualitative analytic procedures followed guidelines for assessing themes, domains, issues, and items as outlined in Strauss and Corbin.³² Coding was accomplished using NVivo and conducted by 2 doctoral students in clinical-community psychology who were not involved in project implementation. These coders worked under the supervision of 2 doctoral-level psychologists who served as co-investigators throughout project implementation. Given the heterogeneity of the participants within each focus group, all transcripts were combined into a single dataset and underwent thematic coding. The 2 coders independently analyzed the data, starting with line-by-line open coding to discover concepts and develop free nodes.³² Once saturation of node development was reached, all generated free nodes were discussed by the 2 coders to arrive at a single node list. Transcripts were then coded with the complete node set by both raters. Periodic meetings to compare coding assisted the raters in avoiding coding drift. Interrater agreement was maintained above 90%. Once coding was completed, free nodes were grouped into larger categories, resulting in the emergence of several themes related to the challenges, adaptations, and rewards experienced in providing health care in rural communities.

Results

Based on qualitative data analysis, 8 themes emerged from the data, representing the consolidation of smaller thematic items that surfaced in the data coding. These 8 emergent themes were coalesced into the following 3 overarching themes addressing practice-related factors surrounding:

- challenges of rural health care provision
- adaptations to rural health care challenges
- rewards of being a rural practitioner

Challenges in Rural Health Care Provision

Three subthemes were related to the overarching theme of challenges in providing care in rural practice. These subthemes include *Challenges in Community Relationship Building*, *Personal and Professional Boundaries*, and *Rural Lifestyle Challenges and Self-Care Practices*.

Challenges in Community Relationship Building—One challenge expressed by the focus group members included the barrier of establishing a relationship of trust with the community. Challenges expressed by participants included community history with previous providers, high turnover rates of providers, and concerns surrounding confidentiality. Additionally, participants discussed the importance of listening to community members' concerns regarding past providers and being aware of the lack of trust that may exist in the community. One participant clearly described the barrier of overcoming history and distrust planted by past providers:

“People have been uncomfortable with the therapist in town. They are not so much any more but initially they were. I think part of it was the predecessors. You know, people who would come in and smile and not say much and then go and spread the word that this village is a mess. It would break confidentiality. I am hearing stories that are 10 years old. I think rural folks have learned hard lessons from history and they don't forget them easily.”

Personal and Professional Boundaries—Related to the challenge of building relationships with community members was the difficulty that participants noted in

establishing and maintaining personal and professional boundaries. The challenge of maintaining personal and professional boundaries emerged as a theme from participants' discussion of navigating dual relationships and lack of anonymity, as well as setting limits on amount of service one can provide. In discussing dual relationships and lack of anonymity, participants described how rural practitioners often have multiple relationships with their patients or clients when working in a rural setting. Additionally, participants noted that in a small community, residents often discuss other members of the community, thus limiting the amount of anonymity a provider has within the community. As shown in the following quote, practitioners make special note of the intricacies of dual relationships and the power differentials surrounding relationships.

“The boundary thing is what first came to my mind because you will see clients everywhere. The person you see as a client today may pull you over for a speeding ticket tonight, so the power can shift as well with those changing roles. The whole idea of dual relationships is constant. I go to a hospital board meeting and several people there in various positions are people I used to treat.”

In addition to dual relationships and limited anonymity, respondents discussed the need to establish professional limits in service delivery with community members. Participants discussed the need for limit-setting, as practitioners can become overworked and never have a chance to rest or recuperate from their professional role. As one participant stated, *“I think when you work in a rural setting you can find yourself on call 24 hours a day. People will come to you in ways that are unseeing, unbelievably naive or intrusive, or completely innocent, almost with the expectation that you can do much more than you can.”* In addition to the need for establishing professional boundaries, respondents also noted rural lifestyle challenges that can exist and that may affect self-care practices.

Rural Lifestyle Challenges and Self-Care Practices—In addition to discussing multiple relationships that exist between professional and personal realms of living in a rural community, participants emphasized the isolation one can feel in a rural community. Furthermore, participants noted the limited amenities available in a small community. Considering multiple relationships, isolation, and limited amenities, participants strongly encouraged rural practitioners to have a well-developed self-care practice. As one respondent reported, *“Self care is one of the primary things, because of isolation; you have to be a person who knows how to nurture yourself, to replenish yourself.”*

Participants explained that lack of self-care contributes to professional burnout, a common occurrence in rural practice. As described previously, burnout can lead to providers moving in and out of a community, thus reinforcing the challenges in establishing ongoing therapeutic relationships with community members. With regard to self-care, 1 participant described the roles that self-care and limit-setting play in preventing burnout: *“You have to take care of yourself, not get burned out. Know when enough is enough, and not try to save the whole community.”* Although challenges and barriers of rural practice were discussed in great depth, respondents made a point to describe steps they have taken to adapt to such a challenging environment, as well as the rewards of living and working in rural communities.

Adaptations for Rural Health Care Challenges

Participants described several adaptations to overcoming challenges and barriers in rural health care provision, establishing 4 emergent subthemes. The subthemes included *Awareness and Knowledge of Community Diversity and Strengths, Community Involvement and Interaction, Expanded Provider Roles and Responsibilities, and Professional Consultation and Supervision.*

Awareness and Knowledge of Community Diversity and Strengths—Developing awareness and knowledge of a community's diversity and strengths was an adaptation expressed by respondents, particularly with regard to combating distrust and engaging in a therapeutic alliance with community members. Respondents indicated that spending time with local elders and leaders, respecting other established local providers and local people, and acknowledging cultural and communication differences that exist within the community all aid in developing awareness of the community's diversity and strengths. Respondents highlighted the importance of taking time and having patience in developing strong relationships with community members. The need to develop awareness of a community's strengths and diversity is represented in the following comment.

“You got to be patient, and you have to respect the people, their culture, and the area. The first thing I do when I get checked in my hotel in the new place, I get out and walk around. I love it when it's fishing time, all the people working on whatever they are doing. I stop by, I speak. I watch. I listen. We talk a little bit and I say bye and I go on to the next place. I spend my whole first day doing nothing, but just walking around.”

Community Involvement and Interaction—In addition to emphasizing development of a knowledge base about the community, participants indicated that community involvement and interaction is central to being a successful rural practitioner. The *Community Involvement and Interaction* subtheme encompasses participants' discussion of methods to build trust and establish a solid therapeutic relationship with community members. Respondents suggested being open to new experiences, avoiding self-isolation, talking with residents, and understanding that seemingly informal activities (eg, attending church, going to the local grocer, taking a walk) are all avenues to engage with and establish a presence in a community. Respondents noted that providers who practice in isolation and rarely move outside their formal boundaries of employment are often excluded from the community and find it difficult to develop and maintain therapeutic relationships. One individual elaborated on community involvement in both formal and informal functions.

“From a primary care perspective to be involved in your community in a variety of different ways whether it's from a primary care physician, being the team physician of the grade school or high school, being involved with doing sports physicals, or being involved with the community center, or doing volunteer work with the church. I mean being a part of the community and having a better understanding of the community that you're serving.”

Expanded Provider Roles and Responsibilities—Moving beyond community involvement and understanding, participants discussed being flexible and expressed the common experience of having to expand their preconceived professional roles and responsibilities when practicing in a rural community. Participants indicated that due to limited resources in rural service delivery, they had to become generalists in their field of practice and rely more on informal supports within the community. Respondents noted a need to be creative in developing treatment regimens and protocols, adjusting hours of service, and being open to new ideas and responsibilities. One participant illustrated the many roles rural practitioners may find themselves in when working in rural areas.

“I guess some things that I wish someone would have told us, and this may be an experience to private clinics in rural areas, was that I was hired as a clinician, but since then I have also become a grant writer, an administrator, coder, biller, maintenance, receptionist, social worker, pharmacist, and everything.”

Professional Consultation and Supervision—In addition to expanding roles and responsibilities, providers expressed a need to access professional consultation and supervision. Respondents noted the need to establish a network of providers with whom to discuss client or patient cases to provide the best care possible given the limited resources of rural providers. Participants described the necessity of having someone to contact to discuss all aspects of their professional life, including the difficulties of rural service provision and innovative approaches to care. The theme for professional consultation and supervision was clearly demonstrated by the following quote:

“They [providers] need to develop deep and lasting friendships with people they trust. They don’t have to be in that rural area, but some place. If you feel like things are overwhelming you, you have somebody out there. Somebody that you can trust and give you support and that you can bounce things off of.”

In addition to stressing the need for professional consultants, participants expressed a desire to have had a local mentor in the community to help ease the transition from urban to rural practice. Respondents discussed how a local mentor can bring invaluable local knowledge related to providing care in a given rural community. Local mentors can inform practitioners about cultural similarities and differences that exist within communities. Also, they can help bridge knowledge gaps of providers and aid in developing relationships with community members. As one respondent stated, *“The other thing that I really would have liked was to have set up a local mentor, to teach me about the culture, the differences and similarities rather than kind of feeling like an outsider.”*

Rewards of a Rural Practitioner

Beyond discussions of the challenges and adaptations that providers encounter in rural practice, participants expressed the rewards of working and living in a rural community. Regarding personal rewards, respondents described the natural beauty that surrounds their communities, access to outdoor activities, slower pace of life, fewer people, and limited urbanization. Although participants acknowledged the lack of urban amenities, they countered that they have an abundance of natural amenities. As 1 participant stated:

“This [rural community] is different from a big city, but it has just as many positives. They’re just different ones. So, one would want to make sure that this person’s [new practitioner] values were such that they didn’t have to have opera or theater on a frequent basis. I mean that is one of your advantages; we can go hiking in 5 minutes in a beautiful area. So there are certain things that are going to draw you to these areas.”

In addition to the natural beauty and pace of life that exists in rural communities, participants also described satisfaction with the services they provide. Respondents discussed their sense of accomplishment when successfully working in a rural community versus an urban area. This sentiment was poignantly articulated by 1 participant who said, *“I feel like I made a difference when I go home from work here that I never felt when I went home from work in a big city. And so, I feel more self-satisfaction when I go home.”*

Discussion

Multiple themes emerged from the data to represent the challenges, adaptations, and rewards of being a rural practitioner. Consistent with previous research, participants noted that rural practitioners encounter numerous challenges revolving around dual relationships, limited resources, isolation, and difficulty building a trusting relationship with a community. The respondents also provide numerous avenues through which rural providers can face and adapt to these challenges. An examination of how these challenges and adaptations intersect

follows, as do recommendations made by participants to assist new rural providers to move from feeling challenged to feeling satisfied with their rural practice.

One adaptation participants discussed in response to the challenge of community relationship building was the development of awareness of one's community's diversity and strengths, an effort deemed particularly important for novice professionals. As suggested by focus group participants, 1 avenue to building awareness about a community's diversity and strength is through community engagement, including regularly participating in informal community activities to build rapport and trust, engaging local elders and community leaders, and remaining patient in establishing relationships. As discussed by respondents, participation during informal community activities provides practitioners with ample opportunities to bond with community members. Such informal bonding can provide a foundation for future therapeutic relationship development and may help providers appear to be less like outsiders and more like integrated community members. Being viewed as community members rather than as outsiders provides practitioners a sense of belonging and may limit their sense of isolation, another challenge expressed by the participants.

Attendance at informal community activities provides important opportunities to engage local elders and community leaders. Engagement of local elders and community leaders is crucial for rural success, as these individuals often hold historical wisdom of a community and can provide direction for new practitioners. Considering that the elders and leaders may have been appointed by the community, they generally command respect; association with them serves to create a proxy of respect for new providers. Additionally, community elders and leaders may be able to persuade other community members to be more accepting of a new practitioner. Although practitioners are encouraged to engage the community and its leaders, participants recommend that providers be patient in such relationship development. Patience is necessary to overcome community distrust that has developed as a result of negative experiences with past providers (eg, experiences with practitioners breaking confidentiality, speaking poorly of the community, or departing rapidly from the community).

Although the adaptations of developing an awareness of the community's diversity and strengths, engaging the community, and developing relationships with the local leaders and elders can help overcome challenges of building relationships and avoiding isolation within a community, these adaptations can contribute to challenges of maintaining personal and professional boundaries. To overcome challenges of maintaining personal and professional boundaries, focus group participants suggested professional consultation and supervision. Consultants can provide technical expertise, and more importantly, they can foster networking with other providers facing similar issues in their own rural practice, thus reducing professional isolation. As described by participants and as discussed in the prior literature, development of professional and personal consultation relationships is vital for the sustainability of new and existing rural practices.³³

In addition to having a network of consultants, developing a balance between professional and personal boundaries will contribute greatly to professional and personal health. Indeed, balancing professional and personal boundaries is essential to preventing burnout, as respondents pointed out that overwork is a grave risk in rural communities due to limited resources and high need for services. Beyond protecting against burnout, balancing personal and professional boundaries is also an ethical obligation that requires being attuned to community culture, while being tactful in limit-setting. Specific recommendations for boundary-setting depend upon the local context. However, participants offered a few generic guidelines including tactfully avoiding talking about clinically related matters in public

venues (eg, local markets), establishing professional networks to allow time for vacations, and creating a system to allow work breaks throughout the day.

Related to workload boundary-setting is the recommendation for providers to integrate effective self-care practices into their daily lives. Participants strongly encouraged new and existing practitioners to develop and maintain effective self-care strategies to prevent burnout secondary to rural isolation, heavy workloads, and limited resources. Although self-care can consist of a specific set of personal activities to recharge and energize, it also includes healthy boundary-setting; being grounded in a network of consultants and colleagues who can assist with professional concerns; and maintaining rewarding and satisfying personal relationships with family, friends, and community members.

As indicated in the literature and by participants, rural practitioners often face challenges related to limited resources within their communities. To adapt, participants urged new practitioners to adjust their health care practices to the culture and language of the community, to develop creative service delivery solutions to match preferences and needs of the community, and to accept additional roles beyond the role of provider. Adaptation of service delivery must be driven by an accurate understanding and awareness of a community's culture, diversity, and strengths. Understanding the complexity of the community and adapting one's practice to the realities of the community can build upon existing resources and strengths in creative and meaningful ways. Through such integration, rural providers and their services can become part and parcel of the very fabric of the community.

Adapting service delivery to match the community through creative means and by expanding provider roles may contribute to the professional rewards of practicing in a rural community. As noted by participants, professional satisfaction often comes from a sense of accomplishment in providing needed services to a rural community with limited resources.

Limitations

When interpreting these findings, several possible limitations must be kept in mind. One limitation is that data collection was restricted to rural providers in Alaska and New Mexico. Although these 2 states are largely rural and providers in both states face many challenges, findings may not generalize to rural areas in other states or countries. That is, although all rural communities share common traits and challenges, they also have unique circumstances that require different adaptations. Further, given our interest in looking at commonly experienced issues confronting rural providers, we did not conduct sub-analysis comparing Alaskan and New Mexican providers. It may well be that some nuanced differences existed between the 2 states, particularly given the differences in cultural diversity. However, such sub-analysis was beyond the scope of this paper and was further restricted by sample size issues. Another limitation was the heterogeneity of the focus groups in terms of types of health care providers. This heterogeneity may have led to different findings than had the groups been more homogeneous. On the other hand, heterogeneity permitted us to explore challenges that are common to all rural health care providers, thus increasing generalizability of findings. Also related to focus group composition, it is important to note that given the participants were primarily from small rural communities, and despite assurances of confidentiality, they may have felt some restrictions in how they responded to the questions. Finally, although the professions represented in the focus groups were inclusive of medical and behavioral health care providers, findings may have been influenced by the greater proportion of behavioral health care providers, placing possible limits on generalizability.

Conclusions and Future Directions

Rural practice offers challenges and rewards that are far reaching and personal. Rural practitioners and communities can benefit greatly from competent rural practice. To date, little information has been available to help practitioners and communities optimize rural health care; however, this reality is beginning to change as awareness increases about the sizable under- and poorly served populations of rural and frontier regions in the US. This study, despite its limitations, offers valuable insights that can be used by individual practitioners and rural communities to improve rural health care. The proffered recommendations can be taken to heart by individuals, who can learn to enter communities more cautiously, respectfully, and competently. Education and training programs in rural states or with a mission to develop a rural workforce can use these recommendations to enhance curricula to help support and recruit students in rural health care. Better preparing providers for challenges in rural communities will likely lead to increased retention and job satisfaction. The recommendations are also useful for communities and seasoned rural health care providers who can collaborate to develop supportive programs for new practitioners. Such programs would serve to build supports for providers to help them integrate into the community and address issues that may lead to premature resignations. Moving toward an integrative and mutually supportive paradigm of health care delivery wherein practitioners and communities collaborate to enhance care delivery will be critical to advancing rural health care and reducing rural health and health care disparities.

Acknowledgments

This research was supported by grant 1RO1DA13139 from the National Institute on Drug Abuse. Dr. Roberts also acknowledges the support of a Career Development Award (1KO2MH01918) from the National Institute of Mental Health.

References

1. United States Department of Agriculture, Economic Research Services. Rural America at a Glance, 2009 Edition. [Accessed June 3, 2010]. Available at: <http://www.ers.usda.gov/Publications/EIB59>
2. United States Department of Agriculture, Economic Research Services. Rural Poverty at a Glance 2004. [Accessed June 3, 2010]. Available at: <http://www.ers.usda.gov/Publications/RDRR100/>
3. Brems C, Johnson ME. Challenges and uniqueness of rural and frontier services in the United States. *J Psychol Practice* 2007;14(1):93–122.
4. Green-Hernandez C. Transportation Challenges in Rural Healthcare. *Nurse Pract* 2006;31(12):10. [PubMed: 17149129]
5. McCann S, Ryan AA, McKenna H. The challenges associated with providing community care for people with complex needs in rural areas: a qualitative investigation. *Health Socl Care Community* 2005;13(5):462–469.
6. Wong ST, Regan S. Patient perspectives on primary health care in rural communities: effects of geography on access, continuity and efficiency. *Rural Remote Health*. 2009 9:1142. Available at: http://www.rrh.org.au/publishedarticles/article_print_1142.pdf. [PubMed: 19298094]
7. Brems C, Johnson M, Warner T, Roberts L. Barriers to healthcare as reported by rural and urban interprofessional providers. *J Interprof Care* 2006;20(2):105–118. [PubMed: 16608714]
8. DeVoe JE, Krois L, Stenger R. Do children in rural areas still have different access to health care? Results from a statewide survey of Oregon's food stamp population. *J Rural Health* 2009;25(1):1–7. [PubMed: 19166555]
9. Johnson ME, Brems C, Warner TD, Roberts LW. Rural-Urban Health Care Provider Disparities in Alaska and New Mexico. *Admin Policy Ment Health & Mental Health Services Research* 2006;33(4):504–507.
10. Merwin E, Snyder A, Katz E. Differential access to quality rural healthcare: professional and policy challenges. *Fam Community Health* 2006;29(3):186–194. [PubMed: 16775468]

11. Berry AA, Katras MJ, Sano Y, Lee J, Bauer JW. Job volatility of rural, low-income mothers: A mixed methods approach. *J Family Econ Issues* 2008;29(1):5–22.
12. Brems C, Johnson ME, Warner TD, Roberts LW. Exploring differences in caseloads of rural and urban healthcare providers in Alaska and New Mexico. *Public Health* 2007;121(1):3–17. [PubMed: 17169386]
13. Barbopoulos A, Clark JM. Practising Psychology in Rural Settings: Issues and Guidelines. *Can Psychol* 2003;44(4):410–424.
14. Warner TD, Monaghan-Geernaert P, Battaglia J, Brems C, Johnson ME, Roberts LW. Ethical Considerations in Rural Health Care: A Pilot Study of Clinicians in Alaska and New Mexico. *Community Ment Health J* 2005;41(1):21–33. [PubMed: 15934173]
15. Etowa J, Wiens J, Bernard WT, Clow B. Determinants of Black women's health in rural and remote communities. *Can J Nurs Res* 2007;39(3):56–76. [PubMed: 17970460]
16. Hamrosi K, Taylor SJ, Aslani P. Issues with prescribed medications in Aboriginal communities: Aboriginal health workers' perspectives. *Rural Remote Health*. 2006 6(2):557. Available at: http://www.rrh.org.au/publishedarticles/article_print_557.pdf. [PubMed: 16683907]
17. Quintero GA, Lilliot E, Willging C. Substance abuse treatment provider views of "culture": implications for behavioral health care in rural settings. *Qual Health Res* 2007;17(9):1256–1267. [PubMed: 17968042]
18. Roberts LW, Johnson ME, Brems C, Warner TD. Ethical disparities: challenges encountered by multidisciplinary providers in fulfilling ethical standards in the care of rural and minority people. *J Rural Health* 2007;23 suppl 1:89–97. [PubMed: 18237331]
19. Cook AF, Hoas H. Ethics and Rural Healthcare: What Really Happens? What Might Help? *Am J Bioeth* 2008;8(4):52–56. [PubMed: 18576259]
20. Morley CP, Beatty PG. Ethical Problems in Rural Healthcare: Local Symptoms, Systemic Disease. *Am J Bioeth* 2008;8(4):59–60. [PubMed: 18576261]
21. Iversen L, Farmer JC, Hannaford PC. Workload pressures in rural general practice: a qualitative investigation. *Scand J Prim Health Care* 2002;20(3):139–144. [PubMed: 12389749]
22. Glasser M, Hunsaker M, Sweet K, MacDowell M, Meurer M. A comprehensive medical education program response to rural primary care needs. *Acad Med* 2008;83(10):952–961. [PubMed: 18820528]
23. Sen Gupta TK, Muray RB, McDonell A, Murphy B, Underhill AD. Rural internships for final year students: clinical experience, education and workforce. *Rural Remote Health*. 2008 8(1):827. Available at: http://www.rrh.org.au/publishedarticles/article_print_827.pdf. [PubMed: 18271675]
24. Daniels ZM, Vanleit BJ, Skipper BJ, Sanders ML, Rhyne RL. Factors in recruiting and retaining health professionals for rural practice. *J Rural Health* 2007;23(1):62–71. [PubMed: 17300480]
25. Johnson ME, Brems C, Warner TD, Roberts LW. The need for continuing education in ethics as reported by rural and urban mental health care providers. *Prof Psychol: Res Pr* 2006;37(2):183–189.
26. Hedberg PS. Challenges of rural surgery. *Surg Endosc* 2008;22(7):1582–1583. [PubMed: 18401656]
27. Jones JA, Humphreys JS, Adena MA. Rural GPs' ratings of initiatives designed to improve rural medical workforce recruitment and retention. *Rural Remote Health*. 2004 4(3):314. Available at: http://www.rrh.org.au/publishedarticles/article_print_314.pdf. [PubMed: 15885019]
28. Montour A, Baumann A, Blythe J, Hunsberger M. The changing nature of nursing work in rural and small community hospitals. *Rural Remote Health*. 2009 9(1):1089. Available at: http://www.rrh.org.au/publishedarticles/article_print_1089.pdf. [PubMed: 19199373]
29. Weymouth S, Davey C, Wright JI, et al. What are the effects of distance management on the retention of remote area nurses in Australia? *Rural Remote Health*. 2007 7(3):652. Available at: http://www.rrh.org.au/publishedarticles/article_print_652.pdf. [PubMed: 17665965]
30. Hunsberger M, Baumann A, Blythe J, Crea M. Sustaining the rural workforce: nursing perspectives on worklife challenges. *J Rural Health* 2009;25(1):17–25. [PubMed: 19166557]
31. United States Department of Agriculture Economic Research Services. Measuring Rurality: Rural-Urban Continuum Codes. 2004 [Accessed December 15, 2009]. Available at: <http://www.ers.usda.gov/Briefing/Rurality/RuralUrbCon/>

32. Strauss, A.; Corbin, J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2nd ed.. Thousand Oaks, CA: Sage Publications, Inc; 1998.
33. Lea J, Cruickshank MT. The experience of new graduate nurses in rural practice in New South Wales. Rural Remote Health. 2007 7(4):814. Available at: http://www.rrh.org.au/publishedarticles/article_print_814.pdf. [PubMed: 17958475]

Table 1

Participant Demographics, by State

	Alaska (n = 85)	New Mexico (n = 42)
Gender		
Female	58 (68.2%)	20 (47.6%)
Male	27 (31.8%)	22 (52.4%)
Ethnicity		
African American	1 (1.2%)	1 (2.4%)
Alaska Native/Native American	24 (28.2%)	5 (11.9%)
Caucasian	51 (60.0%)	25 (59.5%)
Hispanic American	2 (2.4%)	8 (19.0%)
Other	7 (8.2%)	3 (7.1%)
Occupation		
Agency Director	21 (24.7%)	3 (7.1%)
Mental Health Clinician	16 (18.8%)	9 (21.4%)
Nurse	12 (14.1%)	5 (11.9%)
Paraprofessional	9 (10.6%)	3 (7.1%)
Physician	8 (9.4%)	13 (31.0%)
Physician Assistant	3 (3.5%)	2 (4.8%)
Psychologist	10 (11.8%)	3 (7.1%)
Substance Abuse Counselor	0 (0.0%)	2 (4.8%)
Other Allied Health	6 (7.1%)	2 (4.8%)
Highest Level of Education		
High School	5 (5.9%)	3 (7.1%)
Associates/Bachelor's Degree	11 (12.9%)	8 (19.0%)
Master's Degree	46 (54.1%)	15 (35.8%)
PhD or MD	23 (27.1%)	16 (38.1%)
Years Worked in Profession	17.65 (<i>SD</i> = 8.87)	19.96 (<i>SD</i> = 9.61)
Years Worked in Rural Communities	10.66 (<i>SD</i> = 7.95)	12.66 (<i>SD</i> = 10.10)