Voices from the Wilderness
An Interpretive Study Describing the Role and Practice of Outpost Nurses

Denise S. Tarlier, RN, DOCHN (Dalhousie), MSN, FNP-C (AANP)¹
Joy L. Johnson, RN, PhD²
Nora B. Whyte, RN, MSN³

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.
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.

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 –

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<td><strong>Inclusion Criteria</strong></td>
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<td>1. A minimum of five years nursing practice.</td>
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<td>2. A minimum of three years outpost experience.</td>
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<td>3. A minimum of eight months spent in one community.</td>
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<td>4. Outpost experience within the past two years.</td>
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<td><strong>Demographic Characteristics of Participants</strong></td>
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<td>Education</td>
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<td>Further Education</td>
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<td>BSN / BScN</td>
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<td>Other degree, diploma, certificate</td>
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<td>Outpost-specific course</td>
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<td>Informal physician mentoring experience</td>
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NB: Efforts to recruit an Aboriginal nurse into the study were unsuccessful.
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 the 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 call the local person. I will contact 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, some people are 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 and 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…. Inuitiktuq 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 trust you, they share their skills and they do things that are good for them, that they weren’t willing to do at first.

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 – well the local people … 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 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 make mistakes and you do things wrong but you still do things you think you could have done. But sometimes for nurses who’ve 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 skills 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.

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 procity or mutuality between nurse and acceptance, and a dynamic sense of reciprocity 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 Brycznski,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?21 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.

REFERENCES


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RÉSUMÉ


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 approfondissent 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 pratiques. 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.