Voices from the Wilderness

An Interpretive Study Describing the Role and Practice of Outpost Nurses

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ABSTRACT

Objective: Outpost nurses function as primary care providers and in a community health nursing role, providing comprehensive primary health care in Canada's underserved northern communities. Little information exists regarding how outpost nurses meet this expectation. The purpose of this interpretive study was to address the following research questions: 1) How do experienced outpost nurses perceive and enact their role? 2) How are practical knowledge and clinical wisdom revealed in the practice narratives of experienced outpost nurses?

Methods: Purposive sampling was used to recruit the nine experienced outpost nurses who participated by sharing narratives of clinical practice. Data analysis was conducted in accordance with Benner's model of interpretive phenomenology. Paradigm and exemplary cases served to ground the interpretation in the data.

Results: Four themes emerged from the data: a) primary care competencies are fundamental to outpost practice, b) nurses evolve into the outpost role by learning community health competencies and adapting to context-specific practice issues, c) experienced outpost nurses build and maintain responsive relationships with communities, and d) experienced outpost nurses become comfortable with the autonomy and responsibility of practice.

Discussion: The findings of this study reinforce the complex nature of outpost nursing; it is an anomalous community health nursing role grounded in primary care competency. Interpretation of the data suggests that outpost nurses share practice domains and competencies with nurse practitioners. A better understanding of the outpost nursing role clarifies how nurses might better contribute to improving the health status of northern residents, helping northern communities become healthy communities.

La traduction du résumé se trouve à la fin de l'article.

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Health status indicators confirm that the residents of Canada's northern regions – where the proportion of Aboriginal people is higher – experience higher rates of death, disease, and trauma than do other Canadians.¹⁻³ The issues that contribute to this relatively poorer health are complex, being deeply rooted in the social determinants of health, and overlaid with the multifaceted cultural and mental health issues that have come to typify some northern communities – issues such as loss of cultural identity and self-esteem, soaring rates of suicide, and pervasive alcohol and drug dependence.⁴⁻⁸

Traditionally, health services to northern communities have followed a medical model of care, with care delivered chiefly by nurses functioning in a physician replacement role. More recently, key stakeholders – governments, health professionals, and the communities themselves – acknowledge that this medicalized model of care fails to address the fundamental causes of poor health in northern communities. As primary health care (PHC) is advocated as a more appropriate and constructive approach to improving the health status of northern residents, primary health care expertise is becoming an expectation of outpost nurses.^{9,10}

PHC represents a model of health care delivery that incorporates the concepts of disease prevention, health promotion, population health and community development.¹¹ While primary care is distinct from PHC, the provision of essential primary care is an integral component of an inclusive PHC strategy.^{11,12} Thus outpost nurses, who are often the only health resource in a community of several hundred people, are expected to function as both primary care providers and in a community health nursing role, to provide comprehensive primary health care. There is broad recognition in the literature that these diverse expectations contribute to role diffusion, confusion and ambiguity about the outpost nursing role.^{4,13} The context of practice is conspicuously lacking in resources and support, further imposing unique and challenging expectations.^{4,13,14} Canadian authors clearly associate outpost nursing with a nurse practitioner role.^{4,15,16} Both Canadian and American writers support the role of nurse practitioners in primary health care.¹⁷⁻¹⁹

As the principal employer of nurses in northern and remote communities,

Medical Services Branch (MSB), Health Canada, originally defined and formalized the outpost nursing role. While the extended role functions of nurses are supported by a scope of practice document,²⁰ outpost nurses employed by MSB continue to be classified as Community Health Nurses, reflecting the community focus and public health nursing responsibilities of outpost nursing. Despite the devolution of accountability for health services in northern communities from MSB to the various territorial and Aboriginal governments, the role of nurses in outpost communities has not changed significantly; however, there is a trend towards identifying outpost nurses as nurse practitioners.^{21,22}

There is an identified lack of research in the area of outpost nursing generally, and more specifically, little information exists as to how outpost nurses meet the expectations of what has been described as a “specialized generalist” role.^{4,23,24} Most significantly, residents of the remote northern communities where outpost nurses practice experience the poorest health status of all Canadians. It is imperative that the role and practice of these nurses be explored as a first step towards examining a model of health service delivery that is often perceived as falling short of its obligation to help northern communities become healthy communities. The purpose of this interpretive study was to explore the following research questions: 1) How do experienced outpost nurses perceive and enact their role? 2) How are practical knowledge and clinical wisdom revealed in the practice narratives of experienced outpost nurses?

METHODS

The unique nature and context of the outpost nursing role suggested that outpost nurses themselves may best understand issues pertaining to their practice, although this understanding may be in the form of *unarticulated* or *tacit* knowledge.²⁵ The classic study addressing embedded practice knowledge is Benner's 1984 interpretive study of the practice of acute care nurses.^{26,27} Defining such knowledge as “that knowledge that accrues over time in the practice of an applied discipline”, Benner interpreted nurses' narrative descriptions of practice through extrapolating paradigm and exemplary cases.

TABLE I
Inclusion Criteria

1. A minimum of five years nursing practice.
2. A minimum of three years outpost experience.
3. A minimum of eight months spent in one community.
4. Outpost experience within the past two years.

TABLE II
Demographic Characteristics of Participants

	Range	Mean
Age (years)	43-58	51
Years Nursing Experience	16-38	26
Years Outpost Experience	3-20	12.6
Gender		
Female	8	
Male	1	
Education		
Basic Preparation		
Diploma RN		9
Further Education		
BSN / BScN		5
Other degree, diploma, certificate		3
Outpost-specific course		
3-6 months' program length		6
> 6 months' program length		1
Informal physician mentoring experience		1

NB: Efforts to recruit an Aboriginal nurse into the study were unsuccessful.

Data analysis in interpretive phenomenology is a process wherein the interpreter shifts back and forth between analysis, or examination of the structure and elements of the data, to interpretation, or an understanding and explanation of the meaning contained in the data,²⁸ thus ensuring the interpretation remains grounded in the context. Critical thinking, reflection, and an ability to move inductively between analysis and synthesis of information characterize the process of interpretation and facilitate a progressively deeper understanding of the meaning contained in the data.

Purposive sampling was employed to identify nine participants who were willing to participate in up to two interviews, and who met pre-established inclusion criteria designed to facilitate the selection of experienced outpost nurses (see Table I). Outpost nurses responded willingly to recruitment efforts, resulting in a well-experienced sample (see Table II). Participants' accumulated experience, from which their narratives of practice were drawn, represented experience in virtually every region where outpost nurses are employed, ensuring diversity of experience. A telephone pre-interview was conducted with potential participants to ensure that inclusion criteria were met and to facilitate selection of the most suitable candidates. Ethical approval to conduct this study was obtained from the Behavioural Research

Ethics Board, Office of Research Services, at the University of British Columbia.

Data collection took place over a five-month period and consisted of interviews with participants, either in person or by telephone. After obtaining informed consent, participants were asked to share stories from their practice describing situations that had in some way been significant, memorable, or meaningful enough to influence their practice, or that illustrated some important or essential element of a participant's practice.

Data analysis, following Benner's methodology,²⁹ was conducted on a continuous basis throughout the data collection period. Developing and maintaining a contextual understanding was considered key to interpretation of the four main themes that emerged from the data. These themes were interpreted using paradigm cases and exemplars of practice revealed in participants' clinical narratives. Data interpretation was conducted by the primary author but subjected to ongoing review and evaluation by the two secondary authors. An external consultant with recognized expertise in outpost nursing practice also reviewed data interpretation and provided constructive feedback.

RESULTS

The first theme was that participants evolved – or experienced a transition into –

TABLE III

Exemplar Quotations

Theme 1. Nurses Evolve into the Outpost Role

- a) Adapting to Context — We had a patient who became very sick. He needed to be medevaced. It was going to be a great challenge moving him, a real problem, for a variety of reasons ... but the local people pulled together. I told them I had a problem. I asked the family to help me with getting fluids into this man and when I couldn't be there pushing fluids, they pushed fluids. The community got together — by using local equipment and local knowledge and working together, they made this miracle happen. This community pulled together. They were supportive for the nurse, they were supportive for the patient, and they with their ingenuity made things happen. Just because they didn't have all the fancy stuff, they still made it happen and that's what community nursing is about. Taking what you have and your local people, getting them to help you make things happen — and they can if they're given the opportunity. And that's basically what northern nursing is about — getting the community to pull together to be part of the team.
- b) Shifting to a Primary Health Care Orientation — At first I was just kind of holding the fort and did a lot of sick clinic kind of stuff.... And then as I got to know the local doctor (who came one day every month) and we talked about different things in the communities, I started to realize that people needed more well person physicals and teaching in different areas of health. The more experience I got, the better I knew what I perceive the job now to be, and the better I got at a variety of things that are part of the job. Now I usually try to see what there is in the community to help instead of always trying to bring in experts or specialists. When I have a problem I will talk to the local people — the local administrators, the local social workers, local leaders of the community — to see if they've got some of the answers because sometimes they're very creative and have answers I don't think of (laughing).... Sometimes the problems are big, sometimes they're little, but they have solutions that we don't always think of because of our southern way of thinking.... I guess I've just learned a lot, from different communities, different people ...everything from herbal medicine to spirituality to different ways of thinking than I had as a hospital nurse many years ago.

Theme 2. Experienced Outpost Nurses Build and Maintain Responsive Relationships with the Community

It was around the third year that you could see this gradual opening up. They were starting to trust that I was their nurse; it really felt like they had adopted me. I was their Najanguaq...Inuktituk for nursing sister.... They called any nurse that came in Najanguaq — but by the time three years was finished, I was *their* [emphasis added] Najanguaq (laughing). There's some things that they share with you up front, but it's almost like an onion, there's different levels that they let you get to and once you've been with them through some of their births and their deaths and you've been there through good and bad times, and you're still there when they turn around, they start trusting you more and more. And I found through the years that as they start to trust you more, you're able to get them to do things that are good for them, that they weren't willing to do at first.

I think that if you're going to make any changes at all, there has to be a level of trust there. When I come into a community, I find that it really is important for me to pay attention and to really be listening to the feel of the community. What is their language? What do they do? Do they hunt, do they trap, do they fish...what is it that they do? What are the problems in the community? Is it alcohol, is it drugs, is it STDs, is it lack of parenting skills?.... And whatever it is, try to work from there,

because if you come in and you've got this — I'm the saviour attitude — they don't particularly see themselves as needing to be saved. So you want to be careful about that. You want to effect change, yes, that's true but you have to do it in such a way that they are going to comprehend what is it that you're doing and they're going to buy into it. If they don't buy into it, you might as well forget it. And some ways that I find work well for me: It's always important for me to get on really quickly with my staff, to really align myself with the staff at the very beginning. I don't change a lot of things as soon as I walk in the door. And I never have any opinion about the nurse who was here prior to me. I always go to the band office immediately and introduce myself to everybody who's in there that I'm going to need to know. In this community, I went to the RCMP, introduced myself there, went up to the school, went to the day-care. I spent about two days walking around just telling people who I was and how to pronounce my name and where they could find me and that sort of stuff. And now I would say that I have a very good relationship with my staff. And then the other people in town see that and if Sally, John and Jennifer think I'm not so bad, well then, ok, well I'm probably not that bad, you know. So that starts to build that trust. And if I say I'm going to follow up, then I follow up. If I say I'm going to do this, then I do that. Those kinds of little things go a long way and then when you're trying to do some teaching or make some change, then that trust has already been established.

Theme 3. Primary Care Competencies are Fundamental to Outpost Practice

I did a throat swab and then he explained to me that he also had this cough. His pulse was running around 120 or something What was going through my head was — because I knew that he did use drugs — was that maybe it's cocaine or something that he's taken and he's got this tachycardia. There's something here, there's something wrong with his pulse running at 120...so I decided right then to do the chest x-ray. But what was really going through my head was, it was the drugs. So I did the chest x-ray and got one of the other nurses to run the cardiogram.... When I put the chest x-ray up on the viewer, I could see something in one of the lungs. The other nurse came over and said, you know, there's some tachycardia here but everything else looks okay. So I said — well come and look at this chest x-ray... and she noticed the spot as well.

Theme 4. Experienced Outpost Nurses Become Comfortable with the Autonomy and Responsibility of Practice

The patient arrested. What are you going to do? You start CPR and you're bagging and you'd like to get to the meds but do you get the meds and stop the CPR or what are you going to do? So you just keep on going.... I knew the medevac team was coming, so we did work as a team once they got here.... We continued to work for another 30 minutes before the code was called off. That kind of situation puts you in a position where you're second guessing yourself — what else could I have done? What if I had done this?... and that sort of thing. When you work in the north for a long time or you nurse period, for a long time, you're very comfortable with your skills and your knowledge and what you think you could have done. But sometimes for nurses who've not been here for a long time, those kind of situations can make them leave nursing for a period of time and it's only because you second guess yourself. So much relies on your shoulders, and when something like that happens — the code is finally called, we've done all we can do — it really brings home just how much knowledge you have to have and how confident you have to be and how focused you have to be.... And that sense of isolation really hits you in those kinds of situations.

the outpost role as they gained experience and a better understanding of the role (see Table III). Participants described how they learned to adapt to the context of practice by adapting to a different culture, in terms of both Aboriginal and northern culture: "I wasn't culturally aware, I was thrown in there green as grass...and you get your eyes opened very quickly". They adapted to not only geographical isolation, but also professional and personal isolation.

Participants described learning to live the particular lifestyle that outpost nursing demands — which one participant described by saying, "You go into a community thinking you're going to be the nurse, but you're way more than just the nurse, there's no question about that." Participants also learned to work with structural issues, such as being part of an arm's-length bureaucracy that was frequently perceived as being unsupportive.

A second aspect of the evolution into the role was that participants' orientation to health care shifted from an acute care focus to a PHC orientation, as they comprehended the community basis of their role, and as they learned community competencies. Phrases that reflect the upstream orientation of PHC cropped up in interviews with different participants: "band aid solutions don't work, we need to get to the root of the problems" and "it's this bigger picture" were heard repeatedly.

From evolving into the role and shifting their orientation from an acute care to a PHC focus, experienced outpost nurses learned to build and maintain responsive relationships with their communities, which emerged as the second theme in this study. "Responsive" reflects relationships that were characterized by trust and respect, and also encompassed support, acceptance, and a dynamic sense of reciprocity or mutuality between nurse and community.^{30,31} Participants viewed their relationships as being essential to their ability to influence positive health outcomes. Trust in the nurse was described as a critical element in predicting successful implementation of treatment, and thus with effective treatment outcomes. Participants also described how preventive health strategies, such as immunization programs, were more successful when a positive relationship existed between the nurse and client, at both the individual and community client levels.

The most experienced participants described how they deliberately and proactively set about building relationships in a community; they spoke about this as a competency in and of itself. They described specific aspects of relationship building, including aligning themselves with key players, and being "tested" – "it's not that you walk in and you're instantly trusted...they test you." Participating in the community and being seen to provide safe and competent primary care were perceived as important ways of fostering trustworthiness in the eyes of the community.

A third theme was that primary care competencies are fundamental to outpost practice. Primary care skills – often equated with the physician replacement or extended practice part of the role, is that part of outpost nursing that is perhaps most readily identified with outpost nurses. Yet the experienced participants in this study described complex and high-level primary care skills in a taken-for-granted, casual manner. While the primary care competencies described by participants were essential and integral to many of the stories they related, participants did not relate the story as being a story *about* primary care competency. Instead, participants focused on skills such as teaching, supporting, or counselling, which were the skills they saw as being important to their

ability to "make a difference" to their patients and influence health outcomes.

Autonomous practice implies taking ultimate responsibility and accountability for one's practice. Experienced participants in this study accepted and had attained a level of comfort with the realization that they were ultimately responsible for their practice, which was the fourth theme to be examined. Paradoxically, while the autonomous nature of outpost practice appears to draw nurses to the role initially, recognizing and accepting the degree of responsibility inherent to outpost practice was part of participants' evolution into the role.

On the surface, autonomy and responsibility in practice sounds straightforward. In fact, this study suggested complex interrelationships exist between autonomy, authority, power, ethics, responsibility, and the reciprocity of relationships. Practice autonomy emerged as an important factor in participants' ability to influence health outcomes, and possibly the theme having the greatest significance for understanding autonomous nursing roles.

DISCUSSION

The experienced outpost nurses who participated in this study clearly perceive and enact their role as a community health role. Primary care competencies are essential but represent only one component of a much broader understanding of the role. Interpretation of practice narratives revealed participants' accumulated practical knowledge and clinical wisdom, which have been described in terms of four main themes.

The findings of this study suggest that responsive nurse-client relationships are key to the practice of outpost nursing. The effectiveness of both treatment and prevention in outpost practice remains largely invisible.³² Responsive relationships appear to enable effective nursing practice, by acting as the conduit through which primary and preventive care competencies are actualized into effective treatments and health promotion strategies. Similarly, participants described how responsive relationships with individuals, established through primary care contact, are magnified into responsive relationships at the community level, a practice phenomenon that has also been described by other researchers.³³

To date, practitioners, employers and clients have tended to focus on the primary care competencies of the outpost nursing role.⁴ Articulating and defining relationship-building as a competency of outpost nursing practice may help to make this skill more visible to both outpost nurses and their employers. Recognizing relationship-building as a practice competency may direct nurses to develop and refine their skills in this area. Recognizing responsive relationships as key to practice in the primary health care role may direct employers to institute work structures that better support and value nurses' skills in relationship-building.³² Moreover, increasing the visibility of responsive relationship-building as a competency may in turn increase the visibility of nurses' work in health promotion, particularly at the community level.

While limited by its small size and the lack of participant observation,^{27,29} this study nevertheless represents a preliminary understanding of outpost nursing practice. The work of outpost nurses is complex, involving multiple levels of intervention on multiple client levels, and encompassing knowledge and skills from both acute care and community health. Study findings suggest that outpost nurses share domains and competencies of practice with nurse practitioners, as identified by Brykczynski,²⁷ a finding that may have relevance for the development of the nurse practitioner role in Canada. Further qualitative studies aimed at exploring outpost nursing practice in greater depth are suggested. For example, how do nurses build and maintain responsive relationships? How do they operationalize an ethic of care to balance power and responsibility?³¹ Future qualitative studies might also incorporate the perspectives of other key players, such as community members, who in keeping with the philosophical underpinnings of PHC, deserve a voice in shaping their health care.

Evaluative studies are needed to determine whether and how outpost nursing practice influences health outcomes. Because research in this area is lacking, a first step may require developing tools to measure health outcomes along parameters that are meaningful in outpost communities.

A better understanding of how outpost nurses influence health in remote commu-

nities may hold relevance for health care in other primary health care settings. Ultimately, and most critically, understanding the practice of outpost nurses may suggest PHC strategies aimed at improving the pervasively poor health status of northern Canadian communities.

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RÉSUMÉ

Objectif : Les infirmières en région éloignée [le terme comprend les infirmiers] jouent le rôle de prestataires de soins primaires et, dans un contexte de santé communautaire, offrent des soins de santé primaires globaux dans les collectivités mal desservies du Nord canadien. On trouve peu d'information sur la façon dont les infirmières répondent à ces attentes. Notre étude interprétative portait sur les questions de recherche suivantes : 1) Comment les infirmières expérimentées travaillant en région éloignée perçoivent-elles et jouent-elles leur rôle? 2) Que révèlent les récits d'infirmières en région éloignée sur leurs connaissances pratiques et leur érudition clinique?

Méthode : Par échantillonnage au jugé, nous avons recruté neuf infirmières expérimentées en région éloignée, qui nous ont communiqué le récit de leur pratique clinique. Ces données ont été analysées selon le modèle d'interprétation phénoménologique de Benner. Des cas paradigmatiques et exemplaires ont permis d'ancrer l'interprétation dans les données.

Résultats : Quatre thèmes sont ressortis : a) les compétences en soins primaires sont fondamentaux pour la pratique en région éloignée, b) les infirmières en région éloignée apprennent leur rôle par l'acquisition de compétences en santé communautaire, qu'elles adaptent ensuite au contexte particulier de leur pratique, c) les infirmières expérimentées en région éloignée sont constamment à l'écoute des besoins des collectivités, et d) les infirmières expérimentées en région éloignée s'acclimatent progressivement à l'autonomie et aux responsabilités de leur pratique.

Discussion : Les résultats de l'étude confirment la nature complexe des soins infirmiers en région éloignée : ce sont des soins infirmiers communautaires irréguliers exigeant une bonne maîtrise des soins primaires. L'interprétation des données suggère que les infirmières en région éloignée ont des domaines et des compétences en commun avec les infirmières praticiennes. Une meilleure compréhension du rôle des soins infirmiers en région éloignée permet de clarifier comment les infirmières pourraient mieux contribuer à améliorer l'état de santé des résidents du Nord et aider les collectivités nordiques à devenir des collectivités en santé.