PLACE-BASED RURAL PRIMARY HEALTH CARE NURSING PRACTICE: A STUDY SET IN RURAL OTAGO, NEW ZEALAND.

Dr Jean Ross

INTRODUCTION

The practice of nursing in rural New Zealand has occurred during the past century in a variety of rural places and shifting health care systems. During this time there have been various approaches and changing attitudes of the governance and practice of the delivery of health care, which has moved the responsibility from the state to the local region and community control. Rural Otago situated in the South Island of New Zealand (the setting related to this study) was initially directed by the national government in the 1990s to govern the provision of primary health care and this continues to the present day. In response resident rural primary health care nurses demonstrated a commitment to ensure health care was adapted to accommodate the particular nuances of the rural geographical location and population needs to a ensure that health disparities were minimised.

Background

Primary health care nurses in New Zealand practice relates to numerous diverse rural settings and have cared for local community members throughout the past century, in a shifting health care system (Ross, 2016). The rural place context is one important contributing factor that shapes the practice of these nurses (Bushy, 2012). Likewise the various approaches and changing attitudes of the governance and models of delivering health care have also shaped their practice. These nurses have played a central part in the provision of health care throughout this changing health care landscape. Rural nursing is recognised internationally as a specialty area of nursing practice, situated within the generalist field of nursing (Knight, Kenny & Endecott, 2016). This specialist area of practice is an underrepresented aspect of nursing and its' professional identity is challenged, misunderstood and does not fit easily within the national imaginings, wider nursing profession and policies governing nursing practice (Ross, 2016).

Rural nurses generally care for small populations in isolated and physically remote locations that are considered a unique aspect of rural practice (Francis, Chapman, Hoare & Birks, 2013). Rural practice occurs in either small rural hospitals or in the community, based within the framework of Primary Health Care (PHC) (Carryer, Halcomb & Davidson, 2015; Bushy, 2012). 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 nurses promote the health of the population, manage episodes of illness, including acute and chronic presentations, disease management and end of life care as well as providing for health emergencies (Carryer et al., 2015; Horner, 2008). Rural primary health care nurses care for all ages of the residents, visitors, and transient and seasonal workers (Fitzwater, 2008). Health care is provided within numerous models to ensure residents can access health care '24 hours' a day. However, for some rural nurses 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 majority of rural nurses experience dual-relationships as both an opportunity and 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 (Crooks, 2012). Challenges can be associated with working in the geographical context of frequent socioeconomic deprivation (National Health Committee, 2010), geographical barriers and reduced transportation as well as experiencing poor road conditions (Bushy, 2009). Challenges such as these, together with the recognised barriers associated with personal and professional isolation, limited on-going education; lack of anonymity (Davis, Williamson & Chapman, 2014; Bushy, 2012; Crooks, 2012; Molinari & Bushy, 2012) and conflicting professional boundaries and role conflict, add to the complexity of the factors that compound the difficulties of practising health care in the rural location.

Worldwide there is an uneven distribution of rural health professionals per capita of population in rural locations, when compared with urban areas (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 (Hegney, Francis & Mills, 2014; Hughes, 2009). 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 p. 205) are evident, as the rural geographical location becomes more isolated or remote over time. It is in these rural, geographically isolated locations, in developed countries, that rural nurses form the majority of health care practitioners (Hughes, 2009). These primary health care rural nurses deliver a diverse range of health services, often in demanding circumstances (Bushy, 2012) and New Zealand rural nurses are not immune to this challenge (Ross, 2016).

The New Zealand health care system has evolved over an approximate one hundred and sixty year period, in which the rural context has had a profound influence on the development of the country's health care system (National Health Committee, 2010). This health care system evolved through a number of differing phases, population needs and political aspirations. The initial period was associated with the 'pioneering phase' throughout the 1840-1930s, the 'welfare phase' established between 1938-1980s and the 'neo-liberal phase' from the 1990s into the contemporary period. Nurses have been a part of all of these three phases in different guises and to differing degrees providing them the opportunity to adapt their practice to accommodate change and the health needs of community members. In doing so I acknowledge their practice as representative of their commitment and response to the delivery of health care as illustrative as a place-based practice.

In the 'pioneering phase' there was a need for health care to be provided as the population of New Zealand was increasing with the arrival of gold seekers from Asia and Australia, and the European population increased and settled in rural locations to farm the land. Gauld (2001) suggests that the provision of health care needed to become more organized, however funding and the recruitment of doctors was unreliable and difficult because of the isolation and sparsely populated areas termed, the 'Backblocks' (Wood, 2008). In 1909 the 'Backblock Nursing Scheme' (BNS) was established to provide health care for the increasing European settler population (Wood, 2009). A similar nursing scheme was established in 1911 to care for the rural Māori population (indigenous people of Aotearoa, New Zealand) and was referred to initially as the Native Nursing Scheme (NNS) (Burgess, 1984), and was renamed the Māori Health Nursing Service (MHNS) in 1922. The BNS and MHNS was one aspect of formalised nursing practice that provided a health service comprising nursing, public and emergency health care as well as midwifery services in the remote areas of New Zealand (Wood, 2009, 2008). The Backblock nurses demonstrated their contribution to the delivery of an extensive range of health care activities as a result. They

become the local health resource for the settlers and the indigenous population while maintaining 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). Backblock nurses responded to the changing health care environment and over time adapted and expanded their practice in response to the needs of the community and the context in which the population resided. In the process of this adaptation, so too did the professional status of these nurses change, according to Wood (2008) "[…] 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" (p. 69).

What is of significant interest in this paper is that the practice of Backblock nurses remained unchanged up until the 1940s. During this time nurses who practiced in rural contexts merged for the first time with urban nurses. This was a time of the establishment of the second phase of the health care reforms the 'welfare state' (Dalziel & Saunders, 2014). Nurses from this time 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 and remained constant until the redevelopment of new models of health care in rural regions.

As a result of limited funds associated with the global economic downturn, the government enacted major health reforms resulting in a change to the provision of health care (Prince, Kearns & Craig, 2006). This restructuring during the early 1990s aimed to improve efficiency and access to health services (Barnett & Barnett, 2009, 2005) and was influenced by a neo-liberal philosophy. The health care system at this stage was transformed radically-initially in the 1990s as Rural Community Trusts (RCTs) were established. 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 & Barnett, 2001). The intentions of the RCTs were to identify the health needs of their community residents' and to plan, manage and fund health services and evaluate the outcomes (National Health Committee, 2010; Barnett & Barnett, 2001). Instead of these services being governed and funded nationally they were transferred to that of community control offering rural primary health care nurses the opportunity to develop a health care system responsive to the local community need and effectively self-governance (Barnett and Barnett, 2009).

Aims of the research

This study aimed to generate awareness as to what shaped the identity of the rural primary health care nurses' from the rural Otago region during a significant time of change between the 1990s and 2000s. I was interested to uncover if rural place (as defined in the occupational title of the rural nurses) was a contributing factor. Equally I wished to understand what constitutes being a rural nurse, how they practice and what their contribution has been to the rural health care sector. These were the research questions posed to the participants. This information in turn provides the potential to strengthen the nurses' understanding of their changing and adapting identity and provide them with an ability to articulate the significance of their practice to the rural health care and national nursing sectors. Up until now, there has been little exploration as to the factors that contributed to the innovative practice these rural nurses pioneered.

METHODOLOGY

This qualitative study is positioned within the social sciences, and adopts an interpretivist approach. Unique to the interpretivist paradigm is the notion of 'context' (Whitehead, 2013). 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 impact on the study participants practice. The study was conducted in the rural Otago region in the lower central part of the South Island Rural Otago has a landmass of 32,000 kilometers 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 geographical location which is relatively unpopulated. The aim of this inclusion is an attempt to engage the reader to become familiar with the unique aspects of rural nursing from the study location.

Data collection

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 whether they wished to have a face to face or telephone interview. The 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 duration. The interviews took place at the discretion of the participant at their place of work, or at their home. The remaining four participants were subsequently interviewed over the telephone, during 2007 and 2008. The rural 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 had been the longest in rural practice, in total, twenty-five years at the time of data collection.

Data analysis

The data from these interviews were digitally recorded and then transcribed by a professional typist and analysed by engaging with a thematic analysis, to seek how the practice of these rural primary health care nurses was shaped.

Ethical approval

The University of Otago Human Ethics Committee approved this study in 2006.

FINDINGS

This analysis has led to insightful findings and signal that during the 1990s and early 2000s rural nurses' adapted their practice to ensure the level of health care was initially maintained and latterly, improved. In response rural nurses demonstrated a commitment to ensure that a suitable model of health care has been provided with the benefit that health disparities were minimised. There are some common themes that 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. 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 participants in this study highlighted the dominant characteristics of distance and isolation that define the rural location and the lives of the people who live rurally. Traditionally, rural people have responded to this isolation by developing self-reliance, hardiness and becoming a close-knit community (Bushy, 2009; Cloke, 2006). Distance can be classified by actual distance measured by kilometres, time taken to travel and the perceived time and distance to services (Bidwell, 2001; Bushy, 2000).

New Zealand rural nurses recognised 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 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 that promote isolation in which they adapted their practice in accordance with these factors. This means they are required to become as resourceful as possible as they practice within these contexts. Isolation can compromise the rural nurses' practice, often resulting in ethical dilemmas (Hutton, 2016; Bushy, 2009) 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 (Bushy, 2000; Lee, 1998) and further characterised as a result of distance and isolation as, expressed by these rural nurses:

> *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.*
>
> (P16)

> *You are working alone with no, with no immediate backup if something goes wrong although they [rural nurses] have cell phones there is very limited reception out there.*
>
> (P6)

The findings identified three main themes from the data. First, a sense of change to the health care structure leading to opportunities for nurses to develop their own models of practice. This sense of change led to a sense of self, highlighted as the second theme, in which the self-governing aspects of practice are embedded within different models of care and a sense of practice is revealed. These models of care are further revealed in the third theme, a sense of difference, in which rural nurses' relationship with the rural context, community members and resident health professionals, adds to the unique aspects of the provision of health care.

Sense of change

Some of the participants were actively involved in shaping the model of rural health care as a result of the restructuring of the health care system, during the late 1990s and early 2000s. The analysis further illustrates that the rural nurses' practice was evolving into new models as they engaged and worked in partnership, initially aligned with RCTs in the early part of the 1990s (Barnett & Barnett, 2001; Gauld, 2000) following the philosophical shift from state welfare to a neo-liberal approach. A 'sense of change' became evident from the data, which was indicated by the participants' who had been a part of the health restructuring 'change process'. In response a rural nurse explained that:

> *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.*
>
> (P 7)

I was attracted to learn more about the development of the rural health care services and asked this participant to further expand on how the health services developed during the time of the healthcare restructuring. The rural nurses' response signaled that her practice was driven by having local knowledge of the community and location and the way in which this knowledge was assessed through being a local resident member of that community:

> *I think it's coming from being local in your own community and understanding your community.*
>
> (P7)

Practice was driven by a 'can do it' attitude and the rural nurse aimed to offer and maintain a quality health care service identified from this analysis as being based on a flexible approach, by acknowledging community residents' health needs and providing a health care service that was responsive to the local community as expressed by the following rural nurse participants:

> *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'.*
>
> (P2)

> *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.*
>
> (P5)

The evidence gathered implies that 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. Models of practice such as these have provided an opportunity for rural nurses to further adapt and advance their

practice in accordance with the rural communities' vision and direction that met their health care needs. Rural nurses explain:

> *In a small rural place like the [place name removed] here we have a great relationship with our community.*
>
> (P15)

> *The focus here [rural community] is on doing the best by the person, the person is central within the community.*
>
> (P5)

Sense of practice

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 demonstrates the complexity of rural nurses' practice, in- between these sites. These sites may include, the rural community hospital (unlike tertiary hospitals which are typically associated with urban and city locations) residential care (older adult residential facilities), in general practice clinics, rural schools, client's homes, on the sports field, the roadside and on the farm. What comes from practicing in numerous sites is the visibility of the rural nurse and the expectations that either come from community members or from the way in which rural nurses' wish to govern their own practice and accommodate clients' health requirements. The following experienced rural nurse illustrates how 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:

> *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.*
>
> (P6)

The rural nurse has taken into consideration that resident's recovery could be improved significantly, if they were cared for nearer to their home. 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 following excerpt another experienced rural nurse explains that to adequately care for this client she needs to become competent to perform the care required for the maintenance of a Hickman Line and the administration of Total Parenteral Nutrition (TPN) 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:

> *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 holy 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.

(P5)

In practice settings, such as described above, rural nurses advance their practice to provide a health care service specific to the needs of the community members in a particular 'location'. Rural nurses' practice is constructed through moving between practice sites. The ability to move between sites further promotes the essence of place-based care benefitting community members' access to health care that I refer to as the nurse practicing 'in-between' locations.

Sense of difference

In-between practice locations provides an opportunity for the nurse to care for the same clients in numerous sites in the same rural community, as illustrated by the rural nurse who had cared for an older person in her own home:

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 [in our motor vehicle] with us and put the oxygen on and the doctor will come and visit them.

(P2)

The excerpt above 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. The nurse assesses the person's breathing and determines from 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. 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. The unique insight of the nurses' practice aligned with 'location and the physical sites of where and how practice occurs is highlighted. The nurses have the ability to practice in an autonomous fashion which demonstrates self-govern 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 nurse expresses the importance of getting to know the clients and their living situations, as this way of practising better accommodates the comfort of the client when they are in their own home (McMurray & Clendon, 2015).

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 came in the door even though he's [disability removed] and took his bloods and carried onto work.

(P17)

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. 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 as expressed in the following excerpt:

> *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.*
>
> (P4)

Nursing in diverse locations provides the opportunity for the rural nurse to practice in client's homes, in community facilities such as the local school, workplaces and at the roadside which includes the provision of on-call health care. The provision of on-call may range from palliative care, wound management to acute presentations-or emergencies including accidents such as-motor vehicle accidents involving local community people, visitors and tourists. In the capacity of providing emergency health care the rural nurse does this in connection with the New Zealand Primary Response in Medical Emergencies (PRIME) system (Horner, 2008; Ministry of Health, 1999). The PRIME system relates specifically to rural practice and is identified as specific knowledge related to emergency and on-call events that occur in rural locations, with the aim of improving timely health care because of the particularities related to the 'rural'.

DISCUSSION

Historically rural nurses' have been at the centre of the delivery of rural primary health care in the more isolated and remote contexts of New Zealand, identified initially as the Backblock nurses and the MHNS. How these nurses went about their day-to-day practice has highlighted aspects of place-based care and continues on in the contemporary period. The rural nurses' practice has been shaped in response to international, national and regional changes and the geographical and population health needs. 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 to a neo-liberalist ideology (Dalziel & Saunders, 2014; Oliver, 1988). This shift in thinking began to influence government policy and the provisions of health care funding from the 1980s (Ife, 2013). This new health system changed the philosophy of how health care was to be delivered in rural 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 this study, the collaborative rural community relationships rural nurses were engaged with assisted these nurses to adapt their practice which has improved the provision of health care.

As the neo-liberal changes occurred, self-governance structures evolved and, for the rural nurse participants in this study, an opportunity arose to advocate for social justice. This 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 (McMurray & Clendon, 2015). These changes were primarily made manifest through the establishment of RCTs in the 1990s and from the early part of the 2000's the

health care system came under the influence of and was shaped by the 'Primary Health Care Strategy' (Ministry of Health, 2001).

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 recognised the value of local place-based knowledge, wisdom and expertise and understood that universal knowledge cannot simply be applied to the rural community, as context needs to be considered a necessary contributing factor in the delivery of health care planning and provision. 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 health professionals, have aided in the retention of local facilities and led in some cases to improved community satisfaction of their health care services. This study has exposed that rural nurses governs their own practice, influenced by local 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).

The rural environment comprises a wide range of attributes associated with the physical location, which is broadly identified as context. Context is a central feature of this study and connects all the relational aspects within the social world, the relations between humans and non-humans 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'.

Adapting and broadening the scope of the registered nurses' practice and performing in rural isolation from other nurses is a point of difference. The rural nurse creates a healing place within various rural sites and structures and 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. Through these encounters, a deeper understanding has been revealed as to how the rural nurses' adapted both personally and professionally. Rural nurses' practice encompasses a vast array of knowledge, skill and expertise, in the rural community (Molinari, 2012).

The findings from this study are a useful reference point for rural and non-rural nurses, planners and policy makers to better understand the different approach rural nurses'-engage with in order to provide fundamental care. Difference in this context is considered a valuable and positive concept in which to recognise the unique features aligned with the provision of care associated with rural nursing practice.

Bushy (2012) has indicated that as yet 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 study may capture important aspects of care in respect to rural nursing practice. This knowledge can contribute to the growing body of knowledge associated with the theoretical base aligned with rural nursing practice. It is important to recognise that knowledge associated with nursing practice is different to urban knowledge and urban models of 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 study and the knowledge generated be translated into practice legislation, policy and education which guides and funds rural practice and recognising those rural primary health care nurses are at the forefront of this endeavor. To this effect it is important 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 governed their practice in the process associated with this approach.

CONCLUSION

This study has revealed that during the past century nurses who have practiced in the rural community in differing health care systems have pioneered models of sustainable practice that meets the needs of community residents and reduced health disparities. This study highlights how the rural nurse aligns the self in the rural community as a meaningful provider of place-based primary health care

Jean Ross, BN, MA, PhD, FCNA, GCTLC, CSP is a registered nurse and principle lecturer in the School of Nursing at Otago Polytechnic, Dunedin. Jean's interests focus on the concept of 'place' and community development, particularly rural communities. Jean facilitates rural community knowledge, the place of image and the powerful effects the use of image can have when combined with written text.

Correspondence to Jean Ross, School of Nursing, Otago Polytechnic, Private Bag 1910, Dunedin, New Zealand. Email: jean.ross@op.ac.nz

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