

**UNIVERSITY of
STIRLING**



**Exploring the Influences of Nurses' Career Decisions
to Work in Remote Islands.**

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Declaration

I declare that I have composed this thesis myself and that it embodies the results of my own research. Where appropriate, I have acknowledged the nature and extent of work carried out in collaboration with others included in the thesis.

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I would like to offer my special thanks to all the participants who were so generous with their time and enabled this research to be possible.

On a personal note, my appreciation goes to my family and friends for their encouragement, support, and patience throughout this PhD journey. I would like to thank God, my creator and sustainer, and acknowledge that '*without Him I can do nothing*'. The Lord is my light and my salvation (Psalm 27).

Abstract

Due to global nursing shortages, recruitment and retention of nurses is a major international concern, exacerbated in rural and remote areas. A published paper by Mackay et al. (2021), using systematic review techniques, found that despite the complexity of factors that influence nurses' decisions to work in rural or remote settings, much of the research to date, mainly conducted in Australia, Canada or USA, has focused on specific factors in isolation. Existing evidence does not fully consider the multiple influences that may impact nurses' decisions to remain in or leave rural or remote areas. This limits the effectiveness of recruitment and retention strategies. There is a paucity of rural and remote nursing research studies undertaken in the UK.

This thesis seeks to address the gap in empirical knowledge by exploring the connections between the person/al, profession/al and place related dimensions of rural and remote nursing and examining the complex interplay between the multiple factors that influence decisions made to work in rural and remote settings over the course of a career.

Undertaken in the Western Isles of Scotland (WI), twenty-five biographical interviews were conducted with four groups of nurses with different career trajectories:

- Group 1 (Remainers): Born in WI - trained in WI – remained in WI (n=5)
- Group 2 (Returners): Born in WI – trained WI or mainland – worked mainland – returned to WI (n=9)
- Group 3 (Leavers): Born WI or mainland – trained/ worked in WI- left to work on mainland - remained on mainland (n=5)
- Group 4 (Incomers): Born mainland- trained/ worked on mainland – came to train/work in WI (n=6)

The use of biographical research methods has underpinned this study as semi-structured interviews captured deep and rich data to understand the career journey of nurses and what influenced their decision-making process to work in the Western Isles. Guided by the development of MacKay's 3P model (person/al, profession/al, place) and the rich heritage of Rural Nurse Theory, results of Stage One of the analysis identified twenty-eight interrelated themes within the person/al, profession/al and place related dimensions of rural and remote nursing. Results of Stage Two of the analysis highlighted four

overarching tensions/paradoxes - Anonymity/Visibility; Longing/Belonging; Ancestry/Acceptance; Specialist/Generalist.

This study has added to the body of evidence in Rural Nurse Theory by indicating that a lack of anonymity affected nurses who were born in the WI in a different way from nurses from an urban background and local nurses experienced a stronger sense of belonging than 'incomers' who had difficulties being accepted. There is a need to support nurses transitioning to rural practice by strengthening their connections to people and place and adopting initiatives such as mentoring, preceptorship and socialisation through community partners.

Nurses from all the groups acknowledged the need for a broad range of knowledge of different specialities and a strong demonstration of resilience to be able to cope with the scope, variety and unpredictability of rural and remote nursing. This thesis clearly highlighted that all the groups of participants highly commended the training, education and the support from tutors in the Western Isles but early career pathways of nurses were clearly haphazard due to some having difficulties securing permanent employment after completing their training. 'Incomers' were influenced to contemplate leaving the WI as they saw little opportunity for career progression or promotion.

This thesis proposes that the practice of remote and rural nurses needs to be redefined and considered as a speciality area in its own entity. The term 'expert generalist' which has historically provided a foundation theory for rural and remote nurses does not adequately address the deeper, intangible complexities and interplay of practice required in the rural and remote setting, where nurse's practice is intertwined with and shaped by the community and culture. Giving rural and remote nurses career advancement opportunities through specialist training will result in the recognition of expertise, and a pathway of rural career progression, which may attract nurses to plan a rural career. A whole of community approach to workforce will facilitate opportunities for both family members, and the health professional to be part of the rural and remote community.

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Glossary of Terms

A&E – Accident and Emergency

ANP – Advanced Nurse Practitioner

BiPAP – Bi-level Positive Airway Pressure

BSc – Bachelor of Science

CDU – Central Decontamination Unit

CPAP – Continuous Positive Airway Pressure

CPN – Community Psychiatric Nurse

ECG - Electrocardiogram

ENT – Ear, Nose and Throat

GP – General Practitioner

PIN – Personal Identification Number

UHI – University of the Highlands and Islands

HV – Health Visitor

NHS – National Health Service

NHS WI – National Health Service Western Isles

ICU – Intensive Care Unit

IV – Intravenous

MDT – Multi Disciplinary Team

OYJG – One Year Job Guarantee

P – Participant

RGN – Registered General Nurse

RMN – Registered Mental Health Nurse

RNT – Rural Nursing Theory

SEN – State Enrolled Nurse

UK – United Kingdom

VC – Video Conference

WHO – World Health Organisation

WI – Western Isles

WIH – Western Isles Hospital

Introduction

In the context of global nursing shortages, recruitment and retention of nurses is an increasingly important challenge for the sustainability of healthcare delivery (WHO, 2020). Failure to recruit and retain nurses in rural and remote settings is a particularly acute problem (Roberge, 2009, Trepanier et al., 2013). According to Mbemba et al. (2013) nurse-to-population ratios are significantly lower in rural and remote areas, further exacerbating the problem. Nurse vacancies are anticipated to accelerate over the next decade as more of the workforce retires (Prengaman et al., 2014).

A growing body of literature on rural and remote nursing has explored a variety of individual factors influencing nurses' decisions to work in rural and remote settings. These include a sense of belonging (Rosenthal, 2005), having a rural background, family connections (Hegney et al., 2002) and job satisfaction (Kulig et al., 2009). Much of the literature describes the difficulty within rural and remote areas to maintain skilled and competent nurses in the face of workforce shortages (Yates et al., 2013), increased workload (Dotson et al., 2011, O'Donnell et al., 2010), the generalist nature of the role (Hegney, 1996), and the challenges of professional isolation (Hunsberger et al., 2009).

Much of the research in rural and remote nursing has used quantitative designs and has been undertaken in Australia using large online survey repositories (Campbell et al., 2013; Eley et al., 2011; Eley et al., 2009). Research has focused on describing aspects of rural and remote nursing as individual entities, which does not provide insight into the complex dynamic of experiences that ultimately influences nurses' decisions to work in rural and remote settings. This perspective is important to inform recruitment strategies for students and experienced nurses in the rural and remote setting. This research study focuses on the experiences of nurses in the Western Isles of Scotland and aims to add to a growing body of literature that explores the person/al, profession/al and place related dimensions of rural and remote nursing.

Research aims and objectives.

This thesis seeks to address the gap in empirical knowledge by considering the multiplicity of lived experiences and focusing on understanding nurses' interpretations of their experiences of the person/al, profession/al and place related dimensions of rural and remote nursing. The perceptions of how the interplay and complexity of these factors influence nurses' decision-making to remain in or leave areas of rural and remote work over the course of a career will be presented.

Examining the complex interplay of these multiple factors over time will enhance strategies to address the global shortage of nurses in rural and remote settings through answering the following research questions:

1. What are the person/al, profession/al and place-related factors that influence choosing rural practice?
2. What is the interplay between people, profession, and place?
3. How does the interplay between people, profession and place influence nurses' career destinations and transitions?

Overview of research design

Qualitative biographical interviews were conducted with twenty-five participants. There were four groups of participants, each with different career trajectories:

- Group 1: Born in WI - trained in WI – remained in WI (n=5)
- Group 2: Born in WI – trained WI or mainland – worked mainland – returned to WI (n=9)
- Group 3: Born WI or mainland – trained/ worked in WI- left to work on mainland - remained on mainland (n=5)
- Group 4: Born mainland- trained/ worked on mainland – came to train/work in WI (n=6)

To help the reader discern the characteristics of which group of participants is being referred to throughout this thesis, it was decided to apply a shorthand term for each group - Group 1- Remainers; Group 2 – Returners; Group 3 – Leavers; Group 4 – Incomers.

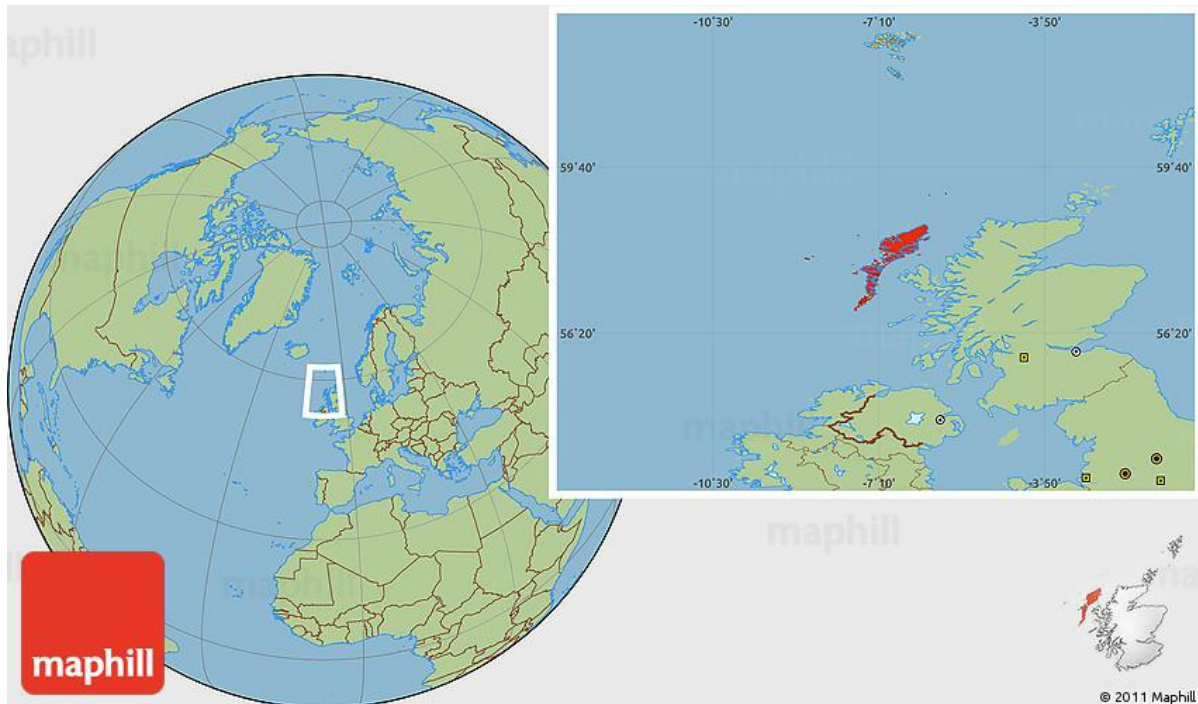
Each biographical semi-structured interview was special and unique and allowed data to be collected in an in-depth manner to gain a rich and deeper

understanding of how the interplay between people, profession and place influenced nurses' decisions to work in the WI over time.

The interviews were all undertaken before the declaration of the COVID-19 pandemic.

Research Setting

Figure 1: Geographical Context of the Western Isles of Scotland



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The Western Isles is an island chain, in the Atlantic Ocean, off the west coast of Scotland. The 130-mile-long archipelago, separated from the Scottish mainland by the waters of the Minch, stretches from Lewis and Harris in the North to the Uists, Barra and Vatersay in the South. There are more than 70 islands, most of which are uninhabited. The 15 inhabited islands have a population of 26,830. Air and sea transport is crucial with scheduled ferries and numerous causeways connecting the smaller islands together.

NHS Western Isles (NHSWI)

Stornoway is the main town on the Isle of Lewis and with a population of over 6000 is home to the Western Isles Hospital (WIH). There is also one small

hospital in Uist and one in Barra. The WIH is a rural general hospital with a range of acute specialities. NHSWI commissions services from other NHS Boards such as Ear, Nose and Throat (ENT), Dermatology, Respiratory Medicine, Child Psychiatry, Rheumatology, Specialised Paediatrics, Ophthalmology, Oral Surgery, Neurology, Oncology and Urology. The hospital situated in Uist provides care for the elderly and General Practitioner (GP) Acute and Midwifery led maternity services. Consultants from the WIH and some from mainland health boards visit to provide Outpatient services. St. Brendan's' Hospital in Barra is a shared building with a local authority care home facility. It is supported by the local GP practice to provide care of the elderly. The hospital has capacity for four patients.

Patients are regularly transferred from the smaller hospitals to the WIH for treatment. Where NHSWI can safely, effectively, and efficiently provide the care and treatment required patients will remain in the WI for care, but it is often necessary for patients to be transferred to mainland hospitals both routinely and in emergency situations.

The Scottish Government (2022) 8-fold classification of rural was used for the purposes of this research study. Classification number 8 is presented in bold text as it relates to the Western Isles:

- **1** Large Urban Areas: Settlements of 125,000 people and over.
- **2** Other Urban Areas: Settlements of 10,000 to 124,999 people.
- **3** Accessible Small Towns: Settlements of 3,000 to 9,999 people, and within a 30-minute drive time of a Settlement of 10,000 or more.
- **4** Remote Small Towns: Settlements of 3,000 to 9,999 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more.
- **5** Very Remote Small Towns: Settlements of 3,000 to 9,999 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.
- **6** Accessible Rural Areas: Areas with a population of less than 3,000 people, and within a drive time of 30 minutes to a Settlement of 10,000 or more.

- **7 Remote Rural Areas:** Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more.
- **8 Very Remote Rural Areas:** Areas with a population of less than 3,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more.

In this thesis the participants refer to the term 'mainland' as meaning the main parts of the United Kingdom. The term 'mainland' excludes all the Scottish Islands, within which the Western Isles of Scotland are situated.

Structure of thesis

This thesis is divided into five chapters.

Chapter One presents a review of existing research and literature. Parts of this chapter have been published in the Rural and Remote Health Journal: (MacKay, S.C., Smith, A., Kyle, R.G. and Beattie, M. (2021) What influences nurses' decisions to work in rural and remote settings? A systematic review and meta-synthesis of qualitative research). This chapter focuses on exploring definitions of '*rural*' and '*rural nursing*' and sets out the methodology and methods applied at each stage of the systematic literature review. Thematic analysis identified three interrelated dimensions that influenced nurses' retention and migration decision-making, namely '*person/al*', '*profession/al*' and '*place*', and eighteen inter-related domains.

Data synthesis informed the development of MacKay's 3P (person/al, profession/al, and 'place-related') model of factors influencing rural and remote nurses' decision making. This chapter will conclude with reflections on the definitions of rural and remote and the context of data synthesised, consideration of the retention and migration decisions in the included articles, a brief overview of the rich heritage of the rural nursing theory base described by Long and Weinert (1989) and will outline the theoretical framework underpinning the research process pertaining to this study.

Chapter Two outlines the research design and methods used in the research undertaken for this thesis. The aims, objectives and research questions are set

out and the process by which the questions were answered is described. This chapter considers the epistemological and ontological roots of the research before outlining the biographical approach using semi-structured interviewing. There is a detailed account of how sampling and the process of data collection was carried out. Ethical issues and data handling approaches were drawn out and consideration was given to how the data were analysed to generate the findings. Emphasis was placed on Braun and Clarke's (2021) reflexive thematic analysis and establishing trustworthiness.

Chapter Three is the first of two chapters outlining the findings. This chapter is concerned with Stage one of the analysis and depicts summaries of the chronological accounts of each participant and presents an analysis of the key person/al, profession/al, and place related themes within the four different groups of participants.

Chapter Four is the second of the chapters outlining the findings. This chapter is concerned with Stage two of the analysis and focuses on the commonalities, similarities, and differences of the four groups to better understand the complex interplay between the person/al, profession/al and place related dimensions that influence nurses' decision-making and experiences of working in the WI. Four tensions/paradoxes were identified from the second stage of data analysis:

- Anonymity/Visibility
- Longing/Belonging
- Ancestry/Acceptance
- Specialist/Generalist

Chapter Five provides a detailed discussion of the findings. The four tensions/paradoxes are discussed and presented with reference to current literature and against the backdrop of the rich heritage of the rural nursing theory base described by Long and Weinert (1989). This chapter emphasises how this thesis has advanced the methodological understanding of biographical research. The evolving MacKay's 3P model is presented as a useful adjunct to aid researchers and policy makers. Implications of this thesis for rural and remote nursing practice, policy, research, and education is outlined. This final chapter provides recommendations, and a conclusion of the thesis.

Chapter One: Review of existing research and literature

Overview of Chapter

As suggested in the introduction to the thesis, due to global nursing shortages, recruitment and retention of nurses is a major international concern, exacerbated in rural and remote settings. This chapter synthesises the literature on the individual factors that influence nurses' decision making to work in rural and remote settings, by using a systematic review and thematic meta-synthesis of qualitative studies. Definitions of '*rural*' and '*rural nursing*' will be explored and existing research evidence will be considered. The chapter sets out the methodology and methods applied at each stage of the systematic literature review and will present the results from a thematic analysis which identified three interrelated dimensions that influenced nurses' retention and migration decision-making, namely '*person/al*', '*profession/al*' and '*place*', and eighteen inter-related domains.

MacKay's 3P (person/al, profession/al, and 'place-related') model will be presented. This model captures the complex phenomenon of the influences on nurses' decision making to work in rural and remote settings.

This chapter will conclude with a brief overview of the rich heritage of the rural nursing theory base described by Long and Weinert (1989) and will outline the theoretical framework underpinning the research process pertaining to this study.

The following systematic literature review forms one of two parts of this thesis. Part one is presented by introducing the rationale for the study, the research background, gaps in the literature and by answering the research question, 'What factors influence nurses' decisions to work in rural and remote healthcare settings?' The findings from the systematic review inform the second part of the thesis and set out the research objectives and methodology and approach to empirically answer the following research questions in subsequent chapters:

1. What are the person/al, profession/al and place-related factors that influence choosing rural practice?
2. What is the interplay between people, profession, and place?

3. How does the interplay between people, profession and place influence nurses' career destinations and transitions?

Parts of this chapter have been published in the Rural and Remote Health Journal: (MacKay, S.C., Smith, A., Kyle, R.G. and Beattie, M. (2021) What influences nurses' decisions to work in rural and remote settings? A systematic review and meta-synthesis of qualitative research)

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<http://creativecommons.org/licenses/by/4.0/>

Introduction

In the context of global nursing shortages, recruitment and retention of nurses is an increasingly important challenge for the sustainability of healthcare delivery (WHO, 2010). Inequities of health outcomes persist in rural populations globally (Pamungkas et al., 2023). Failure to recruit and retain nurses in rural and remote settings is a particularly acute problem (Roberge, 2009, Trepanier et al., 2013). According to Mbemba et al. (2013) nurse-to-population ratios are significantly lower in rural and remote areas, further exacerbating the problem. The challenges of sustaining a strong rural health workforce are not new. Prengaman et al. (2014) anticipated that nurse vacancies would continue to accelerate as more of the workforce retires. Many countries have grappled with and continue to address these challenges as they seek to develop more creative ways to resolve this workforce shortfall (Terry et al., 2021).

The World Health Organisation (WHO, 2020) advocates, within their framework, that improving rural health care and health outcomes relies on system strengthening at multiple levels such as service, workforce, leadership and governance, information, infrastructure and financing. The WHO has focused strongly on some areas such as providing global policy recommendations to inform strategies that are most effective at supporting access to health workers through retention. Many governments in the world have implemented strategies such as the recent development of a national rural generalist pathway in Australia (National Rural Health Commissioners Office, 2018).

The Scottish Government (2022) are committed to developing a remote and rural workforce recruitment strategy by the end of 2024, which will provide a framework which will support employers to ensure that Health and Social Care needs of people who live in remote and rural communities are met. This strategy will aim to transform ways in which the workforce is recruited, trained, equipped, and organised.

Focussing on rural medicine the 'rural pipeline' nurtures candidates from a rural background into training programmes, with the assumption that on qualification they will be more likely to engage in rural or remote practice. The WHO (2020) sponsored a Rural Pathways Checklist to support the implementation of grow your own strategies in low- and middle-income countries. According to O'Sullivan et al. (2020) this strategy was developed with widespread input from rural communities globally and covers any rural context, all health worker types and community needs. A recent Scottish initiative, Scotland's first graduate entry, undergraduate programme (ScotGEM), focuses on rural medicine, and as a monetary incentive, offers graduates a 'return of service' bursary in exchange for a commitment to work in NHS Scotland for four years (NHS, 2023).

A growing body of literature on rural and remote nursing has explored a variety of individual factors influencing nurses' decisions to work in rural and remote settings. These include a sense of belonging (Rosenthal, 2005), having a rural background, family connections (Hegney et al., 2002) and job satisfaction (Kulig et al., 2009). Much of the literature describes the difficulty within rural and remote areas to maintain skilled and competent nurses in the face of workforce shortages (Yates et al., 2013), increased workload (Dotson et al., 2011, O'Donnell et al., 2010), the generalist nature of the role (Hegney, 1996), and the challenges of professional isolation (Hunsberger et al., 2009).

Rural nursing practice has been defined as a unique, demanding, and challenging speciality requiring specific personal qualities such as flexibility, versatility, and adaptability (Caldwell, 2007). The characteristics of rural nursing include the need for rural nurses to assume the role of expert generalist and function as a jack-of-all-trades whilst working in a broad spectrum of clinical settings and performing many diverse tasks (Rosenthal, 2005).

Despite the complexity of factors that influence nurses' decisions to work in rural or remote areas, much of the research to date has focused on specific factors in isolation. The purpose of this chapter is to systematically review existing literature on nurses' experiences to explore the influences on nurses' decision making to work in rural and remote areas. By doing so, findings from this review will form the basis for addressing the research problem and underpin the justification for the subsequent PhD study.

Background

Defining 'rural' and 'rural nursing'

The literature is replete with definitions of rural nursing. The word 'rural' often conjures up images of the idyllic life in the country (McCoy, 2009). 'Rural' is described as a vague and ambiguous term signifying many things to many people, such as agricultural landscapes, isolation, small towns, and low population density (Hart et al., 2005). The literature categorises 'rural' using a range of pre-assigned characteristics including land use, population density, demographic structure, environmental characteristics, population characteristics, non-metropolitan area and commuting patterns (Williams and Cutchin, 2002). The variation in definitions of 'rural' has important methodological implications (Williams, 2012), such as assuring the validity, reliability, and utility of research (Lim et al., 2013). Definitional complexity around 'rural' also impacts understandings of rural nursing (Place et al., 2012). According to Gilani et al. (2023) there is no one definition or classification for explaining rural areas and any areas outside the parameters of urban are defined as rural areas. Remote-rural areas in the paper by Gilani et al. (2023) are informed by the Scottish Government (2020) and defined in terms of five dimensions identified as: 1. Population and population density: Number of residents; number of residents per square mile or kilometre in each area; 2. Proximity to urban area(s): Distance from a given area to the nearest urban area; 3. Development: Access to resources and facilities, e.g., electricity and broadband; 4. Culture: History, language, and rituals in each area; 5. Social perception: Understanding of rural amongst different social groups. Appendix 1 depicts the various Government definitions/classifications of 'rural' using

specific indicators for Australia, Canada, England & Wales, Ireland, Scotland, and USA (see Appendix 1).

Rural nursing is defined by some as the provision of health care by professional nurses to persons living in sparsely populated areas (Long and Weinert, 1989). Although there is debate around whether any difference exists between nursing practices in rural and urban health care facilities (Bushy, 2002), some common features of rural nursing predominate. The term 'expert generalist' is often used to describe rural nursing, with suggestions that rural nurses need to be a 'jack-of-all-trades and master of many' (Hegney, 1996). Rural nursing is conceptualised as being a 'long way from anywhere and pretty close to nowhere, being independent or perhaps just being alone', and the challenges are described in terms of difficulties in separating one's personal life from one's professional life, as rural nurses are 'stripped of their own anonymity while simultaneously charged with protecting their patients' privacy' (Scharff, 2013: 267). The implications of living and working in the same community, such as high visibility, lack of anonymity and privacy, result in nurses feeling as though they are living 'in a fishbowl' (Mills et al., 2010). Despite some consensus around the nature of rural nurses' work, traditional definitions and descriptions are said to provide limited understanding of how rural practice shapes nurses' unique approach to managing healthcare needs (Knight et al., 2016). Within the literature debate is ongoing in respect to the difference between rural and remote area nursing with the context of practice in rural areas described as being more divergent than the context of practice in remote areas (Mills et al., 2010). The generalist role of rural nurses increases as the population declines, thus the more remotely nurses are located the greater the generalist nature of the work (Bushy, 2002; Mills et al., 2010).

Existing evidence

Much of the research in rural and remote nursing has used quantitative designs and has been undertaken in Australia using large online survey repositories (Campbell et al., 2013; Eley et al., 2011; Eley et al., 2009). These studies have investigated connections between personality and career choice, and they highlight that persistence, self-directedness, cooperativeness, and reward

dependence are congruent with the professions' requirements. Results conclude that individuals have a unique combination of traits that make them who they are, and that recruitment and retention policy should not adopt a 'one size fits all' approach (Campbell et al., 2013). Myriad demographic, developmental and environmental factors influence an individual's life and work choices and their psychological profile, which raises a question about whether individuals with the observed temperament and traits are attracted to nursing in rural areas, or whether it is more likely that individuals develop certain character traits as a product of their rural experience and training (Eley et al., 2009).

There has been a tendency to consider rural and remote nursing through cross-sectional studies (Campbell et al., 2013; Bigbee et al., 2010), rather than longitudinally, which would explore a more informed understanding of rural practitioners' decisions-in-the-making. For example, the 'rural pipeline' describes the passage of medical students from the point of developing their aspiration for a career in medicine, through to retaining general practitioners (GPs) in rural locations, while highlighting key stages in between (Fisher and Fraser, 2010). This includes how individuals construct their career choice based on their personal identity and how an individual's attachment to place, such as the influence of rural upbringing (Eley et al., 2007; Somers et al., 2007; Bushy and Leipert, 2005), impacts their career pathway – ultimately influencing their decision to remain part of that workforce. Most studies exploring recruitment and retention focus mainly upon medicine, but extending the concept of the rural pipeline to include other professions such as nursing has the potential to strengthen understandings of rural career choice (Laven and Wilkinson, 2003).

Rural and rurality are inherently geographical concepts but when a geographic location is imbued with meaning, it becomes place (Bender et al., 2007). It is not possible to separate the experience of health and health care from the place in which it is experienced, and space and place have emerged as important and central themes in nursing research (Andrews, 2002). This research needs to move beyond considering places for healthcare merely as geometric points, passive containers or locations of human activity (Brodie et al., 2005), and focus conceptually on the dynamics between nursing and place, encapsulating the powerful social and cultural phenomenon permeated with power, symbolism

and attachments (Bender et al., 2007). Place matters – as a geographical location, a lived experience, as demarcation of space, and as a site of meaning creation (Bender et al., 2007).

Much of the current research has focused on describing aspects of rural and remote nursing as individual entities, which does not provide insight into the complex dynamic of experiences that ultimately influences nurses' decisions to work in rural and remote settings. This perspective is important to inform recruitment strategies for students and experienced nurses in the rural and remote setting. The aim of this literature review was to explore the influences on nurses' decisions to work in rural and remote healthcare settings.

Methods

A systematic review with qualitative meta-synthesis was used to answer the research question, 'What factors influence nurses' decisions to work in rural and remote healthcare settings?' The study is reported following PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines (Moher et al., 2009).

Search strategies

Search strategies were devised for the following databases: Medline, Journals@OVID Full text, and APA PsycInfo. The search spanned from January 1989 to January 2020 to capture the early rural nursing theory work (Long and Weinert, 1989). The following speciality journals were also searched independently: *Rural and Remote Health*, *Journal of Rural Nursing and Health Care* and *Health & Place*. The reference lists of pertinent articles found were also searched. Table 1 summarises the search strategy. All search results were downloaded into RefWorks and duplicates were removed.

Table 1: Medline search strategy

STEP	SEARCH TERM
1	Rural nurs*
2	Remote nurs*
3	Experience*

4	Qualitative Research
5	1 and 2 and 3 and 4
6	1 and 3 and 4

Study inclusion

The publications had to meet the following inclusion criteria: (1) published in the English language; (2) any aspect of experiences of rural or remote nursing; (3) qualitative research. Qualitative studies were targeted as this paradigm is more appropriate to capture the experiences of rural and remote nurses. Inclusion criteria were used to screen the title and abstracts. Full text articles were first scrutinised by SCM (PhD student) to confirm inclusion or exclusion. All screening was conducted by a second independent reviewer, AS, RGK or MB (Supervisors of PhD student). Consensus was reached where debate existed around retaining or excluding an article.

Data extraction

Data were extracted by SCM, and checked by AS, RGK and MB, for the following characteristics for each retained article: author(s) and year of publication, country, focus/aim, design, method/sample, definition of 'rural'/'remote' and study limitations.

Quality appraisal

Retained articles were assessed using the CASP (Critical Appraisal Skills Programme) tool for qualitative research (CASP, 2018), which was modified to include a scoring system from each of the CASP questions where 'Yes' = 1 and 'No' or 'Can't tell' = 0. The maximum score was 10 and the minimum score was 0. All articles were critically appraised and scored by SCM and then independently scored by a second reviewer (AS, RGK or MB). The tool was not utilised to exclude articles from the synthesis but rather to enhance understanding and identify methodological limitations of the primary studies.

Synthesis of findings

Thematic synthesis (Thomas and Harden, 2008) was selected as it relies on an inductive line-by-line coding of text from the primary studies. By staying as close

as possible to the experiential accounts of nurses working in a rural or remote setting, the aim was to generate new insights into this phenomenon.

All data were coded by hand by SCM, and three key steps were undertaken in the synthesis. First, the results sections of each study were extracted and inductively coded line by line. Verbatim quotations and text were entered into NVivo v12 (QSR International; <http://www.qsrinternational.com>). Second, the identified master themes (dimensions) and subthemes (domains) were highlighted and organised into tables, and texts with similar content and meanings were grouped together as descriptive themes. As each study was coded, the bank of emergent themes was added to and developed. The third stage went beyond the content of the original studies by identifying and examining relationships between themes to develop an overarching analytical framework. The use of line-by-line coding enabled one of the key tasks in the synthesis of qualitative research to be undertaken: the translation of concepts from one study to another. Every sentence had at least one code applied, and most were categorised using several codes. A draft summary of the findings across the studies organised by the 18 descriptive themes was written by SCM. AS, RGK and MB commented on this draft and a final version was agreed. The analysis informed the development of a model of rural and remote nursing.

Results

The results are presented in Figure 2 using a modified PRISMA 2009 flow diagram (Moher et al., 2009). All independent reviewers agreed on the application of inclusion criteria and 40 full text articles were included. Prior to the final submission of the thesis, and in concordance with the recommendations of Bramer and Bain (2017), to maximise the currency of the systematic review, the search was updated to span from 1989 to 2023. No further articles were found to meet the inclusion criteria.

All retained articles were published between 2001 and 2018 (Table 2). The geographical context of the 40 studies were as follows: Australia (15), Canada (12), USA (7), UK (4), South Africa (1), Ghana (1). The samples in the articles included were predominantly nurses (20), nurses/managers (6), nurse

practitioners (2), mental health nurses (2), midwives (1), nurses/GPs (3), student nurses (3), dual role – nurse/midwife (1), preceptors/students (2).

Twenty of the 40 articles (50%) did not include a rural definition. Of the 20 articles that provided a definition, most used population based definitions, geographical classifications, accessibility/remoteness indexes such as the Rural/Remote and Metropolitan Area Classification (RRMA) (Mills et al., 2007), the Weighted Inlier Equivalent Separations (WIES) based on number of hospital beds (Kenny and Allenby, 2013), or the Australian Bureau of Statistics whereby hospitals are coded A–E (Kenny and Duckett, 2003; Kenny and Duckett, 2004; Kenny et al., 2007). Several articles offered bespoke descriptions of rural such as ‘rural nursing is carried out by a nurse in a health facility where the support services are predominantly visiting’ (Drury et al., 2005) and ‘mountainous terrain where access can be affected by adverse weather’ (Farmer and Kilpatrick, 2009).

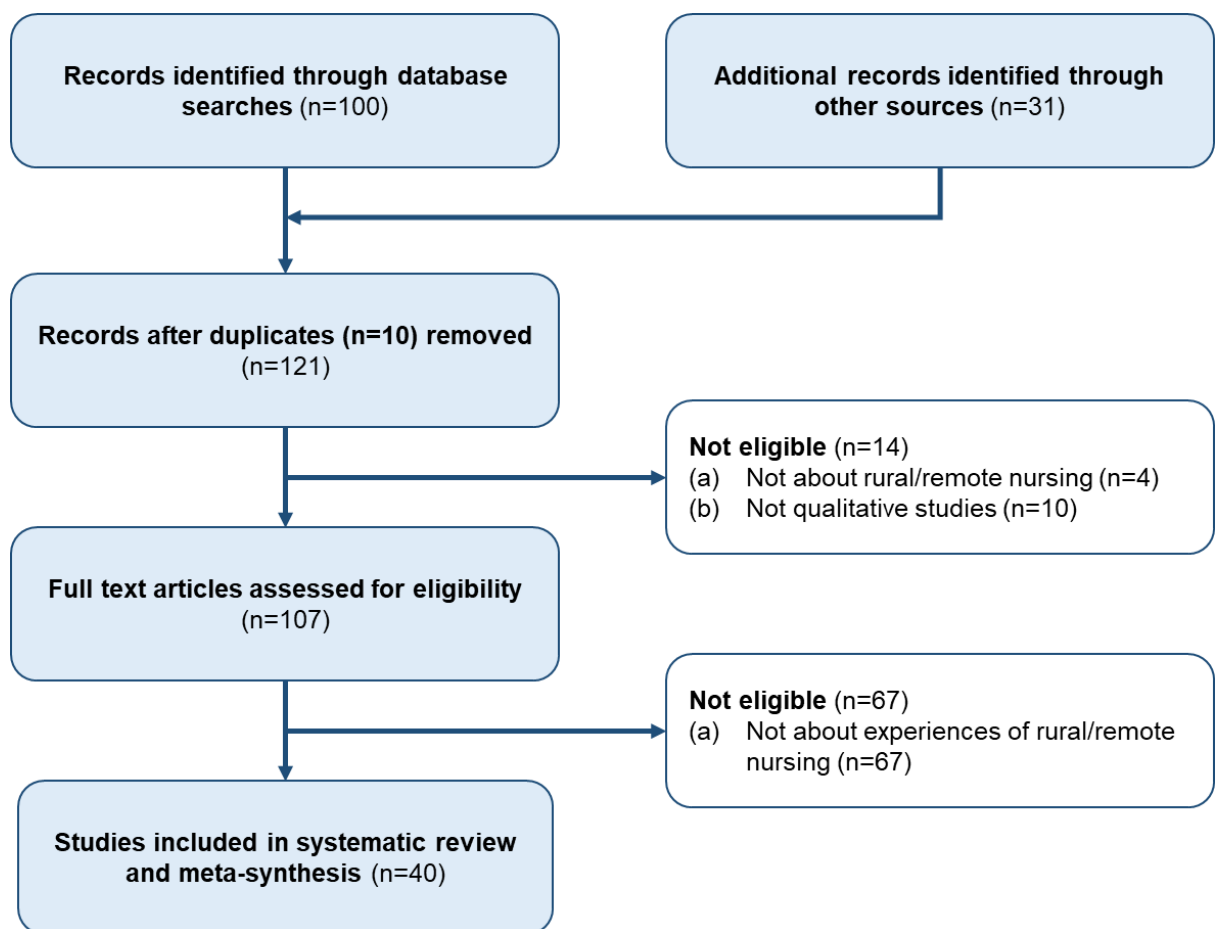


Figure 2: Modified PRISMA 2009 flow diagram

Author & Year of Publication	Country	Focus/Aim	Method / Sample	Definition of Rural/Remote	Limitations
Arnaert et al. (2009)	Canada	To explore homecare nurses' attitudes to palliative care in a rural community	Face to face semi-structured interviews and a focus group discussion with five homecare nurses	Statistics Canada definitions – population density of 1.2 inhabitants per square kilometre; made up of 18 small municipalities	The results may not be generalizable to other regions because each rural community has its own unique characteristics.
Baernholdt et al. (2010)	USA	To identify how rural nurses and their chief nursing officers define quality care	Focus group interviews – staff nurses (n=23), chief nursing officers (n=4), rural hospitals (n=4)	American Hospital Association Statistics – rural hospital = located in a non-metropolitan geographical area with population less than 50,000	Study took place in one specific region of one state in Southern region of USA, so findings may not apply to all rural areas. Insufficient information given regarding the researcher/ participants' relationship.
Beks et al. (2018)	Australia	To explore the experience of rural nurses in managing acute mental health presentation	Semi-structured face to face interviews with 13 nurses	No definition	Sample size of this study was subject to the response of nurses to the study invitation. Novice nurses were not adequately captured.
Birks et al. (2011)	Australia	To report on models of health service delivery in remote or isolated areas of Queensland	Multiple case study research design including interviews and focus groups. Registered nurses (n=35)	No definition	Lack of in depth description of data analysis process. Insufficient information given regarding the researcher/ participants' relationship. Part of a broader study.

Bish et al. (2015)	Australia	To identify factors that influence Directors of Nursing in their approach to leadership when working in rural Victoria, Australia	In depth, semi-structured interviews. Directors of Nursing (n=5)	No definition	Small sample size in one Australian state may limit the transferability of the study. Insufficient information given regarding the researcher/ participants' relationship.
Boucher (2005)	USA	To explore what qualities a nurse needs to 'make it' in rural home care?	Interviews with experienced rural home care nurses (n=12)	No definition	Recruitment strategy unclear. Insufficient details regarding ethical approval. Lack of in depth description of data analysis process. Insufficient information given regarding the researcher/ participants' relationship.
Caldwell (2007)	USA	To reveal the life stories of nurse practitioners in rural Appalachia	Interviews of life stories and ballad elements of the culture. Nurse practitioners (n=7)	No definition	Lack of in depth description of data analysis process. Potential bias as the researchers' role was not clearly examined – everyone knew each other.
Conger and Plager (2008)	USA	To describe rural connectedness versus disconnectedness	Focus groups and individual interviews. Advanced Nurse Practitioners (n=30)	No definition	Difficult to ascertain how many of the 30 participants felt connected and how many did not. Insufficient information given regarding the researcher/ participants' relationship.
Corbett and Williams (2014)	Wales (UK)	To study the interactions between nurses and their older rural patients by considering	Semi-structured interviews and home-care observations between older adults (n=10) with chronic pain	No definition	Recruitment strategy unclear. Methods of observational part of study unclear. Small scale study - findings may not apply to all rural areas.

		professional boundaries	and community nurses (n=4) and carers (n=2)		Insufficient information given regarding the researcher/ participants' relationship. Part of a larger study.
De Valpine (2014)	USA	To ensure the unique stories of bush Alaska nurses are preserved and told, to foster a strong bush nursing tradition and to inform recruitment, hiring and retention practices in remote settings	Semi-structured interviews with long term retained (>15 years) nurses (n=10)	No definition	Bristol Bay may not be representative of other bush communities. Possible biased representation of events as the researcher (also a nurse and friend) prompted the women to speak about issues that an 'outside' researcher would have no knowledge of.
Drury et al. (2005)	Australia	To describe nursing roles of registered mental nurses working in remote and rural areas of Western Australia	Face to face interviews. Rural mental health nurses (n=5)	Rural definition—rural nursing is carried out by a nurse who works in a health facility where the support services (medical and allied health) are predominantly visiting and in a community or district nursing service in a non metropolitan area	Small sample size taken from 1 rural region, placing limitation on the extent to which results can be generalised. Ethical issues not described. Insufficient information given regarding the researcher/ participants' relationship.
Farmer et al. (2007)	Scotland (UK)	To consider Scottish Maternity units and aim to identify issues in the change process associated with rurality and remoteness	Interviews with managers, midwives and community members (n=131) in rural maternity units in the North of Scotland (n=6)	Scottish Executive Classification defining 'rural' as settlements of less than 3000 people and 'remote' as more than 30 min from settlements of 10 000 people or more	Insufficient information given regarding the researcher/ participants' relationship.

Farmer and Kilpatrick (2009)	Australia and Scotland (UK)	To investigate the actions of rural health professionals and consider if they were also social entrepreneurs.	Interviews (majority face to face) with nurses (n=21), GP's (n=7), primary health care managers (n=4), allied health professionals (n=6) in Tasmania and Scottish Highlands	No definition Sites chosen because of physical similarities –“ both have mountainous terrain and remote areas where access can be affected by adverse weather”	Inappropriate to generalise the findings beyond the two countries. Insufficient information given regarding the researcher/ participants' relationship.
Farmer et al. (2010)	Scotland	To investigate older people's health service provision in remote rural Scotland	Semi-structured interviews with men (n=12) and women (n=11), service practitioners (n=9) and service managers and politicians (n=7)	Scottish Government definition of rurality in terms of population sparsity and distance from service centres	Study findings may not typify all of rural Scotland. Lack of urban comparator sites. Insufficient information given regarding the researcher/ participants' relationship. Part of a larger EU project.
Gibb et al. (2005)	Australia	To investigate the culture of workplace learning within a study of 8 small hospitals	Focus groups before and after a series of interventions designed to nurture a culture that supports learning (mentoring, generating cohesiveness within the team) with nurses (n=4-8 in each site)	No definition	Recruitment strategy a bit vague Insufficient information given regarding the researcher/ participants' relationship.
Heilderbeer and Carson (2013)	Australia	To explore what non-resident workers (fly in fly out) see as the advantages and disadvantages	Semi-structured interviews with non-resident nurses working in remote locations in	Population density of less than 0.1 persons per square kilometre	Insufficient information given regarding the researcher/ participants' relationship.

		es of their modes of work, and whether they face the same or different social/personal and professional barriers to rural and remote practice as their resident colleagues.	Australia's Northern Territory (n=7)		
Hunsberger et al. (2009)	Canada	To investigate whether nurses receive the resources and supports necessary to meet the challenges of rural practice	Semi-structured interviews managers (n=21) and staff nurses (n=44) in rural hospitals (n=19)	Advisory Panel of the Canadian Medical Services in Underserved Regions – definition of rural communities = those with a population of 10 000 or less	Insufficient information given regarding the researcher/ participants' relationship.
Joseph et al. (2013)	Canada	To interpret the meaning of bad weather for front-line health care workers in rural long-term care	Interviews with nurses and personal support workers (n=6)	Rurality was defined using the Statistics Canada rural and small town (RST) definition of individuals living in towns or villages outside the commuting zone of major urban centres with a population of less than 10 000	Authors state that Interpretations were limited by the inability of the re-analysis approach to follow-up with the interview respondents on new themes.
Kenny and Allenby (2013)	Australia	To examine issues that rural nurses face in the provision of psychosocial care from a broad general nursing perspective	Focus group interviews. Rural nurses (n=22)	Rural hospitals categorised by measuring the level of inpatient activity measured in terms of weighted inlier equivalent separations (WIES).	The views reported within one rural region in Australia may not be reflective of the broader nursing workforce. Findings may not be generalised to every setting.

				Categorised as B to E	
Kenny and Duckett (2003)	Australia	To explore the issues that impact on the ability of rural hospitals to provide health care	In-depth Interviews with managers, nurses and rural doctors (n=60) in rural hospitals (n=20)	Australian Bureau of statistics – Australian Commonwealth Government (2002). Large metropolitan teaching hospitals = Code A, rural hospitals = Codes B to E, very smallest hospitals = Code E	Insufficient information given regarding the researcher/ participants' relationship.
Kenny and Duckett (2004)	Australia	To identify the critical issues that impact on service delivery in rural hospitals	In depth interviews with hospital managers, chief executives, senior nursing staff and doctors (n=60)	Department of Human Services categorises hospitals according to size related groupings A to E	Large sample size for qualitative study. Insufficient information given regarding the researcher/ participants' relationship.
Kenny et al. (2007)	Australia	To identify rural nurses' perceptions of key issues related to the provision of effective psychosocial care for people with cancer in rural settings	Focus groups with nurses (n=19) in rural hospitals (n=3)	Department of Human Services categorises hospitals according to size related groupings A to E	All female sample Insufficient information given regarding the researcher/ participants' relationship.
Lauder et al. (2001)	Scotland	To describe the care given by district nurses to patients with mental illnesses and the adequacy of relationships between specialist and	In-depth interviews with district nurses (n=15)	No definition	Findings may not be generalizable to nurses in all rural areas as not all rural areas are geographically homogeneous. Insufficient information given regarding the researcher/ participants' relationship. Part of a larger study.

		generalist services			
Leipert and Anderson (2012)	Canada	To explore the use of photovoice to foster learning about and interest in rural locations and rural nursing as future practice settings	Photovoice was used to take photographs that represented challenges and facilitators of rural nursing practice. Nursing students (n=38)	Rural contexts are defined in Ontario as communities "with a population of less than 30 000 that are greater than 30 min away in travel time from a community with a population of more than 30 000"	Authors state that students need to be sensitised to the fact that all may not be as it appears in a photograph, that continuous reflection, consideration of complexity and life and professional experiences and knowledge are needed to accurately understand and effectively work in the rural context.
Lori et al. (2012)	Ghana	To determine the perceived barriers and motivators influencing final year midwifery students' acceptance of rural postings in Ghana	Focus group interviews with final year midwifery students (n=49)	No definition	Authors state that it is unclear whether midwifery students in a more rural setting perceive the barriers and motivators for rural practice in the same way as those represented in the study.
MacKinnon (2008)	Canada	To describe the work nurses do when providing maternity care in rural/remote settings and to explore how interactions with women, healthcare providers and the rural community	Observation and focus group interviews with nurses (n=48)	No definition	Authors state that the diversity of rural communities cannot be represented by studying one area in one Canadian province. Caution when transferring findings.

		influence their work			
Mills et al. (2007)	Australia	To explore rural nurses' experiences of mentoring and their multiple perspectives of 'self'	Semi-structured interviews with rural nurses (n=9)	Rural/remote and Metropolitan Areas (RRMA) classification	Authors state that snowball recruitment attracted one participant who had not had any formal mentoring training.
Mohale and Mulaudzi (2008)	South Africa	To explore and describe the experiences of nurses working in a rural primary health-care setting in Mopani district, Limpopo Province	In-depth interviews with female nurses (n=11)	No definition	Recruitment strategy not fully described.
Montour et al. (2009)	Canada	To describe the nature of nursing work from the perspective of rural nurse executives and frontline nurses	Semi-structured interviews with nurses (n=21) from different hospitals (n=7).	Population size - < 100 000. Working definition of rural employed by the Ontario Ministry of Agriculture, Food and Rural Affairs used in the study	Sample primarily older females with extensive nursing experience. Transferability of study findings limited. Insufficient information given regarding the researcher/ participants' relationship.
Moszczynski and Haney (2002)	Canada	To investigate stress and coping among northern rural nurses in relation to the transfer of trauma or accident patients	Focus group interviews with nurses (n=19) from rural hospitals (n=3)	No definition	Authors state that the small sample size may have limited the range of experiences described.
Newhouse (2005)	USA	To explore the impact of legislative, strategic,	Focus group interviews with nurse	"Rural hospitals are located outside a metropolitan statistical area	Insufficient information given regarding the researcher/ participants' relationship.

		and organisational changes on nursing in rural hospitals since 1995	executives (n=11)	which has a large population base with social and economic networks"	
Pront et al. (2013)	Australia	To understand what influences student learning in the rural clinical environment	Semi-structured interviews with nursing students (n=7)	No definition	No in depth description of recruitment strategy or data analysis. Insufficient information given regarding the researcher/ participants' relationship.
Robinson et al. (2010)	Canada	To better understand experiences and issues related to rural palliative care	Focus group interviews with nurses, physicians, pharmacists and social workers (n=44) and palliative volunteers or family members of those who had received hospice care (n=20)	Rural defined by "distance from an urban centre and population"	Recruitment strategy not clarified. Insufficient information given regarding the researcher/ participants' relationship.
Rohatinsky and Jahner (2016)	Canada	To explore perceptions, processes and organisational features of mentorship in rural healthcare	Semi-structured interviews with seven female nurses. Two follow up interviews conducted to verify and confirm emerging concepts	Rural defined as the local community population is less than 1500, but the facility serves an area of approx. 20 000. The nearest urban centre is 200 km away	There is limited generalizability with this study as it was conducted in one rural facility with nurses only. Individuals whose relationships and experiences with mentors that were not successful may have chosen not to participate.
Rosenthal (2005)	USA	To describe the lived experience of rural generalist nurses who work in an acute care	Face-to-face interviews with rural nurses (n=8)	No definition	The researcher and the storyteller are the same person, therefore only the researcher's perception of the nurses' stories was represented.

		hospital with less than 25 beds, located in a mountain setting			
Sedgwick and Rougeau (2010)	Canada	To describe events that influence undergraduate nursing students' sense of belonging during a rural hospital preceptorship	Individual in-person and telephone interviews with 4 th year nursing students (n=12)	Population size – rural communities designated as towns with a population of less than 9999 people	Recruitment strategy unclear. Insufficient information given regarding the researcher/ participants' relationship. .
Woodhouse (2010)	Australia	To determine the understanding of nurses within a shared care model and the degree of interaction evident in their practice in the shared care nursing environment in a rural care setting	Questionnaire sent to registered nurses with more than 5 years post registration experience in community health, palliative or aged care.(n=6)	No definition	Small sample. Recruitment strategy unclear. No clear justification of research design. Data collection appears inappropriate for purpose of research. Insufficient rigour in data analysis Insufficient information given regarding the researcher/ participants' relationship. .
Yates et al. (2013)	Australia	To explore and describe the experiences of working in the dual role as nurse and midwife in rural areas of Queensland , Australia	Interviews with dual role nurses (n=8)	No definition	Authors state that midwives in different rural locations may have different experiences. Insufficient information given regarding the researcher/ participants' relationship.
Yonge et al. (2013)	Canada	To capture the experiences of	Photovoice study with preceptors (n=4) and	No definition	Recruitment strategy not fully described.

		preceptorship in a rural setting	students (n=4)		
Yonge et al. (2006)	Canada	To examine the experiences of 4 th year nursing undergraduate students and their rural-based preceptors	Interviews with preceptors (n=26) and students (n=23)	Statistics Canada defines a rural area as a place having a population of less than 1000 and a density of less than 400 persons per square kilometre	

Table 2: Data Extraction

Quality appraisal and analysis

Initial inter-rater agreement of the application of the quality appraisal was 85.7% (343 items in agreement of 400 CASP items (i.e. 10 CASP questions × 40 included articles)). The lowest agreement score (15%, 6/40 articles) was for CASP item 6 ('Has the relationship between the researcher and participants been adequately considered?'). Discussion between reviewers identified differences in how this question was interpreted. Interpretation of the question was therefore discussed at a meeting of all four reviewers and agreement reached. Additional differences in assessment were resolved through discussion until agreement of 100% for all CASP items was reached.

Most articles scored highly for quality critique (8–10). Whilst two scored lower – (Woodhouse, 2010) and (Boucher, 2005) respectively – this may have been due to lack of information reported in the article, rather than low quality. Most articles demonstrated clarity in data collection methods, ethical issues, and data analysis. Only 10 out of 40 articles provided evidence of some reflexive practice such as the researcher critically examining their own role and potential bias during data collection (Rosenthal, 2005; DeValpine, 2014; Yonge et al., 2006; Moszczynski and Haney, 2002), an appropriate choice of location (Lori et al., 2012), and a good collaborative researcher/participant relationship based on trust and researcher empathy (Yonge et al., 2013). Several authors described reflexive techniques such as feedback of emerging themes to the participants, which facilitated achieving credibility by ensuring confidence in the

trustworthiness of the data (Mills et al., 2007; DeValpine, 2014; Mohale and Mulaudzi, 2008; Beks et al., 2018; MacKinnon, 2008).

Thematic analysis identified three interrelated dimensions that influenced rural and remote nurses' retention and migration decision making: 'person/al', 'profession/al' and 'place', with 18 inter-related domains. The dimension of 'person/al' contained five domains: a sense of belonging/connectedness, knowledge of rural culture, blurring of personal and professional lives, anonymity, and job satisfaction/stress. The dimension of 'profession/al' contained eight domains: expert generalist, advanced nurse practitioner, professional isolation, mentorship, education, autonomy and empowerment, role conflict and recruitment and retention. The dimension of 'place' identified five domains: terrain and weather, fewer resources, geographical isolation, safety, and rural culture. Table 3 summarises the rural and remote nursing dimensions and domains.

Article	Person/al	Profession/al	Place
Arnaert et al. (2009)	Lack of anonymity, role blurring, emotional isolation, stress	Professional isolation, more education required, poor communication and inadequate team work.	Limited resources
Baernholdt et al. (2010)	Community connectedness can be both a help and a hindrance Patients are what matter most Knowledge of rural culture required		
Beks et al. (2018)	Rural generalist nurses experienced a lack of confidence when caring for mental health consumers. Frustration as high workload obstructs altruistic practice. Lack of anonymity. Stress.	Paucity of mental health education for rural nurses. Need for closer collaboration with the community mental health teams. Lack of clinical skills and knowledge to assess and manage mental health presentations. Poor staffing levels. Professional isolation. Expert generalist. Shortfalls of telephone triage.	
Birks et al. (2011)		Need for - better skill mix - better equipment and IT - clear and consistent communication strategy - appropriate education and training activities	
Bish et al. (2015)	Rich knowledge of rural life and culture Connection with the rural community through forming strong relationships with community members Commitment and attachment to the hospital	Nurturing of professional relationships and empowerment is central to leadership skills	

Boucher (2005)	Qualities needed - flexibility, creativity, willingness to learn Ability to practice independently and to tolerate uncertainty Lack of anonymity	Need for more focus on mentoring and education	Challenges of rural nursing – isolation, weather, terrain, distance, rural poverty, rural unemployment, difficult to access healthcare, and increased costs
Caldwell (2007)	Being deeply rooted to family, mountains, culture and people Seeing patients as extended family Nurse practitioners make a difference		
Conger and Plager (2008)		Need to develop strong support networks - mentoring and collaborating with team -fostering relationships with large urban medical centres -electronic communications More education required to prepare APNs for challenges of working in rural areas and encourage them to stay	
Corbett and Williams (2014)	Strong feelings of social and emotional connectedness - 'knowing each other' and 'feeling connected' are fundamental to the establishment of close relationships between carers and rural patients Boundary crossing commonplace	Nurses face challenges around maintaining appropriate professional boundaries	
De Valpine (2014)	An independent sense of family and childrearing. A strong sense of adventure.	Recruitment and retention	An intense appreciation of Native Alaskan culture and environment Recognition of the hardship of living in an extreme environment.
Drury et al. (2005)	Challenges with clinical confidence and self esteem	Professional isolation	Safety issues

		Autonomy, independence and interdependence of roles Expert generalist Working at an advanced level without recognition Varied educational support.	
Farmer et al. (2007)		Perceived 'distance' between senior managers imposing change Longstanding recruitment issues Pride in teamwork in local hospitals	Distance to urban units Tortuous geography Infrastructure deficiencies and potentially adverse weather.
Farmer and Kilpatrick (2009)	Engagement in a range of community activities enables physical/psychological health benefits that boost confidence	Mentoring Developing leadership skills.	
Farmer et al. (2010)		Tensions in management approach Difficulty in recruiting specialists and maintaining their skills Incorporating the voice of local people in service design would show the degree to which 'mutuality' in service planning and provision is realisable	
Gibb et al. (2005)	Advancing age seen as dis-enabler to education Nostalgia and grief regarding changes to organisational environment	Nurses recognised personal benefits of change through embracing learning and mentoring	Geographical distance, time and cost seen as dis-enablers to education
Heidelbeer and Carson (2013)	Higher incomes and more time off with fly in fly out rural nursing High levels of fatigue due to intensity of work during 'on' time Perceived undervaluing of their contribution	Difficulty accessing professional development/education Professional isolation Recruitment and retention issues	Harsh climate Travel difficulties

Hunsberger et al. (2009)	Commitment to colleagues, patients and community Sense of belonging Blurring of personal and professional lives Stress	Lack of resources, support and influence to manage negative situations Rural nursing can be unpredictable in relation to variety of practice and work arrangements Diversity of rural practice seen as a barrier to recruitment and retention.	Security issues when working at night
Joseph et al. (2013)			Weather related illness and injury leading to staff absenteeism and increased workloads Road closures Dangerous environment Distance to urban centres
Kenny and Allenby (2013)	Psychosocial care more difficult due to staff and clients knowing each other well outside the clinical setting Psychosocial care is significantly undervalued	Lack of collegial relationships amongst staff Issues around 'culture' of organisation Professional isolation Lack of support from management Multi-skilling expectations	
Kenny and Duckett (2003)		Diversity of nursing practice in rural hospitals Lack of university education amongst rural nurses Rural nurses need to be multi-skilled generalists who often make decisions in the absence of other health professionals ANP role recommended	
Kenny and Duckett (2004)		The rural hospital remains the symbol of the social power of medicine but nurses forced to do things that were outside their scope. Notion of ANP's was an extremely controversial subject.	
Kenny et al. (2007)	Lack of confidence and emotional exhaustion	Rural nursing is characterised by diversity multi skilled generalists lacking specialist knowledge	

	Complex dual relationships	Need for mentoring and clinical supervision	
Lauder et al. (2001)	Blurring of personal and professional lives Community embeddedness Viewed as a friend, someone who can be readily approached- a trusting relationship An appreciation of their patients' family dynamics Nurses use their knowledge and experience, together with the trust they have built with the local population, to provide greater insight into health needs	Feelings of being unsupported in multiple roles Nurses' work is influenced by the current organisation of services often unaware of the nature of mental health interventions provided by other professionals. Nurses reported a perceived lack of skills and lack of confidence when dealing with patients with alcohol related problems. Poor communication between specialist and generalist services in rural areas	Nurses have a unique position within the community. Appreciation of rural culture
Leipert and Anderson (2012)	Less stress as slower pace of life Blurring of boundaries between personal and professional life Insider/outsider status	Facilitators noted as increased autonomy, the generalist role and advances in technology Barriers noted as inadequate rural education and professional isolation	Strong sense of community/culture Isolation – distance, weather, road conditions, safety issues
Lori et al. (2012)	Although participants voiced a strong desire to help others and to save lives, they also expressed a deep concern for their own quality of life	Lack of staff No career advancement or continuing professional development	Concerns about unacceptable housing accommodations, no access to potable water, impassable roads, no transportation, non existent schools, poor support structures and poorly equipped hospitals
MacKinnon (2008)		Complexity of rural nursing Difficulties of being an 'expert generalist' Knowing their community contributed to tremendous sense of responsibility Strained relationships with other healthcare providers 'Moral distress' when it was difficult to obtain education and experience needed to be	

		comfortable providing maternity care	
Mills et al. (2007)	Emotional impact of interactions in the course of nursing from 'the womb to the tomb' Feelings of being put down re thoughts of patients receiving 2nd class care in rural areas Role blurring Sense of belonging Lack of anonymity – 'fish bowl existence'	Expert generalists -'we're not specialists in anything but have to deal with anything that comes through the front door' Nurses describe work as 'not something you do between 9-5' Mentoring facilitates the desire to see high quality care delivered, cultivates and grows new nurses and strengthens trust and friendship between the novice and experienced nurse and promotes retention	Sense of close community/culture Family/friends grown up in region Want to see their children enjoy same sense of community
Mohale and Mulaudzi (2008)	Emotional and physical strain as a result of the shortage of human resources	Retaining nurses is a problem	
Montour et al. (2009)	Stress and dissatisfaction	Ageing workforce – anticipation of a substantial increase in retirements during next decade Rural nursing is generalist in nature, requiring personal flexibility and a broad knowledge base Implementation of e-technology and emerging disease patterns in patient population identified as challenges	
Moszczynski and Haney (2002)	Sadness of stress, anger and difficulty in keeping professional life from encroaching on personal life Community ties and relations could be taxing	Tension due to the lack of communication and support Professional conflict Expert generalist role Professional isolation	Geographical isolation Poor weather and terrain - 'there's no road or anything' resulting in delays in help arriving
Newhouse (2005)		Distinctive challenges for rural nurses – patient population, legislation, technology, staff shortages, cultural differences between staff, physicians and patients,	Physical isolation Lack of services

		nurse-physician conflict and maintaining competency Advanced practice nursing recommended	
Pront et al. (2013)	Relationships between staff, students and patients meant an intertwining of professional and private lives	Promotion of learning through supportive preceptorship has the potential to aid retention of nurses in rural areas	Unpredictable nature of rural environment
Robinson et al. (2010)	Strong sense of pride in being able to 'make it work' for patients	Dual relationships leading to numerous ethical challenges Lack of 24 hour service and human resource shortage endemic to rural communities Need for educational opportunities and telehealth	Social solidarity, close-knit relationships, culture and community commitments were strengths of rural communities Adverse weather Safety issues Access to care differed widely among rural communities
Rohatinsky and Jahner (2016)	Lack of anonymity Stressed, overwhelmed and intimidated Role blurring Community embeddedness	Expert generalist – multiple hats Mentorship helped transition to rural healthcare environments Difficulties with recruitment and retention Professional isolation Education	Limited resources Geographical isolation Rural community influences/culture (involvement in community events)
Rosenthal (2005)	Lack of anonymity Sense of belonging - nurses who wish to keep their lives private are generally not well accepted Insider/outsider issues - long period of residency before considered an 'insider'	Rural nurses need to assume the role of expert generalist and function as 'jack-of-all-trades' An ability to respond appropriately to unique challenges Role conflict Professional isolation	
Sedgwick and Rougeau (2010)	Stress Sense of belonging	Fear of being observed or making an error or mistake How students interpret belonging is invaluable for hospital managers who seek	

		to recruit and retain a future nursing workforce.	
Woodhouse (2010)	Confusion around role, skills, communication and care planning		
Yates et al. (2013)	Stress	Nurses recognised the importance of being a multi-skilled generalist in rural areas Concerns that midwifery skills could be eroded due to diminishing work available	Experiences of nurses are shaped by location/culture Limitations of working in rural hospital
Yonge et al. (2013)	Confidence and personal bonds can be fostered through preceptorship	Mutual professional development through preceptorship to aid recruitment and retention	
Yonge et al. (2006)	Students expressed their enjoyment of the 'family feel' that coincides with a rural hospital - majority of students requesting a rural placement originated or grew up in smaller towns Personal satisfaction as knowledge of the community can be used to enhance relationships and care	Lack of technology and lack of academic support Professional isolation More exposure to different clinical areas in a rural setting with unpredictable workloads Need to be an expert generalist Education and rural placements to aid recruitment and retention	Adverse weather

Table 3: Rural/Remote Nursing Dimensions and Domains

Key quotations are highlighted below to exemplify the dimensions and domains of rural and remote nursing.

Results of Thematic Analysis

Person/al Dimensions and Domains of Rural/Remote Nursing

Sense of belonging/connectedness: Previous exposure to rural or remote life, or previous work experience in the country, were the most compelling reasons influencing the attraction of some nurses to rural and remote areas (Rosenthal, 2005; Hunsberger et al., 2009; Caldwell, 2007; Mills et al., 2007; DeValpine, 2014; Yonge et al., 2006; Baernholdt et al., 2010; Bish et al., 2015;

Corbett and Williams, 2014; Lauder et al., 2001; Rohatinsky and Jahner, 2016; Sedgwick and Rougeau, 2010). There was a sense of people returning to their roots:

I'm going back to the rural setting ... I'm a farm girl. I was born and raised in a small community, and I'm headed back ... I'm going to be a rural nurse (Canada) (Yonge et al., 2006).

Knowledge of rural culture: The culture of rural and remote regions was cited in several articles as a major aspect of the nurses' practice and motivation to stay in the region (Caldwell, 2007; Mills et al., 2007; Kenny and Allenby, 2013; DeValpine, 2014; Mills et al., 2007; Baernholdt et al., 2010; Bish et al., 2015).

The community ethos influenced nurses:

I had met some Alaskan Native people as patients and felt a love for them, appreciating their conduct, learning about their lives (USA) (DeValpine, 2014).

Blurring of personal and professional lives: Several studies pointed towards the advantages and disadvantages of familiarity between patients, professionals and the community and the potential blurring of personal and professional lives (Hunsberger, 2009; Mills et al., 2007; Kenny and Allenby, 2013; Kenny et al., 2007; Moszcynski and Haney, 2002; Corbett and Williams, 2014; Lauder et al., 2001; Rohatinsky and Jahner, 2016; Arneart et al., 2009; Leipert and Anderson, 2012; Pront et al., 2013):

Patients do like to bring personal information into the conversation perhaps about a neighbour and as patients may know of others being visited by the same nurse they may ask for an update – that is when I become very professional and try to point out that I can't tell Mrs Jones about their medical situations or what we do for them (Wales) (Corbett and Williams, 2014).

Anonymity: The challenges of maintaining anonymity were highlighted in several articles (Rosenthal, 2005; Mills et al., 2007; Boucher, 2005; Beks et al., 2018; Rohatinsky and Jahner, 2016; Arneart et al., 2009):

I suppose in a rural community ... everything that you do has more of an impact. Like, if you have a relationship or if you have a problem here everybody knows about it. It becomes more of a problem because it's so ... well advertised ... If you were an anonymous

person in an anonymous setting you really wouldn't care for a start, but probably no one else would care either ... It wouldn't become everybody's sort of knowledge (Australia) (Mills et al., 2007).

Job satisfaction/stress: Generally, there was a strong sense of pride in being able to 'make it work' (Robinson et al., 2010) for patients through the provision of responsive, creative, highly individualised care (Yates et al., 2013; Hunsberger, 2009; Mills et al., 2007; Kenny et al., 2007; Drury et al., 2005; Farmer and Kilpatrick, 2009; DeValpine, 2014; Yonge et al., 2006; Moszczynski and Haney, 2002; Lori et al., 2012; Yonge et al., 2013; Mohale and Mulaudzi, 2008; Beks et al., 2018; Rohatinsky and Jahner, 2016; Sedgwick and Rougeau, 2010; Arneart et al., 2009; Leipert and Anderson, 2012; Gibb et al., 2005; Heidelbeer and Carson, 2013). The interplay with a sense of community belonging contributed to enhanced job satisfaction. Rural nurses expressed emotions such as sadness, anger, and feelings of hopelessness due to being overburdened (Mahale and Mulaudzi, 2008). Having to maintain a broad range of skills was considered as both a stressor and a motivator to continue learning (Yates et al., 2013; Hunsberger et al., 2009). Seeking mutual social support from colleagues was a frequently used strategy:

I think nurses must get rid of that kind of sadness of stress by talking to each other – we've really only got each other – we need to do that (Canada) (Moszczynski and Haney, 2002).

Profession/al Dimensions and Domains of Rural/Remote Nursing

Expert generalist: The need for rural and remote nurses to be multiskilled was identified as a recurrent theme (Rosenthal, 2005; Yates et al., 2013; Mills et al., 2007; Kenny and Allenby, 2013; Kenny and Duckett, 2003; Kenny et al., 2007; Drury et al., 2005; DeValpine, 2014; Yonge et al., 2006; Moszczynski and Haney, 2002; Beks et al., 2018; MacKinnon, 2008; Lauder et al., 2001; Rohatinsky and Jahner, 2016; Leipert and Anderson, 2012; Montour et al., 2009). Due to the diversity of the work and a lack of resources and facilities often the nurse became a jack of all trades, prepared and willing to undertake many different tasks:

You took care of a lot of the stuff – plane crashes, burns victims, cardiac, kids (USA) (DeValpine, 2014).

We're not specialists in anything and we can have anything appear at the front door. I feel that we are fighting for survival... you don't do things enough to be skilled. (Australia) (Mills et al., 2007).

Advanced nurse practitioner: In order to address the complexity of the generalist role, several studies supported the view that advanced nurse practitioners provide high quality services in rural settings (Kenny and Duckett, 2003; Kenny and Duckett, 2004; Drury et al., 2005; Conger and Plager, 2008; Newhouse, 2005; Birks et al., 2011):

There is definitely work for a nurse practitioner. To have someone with those sorts of skills would be fantastic but, really, we can't get any nurses. At the moment anyone would do (Australia) (Kenny and Duckett, 2003).

Professional isolation: A number of studies cited professional isolation as a part of everyday experience in rural and remote nursing (Rosenthal, 2005; Yates et al., 2013; Hunsberger et al. 2009; Kenny and Allenby, 2013; Drury et al., 2005; Yonge et al., 2006; Moszczynski and Haney, 2002; Beks et al., 2018; MacKinnon, 2008; Rohatinsky and Jahner, 2016; Arneart et al., 2009; Heildelbeer and Carson, 2013).

I am the trauma team. (Canada) (Hunsberger et al., 2009).

... sometimes you just want another midwife to say 'Oh, what do you think?' you know. (Australia) (Yates et al., 2013).

Professional isolation remained one of the most concerning aspects of rural work. Nurses experienced difficulty finding help when confronted with unfamiliar situations, and the need to become resilient and overcome fears was articulated:

I had to stop crying and realise that maybe I can do this ... I can settle down and do this. (Australia) (Heildelbeer and Carson, 2013).

Mentorship: Mentoring was described as one strategy used to retain novice rural and remote nurses and to combat professional isolation (Mills et al., 2007; Kenny et al., 2007; Farmer and Kilpatrick, 2009; Boucher,

2005; Yonge et al., 2013; Lauder et al., 2001; Rohatinsky and Jahner, 2016; Pront et al., 2013; Gibb et al., 2005; Heidelbeer and Carson, 2013; Conger and Plager, 2008). The lack of an onsite mentor described as 'another pair of eyes' challenged nurses and led to a sense of loneliness and isolation (Conger and Plager, 2008). For rural nurses, working in a close-knit setting, the support of colleagues and managers is crucial:

Just the ability to be able to sit down and say, I did this really well or I did this really badly and want to talk about it (Australia) (Kenny et al., 2007).

Education: Studies considered the significance of education for rural and remote nurses (Hunsberger et al., 2009; Mills et al., 2007; Kenny and Duckett, 2003; Drury et al., 2005; Boucher, 2005; Yonge et al., 2006; Lori et al., 2012; Beks et al., 2018; MacKinnon, 2008; Lauder et al., 2001; Moszczynski and Haney, 2002; Lori et al., 2012; Rohatinsky and Jahner, 2016; Arneart et al., 2009; Leipert and Anderson, 2012; Pront et al., 2013; Robinson et al., 2010; Gibb et al., 2005; Heidelbeer and Carson, 2013; Conger and Plager, 2008; Birks et al., 2011). Some highlighted professional isolation as the main factor leading to difficulty in accessing education, resulting in deskilling (Hunsberger et al., 2009; Heidelbeer and Carson, 2013):

It is hard to maintain skills that you are not using all the time... it makes it a little scary (Canada) (Hunsberger et al., 2009).

Rurality and remoteness were considered a barrier to continuing professional development:

Due to isolation, nurses experience limited access to continuing education, interaction with healthcare professionals, and resources to provide care (Canada) (Leipert and Anderson, 2012).

Autonomy and empowerment: Several studies described autonomy and decision making as core characteristics of rural nursing practice, bringing difficult but rewarding challenges (Drury et al., 2005; Bish et al., 2015; Arneart et al., 2009; Leipert and Anderson, 2012). These challenges, such as trying to provide proper care with limited resources and professional support, appeal to some nurses:

Autonomy is a facilitator because it can enhance nurses' problem-solving skills and innovations in their ability to find solutions to a lack

of resources ... and professional support (Canada) (Leipert and Anderson, 2012).

Role conflict: Professional conflict was reported in some of the articles (Rosenthal, 2005; Yates et al., 2013; Kenny and Allenby, 2013; Kenny and Duckett, 2004; Moszczynski and Haney, 2002; MacKinnon, 2008; Lauder et al., 2001; Newhouse, 2005; Farmer et al., 2007; Farmer et al., 2010). The lack of collegial relationships amongst staff in the rural context was identified as a barrier to effective working:

How do we provide great psychosocial care to clients if we can't provide psychosocial support to each other? ... You'd even see them looking at the roster ... they'd say oh no ... I've got to work with her ... (Australia) (Kenny and Allenby, 2013).

Some nurses believed that they were required to defend the patient care they had provided when dealing with their counterparts in an urban hospital, and cold and judgemental responses from nurses working in larger settings were recounted:

I am often left feeling angry when those guys come and scoop your patients up and spend an hour criticising your care ... it is very, very frustrating ... Will those receiving him down South respect your efforts, see you as professionally competent ... I've always felt that the nurses in the North had to be twice as good as the nurses in the South ... I guess it's some sort of geographic insecurity. (Canada) (Kenny and Allenby, 2013).

Recruitment and retention: The sustainability of rural nursing is threatened when nurses lack resources, support, and influence (Hunsberger et al., 2009). Demographic trends, such as the ageing nursing workforce, exacerbated this situation:

It's only going to get worse because you figure they're telling us that there's at least half of us right now that given the next 10 years could retire. Well, you're already short now and you get another half going out the door? (Canada) (Montour et al., 2009).

Place Related Dimensions and Domains of Rural/Remote Nursing

Terrain and weather: The physical geography that challenges rural and remote nursing practice was described in several articles (Boucher, 2005; DeValpine, 2014; Yonge et al., 2006; Moszczynski and Haney, 2002; Leipert and Anderson, 2012; Pront et al., 2013; Robinson et al., 2010; Heildelbeer and Carson, 2013; Farmer et al., 2007; Joseph et al., 2013). Some nurses considered that:

Getting in and out of the area is difficult. There is no road system ... you can't get out of here (USA) (DeValpine, 2014).

We have had times when ambulances have been stuck in our laneway or ice storms, that kind of stuff, where you don't have the availability of quick response or a snowplough to help out. In the winter it can be a detriment (Canada) (Joseph et al., 2013).

In the Highlands of Scotland, travelling on poor roads impacted on emergency calls and travel, and for island populations this was further challenged by unpredictable seas:

We are just too remote. If there wasn't the stretch of water between us and the mainland that might be different, but there is and there always will be (Scotland) (Farmer et al., 2007).

Fewer resources: Fewer patient resources were described in some rural and remote communities (Yates et al., 2013; Boucher, 2005; DeValpine, 2014; Moszczynski and Haney, 2002; Lori et al., 2012; Arneart et al., 2009; Robinson et al., 2010; Heildelbeer and Carson., 2013; Newhouse, 2005; Farmer et al., 2007), including those requiring specialist services such as mental health and drug addiction, which further compounds the challenges of treating a disadvantaged population (Newhouse, 2005). A lack of local support structures resulted in patients being referred to better equipped facilities (Lori et al., 2012). Poor resources also impacted on nurses' lives and might preclude them from accepting permanent positions in a rural or remote area:

They gave me this place to live in. It hadn't been cleaned, had almost no kitchen, the television didn't work, the washing machine didn't

work, there was no ironing board. It's a basic level of accommodation
(Australia) (Heidelbeer and Carson., 2013).

Geographical isolation: Geographic isolation and the fragility of life were highlighted by nurses (Boucher, 2005; DeValpine, 2014; Moszczynski and Haney, 2002; Lori et al., 2012; Rohatinsky and Jahner, 2016; Arneart et al., 2009; Leipert and Anderson, 2012; Robinson et al., 2010; Gibb et al., 2005; Heidelbeer and Carson., 2013; Newhouse, 2005; Farmer et al., 2007; Joseph et al., 2013):

Life is fragile out here – the isolation (USA) (DeValpine, 2014).

More positively, geographical isolation was also considered a source of restoration as nurses enjoyed the slower pace of life in rural and remote communities, which resulted in less stress:

Remote areas are less contaminated by ... garbage ... you'll be in awe of the power and beauty of nature (Canada) (Leipert and Anderson, 2012).

Safety: Some nurses cited personal safety as being a concern (Hunsberger et al., 2009; Drury et al., 2005; DeValpine, 2014; Moszczynski and Haney, 2002; Lori et al., 2012; Leipert and Anderson, 2012; Robinson et al., 2010; Heidelbeer and Carson., 2013; Newhouse, 2005; Joseph et al., 2013). Nurses described lone working without security personnel in the evening:

There are four of you in the whole hospital and we don't like people to know that because we are very much at risk (Canada)
(Hunsberger et al., 2009).

Rural culture: A desire to have a level of immersion into the culture of rural and remote communities influenced nurses personally (Bish et al., 2015). In several studies the culture was a major aspect of the nurses' motivation to stay in a rural or remote region (Rosenthal, 2005; Yates et al., 2013; Mills et al., 2007; Farmer and Kilpatrick, 2009; DeValpine, 2014; Bish et al., 2015; Lauder et al., 2001; Rohatinsky and Jahner, 2016; Leipert and Anderson, 2012; Robinson et al., 2010). For example, nurses portrayed an intense appreciation of Native Alaskan culture and environment:

I love the Native population here. I like this community. It's beautiful, it's abundant with salmon ... a moose rack ... a haunch of caribou ...

(USA) (DeValpine, 2014).

Explaining the cultural complexities of rural and remote communities such as the accepted norms and practices is integral to cultivating and growing new novice nurses (Mills et al., 2007).

MacKay's 3P model

Data synthesis informed the development of MacKay's 3P model of factors influencing rural and remote nurses' decision making (Figure 3). The model provides a theoretical framework to explore the complex interplay between the person/al, profession/al and place-related dimensions of rural and remote nursing and capture the complex phenomenon of the factors that influence nurses' decision making to remain or leave rural and remote areas.



Figure 3: MacKay's 3P model of factors influencing rural and remote nurses' decision making.

Discussion

This systematic review and thematic synthesis highlights the complexity of factors that influence nurses to work in rural and remote locations. Examples are the influence of family ties and connections (personal), appreciating the local culture (place) and accepting the flexibility required to adapt to whatever the immediate healthcare needs may be (professional). Being part of a team, job satisfaction, a rural lifestyle, a sense of belonging and being part of a culture that supports education and learning through mentoring had a positive effect on

the retention of rural and remote area nurses. Professional isolation, lack of anonymity, challenges in maintaining continuous professional education, fewer resources and fears for personal safety were the main negative findings of the review. These findings were used to develop MacKay's 3P model, which provides a graphical representation of three distinct but interrelated dimensions of rural and remote nursing: person/al, profession/al and place. The review also highlighted the fluidity of the domains and dimensions, recognising the interrelated nature of factors affecting nurses' experience and decision-making to work in rural and remote areas. Despite clear connections between these three dimensions, few articles have explicitly considered this interplay. Around a quarter (11/40) of the articles only focused on one dimension. Of those that considered more than one dimension these were generally treated in isolation. Whilst these connections were not explicitly made within individual articles, the authors' analysis across the studies has highlighted and described multiple relations. MacKay's 3P model illustrates the complexity and interplay of the person/al, profession/al and place-related dimensions of rural and remote nursing.

This review found that there are no universally accepted definitions of 'rural' (Kulig et al., 2008). Less than half of the articles included in this review presented a definition of the term 'rural'. Of those, half used census or other administrative data defining rurality in terms of population distribution across land mass, whereas the other half used bespoke definitions based on a nurse's role (Kulig et al., 2008). According to Muula (2007) there is a need for authors to explicitly report the definition of a rural area used in their research. Of the 15 Australian articles included in the review, only seven presented a definition of 'rural' and only one of these articles considered remote nursing (Heilderbeer and Carson, 2013). The three remote nursing articles included in the review (DeValpine, 2014; Heilderbeer and Carson, 2013; Birks et al., 2011) were retrieved using the search term 'rural nurs*'. By applying the search term 'remote nurs*' no qualitative remote nursing research articles were retrieved. This further clarifies that in addition to the paucity of remote nursing qualitative research is definitional complexity around the terms 'rural' and 'remote'. The categorisation of articles within databases did not differentiate between rural

and remote –all were classified as rural. Of the three articles considering remote nursing two were set in Australia (remote Queensland) (Yates et al., 2013; Birks et al., 2011) and one was set in USA (south-west ‘bush’ Alaska) (DeValpine, 2014), all focusing on nursing experiences in delivering care in indigenous communities.

Reflections on the definitions of rural and the context of data synthesised

Definitions of measures of rurality are important to policy makers, researchers and communities as they have strong implications for policies and practices across governing levels. Issues of community sustainability, wellbeing, equity and access to services and amenities are closely linked to rural life (Nelson et al., 2021). Appendix 1 highlights the Government definitions/classifications of rural for the countries included in this systematic literature review. Some of the forty articles reviewed highlighted the diverse geographies and social compositions of places but twenty of the articles did not include any definition of rural (Table 2).

According to Jakobs (2017) rural life may entail residing in a county with a population of 100,000, access to a small hospital, several grocery stores and a local emergency department. This could be contrasted to living in the frontier which may have a population of 3,000, one grocery store and possibly a rural medical centre but access to an emergency department could be at least an hours’ drive away. Studies involving access to medical care in each of these settings would likely yield vastly different results, although Jakobs (2017) states that both settings fall under the umbrella designation of ‘rural’.

In Australia, for example, around seven million people, or 28% of the Australian population, live in rural and remote areas, which encompass many diverse locations and communities (Australian Government, 2024).

56% of America is considered to be frontier with over twelve million people living in remote areas. American frontier lands are often historically indigenous. They are rural and agricultural and although the National Centre for Frontier Communities (NCFC), (2024) use a three-variable matrix of population density, travel time and distance to services to describe frontier communities, to date there is not a conclusive and complete definition shared by policy makers, governments and organisations. Nelson et al. (2021) concur that even within a single country, rural areas are heterogeneous. The above examples

demonstrate the importance of properly describing the research setting and context (Jakobs, 2017). Rural and urban taxonomies often do not discuss important demographic, cultural and economic differences across rural places which according to Hart et al. (2005) hampers comparisons between countries and studies.

Within this review, none of the articles set in the Appalachian Frontier (Caldwell, 2007, Rosenthal, 2005), Bush Alaska (De Valpine, 2014), or rural Ghana (Lori et al., 2012) included any definition of rural or remote but according to Jakobs (2017) there are population and geographic characteristics that make these communities unique. Rural research must be more than research about nursing in rural places. It must be rooted in place, research in, for and with rural people and communities (Roberts et al., 2024).

Retention and Migration Decisions

Of the forty reviewed articles there were fourteen that focused on interventions that aimed to increase nurse retention in rural and remote areas (Education and Continuous Professional Development (CPD) Interventions; Financial incentives; and Personal and Professional support). Three studies highlighted barriers to recruitment and retention. Heilderbeer and Carson (2013) stated that pressures and tensions between resident and non-resident workers resulted in non-residents feeling undervalued for their contribution which had a negative impact on recruitment and retention. De Valpine (2014) considered that adaptability to hardship appeared to be common to retention in Bush Alaska and nurses that were unable to fully appreciate and navigate the Native Systems Structure and culture and climactic hardships were unlikely to stay. Emotional and physical strain because of the shortage of human resources led Mohale and Mulaudzi (2008) to recommend that policies should meet the health care needs of rural communities by developing strategies to retain professional nurses.

Education and CPD interventions were highlighted in four of the articles. Conger and Plager (2008) advocated that as well as strong support systems, the goal of educational programmes must be to make rural and remote area nursing a place where nurses want to work and stay. The diversity of rural practice was emphasised as a barrier to recruitment and retention due to the difficulties of replacing retirees with nurses who were 'comfortable with all the different things

they have to do' (Hunsberger et al., 2009). Education interventions to target and transition new nurses into the system were advocated as the current cadre of rural nurses approach retirement. 'If the status quo is maintained, the future for rural hospitals, rural communities and rural nursing is bleak' (Kenny and Duckett, 2003: 620). By early and increased exposure to rural practice during undergraduate studies there is more likelihood of recruiting and retaining staff in these areas. According to Montour et al. (2009) stress and dissatisfaction associated with intent to leave amongst rural nurses can be alleviated by providing student placements to offer support and preparation for the challenges of the scope of rural nursing practice. Mackinnon (2008) stated that there needs to be a careful review of the effects of policies and guidelines that are developed in urban and suburban settings and how these texts impact rural nursing work. Policies need to be adapted to reflect the local context for care and supporting rural nurses. MacKinnon (2008) concluded by stipulating that funding for CPD for all rural nurses should be available to enable affordable and accessible education.

Several articles stated that, for practicing rural nurses, personal and professional support within the workplace represented a pragmatic commitment that enticed them to stay. Having a rural-specific formal mentorship programme was considered by Rohatinsky and Jahner (2016) and Mills et al. (2007) as a means to recruit and retain nurses in rural areas. Yonge et al. (2013) and Yonge et al. (2006) contended that a positive preceptorship experience for both the student and the preceptor significantly impacted recruitment and retention by preparing the student to learn in rural settings and develop knowledge about the nature of rural nursing and how to contend with the unexpected.

Boucher (2005) stated that nurses of working age were leaving rural areas for economic reasons which altered the demographics of rural populations. To attract and retain nurses Lori et al. (2012) deemed those financial incentives such as increased salary, and material incentives such as improved housing was desirable.

Unanswered questions and future research

This literature review has identified the many factors that influence nurses' decisions to work in rural and remote areas. A model of factors that influence nurses' decision-making to work in rural and remote areas has been outlined that can be used by policymakers to shape targeted recruitment and retention strategies and serve as a framework for future research in this field. However, in the face of global nursing shortages, which have a disproportionately negative impact on remote and rural areas, this review shows that further research examining the interplay between the personal, professional, and place-related dimensions of rural nursing is required. (Auto)biographical narratives have been used by health researchers to enable participants to understand the flow of their lives through time and space, and the interrelation between the two (Milligan et al., 2011). Using autobiographical (or life history) approaches in rural nursing research may help to uncover nurses' rationale for their career decisions in the context of the relationships with people and places in which they were made. Through narrative, life stories are appropriate for understanding a lifetime of occupational experiences and for appreciating the personal, professional, social, economic, historical and geographical influences that shape these experiences (Wicks and Whiteford, 2006).

Strengths and limitations

This appears to be the first systematic review and thematic synthesis to explore the evidence around the dimensions and domains that influence nurses' decision-making and experiences of working in rural and remote healthcare settings. Studies were generally of a high quality, perhaps reflecting the use of qualitative reporting guidelines such as COREQ-32 (consolidated criteria for reporting qualitative research) (Tong et al., 2007). Notwithstanding the use of the CASP tool (CASP, 2018), quality appraisal retains a degree of subjectivity, and although all articles were critically appraised and scored by SCM and then independently scored by a second reviewer (AS, RGK or MB) it is possible that other researchers may have appraised the quality of the studies in a different way. Only English language articles were included, and thus the findings of this review may have limited relevance to countries where English is not widely spoken. Although limited, due to the inclusion of only three qualitative remote nursing articles, this review has highlighted that the dimensions and domains of

rural nursing seem to be synonymous with those of remote nursing. There is a scarcity of international qualitative remote nursing research evidence to enhance understanding of nursing in more isolated and remote settings.

Conclusion of chapter, Rural Nursing Theory and Theoretical Framework.

This literature review identified the factors influencing nurses' decision-making to remain in or leave areas of remote and rural work. To date, there is a paucity of qualitative rural nursing research undertaken in the UK, a lack of explicit definitions of rural and remote nursing in many studies, and a tendency to examine factors in isolation. This thesis seeks to address this gap in empirical knowledge by examining the complex interplay of these multiple factors over time to enhance strategies to address the global shortage of nurses in rural and remote settings through answering the following research questions:

1. What are the person/al, profession/al and place-related factors that influence choosing rural practice?
2. What is the interplay between people, profession, and place?
3. How does the interplay between people, profession and place influence nurses' career destinations and transitions?

MacKay's 3P model will be utilised to highlight the multiple and complex factors at play that guide nurses' decisions to remain in or leave rural and remote settings. This three-dimensional model (person/al, profession/al and place) has the potential to aid policymakers to tailor recruitment and retention strategies for rural and remote areas.

Rural Nursing Theory and Theoretical Framework

A brief overview of the rich heritage of the rural nursing theory base described by Long and Weinert (1989) will now be presented and the theoretical framework underpinning the research process will be outlined.

Rural nursing theory (RNT) was founded on qualitative and quantitative studies conducted in the last quarter of the twentieth century and is a framework for practice that considers the environment and the perceptions and needs of rural persons (Lee and Winters, 2004). RNT recognises that rural people have different definitions of health, self-reliance, and care-seeking behaviours than urban people and the theory also encapsulates the challenges and realities of

rural living, such as weather, distance, and isolation, that impact health care access and delivery.

Rural nursing theory contains three statements and their related concepts. The first statement is concerned with work beliefs and health beliefs and states that *“rural dwellers define health primarily as the ability to work, to be productive, to do usual tasks”* (Long and Weinert, 1989, p.120).

The second statement is *“rural dwellers are self-reliant and resist accepting help or services from those seen as ‘outsiders’ or from agencies seen as national or regional ‘welfare’ programs”* (Long and Weinert, 1989, p.120). According to Lee and Winters (2004) rural persons preferred to seek health care from “insiders,” who were classed as persons with whom they were familiar. The RNT concept of self-reliance connects to the theme of resourcefulness (Pullyblank, 2022).

The third statement of RNT focuses on health care providers (HCP’s). This statement indicates that HCP’s experience lack of anonymity and much greater role diffusion than providers in urban or suburban settings. Lack of anonymity also applies to the recipients of health care in rural areas as all persons in that environment have a *“limited ability . . . to have [a] private area in their lives”* (Long and Weinert, 1989, p.120).

According to Fawcett and DeSanto-Madeya (2004) theories are developed for the purposes of describing, explaining, and predicting phenomena. The content of Long and Weinert’s (1989) RNT is widely quoted in nursing literature but following a review of literature up to early 2017, findings by Lee and McDonagh (2022, p. 42) recommended that RNT should be revised. These revisions included changing the definition in the first theoretical statement from that of a functional nature to a more holistic view that includes physical, mental, social, and spiritual aspects.

The concept of the second statement of RNT whereby rural residents are seen as being self-reliant is largely supported although the resistance to seeking help from those seen as ‘outsiders’ has still to be tested. One such research question identified by a core group of nurse researchers from the North American Study group was *‘Are rural dwellers more accepting of ‘outsiders’ if they are healthcare professionals working in partnerships with the rural*

community and local health professionals? Although the revised statements have been ready for more than ten years, to date they have not yet been fully explored or tested (Lee and McDonagh 2022, p. 48)

The third RNT statement regarding the lack of anonymity and role diffusion that healthcare providers experience in rural communities is well supported in the literature (Lee and McDonagh 2022, p. 44). The related concepts of privacy and confidentiality remain important factors in terms of health-seeking behaviours among rural populations and the consequences of a lack of anonymity such as 'familiarity', 'visibility', 'awareness of privacy', and 'balance of lack of anonymity' continue to have an impact on healthcare professionals (Swan and Hobbs, 2017).

The Rural Nurse Theory is an ethnographic theory that informs researchers about rural culture (Jakobs, 2017). It remains a valid and relevant contextual framework for rural and for frontier nursing research. The disparate access to healthcare services makes frontier dwellers a vulnerable population and this issue alone makes research with frontier populations an important contribution to nursing knowledge. According to Jakobs (2017) the following RNT concepts are related to frontier research: Health is defined as the ability to work; Self reliance is due to the lack of available resources and an independent spirit; The concept of insider/outsider is related to both the scepticism that frontier dwellers have about accepting help or services from outsiders, and the notion that health care providers that are new to the community are outsiders; Role diffusion was described as the need to function in multiple roles; A lack of anonymity may be broadly applied to include patient confidentiality (Jakobs, 2017).

According to Lee and McDonagh (2022, p. 48) it is crucial that nurse researchers with an interest in rural nursing conduct research to enhance the development of RNT. Pullyblank (2022) considers that RNT is an applicable, yet underutilised middle-range theoretical framework that could be used to underpin future research work in rural and remote settings. As a result of the paucity of literature on RNT none of the qualitative articles included in this review used or made reference to RNT. This thesis does not seek to test rural nursing theory,

rather, it will reflect on existing literature and use RNT as a lens with which to view the interpretation of results.

According to Varpio (2020) qualitative research is not an absolute science, and while not all research may need a framework or theory, the use of a framework or theory can help to position the research questions, research processes, conclusions and implications within the relevant research paradigm. Grant and Osanloo (2000) consider that the theoretical framework is one of the most important aspects in the research process, yet it is often the most poorly understood. The theoretical framework is the foundation from which all knowledge is constructed for a research study. It serves as the structure and support for the rationale for the study, the problem statement, the purpose, the significance, and the research questions. The theoretical framework provides a grounding base, or an anchor, for the literature review, and most importantly, the methods and analysis. Grant and Osanloo (2000) suggest that the theoretical framework needs to be aligned with the research problem, purpose, and significance of the research. The problem identified in this research study is that due to global nursing shortages, recruitment and retention of nurses is a major international concern, exacerbated in rural and remote areas and existing evidence does not fully consider the multiple influences that may impact nurses' decisions to remain or leave rural and remote areas. There is a lack of studies undertaken in the UK. The purpose of this study is to address the notable gap in the literature around the interplay between people, profession and place and the different aspects of decision-making to work in a rural and remote area over time. Findings from this research will add to the body of existing knowledge by understanding the connections between the person/al, profession/al and place related dimension of rural and remote nursing over time, rather than as a snapshot of nurses' experiences at a single moment in time. Results will inform the development of future recruitment and retention initiatives.

Viewing existing knowledge through the lens of Rural Nursing Theory (RNT) connected the researcher to develop the research questions which helped to build the research and inform the rest of the design. Framing the research within the clearly defined field of rural and remote nursing gave direction and influenced epistemological beliefs and assumptions. This research has adopted

an interpretivist qualitative approach informed ontologically and epistemologically by interpretivism which facilitated the choice of the study's design and analysis plan. MacKay's 3P model of factors influencing rural and remote nurses' decision making also provides a theoretical framework which will inform data analysis. The model was developed as a result of undertaking this systematic review and meta-synthesis of qualitative research. Thematic analysis identified three interrelated dimensions that influenced rural and remote nurses' retention and decision making: person/al, profession/al and place and eighteen inter-related domains as illustrated in this chapter. MacKay's 3P model was developed from the literature review and has been a key driver in the development of the research questions for this study (Mackay et al., 2021). The subsequent methodological chapter will give a detailed account of the biographical approach and thematic analysis of interviews.

Chapter Two: Methodology and Methods of the Research Process

Introduction: a qualitative approach

This chapter sets out the methodology and methods applied at each stage of the research process. Philosophical assumptions will be considered as key premises that are encapsulated into interpretive frameworks used in qualitative research (Denzin and Lincoln, 2011). The study design and justification for the qualitative approach and the use of the biographical research method will be outlined. An account of the data collection process will be given with emphasis placed on how the research was conducted. Ethical issues and data handling approaches will be drawn out and consideration will be given to how the data were analysed to generate the findings. Emphasis will be placed on Braun and Clarke's approach to reflexive thematic analysis (Braun and Clarke, 2021) with a focus on striving to meet the trustworthiness criteria in qualitative research (Nowell et al. 2017). Reflexivity and researcher positionality will be considered.

From reviewing the current literature in the previous chapter, the research questions were:

1. What are the person/al, profession/al and place-related factors that influence choosing rural practice?
2. What is the interplay between people, profession, and place?
3. How does the interplay between people, profession and place influence nurses' career destinations and transitions?

These questions required a qualitative methodology to be addressed. There was a notable gap in the literature around the interplay between people, profession and place and the different aspects of decision-making to work in a rural and remote area over time.

According to Bingham and Witkowsky (2022) drawing on both deductive and inductive strategies are important in qualitative analysis as they support a more organised, rigorous, and analytically sound study. Data synthesis from the literature review informed the development of MacKay's 3P model of factors influencing rural and remote nurses' decision making (Figure 3). This model

provided a theoretical framework and captured factors/codes that influenced nurses' decision making to remain or leave rural and remote areas. Drawing on the theoretical framework, with emphasis on existing rural nurse theory with its pre-determined categories and codes, helped maintain a focus on the purpose of the research and guided the development of the research questions. The researcher was watchful that to answer the research questions and produce rich findings from the interviews an inductive approach to coding was necessary to approach the data with an open mind, inductively looking for emerging patterns and themes and interpreting these for meaning.

The study design - philosophical stance

The term 'research philosophy' refers to a system of beliefs and assumptions about the development of knowledge, and according to Saunders et al. (2009) these assumptions will be made at every stage of the research process. They include assumptions about human knowledge (epistemological assumptions), about the realities encountered in the research process (ontological assumptions) and the extent and ways that the researchers' own values influence the research process (axiological assumptions).

The qualitative method of enquiry examines the 'how' and 'why' of decision making and is rooted in the interpretive perspectives found in the humanities and social sciences that emphasise the importance of understanding, from the viewpoint of the people involved, how individuals and groups interpret, experience, and make sense of social phenomena (Pope et al, 2002). This research has adopted an interpretivist qualitative approach informed ontologically and epistemologically by interpretivism. The theoretical perspective of interpretivism emerged in contradistinction to positivism and attempts to understand and explain human and social reality. According to Crotty (1998: 3) the process of learning and developing new knowledge by exploring "*how we know what we know*" embraces the concept of ontology which is concerned with how we perceive reality and epistemology which is what constitutes as knowledge and knowing. As interpretivism focuses on complexity, richness, meaning making, and creating new understandings of social worlds and contexts, it is explicitly subjectivist (Saunders et al, 2009). In the interpretive paradigm, "*knowledge is relative to particular circumstances* –

historical, temporal, cultural, subjective – and exists in multiple forms as representations of reality (interpretations by individuals)”, (Benoliel, 1996: 407). Hence, the participant has their own individual subjective reality and interpretation of that reality. This research aims to consider the multiplicity of lived experiences and particularly focuses on understanding nurses’ interpretations of their experiences of the person/al, profession/al and place related dimensions of rural and remote nursing. The perceptions of how the interplay and complexity of these factors influence nurses’ decision-making to remain in or leave areas of rural and remote work over the course of a career is presented. Interpretivism meets this aim and has guided the research design and data analysis. It is through the interaction between the researcher and the research participant that knowledge is generated to uncover the deeper meanings of human experiences and behaviours (Renjith et al., 2021).

Qualitative stance

Drawing from the interpretivist paradigm, qualitative research seeks to deeply understand a research subject rather than predict outcomes, as in the positivist paradigm (Denzin and Lincoln, 2011). According to Tomaszewski et al. (2020) qualitative research values people’s lived experiences and is inherently subjective and sensitive to the biases of both researchers and participants. That subjectivity, while considered a serious flaw from the positivist perspective, speaks to the core value of qualitative research. Lincoln and Guba (1985) state that qualitative research, conducted thoughtfully, is internally rigorous, and facilitates answering important questions about people and their lives. The qualitative research method incorporates the recording, interpreting, and analysing of non-numeric data with an attempt to uncover deeper meanings of human experiences and behaviours. Understanding the richness and complexity of human behaviour is the crux of qualitative research (Renjith et al., 2021).

All qualitative research is contextual; it occurs within a specific time and place between two or more people. In qualitative research, it is assumed that who the researcher is makes a difference in the findings of the study (Dodgson, 2019). Objectivity is not present and according to Dodgson (2019: 220) it is often said

'the researcher is the research instrument'. Readers of qualitative research need to understand who is doing the research in ways that go beyond their name and professional affiliations to include the researcher's positionality in relation to what is being studied. Transparency and clarity are a minimum requirement for quality in published qualitative studies. The concept of reflexivity refers to critical self-appraisal about one's own biases, values, preferences, and preconceptions about the phenomenon under question (Renjith et al., 2021). Creswell (2014) concurs that reflexivity increases the credibility of the study by enhancing more neutral interpretations. A reflexive diary/journal was added to throughout the research process within this study. This is considered a widely recognised way to foster reflexivity (Ortlipp, 2008, Patnaik, 2013).

The qualitative research approach encompasses a wide array of research designs. Words such as types, traditions, design, strategies of inquiry, varieties, and methods are used interchangeably (Renjith et al., 2021). The main types of qualitative research designs are narrative research, phenomenological research, grounded theory research, ethnographic research, historical research, and case study research.

Qualitative research exists alongside other social science research methods, described by Yin (2011: 282) as *"non-qualitative methods"*, including surveys, experiments and cohort studies. What differs is that the qualitative approach is subjective and utilises language, narrative and description and the quantitative approach is objective and relies heavily on statistics and figures.

The literature review in the previous chapter demonstrated that much of the existing rural and remote nursing research has used quantitative designs using large online survey repositories (Campbell et al., 2013; Eley et al., 2011; Eley et al., 2009). Much of the current qualitative research has focused on describing aspects of rural and remote nursing as individual entities, which does not provide insight into the complex dynamic of experiences that ultimately influences nurses' decisions to work in rural and remote settings.

In this study the aim was to capture the richness of experience through qualitative semi-structured biographical interviews to generate insights into the complex interplay between the person/al, profession/al and place related

dimensions of rural and remote nursing. Further support for a qualitative approach is provided by considering the research objectives of this study to understand the nurses' experiences over the course of a career, the complexity of the decision-making process and the implications of decisions made to work in rural and remote settings.

Justification for the use of the biographical approach

Qualitative research has no single agreed approach to study design.

Biographical research is part of the broader practice of qualitative methods (Roberts, 2002) and according to Brannen (2019) biographical research overlaps with narrative research. Tomaszewski et al (2020), and Curtis (2022), by considering that there was currently no concise resource that explained and differentiated among the most common qualitative approaches, presented four frequently used qualitative study designs:

1. *A Case Study Approach*, the examination of the particularity and complexity of a case, to understand its activities and particular circumstances. Case studies are often used for evaluation purposes (Yin, 2017).
2. *Ethnography*, to study the culture of groups of people to understand how a cultural group works or share lived experiences of the group. Ethnography relies heavily on researcher observational skills and extended periods of contact with the culture (Cresswell and Poth, 2018).
3. *Phenomenology*, focuses on the lived experience that can be observed or felt by people who have different viewpoints (Flood, 2010). e.g. the experience of patients with asthma.
4. *Narrative*, focuses on the meaning an individual attaches to an experience through the process of story telling (Esin et al., 2014).

Biography is a unique narrative record of an individual's life often chosen to record major life events and according to Denzin (1989) the biographical approach builds information up to provide an overview of the events that have shaped a person's life resulting in a complex analysis of emotion and experience.

'*Biographical methods*' is an umbrella term for an assembly of loosely related, variously titled activities such as narrative, life history, oral history, biographical

interpretive methods, storytelling, auto/biography, ethnography, and reminiscence. Bornat (2008) suggested that these activities tend to operate in parallel, often not recognising each other's existence, and that by their very nature, biographical methods encourage a universalistic and encompassing approach, encouraging understanding and interpretation of experience across national, cultural, and traditional boundaries to better understand individual action and engagement in society.

The personal and individual nature of biographical data adds an additional layer of complexity. A focus on story or narrative sees telling, relating, and recounting as a central and universal human activity. Lives, it is argued, are constructed, presented to listeners in storied forms. As Widdershoven (2003:109) confers, a story is never a pure ideal, detached from real life. Life and story are not two separate phenomena. They are part of the same fabric, in that life informs and is formed by stories (Bornat, 2008).

Biographical research enables the recognition of different parts of individuals' lives that are interconnected, by considering the turning points within their lives that shape their decisions and journeys and providing an interpretation of their lives as part of human understanding (Rahman and Wills, 2013). The biographical approach also addresses ontological concerns since it uncovers a distinct form of knowledge. Its interpretive focus embraces the complexities of subjective words and lived experience (Fillis, 2014).

Biographical research has several uses in practice, including its contribution to psychology, education, and health (Roberts, 2002). The value of biographical research is now being realised within management studies and more specifically within the entrepreneurship and small business arena. Biographical interviews have been utilised to appreciate the career journeys of senior managers in small construction firms (Lu and Sexton, 2010). Pool et al. (2015) used a biographical approach to explore continuing professional development strategies among nurses and Huber et al. (2017) suggested that researching individual biographies in depth can provide a contextualised understanding of tourism behaviour. The career journeys of health trainers were studied by Rahman and Wills (2013) through biographical research methods which

explored the motivations for lay people to become health trainers. Semi structured interviews explored the stages of becoming, being and moving forward as a health trainer.

A biographical approach, using interviews, was undertaken in this study for several reasons. Firstly, the epistemological and ontological philosophical underpinnings of this research complimented the biographical approach as it treats humans as agents who actively give meaning to their lives and learning (Stroobants, 2005). Secondly, the biographical approach takes the complex interwoven relationship between social structure and subjectivity into account, and thirdly, through narrative, life stories are appropriate for understanding a lifetime of occupational experiences and for appreciating the person/al, profession/al, social, economic, historical, and geographical influences that shape these experiences (Wicks and Whiteford, 2006).

Chapter One identified that most current literature tends to concentrate on just a 'snapshot' of rural and remote nurses' experiences at a single moment in time. The aim of this research study was to explore nurses' experiences over time. This added credence and justification for utilising the biographical approach. Kyle and Atherton (2016) consider that nurses are already biographers and that they are well placed to author accounts of individuals lives such as through stories related in nursing notes and handovers and exploring lived experiences through conversations.

Data collection

Denzin and Lincoln (2011) outline many different methods by which data are collected in qualitative research including archival study, observation, interviews and focus groups. This study made use of semi structured interviews which were highly instrumental in gleaning rich data to examine the dynamic and complex interplay of the person/al, profession/al and place related dimensions of rural and remote nursing over the course of a career.

Sampling

Atkinson (2000) refers to the term *population* as all those people about which a researcher wishes to make statements, and the term *sample* as the group of people that a researcher selects from a defined population. These are the

individuals about whom information will be collected. Sampling is the process of choosing a part of the population (Naderifar et al., 2017). According to Rapley (2013) sampling really matters in relation to an array of issues, for the whole trajectory of the analytic process, from the initial questions asked about a phenomenon to the presentation of the results of the work. Literature on sampling highlights the diversity of approaches that are available, for example, Sandelowski (1995) refers to three approaches – maximum variation, phenomenal variation, and theoretical variation – all described as purposeful. Gobo (2004) refers to four: purposive, quota, emblematic and snowball. Patton (2002) refers to sixteen different types – including critical case, stratified purposeful, snowball and convenience – all again described under the label purposeful.

The sampling method for interviews with the four groups of nurses engaged in this study was purposive and was used to target nurses who fulfilled the following inclusive criteria:

- Group 1: nurses who were born in WI – trained in WI – remained in WI (Remainers).
- Group 2: nurses who were born in WI – trained in WI or mainland – worked mainland – returned to WI (Returners).
- Group 3: nurses who were born in WI or mainland – trained/worked in WI – left to work on mainland – remained on mainland (Leavers).
- Group 4: nurses who were born on mainland – trained/worked on mainland – came to train/work in WI (Incomers).

Purposive sampling met the objectives of the biographical approach used in this study. Snowball sampling was also utilised and resulted in four participants being recruited. Snowball sampling, a non-probability sampling method, is widely used in qualitative research whereby participants are recruited by other participants to form part of the sample (Naderifar et al., 2017). This process was particularly useful for finding participants who met the inclusion criteria pertaining to Group 3 (leavers) as these nurses were working on the mainland at the time of participant selection. Snowball sampling is beneficial to conduct research about people with specific traits who might otherwise be difficult to identify. Participants were selected based on recommendations or introductions made by earlier research participants.

Selection of participants for interview

Successful recruitment and retention of study participants are essential for the overall success of a research study (Manohar et al., 2018). According to Negrin et al. (2022) it is advantageous if the nurse researcher is familiar with the population under study and has expertise in that field to facilitate ascertaining the inclusion/exclusion criteria that will answer the research questions. The researcher in this study was employed by NHS WI as an ophthalmic nurse practitioner.

After completing the Integrated Research Application System (IRAS), ethics approval was received from the University of Stirling's NHS, Invasive or Clinical Research Committee (NICR) (see Appendix 2). NHS Western Isles also granted research and development (R&D) approval for the project (see Appendix 3). Recruitment could not begin without the researcher gaining entrance to the field which required the expressed approval of gatekeepers. Negrin et al. (2022) state that gatekeepers control access to potential participants and they can be either obstructive or supportive of research. The researcher in this study experienced a positive and supportive reception from gatekeepers. This influenced the recruitment process positively. Meetings were arranged with managers in both the hospital and community settings and permission was sought to display posters on the noticeboards in the WI hospital, clinics, and GP practices. Providing relevant information and clearly communicating the purpose of the study was key to establishing a good rapport with gatekeepers and potential participants and positively impacting recruitment. The succinct and visually appealing poster (see Appendix 4) invited potential participants to a one-to-one interview, at their chosen setting, to explore their experiences of rural and remote nursing in the WI and their career destination/transitions over time. The poster was also placed on the University of Stirling's Western Isles Campus noticeboard and in the local public library.

Other passive or indirect methods of recruitment were utilised. An article describing the research study featured in the NHS WI 'Team Brief'. This is an online platform run by the WI communications team to pass on information to all NHS WI staff by email. Participants were recruited through email and poster

advertisements within the networks of the researchers' university and health service contacts. In accordance with Broyles et al. (2011), who state that some researchers advocate a multi-modal approach to recruitment using both active and passive methods, direct person-to-person interactions took place. As a result of viewing the study posters and online information conversations amongst colleagues both known and unknown to the researcher were generated which was also a useful adjunct to successful recruitment.

The researchers' contact details were available within all the online recruitment initiatives and on vertical tear-off strips on the bottom of the posters.

Twenty-five participants engaged in the study. The passive strategies for recruitment were successful and resulted in twelve participants ($n=12$) responding by email or phone with an interest in the study after reading about it online or via poster displays. Of these twelve participants nine were unknown to the researcher, one was known to the researcher and two were loosely known by the researcher.

The recruitment of nine ($n=9$) of the participants was through a more direct method whereby discussions and conversations about the study were undertaken with the researcher and an interest in taking part was generated. Of these nine participants one was unknown to the researcher, seven were known to the researcher and one was loosely known to the researcher. Most of the participants who engaged in conversation about the study prior to recruitment had a professional relationship with the researcher based on trust and respect. This positively influenced recruitment. The participant who was previously unknown to the researcher engaged in conversation about the study whilst they were both undertaking an educational course in the WI campus and expressed a desire to take part.

Of the twenty-five participants recruited in the study, seven were known to the researcher, five were loosely known to the researcher, and thirteen were unknown to the researcher. Four participants ($n=4$) were recruited through snowball sampling. The description of being 'loosely known' meant that the researcher knew of the participants through a 'friend of a friend', or that the researcher knew the participants' name but had never met them.

All the participants who expressed an interest in the study were recruited. They all met the inclusion/exclusion criteria. The initial research proposal recommended that five participants would be recruited into each of the four groups. Group one and Group three recruited five participants, but Group two recruited nine participants and Group four recruited six participants.

Participant characteristics

The following two tables highlight the career trajectories of the four distinct groups of nurses who participated in the research (Table 4). Table 5 displays the role each participant held at the point of interview data collection.

Table 4: Career trajectories of each group of participants

GROUP	CAREER TRAJECTORY	NUMBER
1	Born in WI – trained in WI – remained in WI (Remainers)	5
2	Born WI – trained in WI or mainland – worked mainland – returned to WI (Returners)	9
3	Born WI or mainland – trained/ worked in WI- left to work on mainland - remained on mainland (Leavers)	5
4	Born mainland- trained/ worked on mainland – came to train/work in WI (Incomers)	6

Research Participants (n=25)

Table 5: Participant's role at time of interview

GROUP 1 5 PARTICIPANTS (REMAINERS)	GROUP 2 9 PARTICIPANTS (RETURNERS)	GROUP 3 5 PARTICIPANTS (LEAVERS)	GROUP 4 6 PARTICIPANTS (INCOMERS)
P1 Hospital Nurse P2 Community Nurse P3 Hospital Nurse P4 Specialist Nurse P5 ANP	P6 Specialist Nurse P7 Community Nurse P8 Hospital Nurse P9 Hospital Nurse P10 Health Visitor P11 Health Visitor P12 Health Visitor P13 Hospital Nurse P14 Hospital Nurse	P15 Hospital Nurse P16 Hospital Nurse P17 Hospital Nurse P18 Midwife P19 Hospital Nurse	P20 Hospital Nurse P21 Hospital Nurse P22 Health Visitor P23 Hospital Nurse P24 Community Nurse P25 Community Nurse

Research Participants (n=25)**Conducting the research**

According to Bryman (2012: 426) when contemplating sample size, the question '*How many qualitative interviews is enough?*', is difficult to answer. Due to the exploratory nature of qualitative approaches that attempt to generate a subjective understanding of *how* and *why* people perceive, reflect, role-take, interpret and interact, qualitative researchers may not know how much data to gather in advance. Most qualitative researchers aim to keep gathering data until they have saturation which Hennink et al. (2022) suggests is also called '*thematic saturation*'. This refers to the point in data collection when no additional issues or insights are identified, and data begin to repeat so that further data collection is redundant. This signifies that an adequate sample size is reached. Saturation is an important indicator that a sample is adequate for the phenomenon studied – that data collected have captured the diversity, depth, and nuances of the issues studied – and thereby demonstrates content validity. This was evident in all the groups, and particularly in Group 2 where it was beneficial to interview nine nurses who had worked in both an urban setting and the remote and rural setting of the WI, hence making a significant contribution to answering the research question 'How does the interplay between people, profession and place influence nurses' career destinations and transitions?'

The concept of generalisability in qualitative research can be troubling to many researchers. Becker (1995) as cited by Silverman (2000: 111) argued that *'Generalisation is a word that should be reserved for surveys only. What can be analysed instead is how the researcher demonstrates that the analysis relates to things beyond the material at hand... extrapolation better captures the typical procedure in qualitative research'*. This thesis argues that by using purposive sampling and through biographical interviewing with the four groups of participants certain patterns and repetitions arose. The process of thematic analysis was key to demonstrate the existence of a given discourse about how person/al, profession/al and place related dimensions influenced nurses to choose rural and remote practice.

The twenty-five participants all met the inclusion criteria and were motivated to volunteer. Some cited a desire to *tell their story* to add to existing knowledge regarding the person/al, profession/al and place related dimensions of rural and remote nursing. Others were interested in the research topic and altruism seemed to be reflected in their desire to help further knowledge in the field. There are comprehensive reasons for participants being motivated to volunteer for research and in this study one participant who was planning to undertake a research study in the future was keen to become an interviewee to learn more about the research process.

Use of interviews

Each biographical semi-structured interview was special and unique and allowed data to be collected in an in-depth manner to gain a rich and deeper understanding of how the interplay between people, profession and place influenced nurses' decisions to work in the WI over time. The semi-structured interview has been widely used in social sciences. According to Flick (2006) the premise being that it is interrelated to the expectation that the viewpoints of participants are more likely to be expressed in a reasonably openly designed situation rather than in a standardised type of conversation, such as in questionnaires. While the structured interview has a formalised, limited set of questions, the semi-structured interview on the other hand is flexible, allowing new questions to emerge during the interview because of what the interviewees

have said.

Process of conducting interviews

To facilitate an efficient process of conducting the interviews several steps were taken: contacting potential participants; providing the participant with an information sheet prior to interview; gaining permission to interview; arranging time and place of interview; confirming interview arrangements; consent and conducting interviews; sharing transcripts with participants following interview; following up with an email to convey thanks to participants.

Initial communication with participants was by email or telephone. Most of the participants contacted the researcher in the first instance and through email or telephone conversation it was determined if the inclusion criteria were met. A brief explanation of the aims of the research were discussed and verbal permission was sought for the researcher to send a participant information sheet (see Appendix 5) on the understanding that if the potential participant felt that they required more information, they were welcome to contact the researcher at any time, before making a decision to engage in the study, to have any further questions answered. The participant information sheet contained all relevant contact details.

The participant information sheet was sent by email. In most cases the participant used their NHS email accounts. The researcher used both the University of Stirling and NHS email accounts, depending on which email address the participant chose to use, as both email addresses were provided on the tear off strips on the recruitment poster. At the time of the information sheet being sent the researcher stated in the email that if the potential participant would be willing to engage in the study, they were invited to contact the researcher. If there was no response within ten days, the researcher had detailed that there would be a further email or telephone contact to ask if they had considered the request. Participants were assured that if they indicated that they were not willing to participate then there would be no further contact. There were only two potential participants who did not respond.

Once the initial approach had been made, and a participant indicated that they were willing to be interviewed, a further email or telephone exchange took place

to agree a date, time, and place of their choosing for interview. Most interviews were undertaken either in the participants' workplace (NHS) or in a pre-booked room in the University of Stirling's Western Isles Campus. Several participants requested that they were interviewed in their own home and two participants chose to be interviewed in a local café.

Two participants wished to be interviewed by telephone as they were working on the mainland and one participant who was overseas chose to be interviewed through Skype. VoIP (Voice over Internet Protocol) technology such as Skype provided an ability to interview using voice and video across the internet via synchronous (real-time) connection (Lo lacono et al., 2016) thus creating an opportunity to contact participants worldwide in a time efficient manner. The participant who was interviewed through this means was known by the researcher so building a rapport, which is often one of the challenges of interviewing online, was not an issue. A small but growing body of literature has also documented the potential of in-depth telephone interviews as a viable option for qualitative research (Drabble et al., 2016) and advantages such as logistical conveniences, enhanced access to geographically dispersed interviewees and greater flexibility for scheduling were cited.

An email reminder sent from the researcher several days before the interview was due to take place confirmed the date, time, and venue.

Prompt arrival at the interview venue was followed by a welcome, introductions, and an opportunity for the researcher to voice an appreciation for the participants' willingness to take part. The researcher ensured that the participants were aware who the researcher was, what institution the researcher represented and what the research was about.

The researcher confirmed that the participant information sheet had been read and opportunity was given for further clarification if needed. A consent form was signed by both the researcher and participant (see Appendix 6) which requested the participants confirm that they had read the information sheet, that they agreed to the interview being recorded, and that the information gathered would be used for research purposes. The consent form also stated that the

participant was at liberty to withdraw from the study at any time without having to give a reason and that interview transcripts would be anonymised.

The data collection process was commenced by the completion of a demographic data form (see Appendix 7). Initially it was thought that this form could have been sent to the participant for completion prior to the interview but the researcher decided that it would be of benefit to complete it together with the participant at the time of interview. As there were thirteen participants who were unknown to the researcher this decision proved beneficial in establishing rapport, building trust, and exhibiting confidence and respect. The demographic data form included personal details, current employment details, employment history and reasons for leaving previous employment positions. Completing this form in the presence of the researcher served to *break the ice* and provided a good insight into the career trajectory of the participants over time and set the scene for the succeeding interview. The process of completing the form was not audio recorded, but if there were any important points raised that would be good to capture within the interview, the researcher made note of them on the form which was then used as a guide to navigate through the participants' career journey. By referring to the employment history the researcher was able to ensure that the flow of events was captured in sequence.

In keeping with a biographical approach, and with the aim of capturing data over time, the interview began with the following generative narrative question:

Please tell me the story of your experiences and the events that were important for you personally and professionally, up until now. If you could please start with where and when you trained and how your career developed, the factors that influenced you choosing to work in the Western Isles or elsewhere, and what it was like working in these places.

The interviews were conducted in an emergent, conversational manner with prompts only being used to preserve the flow of the story such as:

Could you tell me a little more about that?

What happened next?

How did that make you feel?

Could you tell me a little more about what influenced you to remain in the WI, leave the WI, return to the WI, or come to the WI?

With this style of interviewing the participants were able to share a lifetime of occupational experiences and an understanding of how personal, social, economic, historical, and geographical influences shaped these experiences. The interviews did not have a complete or sequential set of questions, rather the participant was empowered to tell their story within a fluid and flexible structure. This gave participants voice to develop unpredictable themes which otherwise may not have been captured.

All interviews were digitally recorded. The average time for each interview was approximately one hour.

The researcher intentionally chose to independently transcribe the twenty-five interviews from audio into written form for closer study. This was a lengthy procedure, although through an interpretive process, it was of great benefit in forming the first step in data analysis. Authors' descriptions in papers tend to convey the impression that transcribing is a straightforward technical task, summed up using terms such as 'verbatim transcription' but Bailey (2008) suggests that representing audible talk in written words requires reduction, interpretation, and representation to make the written text meaningful and readable. In the first instance, the researcher transcribed the interview accounts in detail, capturing how things were said, as the meanings of utterances are profoundly shaped by the way in which something is said, in addition to what is said. Features were captured such as emphasis, speed, tone of voice, timing, laughter and pauses. Representing some non-verbal features of the interaction on the transcript served to help notice and give a deeper understanding of unanticipated phenomena.

Participants were offered the opportunity to review their interview transcripts, and they were encouraged to consider whether they wished more information to be added or withdraw from their account.

To ensure the accuracy of the typed transcripts they were returned electronically to each of the participants for confirmation that the content was a

true reflection of the interview. This process of member checking was considered a means of maintaining validity and enhancing reciprocity, equality, and openness (Shenton, 2004, Birt et al., 2016). It was stated that if no notification to the contrary, by a given date, was received then it would be assumed that the accuracy of the transcript had been verified and accepted. Most participants who responded were in agreeance with the contents of the transcripts. Only four of the participants requested changes to be made to their interview transcripts. These were positive changes whereby the participant wished to give more details about their experiences of rural and remote nursing by adding to their stories. Five participants did not respond. Interview transcripts were also shared with the researchers' PhD supervisors through the University of Stirling's secure internet platform for collaboration.

Ethical issues

Ethical issues in qualitative research are concerns that arise from the use of qualitative data collection techniques, such as interviews that involve human subjects and include informed consent, confidentiality, anonymity, and the role of the researcher as a data collection instrument. The dignity and rights of participants must always be protected and respect for ethical principles upheld during the entire research process, including the dissemination phase (Taquette and Borges da Matta Souza, 2022).

On completion of the Integrated Research Application System (IRAS), ethics approval was received from the University of Stirling's NHS, Invasive or Clinical Research Committee (NICR). NHS Western Isles also granted research and development (R&D) approval for the project (see Appendix 2 and 3).

The researcher was duty bound to follow the University of Stirling's Ethical Code (2014) as a means of guidance and clarity on research ethics. Informed consent (previously discussed in relation to interviews) is central to ethical practice. Care was taken to guarantee that participants were fully informed of the research aims and potential benefits and harms, and that consent was given voluntarily. All information was given in a transparent way with emphasis placed on the rights of the participant to withdraw from the research study without

prejudice. The following other ethical considerations informed the research process to ensure that it was safe and that risk to participants was minimised.

Confidentiality and data protection

The researcher had an awareness that throughout the research process there were unique challenges associated with maintaining participant confidentiality while presenting the rich, experiential accounts of the dynamic and complex interplay of the person/al, profession/al and place related dimensions of rural and remote nursing over the course of a career. Deductive disclosure, also known as internal confidentiality, can occur when the traits of individuals make them identifiable in research reports (Kaiser, 2009). According to Wiles et al. (2008), despite emphasising the importance of confidentiality, literature on research design and the ethical codes of professional associations offer virtually no specific, practical guidance on disguising participants' identities and preventing deductive disclosure in qualitative research.

This research study was undertaken in a small, remote community and several practical precautions were taken to disguise individuals' identities. Names of participants were replaced by numbers eg, P1, P2. Place names were changed, and job titles were disguised. Several specialist nurses participated in the study and instead of referring to the unique specialism, as there may only be one specialist nurse within that discipline, it was decided to use the name 'specialist nurse' to better protect anonymity. It was explained to participants that the best efforts would be made to ensure confidentiality and anonymity.

Data handling

The Data Protection Act (1998) was an Act of Parliament of the United Kingdom designed to protect personal data stored on computers or in an organised paper filing system (UK Government, 1998). The Data Protection Act (2018) is the implementation of the General Data Protection Regulation (GDPR), (UK Government, 2018). It was necessary to ensure that the handling of data was in concordance with the following eight principles in the Data Protection Act (1998):

- Fair and Lawful: Data must be collected and used fairly and inside the law.

- Purposes: Data must only be held and used for the reasons given to the Information Commissioner.
- Adequacy: Data can only be used for those registered purposes. You cannot give it away or sell it unless you said you would initially.
- Accuracy: Data must be accurate and up to date.
- Retention: Data must not be kept longer than necessary.
- Rights: Data subjects must have the right to access, correct or delete their data.
- Security: Data must be protected from unauthorised or accidental use, loss, or damage.
- International: Data must not be transferred outside the European Economic Area unless the country has adequate data protection laws.

This research was concerned with data from interviews which were digitally recorded and then transcribed.

Interview recordings and transcribing

Recordings and transcripts of all interviews were stored securely as digital files on a password protected computer. These recordings were used to generate a verbatim transcription. During the preparation of the transcripts any identifiable data, such as names, job titles, and locations were anonymised. Names of participants were replaced with an alpha-numerical code e.g. P1, P2. Signed consent forms and other non-digital records which may contain identifiable information were stored in a locked filing cabinet. In accordance with guidance from the University of Stirling's (2023) Code of Practice: Research Degrees, and in keeping with the Data Protection Act (1989), all anonymised data will be securely stored for a period of up to ten years.

Potential harm/potential benefits

According to Taquette and Borges da Matta Souza (2022), to ensure the integrity and quality of research and the respect for the participants' dignity and liberty, the main factors to be embraced are self-awareness, reflexive action, continuous informed consent, and ethical mindfulness.

Beneficence, a key principle in qualitative research, is about maximising potential benefits for the research participants and minimising potential harm. As suggested previously, the benefits of participation were expressed by many in terms of their interest in contributing to new knowledge, enhancing further

understanding about the person/al, profession/al and place related dimensions of rural and remote nursing, and potentially informing policy or practice changes. Potential harm might involve psychological distress or invasion of privacy. One participant through giving a very open and candid account of certain aspects of her personal and professional experiences did become emotional during the interview. Given the opportunity to stop the interview or take a break, the participant decided to continue. The researcher must be responsive to the ethical dimensions of the research process and show empathy and understanding. This is crucial for building and maintaining trust. This research did not involve any clinical intervention. The potential harm related to aspects of inconvenience, most noticeably in the time the participants spent in relation to arranging an interview date, time and venue, the interview process, and spending time reviewing the interview transcripts which also generated extra work for them. Issues concerning maintaining anonymity could also be perceived as harmful.

According to the British Psychological Society (2013) the same principles of ethical research with human participants apply to internet-mediated research (IMR). However, the implications of these principles for practice may differ in IMR contexts. The absence of face-to-face co-presence with the use of Skype or telephone for interviews restricted the researcher's capacity to decide whether the research interview was happening within a private or public space, given that these boundaries are often blurred online. Research participants using Skype have a right to privacy, anonymity, and data security. Potential risks were minimised due to Skype using encryption algorithms to protect participants' communications from falling into the hands of hackers and criminals.

Data analysis

According to Pope et al. (2002) qualitative analyses attempt to preserve the textual form of the data gathered and to generate analytical categories and explanations. This may be done inductively that is, obtained gradually from the data, or deductively, that is, with a theoretical framework as background. There are various software packages available which are designed to assist with the organisation and retrieval of qualitative data such as NVivo (Bazeley and

Jackson, 2019). NVivo is a useful tool which helps identify co-occurring codes and provides opportunities to annotate codes or portions of text. Pope et al. (2002) suggested that whether software is used or not, the key point about data analysis is that it relies on systematic and rigorous searching of text for categories and themes which are collected together, compared, and re-analysed to develop hypotheses or theoretical explanations. For the purposes of this research study the data was analysed through using a combination of NVivo and paper formats. Although software packages help to alleviate the labour-intensive process of data analysis, Pope et al. (2002) considered that they are not a substitute for thorough knowledge or 'immersion' in the data which leads to the researcher identifying connections and patterns, making systematic comparisons, and developing interpretations.

Analysis of interviews

Different versions of Thematic Analysis (TA) have been developed over time and Braun and Clarke (2021) have contributed immensely to understandings of thematic analysis as a foundational method for qualitative analysis. What broadly unites different versions is the use of processes of coding and theme generation for analysing qualitative data, and the production of a set of analytic themes, with a theme capturing a pattern of meaning across a dataset.

Reflexive Thematic Analysis (RTA) has been described by Finlay (2021) as an artfully interpretive approach which combines qualitative data and techniques with qualitative research values. This approach goes beyond description and summary, to ask questions related to how particular patterned meaning might relate to the wider social context, and about the significance and implications of the patterned meanings. According to Campbell et al. (2021) Braun and Clarke argue that their reflexive approach to thematic analysis should be firmly situated within a 'Big Q' qualitative orientation (qualitative research conducted within an interpretivist paradigm), instead of a 'small q' qualitative orientation (qualitative tools used within a positivist paradigm) (Braun and Clarke, 2019).

Reflexivity acknowledges that knowledge is never free of researcher influence, and that our assumptions and choices inevitably shape the knowledge we

create (Braun et al., 2022). A description of the six phases of the analytic process of reflexive thematic analysis are outlined below:

1. Familiarising yourself with the data
2. Generating initial codes
3. Searching for themes
4. Reviewing themes
5. Defining and naming themes
6. Producing the report

Every data analysis technique starts with familiarisation with data. As referred to in this chapter, since the interview accounts were transcribed independently, the researcher in this study was well acquainted with the discursive content of all the interviews and was focused on the depth and breadth of the participant's stories. Stories can be broken up into key elements, such as past, present, and future or time, place, and scene. Becoming immersed in the data involved the repeated reading of the transcripts in an active way. Aspects of the data that felt most familiar became noticeable but at this point the researcher was not trying to notice patterns or develop themes, but rather was fully getting to know the data. It was beneficial to have highlighted particularly vivid data extracts and make familiarisation notes and observations. Reflective thoughts such as being honest and vigilant about pre-existing opinions and beliefs were documented as growing insights into the research topic were emerging.

The whole thematic analysis process is underpinned by coding, which is the second phase, beginning after familiarisation with the data. Coding is the identification, marking and labelling of pieces of text that hold any meaning or is of interest in answering research questions. It is a move from unstructured data to the development of ideas about what is going on in the data. Thorough debriefing with PhD supervisors and reflexive journaling throughout the coding process helped keep track of emerging impressions of what the data mean and how they relate to each other. Another benefit of regular meetings with PhD supervisors was to discuss initial impressions, consider different 'takes' on the data and open discussions around different ways of thinking about them to achieve richer interpretation of meanings (Byrne, 2021). For example, from the initial broad code '*Anonymity*' which contained any information about the

participants discussing their experiences of anonymity, further sub-codes were created such as '*Blurring of personal and professional lives*' and '*Retaining confidentiality*'. By writing descriptive summaries of each participant's experiences contained in the first level '*Anonymity*' code, and examining sections of text, distinctions were made within and between cases. Participants who were born in the WI had a greater tension around *anonymity* whereas participants who were not from the WI embraced the lack of *anonymity* and found that it enhanced their feelings of acceptance. Sections of text were coded into as many different themes as they fitted in to and memos were recorded to identify interesting aspects in the data such as the similarities, commonalities, and differences between the themes within the four specific groups of participants.

According to Nowell et al. (2017) the third phase of thematic analysis begins when all data have been initially coded and collated, and a list of the different codes identified across the data set has been developed. This phase involved sorting and collating all the potentially relevant coded data extracts into themes by using NVivo. The first three phases were initially engaged in sequentially which helped to build a robust foundation for the analysis. Subsequent analysis was recursive due to developing insights requiring a return to some of the earlier phases.

The fourth phase began once a set of themes had been devised and they required refinement. It was during this phase that the researcher found that some themes did not have enough data to support them, and other themes had to be broken down into separate themes. It was necessary to read and re-read the summaries to refine selected themes so that they were specific enough to be discrete and broad enough to capture a set of ideas contained in the numerous text segments. By the end of this refinement process it was clearer to see how the themes fitted together and how they told the overall story about the data. By returning to the raw data, it was clarified that the themes reflected the participant's voice.

By the end of the fifth phase the themes were named in such a way that they immediately gave the reader a sense of what the theme was about. They had to be sufficiently clear and comprehensive (Nowell et al., 2017). According to Lincoln and Guba (1985) investing sufficient time to develop the themes will increase the probability of developing credible findings.

The final phase begins when the researcher has fully established the themes and is ready to begin the final analysis and write up of the report (Braun and Clarke, 2019). In this study direct quotes from participants were an essential component of the write up. Embedding extracts of the raw data within the analytical narrative to illustrate the complex interplay between the person/al, profession/al and place related dimensions of rural and remote nursing had the potential to go beyond a description of the data and convince the reader of the validity and merit of the analysis (Braun and Clarke, 2021). By telling the story of the data, rather than relying on the data to speak for themselves, credibility was added to the themes (Braun et al., 2021).

Establishing trustworthiness

According to Nowell et al. (2017) trustworthiness is one of the ways researchers can persuade themselves and readers that their research findings are worthy of attention. Lincoln and Guba (1985) refined the concept of trustworthiness by introducing the criteria of credibility, transferability, dependability, confirmability and authenticity.

To enable credibility and ensure that the results of this research study were true and believable PhD supervisors were involved in verifying the researchers' interpretations. This has often been called 'member' checking (Stahl and King, 2020) and is seen as a productive research practice. The researcher also spent sufficient time to build trust and rapport with the participants which in turn made it more likely that useful and rich information would be obtained. Transferability refers to the generalisability of inquiry (Nowell et al., 2017). Lincoln and Guba (1985) noted that it was the researcher's responsibility to provide sufficient descriptive data so that readers can evaluate the applicability of the data to other contexts. Comprehensive and intricate depictions of the study's environment, participants and methodology led to rich and thick descriptions which were gleaned using biographical interview techniques. Dependability

pertains to the enduring nature of data over time. By ensuring that the research process in this study was logical, traceable and clearly documented and through creating and preserving an audit trail, by making a record of the decisions made throughout the research process, other researchers would be able reproduce this study.

According to Lincoln and Guba (1985) confirmability is concerned with establishing that the researcher's interpretations are clearly derived from the data. Confirmability concerns the aspect of neutrality (Lincoln and Guba, 1985) and in order to secure the inter-subjectivity of the data and demonstrate the meticulous guarantee of trustworthiness the researcher engaged in member checking, a process whereby participants are given the opportunity to thoroughly examine and validate the accuracy of the findings. The findings must reflect the participants' voice and conditions of the inquiry, and not the researcher's biases, motivations, or perspectives (Elo et al., 2014). Providing 'raw quotes' lends itself to authenticity and credibility.

Lincoln and Guba (1985) argue that trustworthiness criteria make an incomplete set because they deal only with issues that appear important from a positivist paradigm. To contend with and address further issues such as power, pluralism, multiple values, representation, empowerment and accountability Lincoln and Guba (1985) proposed the term authenticity. Certain initial conditions are pre-requisite to achieve authenticity sub-criteria, including fairness, ontological authenticity, educative authenticity, catalytic authenticity and tactical authenticity (Amin et al., 2020). Fairness requires fully informed consent and constant use of the member-check process as defined earlier.

Reflexivity and the decision trail

A decision trail provides readers with evidence of the decisions and choices made by the researcher regarding theoretical and methodological issues throughout the study. Reflexivity is central to the decision trail (Nowell et al., 2017). In this study, and in accordance with Lincoln and Guba (1985), a reflexive journal was used by the researcher to record and document the daily logistics of the research, methodological decisions, and rationales and to record the researcher's personal reflections of their values, interests, and insightful information about self. According to Akkerman et al. (2008:270) the main aim of the decision trail is 'to link interpretations and conclusions in the final research

document to the data, through all steps in-between'. Documents were created detailing the conceptual framework, methodology, reflection on the researchers' position in the study, the raw data and the processed data such as coded records and summaries.

The researcher undertaking this study had experience of training and working in both the rural and urban setting. Having trained in the city and after gaining experience in general nursing, ophthalmic nursing, and midwifery, she decided to return to the WI, initially gaining employment as an occupational health nurse in the oil industry and subsequently as a theatre nurse and ophthalmic nurse practitioner in the Western Isles. Being embedded in the rural culture and having a strong sense of belonging to the WI led the researcher to be mindful about her own preconceived ideas or notions about the research context and topic and reflect upon her positionality throughout the research process. According to Day (2012) one of the most important ways of understanding positionality as a methodological dilemma arises from an insider/outsider positioning, that is, troubling the assumption of one's positioning as a researcher outside the community/location under study, versus the insider positioning of those we study. As suggested by Holmes (2020) the advantages of an insider position include easier access to the culture being studied, the possession of a priori knowledge enabling the ability to ask insightful questions, the researcher may be more trusted, and the ability to produce 'thick' description due to having a better understanding of the culture and language. The use of biographical interviews within this study gave voice to the participants and empowered them to share their subjective experiences of the person/al, profession/al and place related dimensions of rural and remote nursing. As the interviews were semi-structured and contained no pre-set questions they were largely directed by the participant. On reflection, the researcher felt that it was also beneficial that the systematic literature review by MacKay et al. (2021) was not published until after the interview data had been collected. This paper outlined the complex factors that influenced nurses' decisions to work in rural and remote settings, so rather than the interviewees having prior knowledge of the results of the paper they were given the opportunity to provide insights from their own perspective.

Conclusion to chapter

This chapter provided a detailed exploration and justification for the qualitative stance taken in this thesis. It also accounted for the study methodology, selection of participants, ethical considerations, and the approach to data analysis. Braun and Clarke's approach to reflexive thematic analysis (Braun and Clarke, 2021) was discussed with a focus on striving to meet the trustworthiness criteria in qualitative research. Reflexivity and researcher positionality was considered.

A methodological strength of this research has been the application of the biographical approach which through semi-structured interviews captured the richness and depth of experience to generate insights into the complex interplay between the person/al, profession/al and place related dimensions of rural and remote nursing.

Chapter Three: Results of Stage One of the Analysis

Purpose of the results chapters

The purpose of the following two chapters is to outline the findings generated from thematic analysis, hence answering the following research questions:

1. What are the person/al, profession/al and place-related factors that influence choosing rural practice?
2. What is the interplay between people, profession, and place?
3. How does the interplay between people profession and place influence nurses' career destinations and transitions?

Chapter three (Stage one of the analysis) depicts summaries of the chronological accounts of each participant (see Appendix 8) and presents an analysis of the key person/al, profession/al, and place related themes within the four different groups of participants (see Table 4). Chapter four (Stage two of the analysis) focuses on the commonalities, similarities, and differences of the four groups to better understand the complex interplay between the person/al, profession/al and place related dimensions that influence nurses' decision-making and experiences of working in the WI.

Illustrated Timelines

Summaries of the chronological accounts of each participant are presented in the form of a timeline (see Appendix 8). The illustrated timelines serve as a visual representation of the career trajectory of each participant over time. The first arrow on the left identifies the participant, and the descending arrows represent key chronological events in the participants' career pathway. The first white box to the right on each individual timeline contains key socio-demographic characteristics while subsequent boxes on the right set out some of the thoughts or themes associated with that event as the participant depicts it, with italicised text being direct quotes.

The use of timelines can enable the researcher to identify patterns and relationships between events as the participants recalled and expressed complex thoughts and ideas about the person/al, profession/al and place

related dimensions of rural and remote nursing. Timelines help the researcher to focus on the chronological dimension of the narrative and according to Adriansen (2012) can increase chances of seeing events and perceptions of these events in context with the wider life experiences. The researcher generated timelines used in this study were a useful adjunct to answering the research questions.

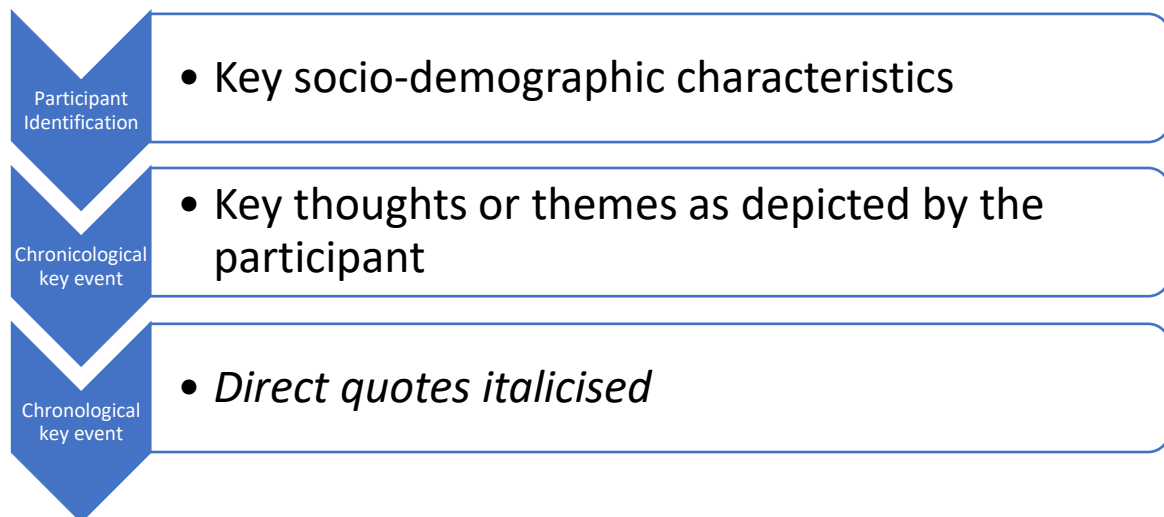


Figure 4: An example diagram of a timeline

Thematic analysis identified three interrelated dimensions that influenced nurses' career destinations and transitions, namely 'person/al', 'profession/al' and 'place'.

Visual diagrams will be utilised to illustrate the dimensions and connecting themes/sub themes pertinent to each group. Guided by the diagrams each of the themes/sub-themes will be considered in turn and form the results of thematic analysis pertaining to the biographical accounts of the participants.

Group 1: 'REMAINERS'

Nurses born in the WI – trained /worked in the WI – remained in WI (n=5)

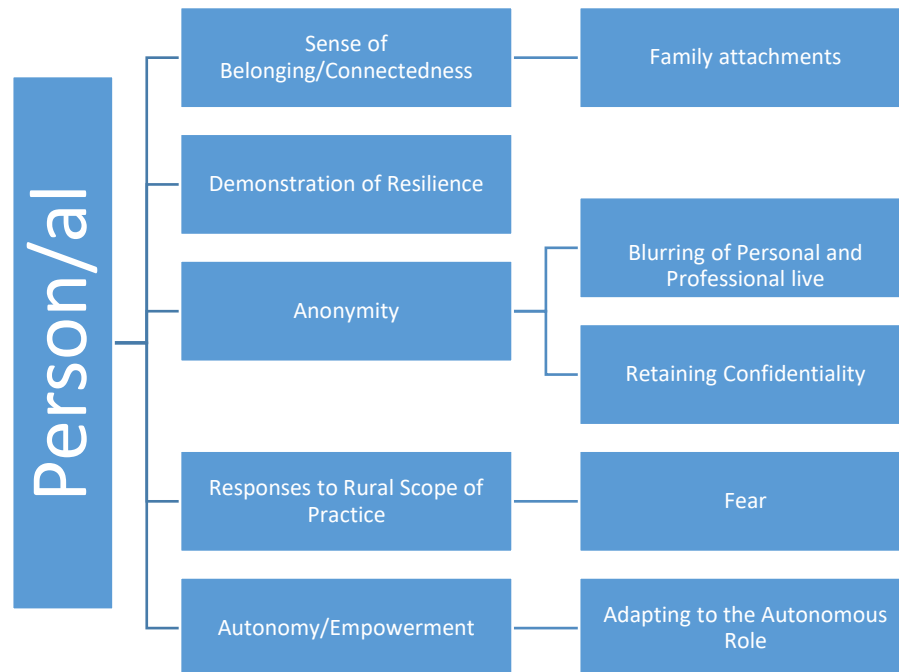


Figure 5: Visual schemata of person/al themes and sub themes – Group 1

Person/al Dimensions – GROUP 1: 'REMAINERS'

Sense of belonging/connectedness

The participants in Group 1 (remainers) expressed a sense of belonging and connectedness to the Western Isles (WI). The following quote encapsulated their feelings of contentment and their strong desire to remain in the WI:

I have lived here for ever; I haven't lived anywhere else. I have a huge attachment to the area. (P2)

Family attachments

In the biographical accounts there was a strong interplay between a sense of belonging/connectedness to the WI and family influences and ties. Several participants in this group (P1, P3 and P4) expected to remain in the WI and this was largely due to family attachments:

I always say to my husband it's family first. Because my family is here, and I am very attached to family. (P4)

The career trajectory of several participants was influenced by a desire to care for elderly parents and be involved with younger members of the extended family. The strength of family attachment made it difficult to consider leaving the WI:

I most definitely plan to stay on the island. I think, more so now, as my parents, although they are fit and well, are moving into old age. It's lovely to be part of my nieces and nephews lives as they grow up. If I had been anywhere else, I would have missed out. (P3)

Two of the participants in Group 1 (P2, P5) were unsure about whether they would remain in the WI as the challenges of living on the island and having family on the mainland were highlighted:

We have a family on the mainland and it's hard to see them. Our middle daughter is in university, so you can't just jump in the car if something goes wrong. It makes it much more difficult to keep that attachment here. (P2)

Participants revealed how a sense of belonging to the WI and attachment to place is shaped over time. The following extract from P5's interview depicted how the emphasis of attachment has shifted to become more towards family members who have moved to the mainland, rather than to the WI as a place. The changing family dynamics and family ties that bind made separation difficult:

So, my attachment to the place. If you had asked me that question five years ago, rock solid, I'm here. I love being here, but it's a little bit looser than that now. We have family on the mainland, and we are not long back from a spell on the mainland, and I was extremely reluctant to come back. (P5)

As suggested in the following quotation P2 purported that the separation from family who have moved to the mainland would be a key driver influencing a

potential decision to leave the WI especially if opportunities for professional development were not available in the future:

Thinking about the future, I wouldn't be averse to taking an opportunity somewhere else if it came up. But that's not an immediate plan and I wouldn't jump at it, but I wouldn't discount it either. If opportunities to progress are available here, I would stay here. But family ties make it more difficult. (P2)

Demonstration of resilience

Demonstration of resilience among the 'remainers' referred to their ability and strength to keep going despite challenges and obstacles in the workplace. Within her account, P2 who was engaged in 'bank' nursing prior to securing a permanent post as a community staff nurse, described how although there were shortages of staff and she had feelings of being unsure about her duties she just 'had to get on with it':

You are there on 'bank' because they are having a staff crisis. You just have to get on with it. There's no saying 'I'm just qualified – I don't know how to do this and how to do that'. You just have to get stuck in. You learn faster. You just have to do what you have to do. (P2)

P2's account continued by showing the connection between a demonstration of resilience in light of having fewer resources, and the need for continuous professional development to ensure job satisfaction in the WI:

You just have to pick up and go with it. There's not a great deal of support. They can't physically do that, so it kind of makes you or breaks you. It makes you realise what you need to do to do a better job and certainly I don't want to be going to work not knowing what I need to do. So that has encouraged me to do background reading to make sure. (P2)

Reflecting on her experience as a theatre staff nurse, depicting professional and geographical isolation, P1 suggested:

You've got no choice but to knuckle down and get on with it. We're on our own. (P1)

The afore-mentioned interview extracts illustrate that there is a strong sense of resilience underpinning self-motivation as nurses in the WI need to learn at a faster pace to constantly update their skills and knowledge to deliver the best care that they can.

Anonymity

The challenges associated with maintaining anonymity whilst working in the WI was a strong thread running through the accounts of the participants in Group 1. P1 described the strain of administering care to close family and friends:

Quite often you end up looking after either your neighbour or even your auntie, or someone you know. It can have challenges for both us and them, and if I'm uncomfortable, what are they going to be like? (P1)

There was a tension between a sense of belonging and anonymity which was highlighted in the following account. P2 alluded to patients in the WI being more comfortable and having a preference to be cared for by a health professional who comes from the island rather than an 'incomer':

Most patients want to find out who you are and where you are from. It's the first thing they ask really, and once they find a little bit of information that they can place, they know your mothers' cousins' brother, they feel more accepting. They do like to have that link. They all feel confident about having someone local. (P2)

P5 found that a lack of anonymity was beneficial, and it was often used to his advantage when caring for patients in the WI:

Often, I have found that it's a bit of an opener. People often know who I belong to, or know who I am, or have heard about me, and it's kind of like, well we know who you are so you're ok. And that can be a real advantage when you are trying to do something. People either

know you by reputation or they know your family by reputation, and they are accepting. (P5)

Working in a small community, it can be a double-edged sword. But on the whole, you can play it to your advantage. (P5)

The afore-mentioned quotations signified the importance and advantages of kinship. Being identifiable, known, and visible to others and having a personal and professional reputation may increase acceptability and accountability of individual actions. This highlighted that communities often sit within other communities where there is a set of relationships between people in a social or cultural network.

There was interplay between the degree of lack of anonymity experienced by nurses within different roles. In the following quote P3 described this concept in her role as a hospital nurse and then contrasted this, as her career progressed, with her experiences whilst working as a practice nurse:

Going from the hospital from where you are fairly anonymous in a team of nurses to being a single practice nurse, you feel as if you are in a goldfish bowl. It was far more difficult to nurse, because I knew a lot of the patients. You could have a conversation with somebody about their smoking or drinking habits and then you end up meeting them in town. You just felt as if you were being watched. You were quite conspicuous as a practice nurse. (P3)

Throughout her interview P4 also asserted that being a specialist nurse, presented challenges with a distinct lack of anonymity:

If you go off sick, and if you are out and about, and you bump into patients who say, 'Oh we are missing you so much' and then you feel bad for being off, but actually I'm not well just now. There are huge challenges with that. And privacy, and maybe you would like to be in a bigger community and be more anonymous and have more privacy. That's when you would like to be in a city! And just go out to the shops or go to church or whatever. (P4)

Largely, the participants in Group 1 (remainders) were challenged by their experiences of lack of anonymity connected with working in the WI. They felt that it had an impact on their personal and professional lives, and some felt uncomfortable and reticent to engage with community events. Several felt that, in the workplace, it could be a facilitator at times. Participants generally accepted that a lack of anonymity was a way of life in the WI.

Blurring of personal and professional lives

A lack of anonymity leading to the blurring of personal and professional lives amongst participants in Group 1 was exemplified within the following quotes:

I guess it's difficult being a specialist nurse in a small community because you can be walking along the street, and someone will say 'Oh when can I get an appointment with you?' It's not very good if you are just going in town on a Saturday, and some people may take advantage of that (P4)

This patient knew my husband and she said, 'I knew you wouldn't be at work because I knew your husband wasn't at work and I thought you were on holiday'. I was just thinking that's a bit crazy that you even know what's going on in someone's personal life, but I guess that's just a small community thing. (P4)

These challenges led to the development of 'awkward nurse/patient relationships' resulting in nurses preferring to avoid patient contact when not in the work setting.

Retaining confidentiality

Difficulty in retaining confidentiality interplayed with the lack of anonymity and blurring of personal and professional lives. Often when patients interacted with each other, and discussed their treatment pathways, this presented challenges as suggested in the following account from P4. It was evident that in her role as a specialist nurse the tensions of retaining confidentiality were expounded, mainly due to being professionally and geographically isolated from the rest of the team and being always in the public eye and having to deal with feelings of stress when confronted with confounding situations:

They still speak to you despite your children being there. They are breaking their own confidentiality in a way because your children then realise that that person is a patient and that's kind of difficult. It's patients talking to each other too, because you do get that, and everybody knowing each other.

I knew that patient was talking to other patients and telling them all about me. It's such a challenge because although you protect patient confidentiality and patient dignity and all that, sometimes the patients themselves are compromising that. So, there's always that tension.

(P4)

Responses to rural scope of practice

This theme recurred frequently in the accounts of the participants in Group 1 (remainers) and was attributed to feelings of professional and geographical isolation. There was also an association with having fewer resources and having to maintain a broad range of skills to meet the healthcare needs of the patients in the WI. Some participants found that the variety and scope of practice which was often unpredictable was a facilitator, but others described how the variability of the clinical work led to feelings of fear, being overwhelmed and out of their depth. P1 attributed her job satisfaction as a nurse in theatre to having to possess a wide knowledge base, due to the variety and scope in her field of work. This maintained her motivation and enthusiasm:

I like it. Yes, definitely, it kind of gives you more of a variety. You don't get too much routine, so you don't get that element of complacency, that maybe you would if you were doing the same procedure every day for years on end.

Yes, I am very content in my job. I like what I do. I get on well with my colleagues, and Yeah, I quite like going to work! (P1)

Fear

Participants' word choices such as 'fear' and 'terrifying' suggested that they faced situations in their scope of rural practice where they clearly felt out of their depth. Whilst looking after sick children P5 explicitly discussed feelings of being

overwhelmed and related the intensity of these feelings to working in a ward with a variety of different specialities and looking after all age groups:

Anything from 'gynae' to orthopaedics to general surgery, and everything in between plus the 6 kids. When the need arose then you had to do what you had to do. It was terrifying, particularly when looking after sick children, absolutely terrifying. Children come with parents, so not only do you have to deal with the child who is unwell, but you have these adults who are screaming at you 'My kid is sick. Look after them. Why are you not making them better'? (P5)

To cope with the wide knowledge base required and the scope, variety and unpredictability of the work and the fear of caring for sick children requiring transfer to mainland hospitals P5 took advantage of every training opportunity that was afforded:

I did my European paediatric immediate life support. I did some immediate life support training. I had opportunities to do lots and lots of training. We had a child who had a tracheostomy, so we had to do some tracheostomy training as well. (P5)

Some things would stay in the ward and sometimes you would stabilise them just enough for them to be evacuated out. And then you had the days when children were getting tonsillectomies or minor operations and they were busy times and terrifying, utterly terrifying, utterly terrifying, and I look back on it now and the amount of responsibility. I was less than six months qualified. (P5)

The following account from P1's interview also conveyed a sense of fear and the risks associated with looking after very sick patients in the WI. Professional and geographical isolation was compounded with a lack of resources such as the necessary medical equipment and expertise which would be found in an intensive care unit (ICU):

You've always got that little bit of nervousness. You can't help it. My first retrieval patient terrified me. I was absolutely petrified. I think it was 4 hours we were waiting, at night as well, and it's always scary

because you've got a patient who is likely to deteriorate on you at any given moment. It's not one we do every day. If you were in a city, they've got ICU, but here you've got to make do with what you've got so in that respect we have probably got more experience than you would if you were in a big city hospital. (P1)

Autonomy/empowerment

Nursing roles are evolving and changing with the introduction of advanced nurse practitioners (ANP) and specialist nurses in the WI. Having responsibility for a caseload was a mark of autonomy for P5. Job satisfaction was enhanced, and the following account portrays how through striving to become more effective as an ANP there was a wish to excel in the role:

At the moment my 5-year plan is to be better at what I do. I genuinely love what I do. It is a huge privilege to do what I do. To be invited into somebody's' home when they are acutely sick and try and make them feel better. It's a huge privilege. I wish I was better at it. There are some things that I am really, really good at, and there are some things that I am not so good at, but I want to be better. (P5)

Adapting to the autonomous role

There was an interplay between how nurses had developed professionally and how they adapted to their more autonomous roles. Adapting to the role of ANP or specialist nurse presented some challenges for the participants in Group 1. P5 alluded to how difficult it was to cope with how influential and autonomous the role was, and highlighted that a wide knowledge base was essential, especially when risks escalated, and situations go awry and there were feelings of professional and geographical isolation:

This is the challenges of remote and rural. In a remote and rural environment, it is just so tough when you don't have the back up and you are so isolated, so that means that the person delivering the care whether it be the GP, the ANP, the district nurse. they need to know what they are doing. (P5)

ANP's and specialist nurses also had to adapt to delivering care and treatment which in the past would have been delivered solely by medical staff. Managing patient expectations was often challenging:

Number one obstacle is patients because you walk in the door, and you say 'Hi, my name is [], and I am a nurse', and they say, 'We phoned the doctor' I say 'Well, we're working alongside the doctor'.

(P5)

The challenges experienced by specialist nurses adapting to their autonomous role in the WI were also escalated when patients questioned their decision making. P4 spoke of how patients discussed the nurse and their personal management plan to other patients in the close-knit community. This presented a tension between autonomy and confidentiality:

There were one or two instances, where patients viewed that you didn't make the right decision, but they felt like very reasoned decisions to me. You know that a patient maybe isn't happy with you and they've maybe been speaking to other patients and saying what they found wrong. Patients do speak to each other. So that was hard. I just try to keep in my head what I have done, made the right decisions and have it all documented. Yes, that's the best you can do. (P4)

Profession/al Dimensions – GROUP 1: ‘REMAINERS’

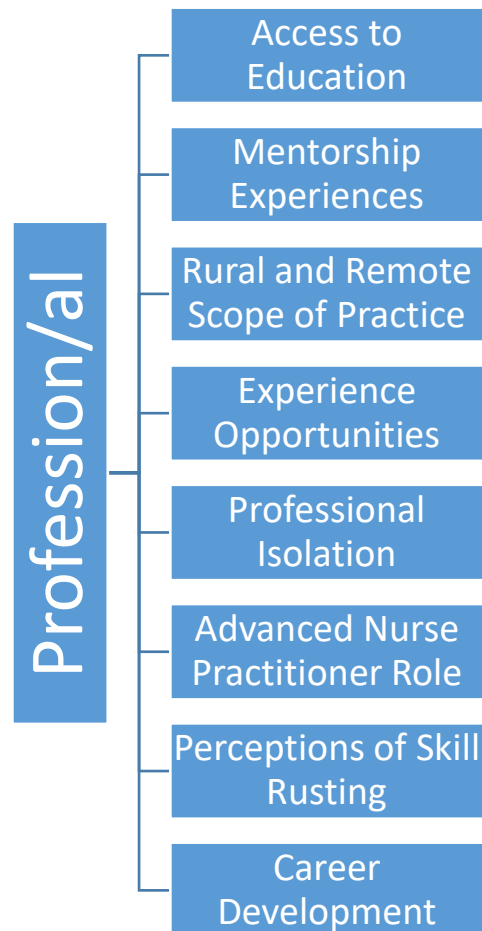


Figure 6: Visual schemata of profession/al themes – Group 1

Access to Education

The participants in Group 1 (remainers) were very appreciative that their nurse education programme could be delivered to them locally, and they found that they were supported well in their learning experiences:

The university here, I think they're a lot more supportive given that they are just up the stairs. You can just nip in on your way past and just knock on whoever's in's door, and say 'Oh, is there any chance that you can just go through this, or can you clarify this. Being remote and rural, being in a small place is beneficial to us. There are less students. They can give us more time. We get more support than we would if we were on a big campus. (P1)

We were very well off in such a small campus. Our tutors are available on a day-to-day basis, you know, they are always there if you need support. (P2)

I had a brilliant class. We all got on really, really well. The lecturers were all very, very supportive. (P5)

Initially P4 had a desire to leave the WI for nurse training but there was evidence of the interplay between family influences and needs and the convenience of local training. She was able to take advantage of the availability of local training opportunities when her situation allowed:

I was going to go to [CITY name] to study, and life happened. I got married, had a baby. I deferred for a year and decided to stay at home to support the family and I didn't go back. It was too difficult with a baby. We had the rest of our family, and the plans went to the back of my mind. (P4)

Two of the participants in Group 1 undertook some city placements. The following statements highlighted an ongoing attachment and sense of belonging and personal connectedness to the WI and a strong desire to return:

For the final year, I did some placements in [CITY name]. It was great to know I could just jump on the ferry whenever I wanted to, you know, for a weekend. (P4)

I always knew I was coming home. I never entertained the thought of staying away. I wanted to be nursing at home. (P3)

The participants in Group 1 (remainders) embraced the concept of continuous professional development. With reference to the timelines there was clear evidence that all the nurses in Group 1 were highly skilled and competent with some engaging in advanced practitioner and specialist roles. Some felt challenged by the difficulties of professional and geographical isolation in accessing further education. As can be seen from the following account there was also an interplay with ongoing education and the variety and scope of rural and remote practice in the WI:

Having lots of different specialities keeps you on your toes a bit more than like in a mainland hospital when you are just doing a list of, for example, phacos (eye operations) every day. Yes, you have got to keep up to date with things more. It is a bit more challenging because you can't afford to 'take your eye off the ball'. (P1)

In relation to further education, P2 had an opportunity to undertake a master's degree but the interplay between her family needs and geographical isolation, was a barrier to her ability to attend the study days on the mainland. This meant that she could not continue with the course. Had this training opportunity been available locally it would have been much easier but accessing continuing education on the mainland was much more challenging. The following quote expressed P2's concerns:

Working on an island and trying to train where the course to be delivered was so far away was a challenge. You had to go away for one day a week. That would have involved three days for me. Flying away one day, then the actual class, then flying back the next day. I pulled out. I worry because as it's a very small area here, that having failed or pulled out of a study opportunity, that I may not be offered this opportunity again because everybody knows every individual person in terms of your working environment. It might go against me. (P2)

P2 had concerns that her colleagues would know all the barriers and facilitators to her engaging with this opportunity. Tensions around anonymity in the workplace were evident as she felt disadvantaged due to close personal and professional contacts recognising her predicament.

Mentorship experiences

Several participants in Group 1 described varying experiences of mentorship throughout their training and when they engaged in the 'one year job guarantee' (OYJG) scheme post qualification. The OYJG scheme, a Scottish Government supported transition into employment was built on the clinical experience gained by nurses and midwives during their pre-registration programme. Placements included working within community nursing, public health nursing and independent care home settings (Scottish Government: 2014).

Good mentorship experience interplayed with a sense of empowerment, autonomy, and job satisfaction. The following accounts described positive mentorship experiences where nurses were supported, encouraged, and empowered in their practice:

I had a wonderful mentor there who just couldn't do any wrong and she gave me so much attention and advice and really helped me move forward and I got so much out of it. (P2)

I had a mentor who didn't stand over me. She was a vastly experienced nurse. She said, 'This is what I want you to do, go and do it'. And she kind of kept her eye on me but she always made me feel a bit more empowered, but also made sure that I was safe. (P5)

Participants in Group 1 highlighted that in some placements they did not feel accepted or engaged by their mentors. The quality of mentorship was variable and had a negative effect on the learning experience:

The one-year job guarantee. You are supposed to have a mentor, yeah, somebody who sort of was allocated to you, but actually nobody really knew what that was, so it didn't turn out to be anything. (P2)

My first placement was a community nursing placement, and the irony is, considering where I am now, I absolutely hated it. I was told 'Sit in the corner and watch what we do'. Yeah, it was a bit dull. (P5)

Rural and remote scope of practice

The need for rural and remote nurses to be multiskilled was a recurrent theme in the experience of the participants in Group 1 (remainders). They spoke of the need to be able to handle almost anything and assume multiple roles, often in isolation, and how in the WI a broad knowledge of multiple specialities was required:

Well, primarily, I'm probably a scrub nurse, but we kind of, dip in and out of other roles. We do anaesthetic/recovery nursing, we might be in the endoscopy suite, and there's a variety of different specialities;

there's gynae, ophthalmics, ortho, general, and so on, so we kind of rotate between these different specialities. (P1)

There is great variation in the role, part nurse, part social worker, part OT, part physio. It can be quite challenging because you have to know a little about a lot of different things rather than being specialist. Sometimes I do wish I could be a specialist and know everything about one thing (P2)

P3 added credence to the notion that rural healthcare environments are unique from their urban counterparts as she described how she was expected to keep her skills up to date and to be competent when undertaking various diverse roles even when some of these skills were utilised infrequently:

It makes it so much harder to learn something that you are not doing every day, whereas, if you were on the mainland you would be working in orthopaedics, or general or 'gynae' or whatever, and just have the one speciality to learn. But here you have to learn a little bit of knowledge of all of it, which is challenging. (P3)

Whilst working in the WI it was not unusual for nurses to be assigned to care for patients from various specialities such as orthopaedic, general, gynaecology and paediatrics all in the same ward and all in the same shift. Although nursing in the WI offered nurses a wealth of experience there were challenges such as maintaining a wide knowledge base and feeling overwhelmed due to professional and geographical isolation as described by P5:

I felt isolated lots of times. Yes, I always felt out of my depth. I always felt I was treading water and barely keeping my head above water at times because general surgery, gynae, orthopaedics, they all have their unique challenges, and that is why they are specialities. Yes, it was a baptism of fire. (P5)

Within the above accounts it was apparent that there was an interplay between the scope and variability of the clinical work, professional and geographical isolation, and the vast experience opportunities afforded to rural and remote nurses.

Experience opportunities

The participants in Group 1 (remainders) considered that a varied experience base was vital in rural and remote nursing to satisfy the requirements of their diverse role. As suggested in the following account P3 appreciated the experience opportunities gained working in the medical ward and the high dependency unit on an ad hoc basis. Although P3 spoke of geographical isolation and described the environment as 'scary' and how she gained her professional knowledge as '*learning on the hoof*', she equated the strength of the emotions she felt to have been a motivator to a good and appealing learning experience:

The experienced ones [nurses] were there to teach us. It was a great learning environment. You sort of learn on the hoof sometimes and find yourself in some very scary surroundings, but it was good. You learn loads. (P3)

Experience opportunities to work in more diverse roles in the WI led to increased independence and autonomy. In her interview P1 suggested that due to the scope, variety, and unpredictability of the clinical work in the WI nurses gained more experience opportunities than their mainland counterparts:

If you were in a city hospital, they've got ICU, you've got specialist consultants, but here you've got to make do with what you've got. So in that respect we have probably got more experience than you would if you were in a big city hospital. (P1)

Opportunities to add to academic experience as well as practical experience in the rural and remote setting were embraced by P4:

An opportunity came up to be involved in a research project with the University. I have no background in research, and it terrified me. I learned a huge amount from a very experienced researcher. My amount was tiny, absolutely tiny, but to be part of it, to be involved and to learn, was so beneficial. (P4)

Professional isolation

Professional isolation was often alluded to as one of the most concerning aspects of working in the WI. Nurses experienced difficulties finding help when confronted by unfamiliar situations such as waiting for a retrieval team to transfer a very sick patient to a mainland hospital. The interplay was evident between the clinical diversity and unpredictability and the need to become resilient to overcome fears such as being ‘terrified’ and to be able to ‘get on with it’:

We are very much on our own up here, although, yes, we have consultants and we have anaesthetists, but if we have a very, very sick patient we’re doing things that we maybe wouldn’t if we were away. It would go to a specialist team. So, we are having to know a little bit about everything, and our back-up, you know, we’ve got to wait for a retrieval team to come. Yes, so you can be hours waiting with a very, very sick person. You’ve got no choice but to get on with it. (P2)

Linked to professional isolation and being a lone worker P5 felt largely unsupported in his role as a community nurse:

Being a community nurse out of hours my role was to ‘fire fight on my own’. (P5)

P4, a specialist nurse found that by embracing technology it somewhat eased her feelings of professional isolation. Networking and collaborating with other health professionals through digital means eased the concept of just ‘firefighting’ for P4 and had a positive transformative effect on the service:

Some months there would be no locum coming over. It was very much a firefighting kind of service when I first started. The case load has grown a lot. When I came into the service there were maybe about fifteen people on biologics and now we have over sixty, so it’s a lot. We do the video clinics and there’s a lot more support there now which is good. The technology is amazing. (P4)

Advanced nurse practitioner role

To address the scope of rural nursing with its complexity, clinical diversity, variability, and unpredictability several participants in Group 1 (remainders) were proponents of the advanced nurse practitioner role to further develop knowledge and skills to provide high quality services in the WI. At the time of interview, one participant was currently employed as an ANP (P5) and one participant was undertaking the course (P1). Their feelings about the ANP role were encapsulated in the following quotes:

With it being such a small place, we need to have the knowledge because we have nobody else to fall back on. So that was the main motivator for doing this extra course. It was the fact that I kind of felt, yes, ok, my nursing degree gave me a good basis, but I felt I needed to build on that knowledge. The more you learn the more you realise there is to learn, and you have to keep on top of it, just so I can do the best for my patients. (P1)

Essentially what I do is I am an inexpensive doctor because I assess, I diagnose, I treat. That's what I do, daily, and more and more of what I do will be the norm for nurses. But the challenge is that you cannot staff the whole of the primary nursing team as advanced nurse practitioners. Most people are capable of it but most people don't want to do it, it's the level of responsibility. I've gone grey in this job! (P5)

As is suggested in the previous quote, the ANP role did not appeal to all nurses. P3's narrative suggested that a tension was created when she felt pressurised to undertake the ANP training. This tension influenced her decision to leave practice nursing and return to nurse in the hospital setting:

We had then joined with [NAME] practice and their emphasis was slightly different. They were looking at having nurse practitioners rather than practice nurses. It was the direction they were taking. So that wasn't really a role I wanted to do, and as much as I enjoyed the practice nursing side of it, I don't know how to describe it really, I just

felt that I wasn't doing what they wanted me to do, which was advanced nurse practitioner. So they wanted us to be assessing, which would have been, they were using them as GP's. and it wasn't really what I wanted to do. (P3)

Perception of skill rusting

With reference to the timelines and career trajectories relating to the nurses in Group 1 (see Appendix 8), it was apparent that they all engaged in continuous education and development and career progression to deal with the variety, scope, and unpredictability of rural and remote nursing. Despite this, several of the nurses described how they perceived skill rusting and embedded practice in colleagues, particularly in those who were nearing retirement age and had become entrenched in assumptions of how things should be done:

Some of the staff that work there is a challenge for me personally, as they have been in their roles for a very, very long time. They have a very fixed way of doing things, how can I word this? They are coming to the kind of twilight of their career, and they don't necessarily feel the need to go to training that I would feel would update and upskill. (P2)

P2 pointed out that she met some opposition to skill development from several of the senior staff members in her team which had the potential to create a barrier to learning new skills. Her self-determination motivated her to continue to develop professionally:

In community nursing you do a lot of your own research and there's training as well and if you want the opportunity, you can find it. You can get to do things which certainly is beneficial and makes it easier to do the job. The likes of specialist things we do like IV administration of drugs in the community, which is quite new, and not all staff, especially those who have been in the community for quite a while, they don't really see that that's important. (P2)

As suggested here, P2 felt that her knowledge was not appreciated, and due to fear of being judged negatively amongst colleagues, she felt constrained to

voice her opinions or give advice on how to encourage others to engage in lifelong learning:

It was kind of nice to realise that your knowledge was useful and worth something [in other areas], whereas here it's kind of hushed and 'Don't tell us anything we don't really want to know'. Being in an area with established staff members who have always done things in a certain way at a certain time, it's very challenging. I do not find it easy to open conversations to kind of see if I can influence them to achieve. They seem to want to shut that down quite quickly. (P2)

Career Development

Most of the participants in group 1 had difficulty securing a permanent post following the completion of their education programmes mainly due to a lack of employment opportunities. Finding a permanent post following qualification was extremely challenging and led to disappointment, despondency, and low morale:

So, qualification time came, and I felt very accomplished but there were very few jobs coming up. I tried to get on the 'bank' but there were so many hold ups for me. I hadn't had a single shift. I hadn't had any work at all, and I was starting to feel a bit down in the dumps, you know, I didn't do all that training to just sit at home (P2)

After P5 qualified there were no nursing vacancies and in order to financially support his family he became a shop assistant:

There was nothing. I had a family to support, and I needed to work, and I couldn't get any shifts. There was no 'bank' nursing. There were no jobs available, and a customer came in who I knew from the hospital and said 'What on earth are you doing in here? She said 'You need to make up your mind, if you are going to work in a shop for the rest of your life or are you going to take a chance. (P5)

After a period of self-determination, self-motivation, and persistence, P5 was glad to be offered 'bank shifts':

Basically, I had business cards printed off and I put my name and phone number in every ward in the hospital. And a couple of days

later I got a phone call from a ward, 'Can you come in and do a back shift for us', so I got my whites, my tabs. (P5)

P2 and P4 engaged with the 'one-year job guarantee' scheme. On completion P2 had two unsuccessful applications prior to eventually securing a permanent post on the community. At the end of the one-year contract P4 was unable to find a full-time post within the NHS and commenced work with the local council home care team:

They said that there might be a couple of part time posts, but I thought I can't really afford to be part time. I saw this job advertised in the council with the home care team working with and managing carers, and I thought maybe my skills would be quite transferrable to that as community nurses work quite closely with home carers. It probably wasn't the wisest move because it was just getting stuck in bureaucracy and home care politics. So that job was just for 6 months. I actually really missed patient care and thought, this really doesn't suit me. (P4)

On return to the NHS P4 had a succession of short-term contracts in community nursing, before securing her post as a specialist nurse. Similarly, over several years, P5 experienced short-term employment opportunities. The following account exemplified the challenges of P5's career trajectory prior to gaining a permanent post as an ANP:

I got a job in a ward to cover maternity leave, then a temporary contract in another ward. Then there was a 2–3-month post in community,

My 3 months were coming to an end again and I applied for a post in a ward. So, the post that I had left I applied to go back to, and I didn't get it and I was a bit gutted. The 3-month community post got extended for a further 3 months which was fine. (P5)

Place Related Dimensions: GROUP 1: 'REMAINERS'

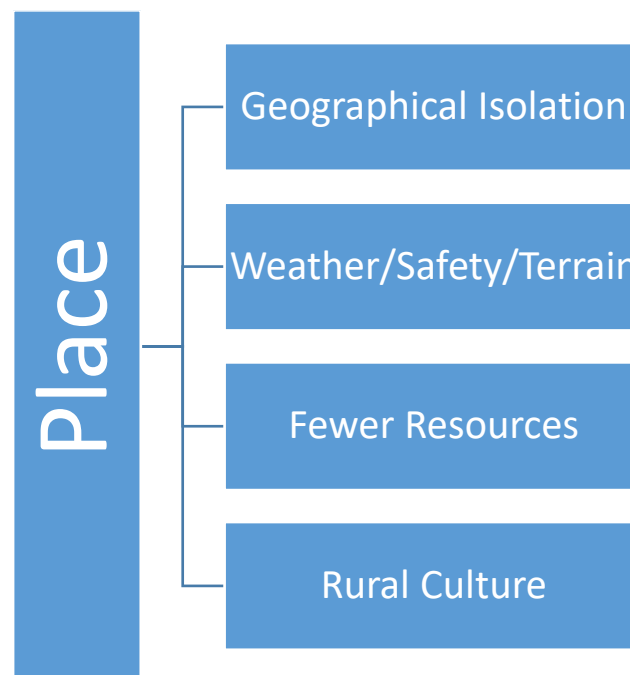


Figure 7: Visual schemata of place related themes – Group 1

All the participants spoke about their interconnection with family, people, and place. A strong thread which ran through the interview accounts was how they portrayed the WI as having beautiful scenery and accessible amenities and a close community ethos:

It's home. It's family. There's a closeness that will always be there.

The island has a very fond place in my heart. (P3)

It's such a beautiful place and everything is so compact. And there's no traffic jams. It's a nice community and I can go to the beach within just 5 minutes walking. That's what I like, just being in the outdoors.

(P4)

Geographical isolation

Being geographically isolated from urban centres had an impact on the participants in group 1 both personally and professionally. From a personal perspective the challenges connected with travelling from the island to the mainland in terms of time and cost were explained by P5:

Unfortunately there is that stretch of water between us and the mainland, and that stretch of water is a massive obstacle, because if

you want to do anything, if you want to go and browse a shop, it's a flight, an expensive flight, or a three hour ferry journey, but actually it's 5 hours because you've got to turn up an hour before, then it's 3 hours on the boat, and then it's an hour to Inverness. So, before you can do anything, you've got to plan it that way. (P5)

From a professional perspective, in the WI, community nurses had long travel times to see patients and there were often long physical distances in between patient visits. The following quote highlighted the interplay between geographical and professional isolation, weather and terrain and safety for lone workers:

Driving in the middle of the night to the deepest, darkest bowels of [PLACE – WI] to see this person and then trying to find out what was wrong with them and trying to do the best that you could. I think the most I travelled was about 150 miles in one night. (P5)

The long drive between visits resulted in less patients being seen:

On community on the island, I spent most of my day driving to get there and then I spent the whole day driving. It was really tiring, and you would only maybe see, it was a lesser amount of patients because you are on the road for longer distances. (P4)

Weather/Terrain/Safety

Several participants were required to work 'on call' and this presented challenges such as safety concerns due to driving in adverse weather conditions through the night to attend to emergency work:

We've got an awful lot of on call, and that has its challenges, like, having to drive in to work in the middle of the night in harsh weather conditions and icy roads. (P1)

Fewer resources

Several participants described how fewer resources, especially in the smaller hospitals in the WI, impacted on care delivery and typified how a lack of support structures can result in patients being transferred to better equipped facilities. In P5's account he spoke of the A&E department having very few resources which made it more challenging when looking after very sick patients with minimal basic medical equipment:

There is a room that is called A&E, but it is a room that is probably just 10-foot square with a bed in the middle and cupboards round about it. I can still see it now. There is an observation machine, there's an ECG machine, a cupboard with drugs in it, and that's it.

(P5)

Participants equated having fewer resources with being geographically and professionally isolated and accepted that this was the norm in the WI:

Because its rural, a big part of that was that there was very little support for looking after ill patients. If you were on the mainland, you would have a team of people, all qualified and trained, but there they had me, and somebody else with similar experience which was very limited really. (P3)

Well, that's the joys of remote and rural working, because you are so isolated, you are so far away from tertiary care, you are so far away from the centres where this stuff is done routinely. (P5)

Rural culture

A desire to have a level of immersion into the culture of the WI influenced participants personally. P2 found it of mutual benefit that she was able to understand Gaelic as some patients preferred to communicate in their native language:

I can't imagine working anywhere else. I do enjoy working here.

When you are used to the ways of people. I don't speak Gaelic although, I know some people like to speak Gaelic, but I do have the basics to understand. (P2)

Summary – GROUP 1: 'REMAINERS'

A sense of belonging and connection to the WI was one of the most dominant themes in Group 1 (remainers). This theme was influenced by the strength of family attachments and needs. Most of the participants expressed their desire to remain on the island, primarily due to having a close-knit family or wishing to be nearby to look after elderly parents. However, two of the participants felt that their attachment to the island was not as strong as it had been in the past due

to changing family dynamics and having grown up children on the mainland that they were unable to see as often as they would like because of geographical isolation and travel difficulties. One of the participants with family on the mainland felt, that if there was no prospect of future opportunities to progress and develop in her current role as a community nurse on the island, she may decide to leave.

A lack of anonymity occurred as a predominant theme and was linked to feelings of stress as the participants in Group 1 were identifiable, visible, and known in their social and working environment. They felt challenged because of regularly caring for family, friends, and acquaintances and being burdened with intimate knowledge of their health history, including social and psychological issues. It was very common to be stopped and asked health related questions by patients in places such as the grocery store. The participants felt at risk in these conversations as they were held in a public arena and in their personal time. There were increased challenges of maintaining confidentiality when a lack of anonymity existed. Despite the tensions and stress that a lack of anonymity created nurses remained working in the WI due to the strength of family and lifestyle connections.

Another key feature of nursing in the WI was the variety, scope, and unpredictability of the work. All the participants in Group 1 experienced the struggles, challenges and opportunities associated with caring for a diverse group of patients. These challenges were compounded when there was a need to look after patients who would have been admitted to a speciality unit had the care episode occurred in an urban setting.

Interview accounts alluded to a strong interplay between needing to exercise a demonstration of resilience when realising that in many situations nurses were professionally and geographically isolated and overwhelmed by how their confidence was challenged because of the breadth of knowledge required. Being resilient was having to adapt successfully in the face of adversity when there were often no resources available to share the load.

The variety, scope and unpredictability of practice led to nurses experiencing strong emotions such as fear, and terror as they felt out of their depth as they experienced the challenges of looking after a variety of specialities and all age groups of patients including very sick children. When critically ill patients were awaiting transfer to mainland hospitals the nurses described the fear and heightened anxiety they experienced, due to geographical and professional isolation and having fewer resources, as they administered emergency immediate care.

Limited career progression featured as a major theme. 'Bank' nursing was unpredictable, difficult to access, and participants would go for long periods without any shifts. Work patterns were largely determined by the needs of the organisation which had a negative impact on career progression. Two of the participants had to leave the NHS at the start of their career journeys', in order to secure employment and support their families. Early career pathways were clearly haphazard and fraught with challenges such as despondency and lack of direction. Despite these initial challenges all the nurses in Group 1 (remainers) went on to develop lucrative careers in the WI.

GROUP 2: 'RETURNERS'
NURSES BORN IN THE WESTERN ISLES (WI) – TRAINED IN WI or MAINLAND –
WORKED MAINLAND - RETURNED TO WI (n=9)

Person/al Dimensions – GROUP 2: 'RETURNERS'

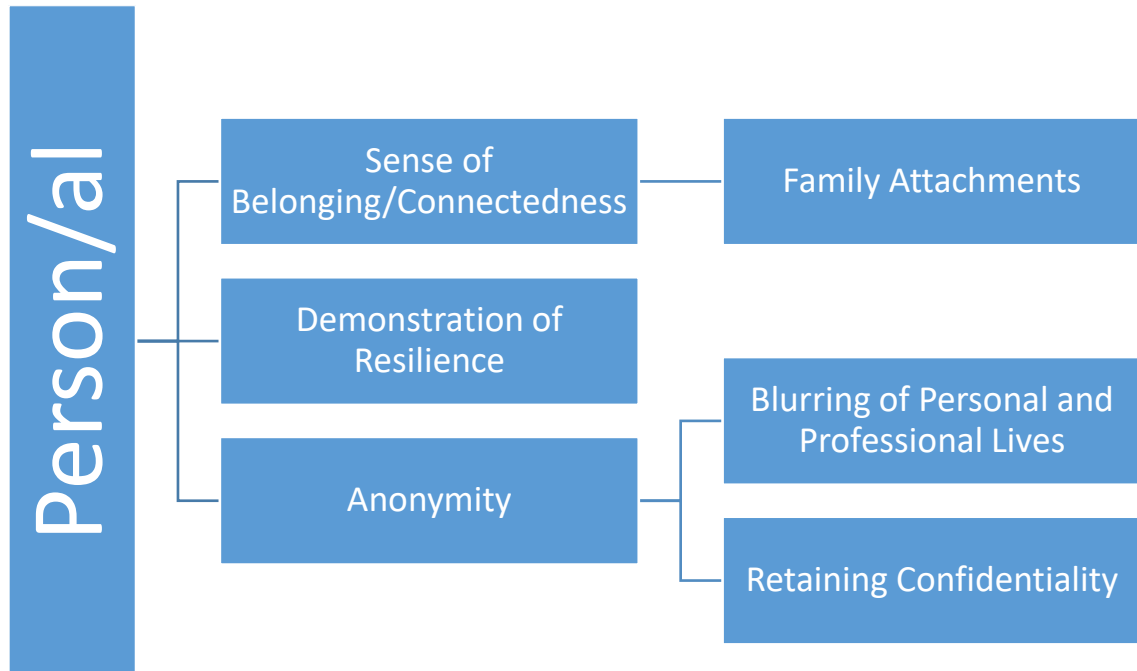


Figure 8: Visual schemata of person/al themes and sub themes – Group 2

Sense of belonging/connectedness

Of the nine participants in this group, seven (P7, P8, P9, P11, P12, P13, P14) described having a strong connection to the island and family, and after experiencing living and working on the mainland, were motivated to return to the WI. Some found their experiences of living in a city daunting:

I found it daunting. I found it overwhelming, and busy. I'm just not a city person. I have a strong attachment to the island and also a very strong attachment to my family. I was homesick and that was the bottom line. I miss the sea. (P7)

The following accounts depicted how understanding the rural community and having a knowledge of the place and people was a positive motivator for remaining in the WI. Being able to compare nursing in both an urban and rural

setting led the participants to favour the familiarity and closeness of nursing in the WI:

I see myself staying on the island. Definitely. I love island nursing. I've been away and experienced being with people that I don't know, and coming back with people that I do know. I like it. (P8)

I am born and bred here, and it is just so nice to be able to look after your own community. And it is nice to be at home and you often find that you are looking after the same patients, some that you might meet in hospital and then you might meet in the community, and vice versa. I enjoy that and I think they enjoy that too, having a familiarity with the nurses. (P9)

P7 experienced home sickness and disconnection when she returned to work in the city. The Gaelic word 'Cianalas', unique to the Outer Hebrides, describes a deep-seated sense of belonging to the place where your roots are. Socialising and working with a colleague who came from her home village in the WI and subsequently meeting her partner and following him as his career journey took him to a variety of places both in the UK and overseas helped to make the transition to the city easier:

I knew people, I was with somebody as well. That was a comfort in itself.

When I saw [name] who was from my home village, it just felt like a wee bit more familiar. It was good. (P7)

As a result of enjoying seasonal work on the mainland as a teenager, P10 was influenced in her decision to undertake nurse training in [PLACE- CITY]. At this time the Registered General Nurse (RGN) training was not available on the island, and this also provided her the opportunity to leave:

I think I saw my training also as a route to get away. I think I would have probably wanted to go even if the RGN training had been on the island, but I think that my family would have wanted me to stay. (P10)

The following accounts portrayed that, although during training or working on the mainland, most of the participants in Group 2 expressed a desire to return to the WI in the future, either to seek employment or to retire:

I'd been used to being away from home, and I think when you are younger you want more from life, so I enjoyed city life. I enjoyed meeting lots of different people, doing lots of different things, having the opportunity to having more of a social life as there were more places to go, but I always wanted to go home at my holidays. I could never live in the city all the time without knowing I could come home (P14)

I was always going to come back to retire. That was always going to be the plan. I thought it would be better if I went home and made relationships and friendships because I had been away for 30 years, and although most of my class mates are on the mainland, I decided it might be a good idea to come home and see if I would start making a life for myself. (P11)

Family attachments

Family attachments continued to be important when nurses worked on the mainland and were one of the strongest motivators for them returning to the WI. There were several participants who were reluctant to return (P6 and P10). At the outset of her career P6 was enjoying working as a midwife in [PLACE – CITY] but her husband did not like the city and wanted to return home. The interplay between her personal family circumstances and her profession shaped her decision to return home:

It was my reluctant motivation to come back to the Western Isles, I really didn't want to do it, and I tried to make him stay on the mainland, but he just wouldn't. (P6)

As P6's career trajectory developed, family influences and needs continued to impact on her professional choices and led her to engage in practice nursing for thirteen years. This role suited her family situation better although it was not her personal preferred choice of career trajectory:

I wanted to be a midwife, you know, but it's a permanent job. Monday to Friday 9-5, no on call, no late shifts. By then I had started having children and it definitely suited my family. I enjoyed it, practice nursing was great, but I knew it wasn't really what I wanted to be doing. (P6)

Several participants felt that their transition to nursing in an urban setting was made easier due to having the support of close family members and friends who lived on the mainland:

I enjoyed [PLACE – CITY] because there was family there and the girls I trained with and also some in the class ahead. It was like a family and there was lots of support there. (P11)

Moving to [PLACE – CITY], it was ok. I was quite used to it because I had an auntie in [PLACE – CITY] that we used to go and see every Summer. My older sister was in [PLACE – CITY], as well and we had our close class mates too and that made it easier. So I didn't find that a difficult transition at all. It was quite an easy step. (P13)

Although both P6 and P10 recounted their feelings of being reluctant to return to the WI, the strength of family attachments, changes of circumstances, and the need to support family members who were unwell, or elderly, influenced their decisions to return and remain in the WI. Their accounts highlighting their reasons for remaining in the WI are best encapsulated in the following quotes:

I felt I had to come back because my sister was sick. So family illness did make me come back. I had to support my parents at the time. (P10)

It was my plan to work in WI then go back to [PLACE – CITY]. I thought I would stay for a year in surgical and then I would apply for my district nursing, and that I would get in as I would have surgical experience, but that didn't work. I ended up getting married. (P10)

The children are used to the freedom and you know, the small schools, and so we kind of said, we will just wait until the children leave school. So my youngest left school in August, but, and now my mother is now 86 and dependent, more dependent on me. So there is always something keeping you. (P6)

It was the desire of several participants in Group 2 to return to the WI to seek employment and integrate back into the community prior to retiring. Family attachments interplaying with a sense of belonging featured strongly in their decision making. The participants generally felt that they were missing out on family life in the WI:

I have built a house near where my mum stays and I feel that my roots are there. My family is there, my cousins are there, people I have known all my life are there, so I have just slipped back into the community. (P11)

I think if you have been in a place for a while, and it was very far away, and you know, I managed home once a year. My brothers were growing up and my sister had children that would only be babies and toddlers when I left, and then my brother was getting married and I just felt I was missing out on family life. (P14)

Most of the participants (P6, P7, P8, P9, P10, P11, P12, P14) alluded to a desire to return to the WI to support elderly parents or assist following family bereavements:

I came back home. Unfortunately my dad passed away, and that was a big turning point in my life cos, yeah, he was such an influence in my life. Life was very different knowing that dad wasn't there anymore. (P7)

It's very homely, that's why I'm here now. My mum and dad are here yeah, I'm back here now and my brother is here now too. (P8)

The participants in Group 2 were drawn to return to the WI primarily to be with and support their family but there was also a strong desire to be integrated back into and look after their own community:

There is something nice about looking after your own community, I enjoyed that so I was really quite happy. Maybe that's what drew me to come back home as well. (P9)

Demonstration of resilience

The following quotation from a senior nurse in the WI encapsulated how a high degree of resilience is required for rural and remote work and highlighted how staff go above and beyond the remit of their role by working on days off or whilst on holiday. Due to the variety, scope, and unpredictability of rural and remote nursing practice there was a strong interplay between geographical and professional isolation and the requirements for a wide knowledge base to support what can often be a fragile service:

There's a huge amount of good will involved in the role and there is a lot of teamwork going on here. We often work on our days off or come in on our holidays. So if you've got an emergency coming in you just phone around until you find somebody that is able to come in. (P14)

P14 also described how being able to demonstrate resilience was an adjunct to autonomous practice:

We have a consultant liaison, but they only come every two years. They do training with us, and what is really interesting is that they tell us that they learn as much from us as they are teaching us. Our consultant liaison says, 'Where we work you have everything to hand' but 'Where you work you have to just make do and mend in many ways' and he said, 'We sometimes wonder how you manage to maintain what you do until you can get further help'. So that is a really good thing to know, and a good compliment to get. (P14)

Within her account, P8 who was working as a staff nurse in the operating theatre asserted that:

What we have is what we have. Who we have is who we have. Yes, and that's it. There is nowhere else to go. We have to make the most of what we have. (P8)

Anonymity

The challenges of a lack of anonymity in the WI were expressed in the accounts of all the participants in Group 2 (returners). Some described how the concept of familiarity with patients, the wider community and colleagues impacted upon personal and professional role blurring.

The familiarity with patients in a close-knit community presented difficulties to the extent that many participants did not enjoy going to social events. The following quotations best encapsulated the strength of the impact of lack of anonymity.

There was a sense that the participants were aware of how their actions were both visible and readily observed and how they needed to guard against people finding anything in their personal lives that could possibly mar the essential traits of a good character:

I came with a clean record. A capable practitioner who had a good reputation, which meant that families could work with me, and had nothing, but they always looked for 'dirt' on professionals. 'Who does she think she is coming to tell me? It's really difficult to be doing these roles within the rural community you live in especially when you know the people. I don't like to going to community events, you know, and we all like to have a drink, but there is a line you cannot cross. There's a line you cannot cross in this role. People are watching you all the time. I do not like going into the public arena. I don't. (P6)

I knew a lot of people in that area. Not only did I know them, but they also knew me very well and that can be very difficult because they can say 'Who is she to tell me, she's just the same as me'. So that can be quite difficult as well and when it came to child protection in an area that you were brought up in, that can be quite difficult too. (P10)

P10 found that she was more aware of the effects that the lack of anonymity had on her when she was a midwife in the WI rather than in the urban setting

and expressed that it was more difficult to look after people they knew as opposed to people they will likely never see again:

It was harder in midwifery I think because you were delivering the babies of people you knew, and when they were my own age that was quite challenging because you wanted to do everything right for them, but it didn't always go right. You felt responsible, whereas in [PLACE – CITY], you don't see these people ever again. (P10)

Throughout her interview P8 asserted that the lack of anonymity interplaying with personal and professional role blurring would make it very difficult for her to work in the Accident and Emergency (A&E) department in the WI. A&E work had been her passion in the urban setting but due to close community attachments and relationships, A&E work in the WI was not an option:

In the city I used to sit and cry with families that I didn't know and I think, I think could I actually do that at home, could I? You know, and that's what stops me from working in A&E on the island. Does that make sense? The difference is that in a city you can get a kind of disconnection and you don't have to face their families tomorrow. I don't have to walk down the street and they're going to say to me 'Oh, by the way how is 'so and so', you know, there's a difference, and I think when you come from a small island like this, you've got that. (P8)

Although challenging, P7 found that the interplay between the personal and professional dimensions of rural nursing, the sense of belonging, lack of anonymity and embeddedness in the community in the WI could also be advantageous. In the following excerpt from P7's interview the concept of familiarity was described as a facilitator as it allowed rural and remote nurses a special knowledge of those for whom they provide care within their communities:

It's quite rewarding really, sometimes because you know you're living in a village and people know you're a nurse and quite often they phone you, 'Could you come, my daughter's fallen and hurt her knee'

or whatever. My next-door neighbour had a heart attack, and you couldn't, you couldn't just not go. (P7)

The subsequent quotes from P9 described experiences of a lack of anonymity whereby personal and private situations were disclosed to others. These tensions presented a challenge to maintaining professionalism. The negative aspect of a lack of anonymity included challenges in maintaining confidentiality:

Often in the community setting when you would be going to people in their own homes, because its such a close knit community we are in, people often wanted to know who you were. So trying to be professional and almost anonymous in your work, you can't do that. People want to know your background, which can be quite difficult at times. And also sharing what they know about you with other members of the team, which is sometimes a bit unprofessional at times. You don't come across these challenges in places where people don't know you. (P9)

It is clear from P11's account that she decided not to return to the WI until she was nearing retirement age. This decision appeared to have facilitated her transition to rural health visiting when dealing with sensitive issues in her professional capacity:

What I did worry about before I came home was that, you know, because it's a such a small community and everybody knows everything, but I don't seem to have an issue with that now. I quite like being part of a community where people know you, look out for you. I purposely didn't come back until this age that I am at, because the mothers would be grannies by now. My age are grannies. I don't think I would have liked to have come home earlier in my career. I think this has been a good time, as some parts of this job are quite difficult. We are dealing with very sensitive issues with some people. (P11)

P12 who was a health visitor in the WI spoke of the difficulties encountered due to a lack of anonymity especially when dealing with sensitive issues with clients:

I had to go to a child protection consultation, I remember going to the swimming pool that night and the woman from the case conference, and I just remember looking along at the side, and there she was. So, one minute you are in your shirt at the conference and the next minute you are in the swimming pool beside them. (P12)

Blurring of personal and professional lives

All the participants in Group 2 (returners) found it challenging to maintain a high degree of professionalism when they knew their patients on a personal level also. The following quotes best encapsulated the challenges associated with setting and maintaining boundaries:

I find it challenging in the rural setting because I almost want to put out my arms to them and say, you know, but I can't do that because I am a professional. And I won't do that. I have a boundary as a nurse and I have a professionalism as a nurse, and I will always have that, and I will always keep that and if people ask me anything, you know, you can't speak about it. (P8)

The following quotes highlighted the challenges associated with knowing patients both personally and professionally and how these interplayed with a lack of anonymity and impacted on engaging in social activities. Boundary crossing between personal and professional aspects of the nurse-patient relationship may be commonplace and unavoidable in rural and remote practice:

You do have to be professional, but then they get to know you because you live in the same community, so there's different communities and blurry boundaries, if you live say for example if you live in the same community as somebody who has been a patient, do they then become a friend, a neighbour in your village, or are they still just that patient that you once looked after? You often find that living in a small place. (P9)

I have to say that one of the things that happened to me in health visiting was that I stopped socialising so much because I really

wouldn't want to go to the pubs, you know, you just don't want to meet your clients in these situations. And the other thing is when you're listening to people and listening to people's problems when it comes to 5 o'clock you just don't want to hear anyone else's problems, you just want to switch off. (P10)

The following account from P11, a health visitor in the WI, highlighted the potential challenges associated with personal and professional role blurring amongst colleagues and suggested that there are benefits to adhering to strict boundaries:

I think that people that have worked together, some for years together, in some ways that can be a positive, but it also can be negative. Because it is very difficult at times to have difficult conversations with colleagues if you are their friend. I didn't know anybody here when I moved up so it's easier for me to have conversations. There's a sort of degree of anonymity when you don't have a personal and professional relationship with colleagues. It's a professional relationship. I think it would be quite challenging to have both a personal and professional relationship with your colleagues. Also you come with no baggage. I didn't know the history of anyone here. So I started with a clean slate with everybody. (P11)

Retaining confidentiality

The following accounts highlighted an awareness of how trusting relationships in rural health care settings are enhanced by the familiarity common in rural community living. Participants felt much more aware of retaining confidentiality in the WI:

There's always the worry in a small community like this that, you know, the service user will think oh, they know everything about me, and they worry about that sort of thing. And you always have to reassure them that no we don't know everything and we haven't got access to everything. We only deal with what we have to know. (P7)

In many ways it was very good because you got to know people, but certainly I did recognise very early on is that no matter how people on islands are deemed to know everything about everyone else, I can assure you they don't, and in one way that is very reassuring and in another way in some instances with some of the things that you dealt with, it was very sad. You know, and as for confidentiality you just were aware, and very hugely, hugely aware of that, and probably more so than anywhere else. The interesting thing was that you knew when people learned to trust you and you knew when people, you could actually see when you were supporting people, so it was very rewarding (P14).

Professional Dimensions – GROUP 2: 'RETURNERS'

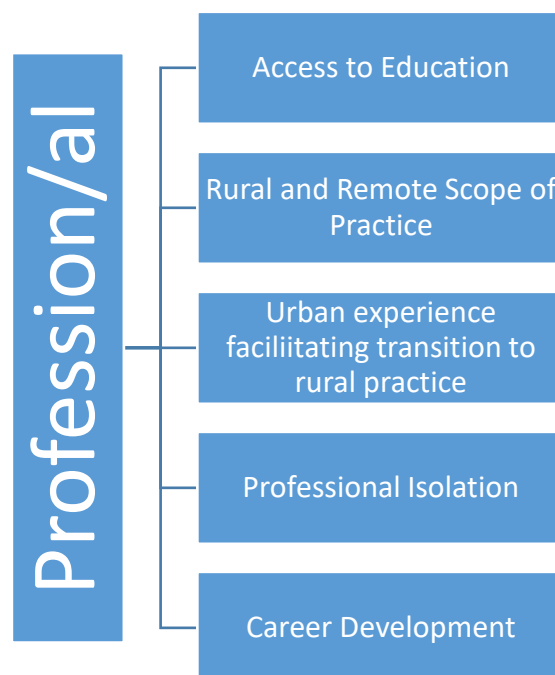


Figure 9: Visual schemata of professional themes – Group 2

Access to education

Six of the participants in Group 2 (returners) who decided to undertake their nurse education in the WI (P6, P7, P9, P11, P12, P13), did so for several reasons which included family attachments, a sense of belonging and financial concerns:

I was really quite keen on staying on the island. Financially as well, because I couldn't afford to travel to the mainland and look for jobs. Again, that's why I did my training in the WI and with my connections to home, I had my father who was quite unwell at the time, so all these points were wanting me to stay at home. (P9)

They felt well supported and alluded to possessing a better level of basic nursing care than their urban counterparts:

I still believe in that training (enrolled nurse). It was a good start and it set me well on my way. Yes, a really good grounding. (P7)

Oh I loved the training. Our tutors were fantastic. We were a small group. So it was a small intimate group and we had pretty much one to one with our lecturers. It was really great access to them, and it was a fab three years. (P8)

I felt very well supported and I think it really gave you a good knowledge of basic nursing care which was a good steppingstone to going to Inverness. (P11)

I had a fantastic grounding in the WI and actually, we got quite a lot of comments when we went to [PLACE – CITY], in that it was noticeable that our basic nursing care was of a different standard to some of the students that were being taught in [PLACE – CITY], at that time. (P13)

Several of the participants voiced their opinions about being proponents of leaving the WI to train and work in different places. P6 and P11 had to leave the WI post registration as they desired to undertake midwifery training which was not available locally:

Midwifery is what I wanted to do. I had to leave the island and I wanted to go to [PLACE – CITY], as it was the best for midwifery. (P6)

I loved being a midwife. I think it is a very responsible position. I qualified very young, and I think I was only 22 when I became a midwife, so I had the responsibility of the wards or labour wards wherever I worked. It was a huge responsibility as a young person. I decided I'd become a health visitor for the main reason that I thought it was a continuation of my career. I got a secondment and had to study in [PLACE – CITY]. (P11)

P10 and P14 needed to leave the WI to undertake RGN training as it was only SEN training that was available locally at that time:

At the time there was no RGN training on the island, it was the enrolled nurse training, so I had the qualifications to get into the RGN training and it was for that reason that I left the island. (P10)

I really enjoyed my training in [PLACE – CITY], as there was so much diversity to it. (P14)

Rural and remote scope of practice

According to all the participants in Group 2 (returners) the need to have a wide knowledge base due to the variety, scope, and unpredictability of rural and remote practice in the WI was evident. Several experiential accounts highlighted that this was dissimilar in the urban setting:

We don't just focus on one thing. I think on the mainland the difference is that you focus on one theatre, and you have one speciality and you're in that. The difference with us is that we have to go from one thing to another. I have had the experience myself that I've been scrubbed for a hip, and I've come out from it and I've been told there's an ectopic, and I have to go to the sink for that. So I'm going from orthopaedics to gynaecology, in like 2 seconds, and having to kind of focus and think differently. (P8)

In any big hospital in a medical ward you would phone your ECG technician, you'd phone your phlebotomist, you'd send your blood to the lab just because you have so many people doing it for you, but

here the staff have to do quite a lot for themselves and it gives them an opportunity to develop these skills as well. (P13)

In Group 2 the participants in the WI also supported the need to have a wide range of knowledge in different areas to support the variety, scope, and unpredictability of their role when professionally and geographically isolated:

We are juggling with roles and need a wide knowledge base (P6)

You have to be really multiskilled in health visiting. Totally, totally (P12)

We have one ward and into that ward can be admitted any patient, for anything. So you could have somebody who has had a heart attack or a stroke, or somebody who is detoxing, or a psychiatric patient, or somebody who has broken their leg, or a child, or a demented patient. All of these things can come through the door at any time. (P13)

We have a treatment room which gets used as A&E, but we are not staffed for A&E because of where we are. So we can get anything from, I mean we have had deliveries here, we have had deliveries in the hospital. So you can have some patients basically from new born right up to end of life care, and anything and everything in between. (P14)

The following quote from P12 highlighted the variety of learning opportunities that was experienced in the training programme in the WI which facilitated progression:

In the Western Isles it was quite good as well. It was varied and it was actually an excellent learning experience because I remember being in surgical and you were catheterising patients, and I remember doing liver biopsies, you know on the ward with the doctor and it was just you and the doctor.

Yes, really hands on and I remember doing ECG's and stuff like that. I think nowadays students wouldn't go near any of that. You know they would just be observing. (P12)

Urban experience facilitating transition to rural practice

Several participants in Group 2 (returners) drew on the experience opportunities they gained when nursing on the mainland where they came across medical situations that they were astonished by:

It was amazing! I saw things there that I never ever knew could even happen. I will never forget. I remember people there getting facial grafts for skin cancers. (P8)

They credited this experience to facilitating their transition to working in the WI and felt that they brought a new and different perspective. There was a perception that their mainland experience helped to better prepare them for employment in the WI.

P11 had to leave the WI to pursue a career in midwifery and health visiting as this training was not available locally, but there was also a desire to leave the WI to experience what it was like to be in different places and experience different things:

I think I looked forward to leaving because I wanted to experience different things. I just liked to experience different places. (P11)

On return to the WI as a health visitor P11 alluded to bringing a different perspective, and drawing on the experience gained on the mainland, to enhance the team dynamics:

I believe that I may have a different perspective to others who perhaps haven't left the island, and maybe have trained here. So, it's a different way of working, different advice and how to do things. So maybe it's helpful that change can help, and I hope it's in a positive way. (P11)

By bringing new ideas into this environment, and also my experiences with families has helped. My colleagues here, when they have maybe come up with challenges that they haven't experienced

before. Yes I think that's what I bring to the team, experience, and hopefully stability as well because there hasn't been a team leader here for quite a while. Well, for me I think I have brought stability.
(P11)

P13 highlighted the value of accessing experience and education beyond what is available in the WI and suggested that training and working in just the one place may limit knowledge:

I am not a fan of people who only train and work in one place. I think it limits your breadth and knowledge of experience and it certainly doesn't demonstrate a wider thinking. I think you need to leave your place of work and do something different and change your way of thinking, to come back and look at it, because it does help. (P13)

On returning to rural practice in the WI P8 recounted several stressful situations which took place when working in the urban setting. She described how 'being an island girl' she often felt overwhelmed in the city:

It takes its toll, like, not sleeping at night. That for me was an issue, because I'm an island girl, and when you don't see it, you don't know it, but when you see it you know it's there. And for me that was difficult because I was in the middle of it all. (P8)

Professional isolation

The participants in Group 2 described challenges associated with professional and geographical isolation. Some spoke of the difficulties of waiting for a retrieval team to transfer a sick patient to a mainland hospital and the feelings of isolation and vulnerability as immediate care was administered to the best of their ability with limited resources:

I've been in theatre on a nightshift from 2 in the morning until 6 until a patient goes. You're waiting for a team to come and get them. When you're on an island that's how it works. It's hard. It's a long time, it's hard, everyone's tired, but it's a case of, we've got nobody else to work with. We are kind of on our own. (P8)

Whilst working in the community setting P9 experienced a lack of mobile phone signal which also intensified her feelings of professional isolation:

A lot of the houses that I would go into were miles apart from each other so it would be quite isolated. So as soon as you left base then that was it for the day, so the distance you had to travel was a lot, and because of that again you maybe didn't have phone signal, so you really were on your own with not a lot of backup. (P9)

Being professionally and geographically isolated in the WI made it very difficult to collaborate with colleagues and ask for help or advice in extreme situations that required an immediate response:

When you are in a bigger unit and you've got 4 or 5 people you go, how do I do this and how do I do that, but when you are on your own it's very difficult to ask somebody.

So, there is professional isolation, absolutely, and it's how you get rid of that. You have to form links with other areas involved or there's some forum for you to express yourself or find out information (P13)

Career Development

Despite an initial reluctance to return to the WI at the outset of their career both P6 and P10 settled and expected to remain in the WI. P6 felt that it was difficult for her to get a permanent post when she returned, and she alluded to being unfairly treated. This created tension around recruitment and retention issues and employment opportunities:

And they asked me to go on the bank. So I was at their beck and call all the time. Now, if they had given me the post they wouldn't have had this person on the bank. I kinda thought you know what they're not treating me fairly here. They knew I was coming home anyway, and they gave the post to someone who would not be in the WI if she hadn't got the job. (P6)

As her career progressed P6 felt that she was overburdened with demands put upon her as she was expected to undertake multiple roles as a school nurse and health visitor:

'Can you cover, can you cover the clinic, can you do a visit?' I had skills as a midwife. I had skills that they didn't have, so I ended up taking on a health visiting caseload and keeping on the schools. (P6)

As P6's role continued to expand and involved travelling to other islands the pressures intensified:

It was impossible. I could not lead the team, hold the case load and supervise students, and I felt I was being pushed into a corner, and I kind of thought, 'No, I'm not going to do this'. I don't know how I'm going to stop it, they weren't listening to me, it was just not viable for me to be doing the 3 roles.

It's not manageable, I'm not going to be able to do this. I mean, I am a strong-willed person, but I kind of thought, I'm just going to get used here, and it's not going to work. (P6)

Several nurses in Group 2 (returners) experienced challenges with recruitment and although P7 felt that she should stay at home as her father was unwell, she was unable to secure a post, so followed her partner abroad:

He was encouraging me to go as well, but I thought I should stay at home because of the family situation so I applied for a job at home, but I was unsuccessful. So that was the deciding factor to go to [PLACE – OVERSEAS]. (P7)

It was P9's desire to remain in the WI after completing her training. Following a one-year job guarantee post there were no further career opportunities:

There weren't many job opportunities here, so the government had run a scheme for newly qualified nurses, but it was just a 1 year post.

When I finished that post there weren't really any jobs to apply for, and almost all the jobs that were there were lined up for people who

had already worked there, maybe on temporary contracts, so I decided then that theatre is what I had enjoyed from my student times and that's what I would like to pursue, so I started applying for posts in [PLACE – CITY], and [PLACE – CITY], and I was fortunate enough to get a post in [PLACE – CITY], So I moved. (P9)

P9 returned to the WI to support her family as her father was ill. She was offered a temporary contract in theatre, but it did not lead to a permanent position:

Following a temporary contract in theatre there were not the right funds in the department at that time to employ new staff. I had to move on. So luckily for me, within the last month of my position I was offered redeployment to the medical ward and also began to do bank shifts in the [specialist] unit. (P9)

The following narrative extracted from P13's interview explored the challenges associated with recruiting nurses to work in the WI. The interview data suggested that there is a difference between nursing in the remote and rural setting as opposed to an urban setting:

You have to figure out that person's way of thinking, that come to remote and rural places. It's different. The challenges that you face. And are the people up to these challenges. And trying to establish that is impossible. Sometimes you have a gut feeling and other times you think, you know, we'll go with it. And the majority of people, I think do it for the right reasons, but I think, when you're interviewing you always get caught out when you think they present brilliantly, and then when they actually start their job you think, oh my goodness, this is not the person I thought I was dealing with.

And I've learned that in some of the people I have brought from the mainland, and they have come in and they've shaken things up a bit, because they've realised that this is not the way to do this, so that has been quite an interesting thing as well, which I wanted to happen. To shake things up a little bit so that even the people who have been there a long while can see that there are different ways of

doing things. It causes a bit of friction, but Hey Ho, You don't want people to stagnate. (P13)

Place Related Dimensions – GROUP 2: 'RETURNERS'

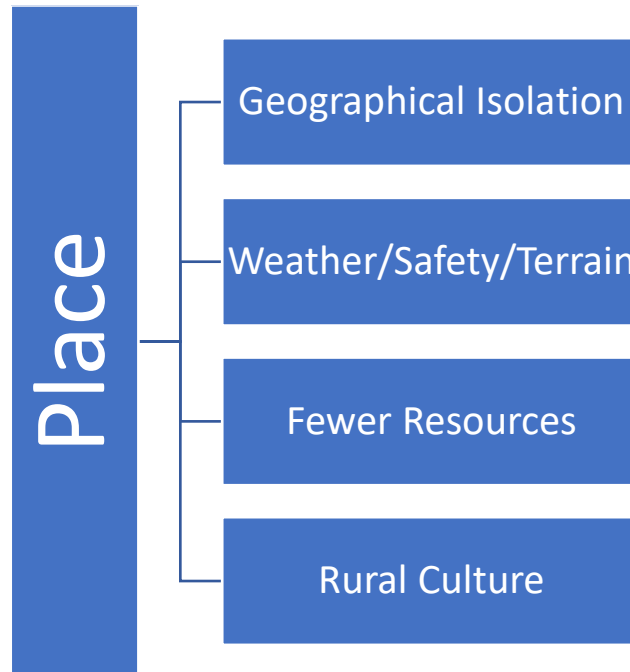


Figure 10: Visual schemata of place related themes – Group 2

One of the attractions of living in the WI was a higher appreciation of quality of life and a strong preference to reside in a clean, natural environment:

I really enjoy the outdoors. I was always into fishing and things like that. It's got a lot of positives, you know, the environment is really clean It's especially good for bringing up children (P12)

Several participants in group 2, (P6, P9, P10) articulated positive psychological associations that are attached to places. Describing the closeness of the sea, which was reminiscent of island life, enhanced P9's experiences of living near a city. P9 had a strong sense of belonging to the WI and felt that living near the sea reminded her of home:

I actually really enjoyed it. When I moved I guess what attracted me to the flat I moved into and also where I worked was that the sea was close by. I actually didn't feel that I was in the heart of the city because I was still on the coast. I lived in [PLACE – CITY], and with me being an island girl I felt really homely, having the sea nearby

which sounds really silly, but that was really attractive to me to be near the sea. (P9)

Geographical isolation

The following accounts portrayed the sense of geographical and professional isolation experienced by rural and remote nurses in the WI and how this impacted on a demonstration of resilience and community cohesiveness:

It's very difficult when you are in an emergency situation and you've got 4 people on shift and that's all you've got. You don't have a full hospital of people. You don't have a hospital down the road to run to. You've got nowhere else to go. That's all you have. (P8)

When you mention hospital most people think of all amenities of a large hospital, and we don't even look anything like that, and we don't have any of these facilities. When you are trying to explain where you are, it's difficult for some people to actually understand exactly where you are, or how you have to work, and having access to people like the emergency medical retrieval service. (P14)

P14 commended how the services and the community worked well together in the face of adversity:

All the services work very closely together because we are too small, too remote and too fragile not to, and not to be involved with each other.

There's more of a community feeling about it and, whether it's in your work environment or out of it, you will find that people will come together when they are needed, and they will work together. It is interesting because you will see people who seem to slot into their roles unconsciously. I've been involved in things here, that I've never been involved in anywhere else, and you can see that person is maybe a crofter today but seeing that emergency, that person was one of the leaders, and another person was really good at coordinating something else, so it is actually very, very interesting. (P14)

With reference to the afore-mentioned quotations the participants believed that geographical isolation, a limited staff pool, and fewer resources contributed to nurses' resilience and positive community engagement.

Weather/Terrain/Safety

Generally, the participants (returners) in the WI related to poor weather and difficult terrain which caused them to feel isolated, vulnerable and frightened when having to drive long distances when visiting patients or on call:

If the roads haven't been treated or you've got difficult driving conditions, we always point out that we are lone working although quite often this isn't recognised by our seniors. It can be really dangerous. One weekend recently the weather was the worst I'd experienced on the road and I was frightened. I've had a few close ones on the roads, believe you me, but one in particular was when I hit black ice and somersaulted twice into the moor, and I did it so as to prevent myself ending up in the Loch. So that was it. I lost my car but I didn't lose my life. (P7)

There were lots of challenges, obviously challenges for driving with the car as well, for maintenance, and there were single tracked roads often covered with sheep, so in the beginning I was anxious about safety issues considering the distance I had to travel. I think I was driving approximately 100 miles a day. Driving, to get to [PLACE – WI], you have huge hills to get over in the snow so that was challenging too. (P9)

Feelings of being cut off and unable to communicate with colleagues was a common feature of community nursing in the WI:

Often not having the signal if I needed backup for something was a bit overwhelming, but as my experience grew and I got to know the rural area, I began to be able to figure out where the signal was, and if I needed something, then I could drive to that point and then phone one of the other nurses. (P9)

Fewer resources

Participants described how access to physical resources and connectivity impacted on work and study. Several participants expressed their frustration at the poor internet connection in some remote parts of the WI which impacted on their occupation and study. This compounded the challenge of undertaking further education:

We have no library with medical books in [PLACE – WI] and the University [PLACE – CITY], have an online library that you need good internet connection for, which we don't have in [PLACE – WI]. It's a real struggle. (P6)

Doing the nurse prescribing course was exceptionally challenging because the connection at home is horrendous so I couldn't download any of my modules, so I couldn't actually do any of my work at home and during the working day I didn't have time. (P14)

Comparing and contrasting the availability of resources to facilitate safe and effective rural and remote surgical procedures, P8 related that in the WI:

When we have an emergency, even like instruments and things, there is no other hospital to go to, we have nowhere to go. We are on our own. One hospital, one Central Decontamination Unit (CDU) and that's it. A plane off the island. That's all we can do.

What we have is what we have. Who we have is who we have. Yes, and that's it. There is nowhere else to go. We have to make the most of what we have. (P8)

Conversely, P9 noted that working in the urban setting, in the past, was less challenging:

Coming from a small island with limited resources in our hospital to going to work in [PLACE – CITY] in neurosurgery.. It was incredible! (P9)

Reflecting on the need to demonstrate resilience and having fewer resources in the WI, in her interview P14 highlighted the expectations of both local people and incomers:

The hospital is small. We have got four bedrooms which are called wards and I think that's maybe to make it sound bigger!

I think if you work in a place like this you are very aware of your limitations. I think you can only do your best, because even if you have all the resources around you there's only so much that you can manage to do, and sometimes things will not work out for you. We are actually very fortunate in that we rarely have an adverse effect.

The original local people here, are very aware and they understand that they are in a very remote area and that there is only a certain amount of what they can expect. The ones here who expect a lot more tend to be incomers. (P14)

Rural culture

When considering her reasons for entering the nursing profession P6 highlighted the occupation expectations for females in the WI was either teaching or nursing:

Being brought up in the WI if you were in any way academic, very few women went into anything more than teaching or nursing. (P6)

P9, who had a strong sense of belonging to the WI, shared a recent discussion she had with a colleague:

Recently I had a medical doctor share that she had been in other environments, working obviously, but that she is drawn to come back to work up in Lewis. And she said that the nursing team here are so friendly and community based and so focused and that everybody really looks out for each other and that its really very homely, and she's drawn to come back here too. That's interesting isn't it? (P9)

The following account encapsulated P14's deep appreciation of rural culture in the WI and how that appreciation deepened when there had been time spent away:

There's a real family bond up here! And I think I often look at the culture and I love some of the older songs, especially the Gaelic songs, and when you listen to the words of these songs, the depth of meaning. That was such an art. Beautiful.

And I think being away from home actually lets you see what you have, and I sometimes think you need to leave an area, leave somewhere, or leave home to actually appreciate what you had there. (P14)

Summary – GROUP 2: 'RETURNERS'

It has been demonstrated within the interviews that most of the participants in Group 2 (returners) generally felt that family attachments, influences and needs largely determined their career pathways and trajectories. Several of the participants (P6 and P10) were reluctant to return to the WI but P6's husband did not wish to stay in [PLACE – CITY], and P10 felt that she had to return to support her parents as her sister was unwell. Despite their reluctance to return, they are both now settled, married, and have brought up their families in the WI and are unlikely to relocate as their family commitments continue. P6 had an elderly mother to help care for.

Six of the participants trained in the WI and three trained on the mainland (P8, P10 and P14). P8 was drawn to train in [PLACE – CITY] as she had previously worked in a local hospice on the island and was influenced by the charge nurse who recommended training in [PLACE – CITY]. She was also motivated to go to [PLACE – CITY] by a friend who was undertaking teacher training there. P10 saw her training as a means of leaving the WI and P14 would have had to relocate from her home in [PLACE - WI], so chose to train in [PLACE – CITY].

The participants who trained in the WI spoke highly of the education they received in an environment where they were well supported. Several alluded to their nursing skills being 'far superior' to their counterparts on the mainland.

Although most of the participants gained much experience in the urban setting there were several who at the outset of their career pathway had decided that they would like to come back to the WI prior to their retirement. Others were influenced to return by family situations, such as illness or bereavement, and several nurses felt that although they enjoyed working in the urban setting they could not imagine living and working in a city indefinitely, and they always looked forward to spending their holidays in the WI. The strong sense of belonging and an attachment to the WI and an appreciation of rural culture was evident in most accounts and quite a few participants felt that they were drawn back as they felt they were missing out on family life and wanted to be a part of seeing nieces and nephews growing up.

All the participants in Group 2 (returners) advocated that compared to nursing in urban areas, nursing in a rural and remote setting such as the WI was associated with unique competencies that required enhanced skills when providing care across the age continuum. They stated that the scope of practice in the WI tended to be varied and unpredictable, rather than focused on one speciality area and they felt as though they were expected to work with a higher degree of independence with limited or often delayed access to resources. Several suggested that continuous education was key to maintaining a wide knowledge base and fulfilling the role of a rural and remote nurse.

Overall, the theme that appeared to negatively impact greatly upon the participants in Group 2 was the distinct lack of anonymity. The high degree of community visibility that they perceived and the unique interconnectedness between their personal and professional lives led to a blurring of their roles. Challenges with a lack of anonymity and privacy also extended to relationships with colleagues as well as patients and the wider community. This affected some participants to such an extent that they felt that they no longer enjoyed socialising.

All the participants had experienced working in both urban and rural and remote settings and their interview narratives were replete with statements about their perceptions of their practice within the context of their work over time. In general, whilst considering place, the participants seemed to find it easier and

less challenging to work in the city, mainly due to having all the resources and support required and at the same time being largely anonymous and disconnected as they nursed people that they would be likely never to see again. Conversely, when nursing in the WI they often felt overwhelmed as though they were living 'in a goldfish bowl' as they encountered their patients at every juncture of their professional and personal life.

This concept is illustrated in P8's account of being passionate about A&E nursing in [PLACE – CITY] but being reticent to work in A&E in the WI as she felt it would be overpowering and too challenging to look after people that she was closely connected to.

Interview accounts highlighted that inherent in the uniqueness of rural professional and geographically induced isolation were the notions of being distanced from some aspect of the profession, either from peers, larger centres, technology, or education. Several participants described their frustration with poor internet connections which prevented them from engaging with colleagues in other centres and became a barrier to participation in online continuous professional development opportunities. There was a strong interplay with the challenges of professional and geographical isolation, the need to have a wide knowledge base to cope with the scope, variability and unpredictability of clinical practice, and the ability to demonstrate a high degree of resilience. Several participants in Group 2 (returners) asserted that much of the delivery of healthcare in the WI depended on a level of goodwill, and that the need for all personnel to work closely together was paramount as the service was too remote, small, and fragile not to.

GROUP 3: 'LEAVERS'
NURSES BORN IN THE WESTERN ISLES (WI) OR MAINLAND –
TRAINED/WORKED IN WI – LEFT TO WORK ON MAINLAND – REMAINED ON
MAINLAND (n=5)

Person/al Dimensions: GROUP 3: 'LEAVERS'

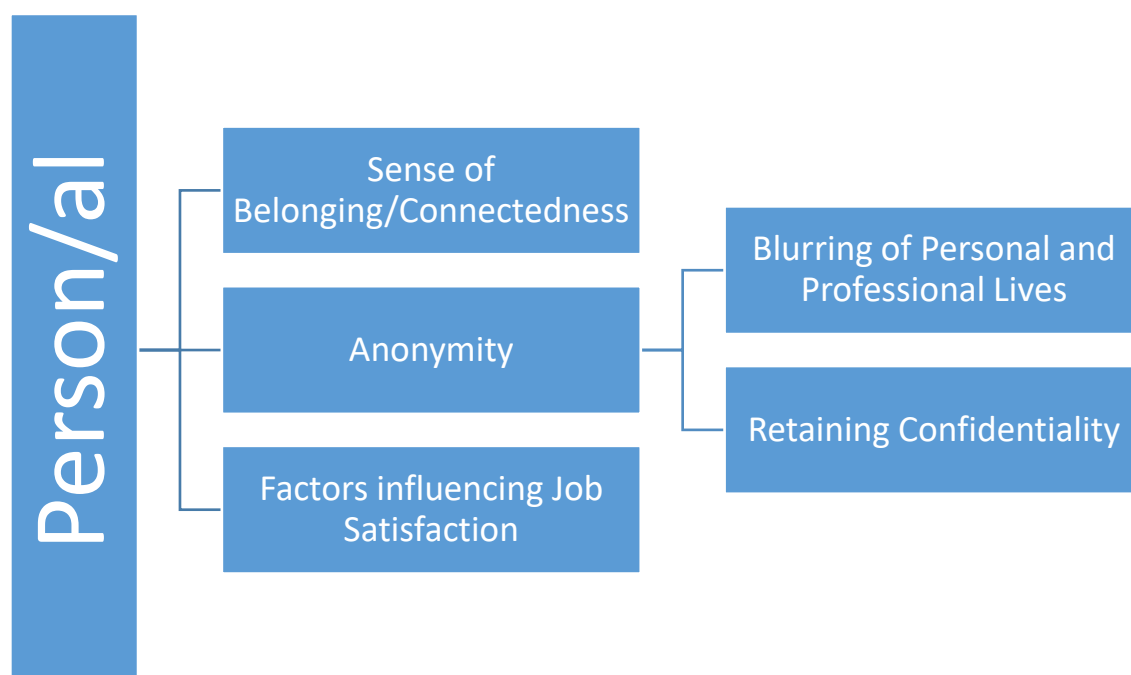


Figure 11: Visual schemata of person/al themes and sub themes – Group 3

Sense of belonging/connectedness

Four of the participants in Group 3 felt a profound sense of belonging to the WI (P15, P16, P17, P18) and highlighted that although now working in an urban setting they still considered the WI as their home:

The island means a lot to me. It's where I've been brought up. It's still my home and I think it will always be my home. I think it's such a unique environment. In my opinion there's no place like it. (P15)

P18 expressed how she felt so much more at ease and relaxed in the WI:

I absolutely love the island. I am a total home bird, and I am very passionate about it, and I love it very, very much. it's difficult to explain. If I was trying to explain it to someone who wasn't from here. There's just such a sense of being home and such a sense of

belonging there and knowing, I don't know, I just feel so much more at ease there. (P18)

Similar feelings of a sense of belonging to the WI were alluded to as P17 described the close-knit community setting where friendships are more meaningful, and people understand each other and look out for each other. This sense of community cohesiveness gave P17 a sense of security:

Most of my immediate family and my grandparents and my parents are still in the Western Isles. I don't think there's anywhere else like it in the world. The friendships you've made from your home life and school are totally different to friendships I have made say when I'm older, that I've moved away now. They are not the same quality of friendships. When you're from the same small-town people just understand everything you go through a bit better, and I think it's just a different type of quality of relationships you get from a small place.

You just have a familiar security with knowing that these people know who you are, they know your people, and the kind of people who look out for you without realising they're looking out for you. So that was a nice security to know that people sort of know where you live, should anything happen to you. So, it was good like that. (P17)

Although P16 had left the WI many years ago, and was now settled and married on the mainland, the sense of belonging and strong connection to the WI was still evident within her interview as she described feelings of *Cianalas*, and how she enjoyed rekindling her links to home whenever she encountered patients who were also from the WI:

I have made a circle of friends since I moved to [PLACE – CITY] and settled down and eventually found my husband and we got married 5 years ago and we are very happy. I still call the Island of Lewis home, although I've got 2 homes now. This is always home, and I think it always will be. It's where I'm from, and you know most people or you know something about them and they are special to you, or they've seen you grow up. It's a totally different way of life. It's just a feeling of belonging and belonging somewhere, and no matter where

you go in the world, if you are from there, you have a connection.

(P16)

If somebody comes into the ward that you know, or if somebody from Lewis is in, because people from Lewis have moved all over, and 'Oh, there's a girl that works here from Lewis, come and speak to her' and they want you to speak to them and to hear the accent and it's that wee link to home again' (P16)

To overcome feelings of isolation, whilst working in the city, several of the participants in Group 3 (leavers) drew comfort from knowing that there were people also originally from the WI close by. Even if these people were just acquaintances and not close friends it was reassuring for them:

I definitely had a feeling of isolation at times. I think what was good was knowing that [NAME] was just a bus ride away and I also had a friend who trained at the same time as I did my training at home, and she was doing her midwifery in [PLACE – CITY], so knowing that both of them were within like an hour away from me was nice to know.

I think that relates back to, you know, people from the island, once you know someone's close by you've already got that connection. And that makes it so much easier even if you didn't really know them.
(P18)

The career trajectory of P19 was largely influenced by family attachments and needs. Although P19 was the only nurse in Group 3 who was not born in the WI, her husband was a native of the WI, so she decided to train there. After qualifying, P19 felt motivated to leave the WI as her youngest daughter was unhappy at the local school. P19 was also missing her older children and grandchildren:

When I qualified there were two reasons I chose to go away. One was because my youngest daughter at that time had said she wanted to leave the school because she had been bullied at school. I had grandchildren by this time as my older children had all started

producing babies and I wanted to be around them, and they all lived around the Highlands. (P19)

Originating from the mainland, P19 was not deeply rooted to the WI so her sense of belonging was not as strong as the other nurses in Group 3. This made it easier for her to leave the WI and at the time of interview she had no plans to return. The sense of belonging was more evident in the interview accounts of P15, P17 and P18 as they fully intended to return to the WI after gaining some experience and further training on the mainland. P16 described how she had '*two homes now*' and although settled on the mainland her sense of belonging was still firmly deviated to the WI.

P16 reflected on her nursing experiences in the WI and how having that sense of connectedness and in-depth knowledge of the patient and their family could be a barrier but could also be beneficial at times and enhance their care delivery:

Sometimes it was a barrier and sometimes it wasn't. It helped. I think that the patient and families felt if they knew you, or they knew of you and they knew how you were or how your family were, then that would give you that closer connection with the patient. (P16)

Anonymity

The challenges of anonymity experienced by the participants in Group 3 when working in the WI were evident in the following interview accounts. Some felt that the lack of anonymity, due to being in a close-knit environment where everybody knew each other, resulted in them facing potential issues with retaining confidentiality:

On the island, because we are in such a small environment when someone gets sick then other people hear. I remember being in the supermarket and someone saying they heard so and so is in hospital, and obviously I couldn't say anything. And I just had to say, I'm really sorry I can't tell you anything. (P15)

Several participants believed that knowing and being familiar with patients and their families enhanced effective care delivery and nursing practice:

I think that living in a small community sometimes you know things that might help you do things a little bit better. When you are talking to somebody you can talk about things that you know that they would know about and it would help you. When they're not well they can't always converse with you but you would be able to speak to them, and it did help a bit that you had a wee bit of knowledge of the family situation and you could ask about their brother or their sister or niece or things like that. (P16)

Some participants spoke of the anonymity associated with being in a city and compared how different that was to the WI. They alluded to feelings of isolation and disconnection from people and place which interplayed with a diminished sense of belonging in the urban setting:

When I moved away it was different, very different, being anonymous, you know, like I would walk through a street and you wouldn't know anybody, You wouldn't expect to see anybody and it's a shock if you see somebody you know. When I used to be at home, you would know everybody and you would stop and speak to everybody and then you move away and you are totally anonymous. (P16)

Blurring of personal and professional lives

Some participants, whilst working in the WI, experienced a high degree of anxiety which they attributed to their in-depth knowledge of patients and their family situations. This made it difficult to separate professional experiences when encountering patients in a personal capacity in the community setting. The blurring of personal and professional lives and feelings of a lack of anonymity influenced the participants on an individual level and also affected their relationships with patients in the wider community setting:

You're so involved in personal situations and in families that you feel like when you see them again, it's all you can think about. And you do feel that you know a lot about people on the island that you wouldn't necessarily know about before, and it can have a lot of anxieties that rest on your shoulders knowing what's going on with

everybody in your community's life, without wanting to know it. It's part of your professional job. You just have to put on your professional head and try and remove yourself from that situation when you are not in your uniform. I think your uniform can bring you a lot of security and you have a sort of different persona when you have that on, and when you take it off you have to just also take off what you know about these people. (P17)

Generally, the participants in Group 3 (leavers) found it easier to work in the urban setting where they had no prior knowledge of their patient's background or family situation and were unlikely to encounter their patients out with the workplace. The following account highlighted how it is less challenging to maintain personal and professional boundaries in the city compared to the WI and how being anonymous had both positive and negative connotations and implications:

Whereas in [PLACE – CITY] I don't have to deal with that, you know, because there's so many people you see day by day. You don't know them and you don't know where they're from or anything. I personally find it easier, yes, I do. In a way it was nice knowing a bit about the patient and knowing their family, but then again it can be nice meeting a patient on the mainland, helping them get what they need and just looking after them without knowing the family. I can go to the supermarket and do my food shopping and I'm not going to bump in to anyone and I'm not going to have someone coming up to me and asking how their mother is or how their relative is, compared to Stornoway, so in that aspect, I enjoy living in a city sometimes, just because I can do my shifts, do my shopping in peace, and not having anyone coming up to me and asking how their loved one is. (P15)

P16 drew on what she learned throughout her training in the WI to equip her with how to deal with maintaining personal and professional boundaries in the WI, and she acknowledged the difficulties that some may have when looking after relatives or friends:

Some people when they haven't dealt with that, they find it a bit difficult. How you could step away. And if a patient came in, they would say 'Oh I can't look after them because I know their mum', or something like that, but it didn't affect me, you know, because I had been taught that way, and that's what you did, and you knew where the border was. And you were not to step over, you know, sort of thing. (P16)

Nursing students were required to undertake a management placement in their final year which afforded them the opportunity to become more independent and autonomous in their practice and enhance their leadership, management and decision-making skills. P19's choice of management placement was influenced by her friendship with a prospective mentor. To avoid the challenges of personal and professional role blurring and feelings of awkwardness that her mentor was also her friend, P19 opted for a placement in community rather than theatre which would have been her first choice:

My management was also in community. It wasn't my first choice but it was what I ended up with. And I enjoyed it, but in retrospect I think I may have enjoyed theatres, but I got on well with [NAME] so much that I felt that, well this isn't fair on [NAME] but I was worried that she would be prejudiced for me, and I would be getting passed because she liked me as opposed to my own hard work. (P19)

P17 experienced a lack of personal and professional privacy from colleagues as her mother was also a nurse. Her decision to leave the WI to gain some experience in an urban setting was influenced by always being known as her mothers' daughter. She sought to increase her autonomy and individuality to be empowered to return to the WI in the future:

I think another challenge I faced was that obviously my mum was a nurse. I always had the fear that I would be in her shadow almost. You're never known as your own person. I didn't want to be introduced as 'Oh, that's [NAME]'s daughter'. I think that was a challenge initially because I didn't want to be known as my mothers' daughter, but I wanted to be known for my independence and known

as a good nurse because I was a good nurse and not just because I was my mum's daughter. (P17)

Although in the previous quotation P17 related to a lack of anonymity and privacy from colleagues in the WI as having a negative impact, in the following extract P17 spoke of feeling personally isolated from colleagues in the urban setting and craving for the close bond and familiarity experienced in the WI:

In the city you never really get to have that chance to get to know people out with the work environment. And I never think that you have that same sort of bond at work that you do, sometimes necessarily when you are familiar with what's going on in peoples' lives and personal lives, and you can sort of know why people are in a happy mood or maybe not so happy that day, and you can support them in a different way. But here in the city, everyone just gets on with it and no one asks any questions and I think that's really difficult when you might need a shoulder to cry on, per se, but no one really knows, because they don't really know you. I think that makes such a difference when you work with a group of people that know you and can support you. Yeah, it's just very different working in a place that you don't have that same bond with people. (P17)

Retaining confidentiality

Tensions around retaining confidentiality were evident in the following extracts. A sense of kinship and familiarity with patients exemplified these tensions and made the participants in Group 3 more aware of the challenges of retaining confidentiality in the WI:

Because you knew the family, and confidentiality is a big thing when you are dealing with people in a small area, you really must be aware and not, you know, disclose. (P16)

You always have that fear that when you are in a small place that you are going to know the patient, and if you don't know the patient, you know the patients' family. And that can make it quite difficult for obviously confidentiality reasons. Seeing patients out with the clinical environment or even families of patients out with the clinical

environment, it can be quite challenging. Knowing what to say, when you know too much about a certain situation, knowing the right thing to sort of say without letting anything that you're not meant to be saying out of the bag really. I find it challenging when it's almost like a big elephant in the room, that you know what's going on, but you're not really meant to speak about it. Yes, you are faced with a lot of confidentiality issues I think in the Western Isles, but obviously you know the rules not to speak about these things. (P17)

Quite often, as P17 indicated, patients in the WI also had an extensive knowledge of the nurses' personal lives which created further tension and challenges around retaining confidentiality. For example, P15 shared that she regularly had to have conversations with patients to explain why it was not appropriate to grant their wishes to inform her father, a public figure, that they were requesting him to visit them in hospital:

And my dad is also a public figure in the community, and I've been looking after a patient, and I've had someone say to me 'Oh can you tell your father to come in and visit me'. And I've had to say a few times, you know, I really will not be allowed to do that because of confidentiality. (P15)

Factors influencing job satisfaction

All the participants in Group 3 (leavers) enjoyed caring for patients when working in the WI and felt that they received more support and encouragement than in the urban setting. A lack of anonymity and sense of belonging and kinship in the WI had a positive influence on their morale and wellbeing:

I really enjoyed working in the place I was born and brought up in, and those within the hospital, whether they knew me or not, they were very supportive, and I think those that did know me there was almost like more of an encouragement. Maybe just when you're needing an extra boost or something or for someone to tell you it's fine and you are doing ok, things like that. (P17)

Most participants favoured working in the WI and being able to spend more time with the patients was another factor that influenced job satisfaction:

I actually preferred it. I prefer the countryside and I found that you got to spend a lot more time with the patients and I thought that was really nice. (P15)

Several participants alluded to how they felt challenged with how busy the city hospitals were and how they found it difficult to adapt to having time constraints which affected delivery of care. Comparisons were made to the nature of the work in the city whereby participants were dissatisfied and pressurised with the high turnover rate, as opposed to the less fast paced work in the WI conducive to having more time to deliver effective, individualised care:

It's very, very fast paced to what I was used to at home. There's such a high turnover. It's constant. Sometimes someone's in and they're just wanting a bed. Sometimes I feel it's not about the patient, it's about the bed. I found that quite difficult because I know up in Stornoway there is not that much pressure to get someone out as quickly as possible. It's even difficult, like small things, like someone going home you would let them have their lunch first before they would go home in the afternoon, whereas in [PLACE – CITY] it's such a fast pace, they are just in and out. In a way I wish they didn't have to do that. I wish I could spend more time with the patients. (P15)

Professional Dimensions – GROUP 3: ‘LEAVERS’

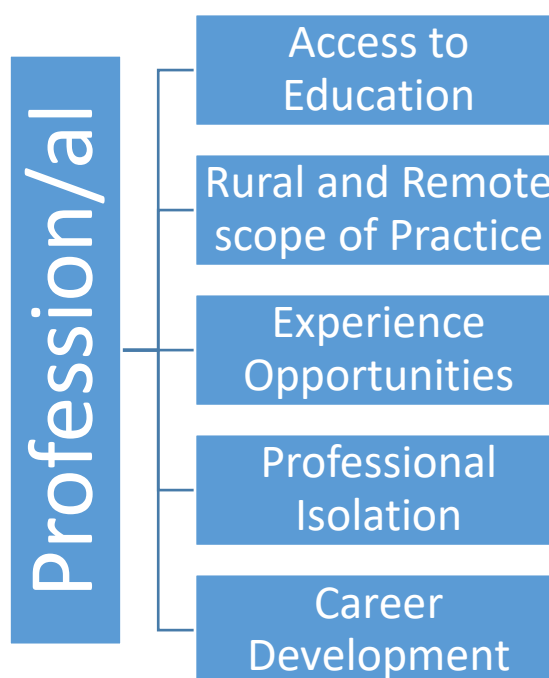


Figure 12: Visual schemata of professional/al themes – Group 3

Access to Education

One of the participants in Group 3 engaged in a pre-nursing scholarship scheme. This scheme supported school pupils' transition to undergraduate programmes in rural and remote areas. By attending university lectures, clinical skills and observational placements in hospital or community settings, with the support of a 3rd year student (buddy) and effective mentorship, this scheme helped school leavers decide if nursing was appropriate for them. The experience gained by P15 on this scheme had a positive influence on her decision to remain in the WI for her training:

When I was in 6th year, we were offered a pre-nursing scholarship, and they did that through the University of Stirling at the Stornoway Campus. It was quite funny because actually I was desperate to move away, and then I kind of thought about it long and hard and I just kind of compared. I spoke to other people who had done their training in Stornoway and they said, you know, it's really good. You have got smaller classes and you will be so much better supported

than you would be on the mainland. And I just thought about it, and I thought also I would be saving money staying at home. (P15)

All the participants in Group 3 appreciated having a small class and approachable lecturers in the WI in comparison to having less support in the urban setting:

The small class and the lecturers were very good, they gave you a lot of support, and if you had any problems with your essays, then they would go over it with you and give you pointers on how to improve it. Students in [PLACE – CITY] say that their lecture hall would maybe have 200 people in it. And they say you'd be scared to ask a question because there are so many people there and your lecturer wouldn't know you. You would just be a number to them. (P15)

The Uni side of it as well at WI was absolutely fantastic. There was so much support, like at any time, and just the campus there with it being in the hospital, I think it allowed us to take ownership of our own training. We could just go in at any time and work. I really, really enjoyed it. (P18)

Several participants also described the benefits of training in the WI in terms of feeling part of a team and enjoying staying at home with their parents which also was a financial incentive:

I realised the great joy of being able to stay with your mum and dad and have all your cooking done for you! It was definitely a good decision for me to stay and train in the Western Isles rather than going away to the mainland. (P17)

Rural and remote scope of practice

P16 described how in the WI it was necessary to have a broader skill set and knowledge base to cope with the scope, variety and unpredictability of rural and remote practice. The vast experience she gained in the medical ward looking after patients with many different conditions benefitted her when she left to work in intensive care in the urban setting:

You really had to have a broad knowledge base in medical, WIH, because it's not one specialised area. You had to know a bit about the cardiac system, respiratory system, what was going on and some different things that would come in and you'd have to maybe try and, 'Oh I remember this happened before and what you'd have to do'. And it does take time before you know what's what and you need to do a bit of studying and get to see all the different things and you get to know what's coming in. So you do need to have a broader knowledge than maybe if you were in one specific area. In a big city normally they would have a respiratory ward, different kinds of medical wards that just concentrate on respiratory or whatever, cardiac or things like that so you have to have a bit of everything. And that really helped when I went on to work in intensive care because that was the background, all the basis was there, so I just had to learn the finite things that I had to do. (P16)

Experience opportunities

The participants in Group 3 spoke of having excellent experience opportunities in the WI and how they felt they were given more responsibility:

And I also worked in A&E in WI and I loved that. That was excellent. A fantastic experience. Really good. It's just got 4 beds there. You felt a part of the team. You were given your own patients, and you were expected to do everything yourself. There was support near you, but you were given a lot more responsibility. It was good because you got to work with the doctors, and obviously as you know you've got the 4 hours to get them to another ward. I don't think I would ever work in A&E on the mainland. Never! Never! I think the difference is it's so vast. Because I feel that on the mainland you may see it on the news, and it's so busy, and the waiting times are so long, you have people waiting in the corridors. (P15)

Several participants decided to leave the WI to gain more experience and to enable future career progression:

I really wanted to gain experience because I knew if I stayed at home, if I was fortunate enough to get a job, I think I would find it very difficult to progress in my career, and I knew I always had an interest to specialise in cardiology, and I know that at home I wouldn't have gained that experience (P15)

Two participants attended a 'jobs fair' in [PLACE – CITY] after qualifying (P17, P18). They had a preference to remain within Scotland to gain more experience but the availability for engaging in a rotational programme was in [PLACE – CITY]:

I applied for a rotation programme that started a few weeks after I qualified in [PLACE – CITY]. So that's where I am now. There's such a wide range of experience in such a short space of time, which is something that I don't think I was seeing advertised anywhere in Scotland, to be able to have that no strings attached 6 months jobs. So that's what I wanted to do, so I wasn't just in one area like cardiology, I was in a cardiology ward then I was in a medical ward, then I was in the community, so it was a very varied experience. It was very challenging initially in the sense that it is very advanced. I was used to everything on paper in the Western Isles as a student and then when you come down here everything is electronic. (P17)

As P17 and P18 adapted to living and working in [PLACE – CITY], portrayed by P17 as a *big and diverse place*, they described their experiences in terms of *cultural and social challenges* (P18).

P18 found her experiences in [PLACE – CITY] overwhelming at times but knew it was only for one year. At the time of interview, she was undertaking a further degree and hoped to return to the WI to work:

[PLACE – CITY] was stressful, and totally different to anything I'd ever experienced in the Western Isles. So, the types of injuries and patients coming in were massive. That was my plan, once I'd finished in [PLACE – CITY] to do a further degree, which is what I am doing just now. (P18)

Professional isolation

Whilst working in the community setting in the WI P15 reflected on the importance of being aware of having limited resources and the need to act quickly in an emergency to summon help when both professionally and geographically isolated. There was a sense of teamwork and community cohesion:

Because it was so rural if an emergency were to occur, you don't have resources near you. And you have to act fast on your feet, definitely, I mean we were going to a patients' house and all their doors were locked and we couldn't get access to the house. It was discovered he had taken a hypo and, of course we had to phone the fire brigade and the ambulance. But it was interesting because everyone kind of worked together and managed to get this patient to the hospital. So, it's these kinds of scenarios where everyone works together. (P15)

Career Development

Following her training in the WI, and undertaking placements in [PLACE – CITY], P16 would have liked to remain there but she was unable to find employment. This informed her decision to return to the WI:

So, I couldn't get a job so I had to come home. I loved [PLACE – CITY], I really did. I really wanted to stay there but at that time there weren't many jobs going (P16)

On return to the WI P16 had difficulty in securing a permanent post and had to rely on bank shifts and home care nursing before commencing work in the hospital. Her decision to leave the WI, after much experience gained in medical nursing, was influenced by an inability to progress in her career and no prospect of promotion. The following account described how her family attachments and sense of belonging to the WI made this decision more difficult:

I was seven years at home, and I was still a D grade and there was no scope for getting promotion. You had to wait for somebody to retire. Because once you got a job, you know, people who are living

here, they stay, so there wasn't much scope for getting further up the career ladder. I loved my job, and it was quite hard to make the decision to go and leave my mum and dad, family was quite a pull, but I felt apart from my work I didn't have another kind of life going on. It was quite difficult too as all my friends that I had made here, they'd all settled down, got family and when family comes along you don't get to see them as much. I just felt I needed a change and I needed to further my career. (P16)

The two participants who undertook the rotational programme in [PLACE – CITY] (P17, P18) both intended to return to the WI. They appreciated that they were gaining experience in a big teaching hospital, but looked on it almost as a means to an end, as they were newly qualified and had found it difficult to get a job elsewhere:

We had wanted to work in Scotland and applied to [PLACE – CITY], but none of us got jobs there, and basically their reasoning was that because we were newly qualified, we were too inexperienced and there were no jobs available for us. But at the Job's Fair, we were writing the application forms for [PLACE – CITY] who approached us and said, why don't you do one for us as well. So I thought 'What is there to lose'. So, I applied and interviewed, and they offered me a job there and then. (P18)

After gaining their experience in the city both participants (P17, P18) felt a sense of satisfaction and achievement and looked forward to returning to the WI:

Yeah, I have made plans now to make these my last 6 months in A&E and I hope to move home. So now knowing that, I think it's quite good because I always knew I didn't want to move away for ever, I just wanted to move away for a different type of experience and I feel that, I've done my time, I've done what I came to do, and that's quite a nice sense of achievement. And I'm proud to want to go back and want to go back to the Western Isles itself because that's where I'm

from. I always knew that I would eventually like to go back, and I now feel that I can. (P18)

A future career in midwifery appealed to P17 and P18 and they both advocated studying and working in the WI within a close-knit community setting:

I think it would be a good opportunity to become dual trained (midwifery) and be able to sort of choose what I want to do in that sense. I am not sure necessarily if I want to do that for ever, but at least it would be a good opportunity to at least have the option. And be able to move home and study at home again, because I think that sort of worked well the first time, and I will quite enjoy doing the same kind of work in a totally different field, but within the same sort of small, close-knit community. So yeah, that's hopefully what I hope to do when I move home. (P17)

What I would really like is to have a job in Lewis as a midwife. Obviously with the current climate and the way things are, there's pretty much like a shortage of midwives all over the Highlands and Islands, and with the course we signed the contract saying that we would apply for jobs within the Highlands and Islands, and essentially if there's a job going, or if there is one at home, we would have to apply for that. So I am hoping, fingers and toes are crossed, that by the time I graduate that there will be jobs going at home. (P18)

P18 reflected on the difference between career progression in the city as opposed to the WI and stated that if she had decided to stay in [PLACE – CITY] for another year she would likely be promoted to a charge nurses' post:

I never got into nursing as a career driven thing, but certainly in bigger areas it is far easier for you to climb the bands if you so wish, than it is at home. Like I think at home you have to be very, very qualified, you know, you have to have been working for years and you have to have been there for a long time, but actually, if I had stayed there another year, I could have become a sister in the ward in [PLACE – CITY], which is bonkers!, cos I don't think I could ever do that! (P18)

The afore mentioned quotation described the perception that working in the urban setting appeared to accelerate career progression whereas conversely career progression was limited in the WI despite nurses having years of experience.

In the future P15 also hoped to return to the WI but emphasised that she felt unsure if a job would be available. She asserted that it seemed unfair that nurses in the WI were retiring and then returning to take up bank shifts:

Jobs don't come up very easily. Often you see that people are retiring and then they are coming back on bank shifts. It's not fair, and it is influencing recruitment and retention. (P15)

P19 decided to go abroad and was unsure whether she would return to nursing. Although her husband was from the WI and she trained and worked there, she had no intention to return to the WI:

We are in a very rural area here in [PLACE – OVERSEAS]. There are a few hospitals in the area but I think if I was going to do nursing in [PLACE – OVERSEAS], I would probably be doing more like district nursing, the usual sort of diabetic ulcers and that type of thing because I think there's an older population. I am running self-catering next door as well and you know, it's not all about nursing, but obviously it is an incredible waste, and I will feel very sad as it has been a lot of investment, but we'll see, we'll see how it all goes. (P19)

Place Related Dimensions – GROUP 3: ‘LEAVERS’

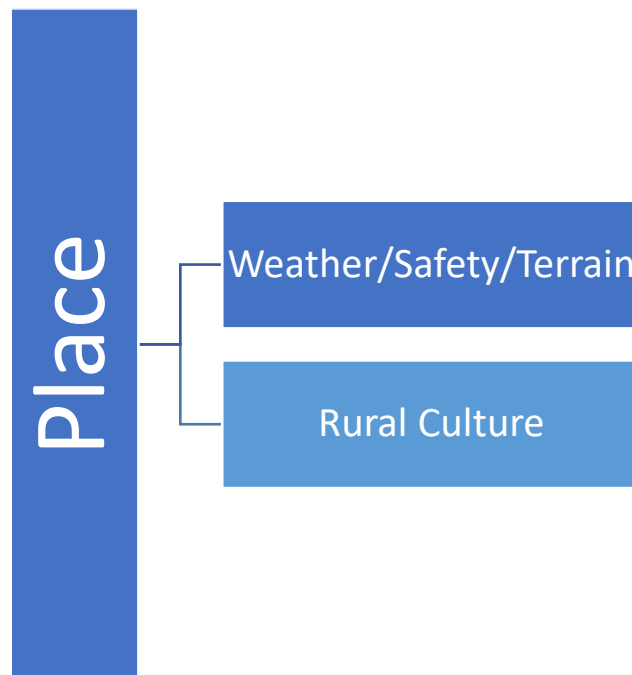


Figure 13: Visual schemata of place related themes – Group 3

Several participants in Group 3 (leavers) described the beauty of the landscape of the WI. When working in [PLACE – CITY] P17 felt quite despondent as she sensed that nobody knew or appreciated where the WI were or what it was like to live there:

It's hard because when I initially introduce myself it doesn't take them long to realise that I'm not from the area. When you say you're Scottish you usually do get quite a good response, but I get so disheartened because nobody has even heard of the Western Isles. You feel like you are from a different planet sometimes because nobody understands quite the length you've gone to to sort of get where you are today. When people are like asking you if you go home often, I have to say no because it's so hard to get home, and they can't make sense of it all. People don't quite realise, and you can't quite understand why, because we feel like the Western Isles is at the centre of the universe, but it's really just at the centre of your universe. Nobody in [PLACE – CITY] has really heard of it and it's really quite disheartening at times because you feel like no one knows what they are missing out on!

You do get a warm reception when you try to tell them it's the most beautiful place in the world, but they don't seem to believe you!!

(P17)

Weather/terrain/safety

P19 had a deep appreciation of the WI and the beautiful beaches and scenery but felt frightened at times due to adverse weather conditions and unsafe roads:

I love it. I do a lot of sailing. I love the scenery and I love the beaches. I found the winter and the travelling challenging. I was scared on a number of occasions when the roads weren't gritted in the morning. That frightened me. (P19)

Rural culture

Within her interview account P16 described her affinity for the rural culture in the WI encapsulated in a sense of belonging, kinship, and her upbringing which was based on religion and faith:

Just the culture, you know, and the family and just my upbringing really, I was brought up here respecting people and the religious sort of aspect of it, and that has continued with me, you know the faith and you know that's quite important wherever you are, but you still have the basis of it here. It's where I'm from, and it's home and you know most people or you know something about them, or they've seen you grow up and they're special to you. It's a totally different way of life. And people away [on mainland], they look at the scenery and things like that, but it's not just about lovely beaches. It's family and people look out for you and wherever you go, 'Oh, you're from there [WI]' I don't know how to explain it really. It's just a feeling of belonging and belonging somewhere, and no matter where you go in the world, if you are from the WI, you have a connection. (P16)

Although not originally from the island, P19 studied the Gaelic language to degree level prior to her nursing qualification and found it beneficial when communicating with patients both in the WI and in several city hospitals:

The Gaelic degree was a real doorway into meeting some wonderful, interesting people and it was fantastic as I was able to speak Gaelic to older people.

In the hospital and even in [PLACE – CITY] where there was a lady who came to us from the highlands and she was terrified coming for a cardiac operation, and I said to her ‘Do you have Gaelic?’, and she said ‘Oh, yes’, so we just started to speak in Gaelic and she said that she hadn’t spoken her native language for about 60 years. So, she was just overjoyed. (P19)

Summary – GROUP 3 (Leavers)

Group 3 consisted of five participants, four of which were born in the WI (P15, P16, P17, P18) and one who came to the WI to train and work for a time (P19).

Although all working on the mainland the interview accounts of the participants who had their origins in the WI all pointed to a profound sense of belonging and connection to the WI and their family. P15, P17 and P18 were young newly qualified nurses who hoped to return to the WI following gaining more experience in the urban setting. They alluded to being ‘*home birds*’ and missing the WI where they felt more supported and at ease and spoke of feeling a deep sense of personal and professional disconnection and a sense of isolation in the city.

P19’s decision to leave the WI was largely due to family attachments and needs and due to her youngest daughter being unhappy in the local school and having older children on the mainland that she was missing.

Despite being settled on the mainland for many years P16 still looked on the WI as her home. Although she alluded to the notion of home as plural, having one home in the WI and one home on the mainland, she still had a sense of longing and feelings of *Cianalas* for the WI. All the nurses who were born in the WI appreciated any link to home such as meeting a patient in the city who was also from the WI, or gaining comfort from knowing that there was a friend from the WI, or even an acquaintance that they probably didn’t know that well, nearby that they could contact if needed.

Another dominant theme was the lack of anonymity in the WI which often interlinked with issues around retaining confidentiality. The interview accounts were replete with comparisons between the WI and mainland nursing and how it was easier to look after patients in the city where nurses were anonymous and unlikely to meet the patients in a social context. Although challenged in the WI with a lack of anonymity the nurses did feel that in many cases it was an advantage to have a prior knowledge of the patient and their family situation. Some were also challenged with privacy issues amongst colleagues as well as patients and the wider community.

All the participants in Group 3 (leavers) spoke highly of the training they undertook in the WI and how they felt well supported in a smaller class with approachable tutors. P17 and P18 hoped to undertake midwifery studies in the future with view to gaining posts in the WI and looked forward to further training in the UHI in a rural and remote setting.

Experience and employment issues featured as a major theme within the interviews and informed the nurses' decisions to leave the WI. The somewhat ad hoc nature of career employment, opportunities and progression had a detrimental effect on many of the participants. P16 decided to leave the WI after working more than seven years in the hospital, as there were no prospects of career progression or promotion. After qualification P15, P17 and P18 felt that there were no job prospects in the WI. P17 and P18 attended a jobs fair in [PLACE – CITY] and would have preferred to work in the Highlands of Scotland but they were not accepted as they had no experience. The major hospitals in [PLACE – CITY] offered rotational posts which the nurses were glad to accept although they seemed to look upon their time in [PLACE – CITY] just as a means to an end, and a steppingstone, to being able to fulfil their desire to return to the WI for future employment. While hopeful, they were not overly confident, that there would be jobs available in the WI in the future and they felt that it was unfair that nurses retired and then returned to work on the 'bank' which had a detrimental effect on recruitment.

GROUP 4: 'INCOMERS'

NURSES BORN ON MAINLAND – TRAINED/WORKED ON MAINLAND – CAME TO
WORK/TRAIN IN THE WI ($n=6$)

Person/al Dimensions – GROUP 4: 'INCOMERS'

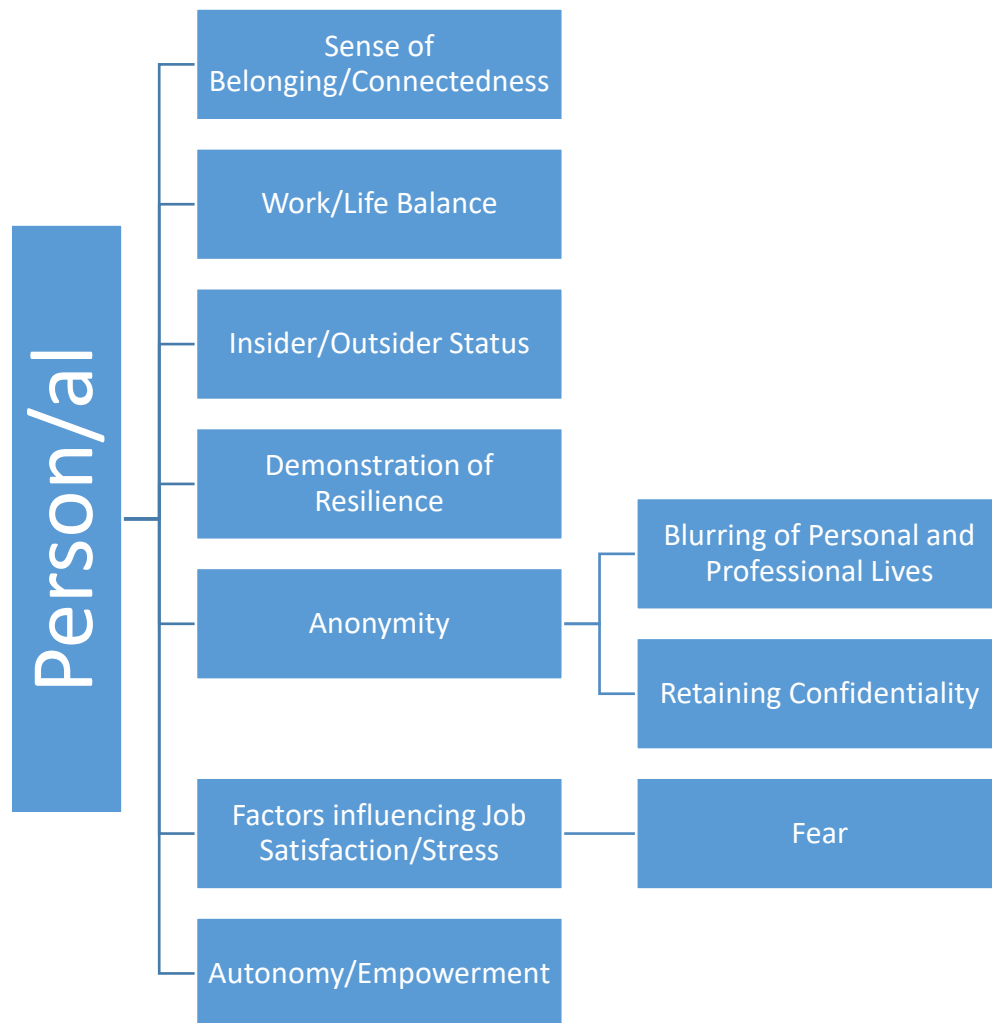


Figure 14: Visual schemata of person/al themes and sub themes – Group 4

Sense of belonging/connectedness

All the participants in Group 4 (incomers) were attracted to the beauty of the landscape of the WI. Four of the participants in this group had affinal kinship links to the WI (P20, P22, P23 and P25). These links fostered a sense of belonging and enhanced feelings of connectedness to the WI.

P25 met her partner, who was from the WI, and decided to move to the WI to undertake her nurse training there. Although the relationship ended, she chose to stay in the WI. Her sense of belonging and attachment was mainly towards her place of birth in the city, but she indicated that she now had *two homes* and her motivation for staying in the WI was largely influenced by the connection and job fulfilment she experienced within the community nursing team:

I love [PLACE – CITY], and I still call it my home. Although this is also my home, because [PLACE – CITY] was where I was born and I am so familiar with it, and comfortable with it.

But now WI is my home because I have a house here, and my job's here. So, I kind of have two homes. If somebody said, 'Where are you from?' I would first of all say [PLACE – CITY] and I always do. I have been on the island for 13 years and I do really love the island, but if I was being totally honest, the one thing that is keeping me here is the job, I really love the job. When I go back to [PLACE – CITY], I do think 'I don't think I could live here in [PLACE – CITY]', so I am always pulled, you know, I get that feeling that I'm looking forward to getting on the plane to go back! (P25)

P23 had a connection to the WI as it was her husbands' birthplace and she had enjoyed holidays there. She also had a desire to experience nursing in a remote place where access to the multi-disciplinary team (MDT) was limited:

I chose to go to the WI, in the Outer Hebrides, as my husband is from there, because we used to go to remote Scottish islands on holiday, and I wanted to see what nursing was like there when you haven't got all the members of the MDT there as you have in the city hospitals. (P23)

Work/Life balance

Several participants made the decision to move to the WI to achieve a more manageable work/life balance. The appeal of rural and remote living was evident as participants spoke of redefining lifestyle and refocusing priorities.

Despite P21 having enjoyed and being motivated in her work in the city, she found it very demanding and felt that it would not have been easy to continue working there as she now had a young family. This also informed her decision to come to the WI. She did miss nursing in the city, but her family needs took precedence. Her mother also moved to the WI to help with childcare:

[NAME] hospital was very stressful, the decisions that you made, everything, and the pressure that was put on you was immense. But don't get me wrong, I loved it and I absolutely thrived on all that. It kept me on my toes, but I can't imagine working there and having my daughter. I wouldn't be a very good parent because I would be too focused on nursing in [PLACE – CITY]. I couldn't focus on [child's NAME] and focus on [PLACE – CITY]. I wouldn't have been the same nurse that they had before. I really don't think I would have been.

My mum moved up as well. The place is fine, but I just wish that [PLACE – CITY] was here as well, which is completely unrealistic!
(P21)

P24 also experienced childcare issues. The transition to the WI was made a bit easier due to P24's parents also accompanying them to help alleviate childcare issues and challenges:

It's difficult having a family now and trying to juggle it all. So, my parents moved up to the island just after we moved up. Yes, I think that massively helped with the transition. I don't know how I would cope. There are childcare issues. So, it's great that they can help.
(P24)

P21 frequently visited the WI on holidays and decided to buy a house with view to renovating it in the future:

We always would come camping here and really enjoyed it. We bought a house here to renovate. (P21)

Concerns about safety issues when raising a young family in the city influenced P21 to come to the WI and look for employment sooner than originally planned:

We just didn't want to bring the children up where we lived in [PLACE – CITY], not at all. We wanted them to have the kind of childhood we had where they could go outside to play without worrying, you know. That was a really big attraction for coming to the island. (P21)

Insider/outsider status

Several participants in Group 4 (Incomers) expressed their concerns about their status as outsiders in the community in the WI and how this affected their interactions, acceptance, and effectiveness. Three participants (P20, P22, P24) had partners who were from the WI and generally they felt that affinal kinship and family ties were a facilitator for their acceptance in the community. P22 recounted how her husbands' family connections to the WI were of benefit due to the local people remembering him when he was a child. This helped when integrating into the community:

My husband's mother was from up here, so he spent a lot of his childhood on the island. We had had a couple of holidays prior to [NAME] being born and we actually got married up here. We had both been married before and we didn't really want another big wedding, so we just came on holiday and got married and didn't tell anybody! Although my husbands' cousin was there and one of his friends came up as well. It was lovely. So that made a connection to the island. My husband's connection and attachment to the island has been a huge benefit. People remember him as a child, so it has been easier to become integrated and accepted into the community. (P22)

Had it not been for that link to the WI it would have been unlikely that P22 would have moved from the mainland as she did not see what else would have attracted her to come to work in the WI:

It was definitely good that my husband had that link to the island. I don't think we would have moved if we had not had that link. I don't really see why we would have. (P22)

P22 highlighted how difficult it was in the WI to get to know people and to make friends and described how she was grateful that she had young children and

that it was through attending their activities that she met other parents who became friends:

I think when I first moved it was easier to get to know people because I had young children, and that's always easy to make friends. Although I did find, I found it quite different to other places I'd lived in as a lot of people, well obviously were born here, grew up here, had their families here, worked here and had never left. They had their friends, and they didn't need to make new friends, they didn't need to welcome new people because they'd had a big group of friends that they'd always had. I have made some really nice friends here especially through highland dancing which my daughter doesn't do anymore, but that was something. Yeah. (P22)

In one of the more remote locations of the WI P23 experienced difficulties when patients questioned her about her English accent and why she had come to the WI. She felt well received due to her occupation but thought that if she wasn't working in healthcare she would struggle to integrate into the community and would not be accepted:

I think a lot of the older generation, as there weren't a lot of incomers who came to the island, as soon as they hear the English accent they ask 'Oh, why are you here?' So, I think I found that quite difficult at first. I felt like it was quite obvious from my accent that I am not from the WI, and sometimes I wished that I had more of a Scottish accent.

I think, on the whole they are very acceptant, and I think that I am grateful obviously because if I had just gone to the island and I wasn't working I don't think I would have been accepted. But as I have gone there to work, I think that they like that. (P23)

When she came to the WI P24 also experienced much questioning from patients and staff which further compounded her feelings of being an outsider:

You can get into this feeling of you know we're incomers and we're not from the island and they'd maybe ask, 'Why are you up here, that's not a local accent?' (P24)

P24 was working as a community nurse engaged in 'bank' shifts and prior to that had undertaken the 'one year job guarantee' scheme, also working on community. Following her maternity leave, she applied for a community post on several occasions but was unsuccessful. Her interview account highlighted that she wondered if it was because she was an outsider that she was unable to secure a permanent post:

I had just come back from maternity leave, and the community job came up, that I was doing as a one-year guarantee, and unfortunately, I didn't get the position. I do struggle sometimes in thinking is it because, you know, as I had been working on the team, I wondered maybe is it because I'm an outsider almost. (P24)

Demonstration of resilience

P21 felt a degree of admiration for her colleagues in the more remote locations of the WI, when confronted with fewer resources they demonstrated a resilience as they often had no alternative but to use what was available to preserve the life of their patients. In the city P21 recounted that she would have chosen to use a CPAP (Continuous Positive Airway Pressure) machine as a breathing mechanism for a patient with cardiac failure but due to the unavailability of CPAP, a BiPAP (Bi-level Positive Airway Pressure) machine was used instead. P21 suggested that she had to adapt to making do with what was available in the WI:

Another one of the biggest challenges is the resources. As an example, when I went to [PLACE – WI] I was very set, you know I did resus a lot in A&E, and looked after really sick patients, for instance we had to have a patient on continuous CPAP as they were in cardiac failure, but there isn't a CPAP machine at the hospital. There's a BiPAP machine, so they used the BiPAP machine on the patient in cardiac failure, but BiPAP is only really used for respiratory patients. And it's a thin line really because I was like saying 'You can't use BiPAP on a cardiac patient, it doesn't work' and they just turned round to me and said 'Well, what are we meant to use, this is

all we've got' and when I looked at it that way I said 'Oh, yeah, put it on quick!'. So, it is better than not putting it on, it will help them, it just isn't the right way to help them. So, what I find interesting here is that they don't have the resources that I am used to, and they almost make do. But in making do they are still fixing the patient.

So that took me down a peg or two, you know what I mean. So I thought, ok, fine! (P21)

Anonymity

P20 suggested that having a lack of anonymity and a familiarity with patients was unique to the remote and rural setting, and alluded to an appreciation of the visibility and interconnectedness in the community, and found it quite humorous:

Knowing your patients and a lack of anonymity is something very specific to the area. You wouldn't get that in most places. That is very much a rural thing. Like there was an elderly man in the village who had a pair of binoculars and he'd say to me for example 'Your bathroom light was on all night', now, I thought that was hilarious. I love that sort of camaraderie and people looking after each other and the sort of closeness of it. (P20)

To overcome the challenges of a lack of anonymity P22 tried not to care for patients who lived in her own village, especially if there were sensitive issues. She thought that it may be more of an issue for younger colleagues particularly if they had young children themselves:

It can be a challenge looking after people, but I think it's easier for me than perhaps it is for my younger colleagues because my youngest child is now just about to go to high school. I do see it with my colleagues, 'Oh I can't go there, my children go to nursery with them', especially when we know there's going to be difficulties and perhaps some concerns where additional support is going to be required. I tend to not take on babies that are in my local village, because it could be potentially a wee bit awkward because you just never know, you know, although everything looks like it's all lovely

and normal and rosy and happy, you just never know what's going to happen down the line. Yes, so I tend not to in my own village. (P22)

P25 had an expectation that in the remote and rural setting her patients would see her when she was off duty, and she was happy if she met them in the grocery store to discuss their treatment and was always willing to help:

With it being a rural area, I don't really mind if the patients see me when I'm off duty. I think it's good to see people and if people see you as well. Yeah, and sometimes you bump into somebody, and they say, 'Well, actually, I don't think it's maybe healed, it's opened up again. Can you have a quick look?' – In Tesco's! That's alright, if I can help. (P25)

Generally, the participants in Group 4 (Incomers) thought that being visible in the community was quite amusing. There appeared to be a link between a desire to become more accepted in the community as a health care professional and being known and accepted as a person:

My husband thinks it's hilarious anytime we are out in Tesco's or the Coop, he says 'Oh, you know everybody!' People say 'Oh hello, hello!' in a way that if you lived in a city, you would never see. You would very rarely see people. People wouldn't want to say hello to you anyway, whereas here they are more than happy to see you! Oh, it's fine. It doesn't bother me at all. Sometimes I duck! It just depends. With the majority of people, it's nice to say hello and see the wee ones as they grow up. (P22)

Blurring of personal and professional lives

The following account described how P20 assumed that a neighbour who was also her patient had crossed the personal and professional boundary by phoning her at home to cancel an appointment. P20 stressed the importance, and challenges, of maintaining personal and professional boundaries:

I have got patients that are also neighbours. The only difficulty I had was when my actual next-door neighbour was a patient, and I tried to avoid doing anything, you know, having anything to do with her care,

but everybody went off sick, or on holiday all at once, and there was nobody left. So I arranged to go and see her, and the next thing she phones me at my home to cancel it because she's got a hairdressers appointment, and I thought, 'Oh, oh, that's not right'. So I just dropped it in.

You do have to be careful about keeping a professional boundary with people. But, there's people, somebody in the village, who knows [husbands NAME] before they knew me. Oh, that has happened more than once actually and I had another recent one where somebody was a good friend of [husbands NAME] and when he met me said 'Oh, I've always wanted to meet you'. But I am your CPN, I am not here as [husbands NAME] wife. (P20)

Retaining confidentiality

As demonstrated in the following quotation P25, a community nurse, felt challenged by some patients constantly asking for information about other patients that she had visited:

One of the challenges is confidentiality in the rural setting and that's very challenging because some people, they won't let it drop when you say you can't discuss another patient. They want to keep pushing you and they try to trip you up, so that's quite difficult. (P25)

Factors influencing job satisfaction/stress

Drawing on all her previous experience in A&E in the city, P21 reflected on how it could be challenging, due to the abuse received from patients, but it stood her in good stead for nursing in the more remote setting where she felt that if appropriate training was available then she felt confident in her role:

A&E in the city was fabulous, frustrating. I loved it but I went home crying for the first 3 weeks because I couldn't believe that the general population could be so mean, because they don't like waiting. I was frustrated with the abuse that you receive in A&E. That kind of nursing is never going to stress me out, well it hasn't to date anyway. (P21)

Fear

Several participants used words such as *scary*, *frightening*, and *daunting* as they described their experiences of working in the WI. P23 felt overwhelmed at times, especially when looking after children, in the remote setting. There was a need to develop a wide knowledge base to cope with the scope, variety and unpredictability of rural and remote practice:

I found it quite frightening at first because with children they can't often tell you how they are, they just cry, and things can go very wrong, very quickly. Especially like, things like eyes. There's a lot of people who come in with sand in their eye and although it sounds like nothing, I had never done anything like that before. So, you do learn a lot of different skills. (P23)

To counteract experiencing the fear of the unknown P24, a proponent of lifelong learning, advocated effective training for staff:

I feel that training is the key isn't it. If you've got a little bit of knowledge then you are alright, it's when you don't know anything when you are presented with that patient, that's when it's scary. (P21)

Two of the community-based participants also indicated that they had the *fear of the unknown* and felt quite anxious and isolated at times and unsure about how they would be able to deal with certain situations especially as they were aware of time restraints and caseload responsibilities:

I love the job. I wanted to try the community side because I hadn't had much experience prior to that in the community when you're on your own in a patients' house, with not as much experience to bring to the table, it does feel a bit daunting sometimes. (P24)

Although you've got phones, but you are always kind of prepared for the unexpected. Even if you are sent to do bloods on someone you just know it's not going to be as straightforward as doing bloods, because you could walk in to the house and they're on the floor, and then, you know, blood everywhere, so you've got a kind of fear of the

unknown and sometimes, yeah, I think some days I feel ok and other days I feel a little bit more anxious especially if I am busier and I'm thinking 'I've still got all these patients to see'. (P25)

Autonomy/empowerment

P23 described how there was a need for ANP's in the rural and remote setting to equip nurses to treat patients effectively and independently especially when there was not always a doctor available. She welcomed the opportunity to engage in this training when she relocated to the WI:

One thing that has been really exciting about living in [PLACE – WI] is that I have been able to do this advanced nurse practitioner training. On the mainland it is a lot more difficult because in a lot of places you don't need them because you've got doctors there that are readily available. But in [PLACE – WI], like during the middle of the night you have got to know, like, you don't want to be calling the doctor out at 3 or 4 in the morning if it is something you can deal with yourself. (P23)

Professional Dimensions – GROUP 4: ‘INCOMERS’

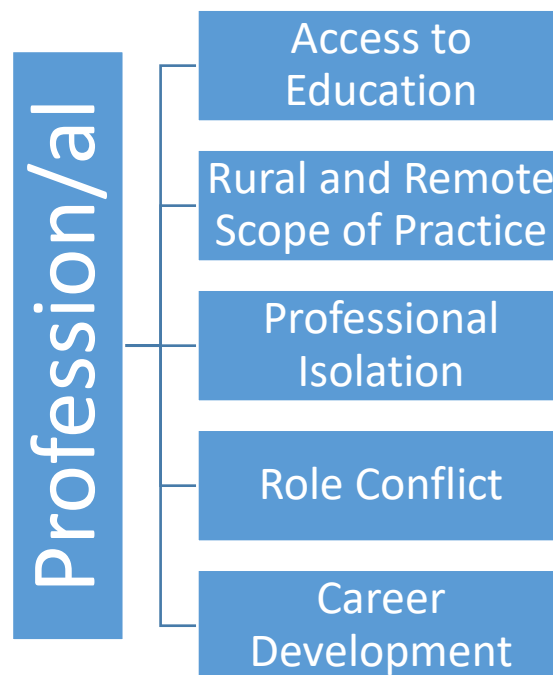


Figure 15: Visual schemata of profession/al themes – Group 4

Access to Education

The only participant in Group 4 (incomers) to have trained in the WI was P25. She applauded the training she received both in the classroom and on the wards and appreciated the support and encouragement she received:

The training was excellent. The training was really, really good. The class was a nice size, so it really felt it was more like that the tutors knew you. And you felt very supported and the training on the wards was excellent (P25)

Conversely, several participants had been dissatisfied with their initial nurse training in the city mainly due to high numbers of students and a lack of direction in the teaching methods. They compared it to what they perceived the nurse training was like in the WI:

At the university the course wasn't very good actually. It was more about reflection and not very much about knowledge in nursing. I

didn't care as long as I got the qualification. When I've got my student nurses now on the island and look at what they're getting taught and how they're getting trained I am a bit disappointed in what we were taught. (P21)

I would say that there were too many students at the university, to really get a one to one a lot of the time, was quite difficult. You know, certainly seeing the experience of students up here on the Island of Lewis, compared to what I had. (P24)

The further training and additional educational opportunities that P21 received prior to relocating to the WI was beneficial and stood her in good stead for nursing in the WI. She was appreciative that her training opportunities continued in the WI to enable her to perform the variety of diverse and unrelated tasks expected in rural and remote practice:

The training that they gave me at [PLACE – CITY] was phenomenal. And it was because it was in the city and they needed the nurses to take up the flak from the doctors that they didn't have, so we had to develop an acute medical clinic to take the pressure off the hospital. They put me through my health assessment there, nurse prescribing there and the start of my masters there. When I got to [PLACE – WI] they put me through my European paediatric life support course and my European trauma course which also was excellent (P21)

To pursue her desire to become a health visitor P22 engaged with distance learning at the same time as working in the WI. She described how her supportive manager, work colleagues and good facilities assisted continuing study:

The hospital has a library that is fantastic to use for studying and my colleagues and my manager were very supportive, and they gave me plenty time to go to the library. I then completed a child protection qualification, distance learning, through the University in [PLACE – CITY]. It was 5 years since I qualified and Oh it was tough when I got

started. And I was lucky, very lucky to have that funded by the health board as well. (P22)

P23 described how quickly and easily she was able to undertake the mentorship course in the WI as opposed to the long waiting lists for training in the city:

I was trying to get on to the mentorship course in [PLACE – CITY] for over a year. I moved up to [PLACE – WI] and I got it done within a couple of months. (P23)

Rural and remote scope of practice

The narratives of the two participants working in the more remote areas of the WI suggested that it was a requirement to have a broad knowledge base and a diverse skill set to meet service delivery needs and deal with the scope, variety, and unpredictability of rural practice:

You have to know an awful lot about everything to be able to look after all these different types of patients with different needs (P21)

So, you can have anything that walks through the door. There's no social work department at the hospital, so a lot of the nurses end up doing that. So, there is a lot of things that I wouldn't have done when I was at [PLACE – CITY], you are expected to do. You've got to know a bit about everything, and like nurses have been round to clean a patient's house and deem it unliveable and things like that. In [PLACE – CITY] if there was someone who needed physiotherapy or something like that you could just refer them on and forget about them, but you can't really do that because the physio only comes once a week. And like things with psychiatry, there is no psychiatrist on the island. They come over from WI so you do get quite a lot of mental health patients who come in and you feel a bit vulnerable because we don't really have the psychiatric training. But I think with my psychology degree, it's helpful. (P23)

Due to the variety, scope, and unpredictability of clinical practice in the WI there were diverse experience opportunities, especially in the more remote locations

where nurses had to undertake various additional roles. In urban settings these additional roles would normally be undertaken by other MDT members. In the following interview extract P23 described her multi professional role:

We have a variety of patients with different conditions. We get quite a lot of palliative patients as there is no hospice on the island. We get the normal A&E people, we get children. So that's a great difference I think because normally you've got an adult ward or a paediatric ward but they are all kind of, they just come to the hospital and are on the same ward. But most of the staff don't really want to look after children because they're scary. In [PLACE – WI] it is quite challenging actually. Like because it's all or nothing. Sometimes there's a mad rush, it's quite difficult, and then other times, there's no patients. I am now like the cardiac rehab nurse on [PLACE – WI]. So that is something I didn't know anything about when I was at [PLACE – CITY]. (P23)

Professional isolation

The following quotations illustrated the challenges and vulnerabilities of being a lone worker in the community setting in the WI and not having an available colleague to collaborate with to help with treatment plans and decisions:

Being a lone worker has its vulnerabilities, you know, sometimes when you're out and about you get that overwhelming sense that, oh, yeah, I'm on my own here and there's no one else. (P24)

You're out there thinking will I prescribe an antibiotic or not, and you don't have the support as if you were in a hospital. You could turn to a colleague who was maybe more experienced and say 'What do you think? Which antibiotic? You have that feeling of isolation at times, you don't have somebody to turn round to, just for that extra support. We use a lot of controlled drugs, so we don't have anyone around to double check that. So, there's a lot of things really and a lot of responsibility. (P25)

Professional isolation was compounded by geographical isolation in the more remote areas of the WI. The following quotation illustrated the challenges that the participant described to keep their patients safe until help arrives:

Basically, you are in charge of the hospital out of hours really, so you don't have doctors in the hospital. It's GP led so any patients that you get in, whoever, and whatever is wrong with them, if it is out of hours, it is likely that you may have to call the doctor to come in, and you don't really know how long it will take him to get here. Or even if you can get hold of them because they might be down south and have no signal. So really we are like a safety harness to keep the patient safe until they arrive. (P21)

Role conflict

P21 experienced much conflict over the extended role of the nurse in the WI. She found that her advanced skills and knowledge was not accepted, and she felt at risk of losing these skills as they were not being utilised:

I have come here and they're telling me, no I'm not allowed to do things that I did do in [PLACE – CITY], and I can't quite get it in my head.. I don't think they can say that about [PLACE – CITY] where colleagues trained me and helped me, and I find some of the doctors here are not so keen on nurses that have got extended skills. (P21)

P21 met some opposition from the medical staff who demonstrated a reluctance to accept or embrace the inception of the nurse practitioners' role:

They're not reluctant that you have advanced skills when you are not calling them at 3 in the morning to manage the patient, but when you speak to them about it then that's when they say, you know, at least in recent conversations, 'Oh these nurse practitioners are just a liability!' I just have to bite my tongue. I was just like, 'Oh for goodness sake'. It's quite outdated (P21)

The following extract from P21's interview expressed her frustration as she felt that although there were well qualified and experienced nurses in the remote locations of the WI these resources were not being utilised:

I come against a lot of resistance to what I would really like to be doing, yes, very much so. The reason I'm doing my dissertation and that I've done all these qualifications is so that I can be as useful as I possibly can, and it's incredibly frustrating when people are saying no, but they can't give you any other reason than 'We've never done it before'. For goodness sake, they are wasting these resources really with the nursing staff they've got. They are really wasting resources because in my opinion they would be much better, allowing us to do the things we used to do. It wouldn't even matter if they would test us, or send us on another study day, or whatever, I am happy to do whatever they want me to do. (P21)

P21's future decision whether to remain in the WI or not was largely influenced by the frustration she felt due to a lack of organisational resourcefulness and a resistance to change and progression:

If this is where I'm going to be I can keep learning and get my qualifications, but I will never be more than a 6 and that's frustrating for me because you always want to be the best that you can possibly be instead of going backwards. Anyway, that's fine, the decision's made. Regarding the hospital, I think it's really good, and they do an amazing job. I'm not sure how long I'll stay there just because I do find it quite frustrating. But we'll see how that goes. (P21)

P24 highlighted that her judgement regarding treatment plans was often questioned and that her role as a community nurse was scrutinised by colleagues:

But sometimes, you know, your judgement is often questioned when you have handover at the end of the shift. And we're discussing patients we've been to see, you know, it's a way of like, bringing out the information, I suppose, but they point to you, did you do this, did you do that, how did you find her leg ulcer today, because you're just casting a judgment on that time. (P24)

Career Development

P22 was passionate about health visiting but communicated that she could not see any prospect of career progression or promotion in the WI. This had the potential to influence her future career plans:

And I just absolutely fell in love with health visiting. (P22)

One of the challenges is, and I know this sounds a bit, is there's no chance of any promotion, or variation. If you were working somewhere where there was bigger, you know there's child protection roles that you could go in to, but here we have a child protection senior nurse, and that's it, it's just her. (P22)

When P21 was working in the city she was employed as a band 7 whereas in the WI she is a band 6 nurse. She felt that the advanced skills and the extended role should warrant being awarded a band 7:

After A&E I was seconded to the band 7 and worked at that for a year and then I got the substantive post. We have to see and treat in [PLACE – WI], and that's another frustration, to a certain extent I feel, and I was just looking at this for my masters' dissertation, I feel that if you are doing that kind of role and taking that kind of responsibility, you should be employed as a band 7.

I am just a band 6. I think that they will get there. It's just waiting for them to get there. (P21)

Following her ANP training P23 planned to leave the WI. Her goal was to gain more experience on the mainland with a view to returning to the WI more confident and equipped to practice extended nursing skills in the remote setting:

I would love to become an ANP at the end of it. But I think my plan is to move, in a few years, to [PLACE – CITY], and to work as an ANP, because you'll see a lot more patients and feel a lot more confident. I think once I have got more experience, because I'm still relatively new to nursing, I'll move back to the WI. (P23)

Two participants in Group 4 (Incomers) had difficulty in securing a permanent post in the WI. Following P25's training in the WI there were no jobs. The following extract from her interview describes how P25 had to work as a hotel receptionist to supplement her 'bank' shifts until she commenced community nursing:

After I finished my training there were no jobs, so I went on to the bank. There just weren't enough shifts going. So at that time I had to work as a hotel receptionist just to support myself. I got a start with the group practice and that was giving the flu vaccinations, and that did help to get my foot in the door a little bit, then in 2013 I got the permanent post working as a community nurse. (P25)

When P24 came to the WI she was surprised that it was so difficult to get a job. The following account outlined the recruitment challenges she faced as an early career nurse fraught with a lack of career opportunities as well as uncertain employment. As afore mentioned, in her interview account, P24 highlighted that being an outsider may have been a contributory factor to being unable to secure a permanent post:

I was applying for even just health care assistant roles initially. Just to get in, somewhere, just to get my foot in the door. I got a position as a staff nurse in one of the nursing homes. Another foot in another door! I struggled in a way because it wasn't the role which I was hoping to go in to as a newly qualified nurse. So, I am on the bank now, so there's no real future progression, like they're not saying that there is any post coming out, so they're keeping a bit, cards close to their chest. So surprisingly, I thought that it was going to be relatively easy to get a job as a health care professional on the island, but it's not as easy as I thought. (P24)

Place Related Dimensions – GROUP 4: ‘INCOMERS’

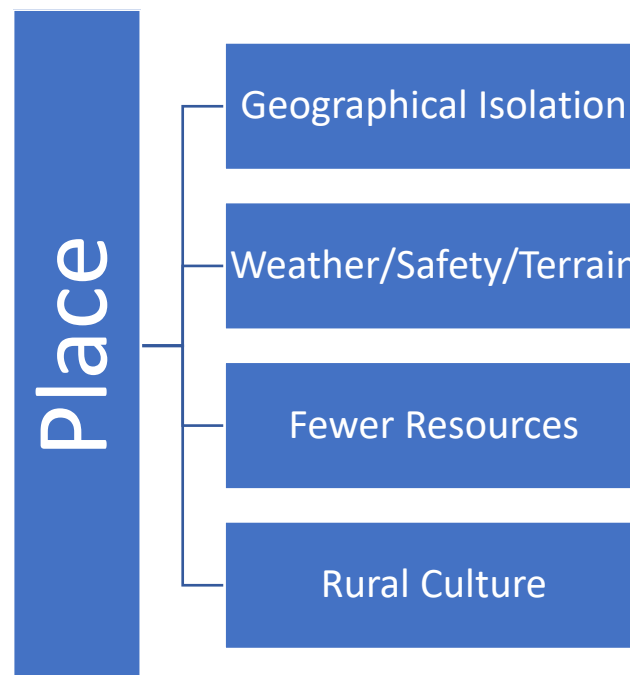


Figure 16: Visual schemata of place related themes – Group 4

The beauty, tranquillity, safety and the high-quality natural environment influenced all the participants in Group 4 (Incomers) to re-locate to the WI:

Rurality makes me think of a safe, quiet place. A beautiful place with a beautiful view. It's the clean air smell. That's what brought me here. It's always been my dream! (P20)

Several spoke of their lifelong desire to move from the city to either the Highlands or Islands:

My dad was a Highlander and he used to tell lots of stories about the highlands. For as long as it was in my mind, really, I was a Highlander although I wasn't living there. I love it. I really love it here on the island. Well, for a start off, as I say, I really always wanted to live in the countryside, and I love the sea too. And you get both here. You actually do. (P20)

I love living here. I've always had a real connection with the beach, and I can see the sea out of my living room window. (P22)

P24 and her family decided to come to the WI as her husband was given the choice of a post either in Inverness, Shetland, or Stornoway. She had no idea where the Western Isles were located but was keen to come to a Scottish island:

We were weighing up our options and we thought that Shetland is a 12-hour ferry journey away, whereas here in Stornoway we're not that far away from the mainland. So that was a real deciding factor. We had no idea where this place was initially!! So we were looking on the map and seeing how far away it was. It was quite some move. Not one to take lightly, but we thought, when are we going to get this opportunity to move to a Scottish island? These sorts of things don't come up often. I love the island, I love the fact that it's so safe. (P24)

Geographical isolation

All the participants in Group 4 (Incomers) were challenged because of being geographically isolated in the WI. Most spoke of travel difficulties and P20 was particularly affected when a family member became ill and required hospital treatment on the mainland:

I suppose there are difficulties when people become ill and have to go to the mainland. One of my family became ill. It was quite sudden. And there was a lot of having to go to the mainland to a specialist unit. So, if there is illness there can be difficulties there. (P20)

Several spoke of the expense of travel to the mainland and the frequency of ferry cancellations at short notice and how they felt quite cut off from family and friends:

If you are just trying to get off the island, if you are trying to go somewhere, the expense, if the ferry's cancelled, the cost of the flights is prohibitive. Sometimes I think 'Why do we live all the way up here!' (P22)

The difficulties of being on an island of being away from family and the ferry links, transport links and that sort of thing, ferries being cancelled. Your bubble becomes very small and you forget about the

bigger picture and what's on the mainland, that you are miles away from!! (P24)

Several participants who worked in the community setting found that it was not unusual for them to be driving around eighty miles per day as their visits were spread around various locations:

Yesterday I drove 80 miles, trying to coordinate visits, that takes quite a bit of skill. And I also cover other rural areas for a colleague. That's the challenges, just the geography of the place! And getting directions for the place. People say, 'Oh well if you come to the post box' and I'm thinking I don't even know where the post box is, so until you get to know somewhere. Houses are just all over the place. There's no rhyme or rhythm! Some don't have numbers or anything! (P22)

The following account described how P23 experienced professional and geographical isolation due to how difficult it was to travel to [PLACE – WI], and how challenging it can be to transfer a patient to Stornoway or a mainland hospital:

[PLACE – WI], I think I would describe that more as remote, because it is very difficult to get to because it takes five hours on the ferry and often because of the weather you are stranded there. You can't get off the island and there has been a few times with emergencies at the hospital. Not that long ago, I had a patient who had had a stroke and they couldn't get a helicopter there. So, I think that's a challenge. So that makes you feel really isolated. In [PLACE – WI] you have to travel about seven hours to get up to Stornoway, because you come up through all the islands. (P23)

At the time of her retirement P25 intended to return to the city, mainly because she expected to have better opportunities to lead a more fulfilling social life. Her interview account described most of the elderly in the WI being geographically isolated and experiencing poor transport systems:

I have always said I don't think I'll retire here because I see a lot of retired people out on my visits and I think they're not really doing much. I think I would have better opportunities back in [PLACE – CITY]. There's way more of a social life. I know what my mum does and she's nearly eighty and she has more going on and easier access to places. You know, if you're looking at somebody who's out in [PLACE – WI] there's one, maybe two buses a day, and if you don't drive. There's that sort of geographical isolation as well. That's going to be a big consideration. Unless I meet somebody really handsome then I'll stay! (P25)

Weather/Terrain/Safety

The participants in Group 4 (Incomers) recognised that the weather in the WI could be challenging and that driving conditions were often dangerous in the winter months:

I am not a nervous driver. I am aware that, you know, you have to be careful. Country roads can be dangerous too, (P20)

The weather, but wind and gales don't really bother me. It's ice and snow. I don't like ice and snow. I don't like driving in it, (P22)

It is incredibly beautiful, but the winters are a bit bleak. (P23)

We do a lot of driving so we have got the weather conditions which can be very challenging. You know, even the darkness, it's dark when you go out in the morning and it's dark when you go home. (P25)

Fewer resources

P23 noted that one of the main challenges with engaging with video links from [PLACE – WI] was the poor connection and lack of signal. This made her participation in the teaching sessions for the ANP training almost impossible:

Half the time the audio quality is really bad so you can see what's going on but you can't really hear what they are saying. When I

moved up to [PLACE – WI], I didn't even know what video link was!
(P23)

P23 highlighted that there was an absence of a mortuary in the more remote parts of the WI:

And also, on the island there isn't a mortuary or an undertaker, so when people die it's kind of like a mad rush to get them buried before they start smelling. It sounds really crude but, yeah, there is nobody who can kind of preserve the bodies (P23)

Nursing practice is shaped by place and geographical location. P21 sensed that the larger hospital in Stornoway took priority over her workplace in the smaller hospital in the more remote setting. She experienced challenges around the resources needed that are particular to place:

I think we are a 'poor relation' to Stornoway which is the basic premise here, so it's an uphill battle really. (P21)

Rural culture

Several participants in Group 4 (Incomers) had an awareness and sensitivity of the religious aspect of the rural culture in the WI, and were cautious about causing any offence to the local people:

I love the culture, so I choose to be part of that because I like this culture and wanted to be part of it. I am not so keen on the religious aspect of it. I'm happy for people to be religious, but putting their views on other people, I don't agree with, but I wouldn't, for example, hang my washing out on a Sunday because, I wouldn't want to offend my neighbours. I think we can give and take with that. You know, they are not telling me I can't hang my washing out. I am choosing not to. (P20)

P24 spoke of the challenges she experienced as she integrated into the rural community and although she struggled to come to terms with different cultural and religious values, she strived to remain respectful:

Coming into a community when everything is established already, and having different mindsets sometimes, different people and

having different experiences in life. Everybody's got, you know, different ideas and things to put to the table and sometimes that's quite a challenge. So, it's just being respectful of peoples' wishes but equally of, you know, not making you change always either (P24)

Where I come from church wasn't really a big, a massive part of the general population, to be honest, but moving up here, that is the predominant sort of aspect that is sometimes a bit of a challenge, but it becomes massive, really obvious. It's just being very courteous of people and making sure that you don't ever offend anyone. People could get offended by using the Lords' name in vain and you know you just have to think your whole mentality, and you know, that's how you've been brought up, you know, so that was a bit of a struggle initially, yeah, so it's just almost a bit like getting used to a different culture really. Yeah, that's it. It's difficult. (P24)

The following interview account described how P21 appreciated and embraced the cultural differences in the death and dying of her patients in the WI, compared to the urban setting, and how through having a closeness and a sense of connection to the patients and their relatives in the WI last offices are performed with cultural awareness and sensitivity:

I like the mentality of the patients and the family here really. They are much more realistic in their expectations. It's very different nursing here, really different to what I am used to. I think it's nice here because it's more community based and you watch, you know, if people die in hospital, then before where I have worked, you know you've washed them, wrapped them in the sheet and then you've got the porter to take them to the mortuary. Here it is very different, you know, you will wash them, you'll do their hair, you will make them look pretty, put them in their best clothes, and then you will take them to the mortuary. So basically, you are the undertaker. You get them how the family want them to look, and that's why it's so nice because you know them, you know what make up they would wear, how much they would wear and how they would normally have their hair done, and things like that. And I do find that, you know, families are so

different here. On the mainland where I've worked, they want to know exactly when their relative is going to die, so they can leave work and be there to say goodbye and then go back to work, because that is the kind of mentality. Whereas here the relatives quite literally move into the hospital for however long it takes them to pass. It could be two to three weeks and the relatives will make sure that they are never on their own and that there is always someone there, and it's really nice to see that because that's how it should be.

It's just a different culture here. Yes, very much so. (P21)

Summary – GROUP 4: 'INCOMERS'

Group 4 (Incomers) consisted of six nurses all of whom were born on the mainland. One of the nurses trained in the WI and the other five trained in the city. They were all working in the WI at the time of interview. There were various reasons that attracted them to come to the WI such as having visited the WI in the past and appreciating the beauty of the landscape (P20) and choosing to escape from the city to rear their children in a safe environment (P21). Five of the participants followed their partners to the WI – P20, P22 and P23 all *married a Gaelic man*, and P24 came as her husband obtained work in the WI. P25's boyfriend was from the WI which influenced her coming to train at the UHI but although her relationship ended, she decided to remain as she enjoyed her employment as a community nurse.

The insider/outsider status theme featured predominantly in the interview accounts. The nurses whose husbands had family origins and roots in the WI found it easier to integrate into the community and it appeared to make them more accepted and increased their sense of belonging. Some found it difficult to make friends and it seemed to be beneficial to have a young family as it was through their children's social clubs and activities that they met new friends and became more accepted. Several nurses with an English accent felt questioned as to where they came from and why they were in the WI and P24 surmised that it was because she was an outsider that she was unsuccessful in securing a permanent post as a community nurse.

None of the nurses seemed to have a problem with the lack of anonymity associated with remote and rural nursing, in fact, they seemed to favour their increased visibility in the community and found it quite amusing. Several participants even embraced the concept of personal and professional role blurring and were quite happy to discuss treatment options and glance at wounds etc with their patients in the grocery store. There appeared to be a link between a desire to become more accepted in the community as a health care professional and being known and accepted as a person.

Strong emotions such as *fear* and *scary* were alluded to in relation to needing to have a broad knowledge base to be able to cope with the scope, variety, and unpredictability of rural and remote practice. *Not knowing what may come through the door* especially when looking after children often led to nurses feeling out of their depth. As nurses were both professionally and geographically isolated, they alluded to *training being key* as the antidote for *the fear of the unknown*.

Several nurses (Incomers) in a more remote location in the WI were advanced nurse practitioners, one nearly finished her training, and the other with a wealth of experience and qualifications gained in the city. There was a sense of frustration and concern around role conflict as there seemed to be an opposition from the medical staff to nurses possessing extended skills and a lack of utilisation of their resourcefulness.

A recurring theme in the interview accounts was the lack of opportunity for career development. P24 had not managed to secure a permanent position and P21 and P22 saw no openings for promotion and despite P21 feeling that she was assessing and treating patients, which would warrant a band 7 level, she was still employed as a band 6. Although still motivated to continuous professional development and engaging in as many training opportunities as possible P21 felt despondent and frustrated with the lack of progression in her role. In Group 4, the lack of career progression was likely to influence the nurses' decisions to remain or leave the WI.

Chapter Four: Results of Stage Two of the Analysis

Purpose of the chapter

The purpose of the following chapter is to look across the four distinct groups of nurses and examine the commonalities, similarities, and differences of the groups by considering themes from the biographical accounts pertinent to each group. Comparing and contrasting the interplay between the person/al, profession/al, and place related experiences of all four groups will lead to a better understanding of what influences nurses to choose rural and remote practice.

Chapter overview

This chapter presents a table which serves as a visual representation depicting the twenty-eight themes/subthemes for thematic analysis (Table 6). Colour coding each group (Group 1 – 4) aids visualisation of which themes are applicable to each group. Discussing the similarities and differences between how each group described their experiences over time, and the complexity of the decision-making process and implications of decisions made to work in the rural and remote setting of the WI's, will form the basis of this chapter.

Table 6 highlights that there is a total of twenty-eight themes and subthemes.

The following ten themes/subthemes are shared by all the groups:

Person/al Dimension

- Sense of Belonging/Connectedness
- Anonymity
- *Blurring of Person/al and Profession/al Lives*
- *Retaining Confidentiality*

Profession/al Dimension

- Access to Education
- Rural and Remote Scope of Practice
- Professional Isolation
- Career Development

Place-related Dimension

- Weather/Safety/Terrain
- Rural Culture

THEMES/SUBTHEMES	GROUP 1 'REMAINERS'	GROUP 2 'RETURNERS'	GROUP 3 'LEAVERS'	GROUP 4 'INCOMERS'
PERSON/AL				
Sense of Belonging/Connectedness	X	X	X	X
<i>Family Attachments</i>				
Work/Life Balance				
Insider/Outsider Status				
Demonstration of Resilience				
Anonymity	X	X	X	X
Blurring of Personal/Professional Lives	X	X	X	X
Retaining Confidentiality	X	X	X	X
Factors influencing Job Satisfaction/Stress				
<i>Fear</i>				
Responses to Rural Scope of Practice				
<i>Fear</i>				
Autonomy/Empowerment				
<i>Adapting to the Autonomous Role</i>				
PROFESSION/AL				
Access to Education	X	X	X	X
Mentorship Experiences				
Rural and Remote Scope of Practice	X	X	X	X
Urban Experience Facilitating Transition to Rural Practice				
Experience Opportunities				
Professional Isolation	X	X	X	X
ANP Role				
Perceptions of Skill Rusting				
Role Conflict				
Career Development	X	X	X	X
PLACE				
Geographical Isolation				
Weather/Terrain/Safety	X	X	X	X
Fewer Resources				
Rural Culture	X	X	X	X

Table 6: Themes and sub themes across the four distinct groups of participants. Colour coding of each group aids visualisation of which themes are applicable to each group (Group 1 'Remainers' – blue; Group 2 'Returners' – green; Group 3 'Leavers' – red; Group 4 'Incomers' – yellow). The 'X' within the table highlights the 10 themes shared by each group.

An explicit decision was made to consider and examine the commonalities, similarities, and differences across the four distinct groups regarding the ten themes/subthemes shared by each of the groups. By reflecting on Stage One of the analysis (in Chapter Three) it was evident that the results from each of the four groups (remainers, returners, leavers and incomers) culminated in the emergence of vast, rich data. Twenty-eight themes/subthemes were included in Stage One of the analysis which captured contextual depth and detailed, nuanced descriptions. The findings for each group were reported on individually thus achieving in-depth, holistic knowledge. In keeping with the interpretivist paradigm which accentuates qualitative research methods which are flexible, context sensitive and largely concerned with understanding complex issues, a pragmatic decision was made to help make sense of the vast amount of data and make it more manageable. By 'homing in' on the ten themes/subthemes pertinent across the four groups in Stage Two of the analysis, this creative approach served to develop a greater understanding of the intricate details of the commonalities, similarities and differences across the four groups, thus enhancing credibility. The use of a decision trail was beneficial to reflect on how the study unfolded and to better assess the importance of ensuring that the findings were grounded in the data.

Person/al Dimensions across four Groups

Sense of belonging/connectedness

A sense of place is a concept that describes the relationship between people and their setting in terms of belonging/connectedness, emotions, attachments, and experiences. Data analysis of the four groups identified that there were several factors such as an emotional connection or disconnection to the local community, social and family bonds and connectedness, and an attachment to the beauty of the natural environment which contributed to an understanding of the complexity of the decision-making process and impacted on decisions made to work in the rural and remote setting of the Western Isles.

In Group 1 (remainers) a sense of belonging and connection to the WI was one of the most dominant themes with most participants stating that:

The Western Isles is where I want to be. I can't picture myself being somewhere else. (P1)

Participants in Group 1 (remainers) spoke of being deeply rooted to family, place and community and had a desire to live and work in the place of their birth. Being home was important to them and they all progressed to develop lucrative careers. Most of the participants in Group 1 were influenced to stay in the WI due to family needs and commitments and a strong sense of kinship. P4 and P5's family were now living on the mainland so their attachment to the island was not quite as strong as it had been in the past as they were unable to see them as often as they would like because of geographical isolation and travel difficulties.

This strong sense of kinship was also evident in Group 2 (returners) and Group 3 (leavers) whereby most participants who were born in the WI and following further training or experience in the urban setting, had a desire to return to the WI to look after elderly parents, sick relatives and to be involved in wider family and community life:

I guess family drew me back. I had my father who was quite unwell at the time, you often find that people who move away have this draw to come home and a lot of people can't pinpoint it, but it must be a strong attachment. There is something nice about looking after your own community, I enjoyed that, so I was really quite happy. Maybe that's what drew me to come back home as well. (P9)

The strong sense of kinship made it easier for participants in Group 2 (returners) to return home and their knowledge of place and understanding of the rural and remote community ethos facilitated their transition. Reflecting on their early career plan most of the participants in Group 2 had always intended to return to the WI after gaining further qualifications/experience on the mainland and at the time of interview they all expected to remain in the WI. Some described their nursing experiences in the city as being daunting.

A commonality experienced with the participants in Groups 1 (remainers), 2 (returners) and 3 (leavers) was a sense of longing for the WI (*Cianalas*). Several participants in Group 1 even when undertaking short placements on the

mainland were homesick, as were some participants in Group 3 who hoped to fulfil their longing to return to the WI after they had gained further nursing qualifications/experience in the urban setting. Even although one participant in Group 3 (leavers) was settled on the mainland and had no plans to return, she still considered that the WI was also her home and looked forward to visiting as often as possible. Several participants alluded to having two homes:

*I still call the island of Lewis home, although I've got 2 homes now.
This is always home, and I think it always will be. You know people
and it's where I'm from. (P16)*

Many participants Groups 1 (remainers), 2 (returners) and 3 (leavers) related to feeling more supported and at ease in the WI and spoke of feeling a deep sense of personal and professional disconnection and a sense of isolation in the city.

There were specific factors which attracted the participants in Group 4 (incomers) to the WI such as the geography of the place or lifestyle factors, finding a work/life balance, having visited the WI in the past and appreciating the beauty of the landscape (P20), and choosing to escape from the city to rear their children in a safe environment (P21). Five of the participants followed their partners to the WI. P20, P22 and P23's husbands all had family connections to the WI, and P24 came as her husband had gained employment the WI. P25's boyfriend was from the WI.

As the WI became home for the participants in Group 4 (incomers) their transition from the mainland was made easier for those who had spouses with family origins and roots in the WI. They found it easier to integrate into the community and it appeared to make them feel more accepted and increased their sense of belonging. Some found it difficult to make friends and it seemed to be beneficial to have a young family as it was through their children's social clubs and activities that they met new friends and became more accepted. Settling in the WI was more difficult for several participants as they envisaged that because of having an English accent they were questioned as to where they came from and why they were in the WI. P24 surmised that it was because she was an outsider that she was unsuccessful in securing a permanent post as

a community nurse. Two of the participants in Group 4 (incomers), with no kinship ties to the WI who also had young children, had difficulties in securing childcare and felt that they would not have managed to work in the WI without the support of their parents who had to relocate to the WI to help them:

So, my parents moved up to the island just after we moved up. Yes, I think that massively helped with the transition. I don't know how I would cope. There are childcare issues. So, it's great that they can help. (P24)

The main similarity among Groups 1 (remainers), 2 (returners) and 3 (leavers) was the strength of kinship, the felt privilege to look after their own people, and the feelings of how having ancestral links to the WI was important regarding career progression and gaining trust from patients and acceptance for delivering rural and remote practice:

People know who I belong to or know who I am or have heard about me and it's kind of like, well we know who you are so you're ok. And that can be a real advantage when you are trying to do something. People either know you by reputation or they know your family by reputation, and they are accepting. (P5)

Conversely, several participants in Group 4 (incomers) with no ancestral links or cultural connection to the WI found it more difficult to gain the trust of patients and colleagues:

When you come into a place you do tend to feel a bit different. I don't know, Sometimes you can get into this feeling of you know we're incomers and we're not from the island. It's obviously, people know everybody, and everybody knew that we were new to the island, and ended up getting asked who are you, and where are you from. (P24)

In Group 4 (incomers) the participants were mainly drawn to choose rural and remote practice and re-locate to the WI due to their husbands having family links to the island. Were it not for these links, one participant stated that she would see no other reason why she would consider coming to work in the WI:

It was definitely good that my husband had that link to the island. I don't think we would have moved if we had not had that link. I don't really see why we would have. (P22)

Anonymity

Blurring of Personal and Professional lives, and Retaining Confidentiality

Participants in Groups 1 (remainers), 2 (returners), 3 (leavers) and 4 (incomers) all acknowledged that they had to deal with a lack of anonymity and greater role blurring which led to subsequent concerns around retaining confidentiality whilst working in the rural and remote setting of the WI.

The way that each group coped with the lack of anonymity varied. Participants in Group 1 (remainers), 2 (returners) and 3 (leavers) felt particularly challenged as they regularly cared for family, friends, and acquaintances and felt overburdened with intimate knowledge of their health history, including social and psychological issues. Participants cited the concept of a lack of anonymity as being unique in the rural and remote setting. Analysis revealed the paradoxical nature of anonymity in that on the one hand, it is often the intimate knowledge of the patient's health and social and psychological issues that can be a facilitator in delivering care, yet it is often the same attribute of rural practice that can lead to profound tensions, stress and concerns around retaining confidentiality. Participants with their roots in the WI felt challenged and reticent to be seen in the public arena and most no longer enjoyed socialising as they were encountering their patients at every juncture of both their personal and professional lives.

Participants in Group 2 (returners) and 3 (leavers) seemed to find it easier and less challenging to work in the city, mainly due to having all the resources and support required and at the same time being largely anonymous and disconnected as they nursed people that they would be likely never to see again. Conversely, when nursing in the WI they often felt overwhelmed as though they were living 'in a goldfish bowl':

I think if you were in the city, you would never have that. No, definitely not. But, they see you as THEIR health visitor, 24 hours a day 7 days a week. So you don't get a break from it at all. (P6)

P8 (returner) was passionate about A&E nursing when working in Glasgow but was reticent to work in A&E on her return to the WI as she felt that a lack of anonymity would be too overpowering and challenging when caring for people that she was closely connected to.

The main difference between the participants that had strong links to the WI as opposed to the participants in Group 4 (incomers) who were not born in the WI was that the nurses in Group 4 (incomers) did not seem to be affected by the lack of anonymity associated with rural and remote nursing, in fact, they seemed to embrace their increased visibility in the community and found it quite amusing. Generally, the participants in Groups 1 (remainers), 2 (returners), and 3 (leavers) tended to try and avoid meeting patients in the public arena, whereas in Group 4 (incomers) the participants were quite content to discuss treatment options and glance at wounds etc with their patients in the grocery store. There appeared to be a link between a desire to become more accepted in the community as a health care professional and being known and accepted as a person.

Professional Dimensions across four Groups

Access to Education

Out of the twenty-five participants, the total number of nurses who trained in the WI was seventeen (Group 1 (remainers): n= 5, Group 2 (returners): n= 6, Group 3 (leavers): n= 5, Group 4 (incomers): n= 1). A total of seventeen participants were educated to degree level (Group1: P1, P2, P4, and P5. Group 2: P6, P7, P9, and P10. Group 3: P15, P16, P19. Group 4: P21, P23, P24, and P25). All the participants who trained in the WI spoke highly of the benefits of learning within a small and close-knit campus and engaging with supportive and accessible tutors. Synonymously, the participants who left to either gain experience or undertake further training compared their initial training in the WI with that of their counterparts in the urban setting:

We could compare our skills to the student nurses that were in [name of CITY], at the time, and our skills were far superior. (P6)

Several participants in Group 4 (incomers) cited how high numbers of students, and a lack of direction impacted negatively and led to dissatisfaction with their training experiences in the urban setting. They were able to resonate with the sentiments of participants from the WI as they observed the delivery of high-quality local nurse education. Group 4 (incomers) participants surmised that, in the WI, compared to the urban setting, there were increased opportunities for them to engage with courses such as mentorship, paediatric life support and advanced nurse practitioner training.

Several participants in Group 1 (remainers) and Group 2 (returners) had a perception that there was some opposition to skill development and education amongst colleagues in the WI and some alluded to the opinion that training and working in the one place had the potential to limit breadth of knowledge and experience. It was apparent that some participants in Group 2 (returners) and Group 4 (incomers) felt that they drew on the education and experience gained in the urban setting as they brought a new and different perspective to rural and remote nursing practice in the WI. Several participants, particularly in Group 4 (incomers), suggested that the wealth of knowledge and experience they brought to the WI was not always well accepted and one nurse felt at risk of losing these advanced skills as they were not being utilised:

It's very frustrating sometimes here I find because I feel my skills are getting taken away from me because in [name of CITY], you know, it was a world renowned hospital that I worked in, a leader in research, and goodness knows what else, and I have come here and they're telling me, no I'm not allowed to do things that I did do in [name of CITY], and I can't quite get it in my head.. I don't think they can say that about [name of CITY] where colleagues trained me and helped me, and I find some of the doctors here are not so keen on nurses that have got extended skills. (P21)

There was a consensus among participants in all the groups that continuing professional development and education was key to developing a wide range of

advanced knowledge and ability to be able to practice proficiently within the varied, diverse, and unpredictable scope of rural and remote nursing practice. The burden for self-responsibility of education appeared greater in the WI than in the urban setting. Participants in Group 1 (remainers) alluded to having to keep up to date with practice and procedures more, and often learning occurred while doing, which tended to heighten the feelings of fear:

You just have to pick up and go with it. So it kind of makes you or breaks you. It makes you realise what you need to do to do a better job and certainly I don't want to be going to work not knowing what I need to do. So that has encouraged me to do background reading to make sure. (P2)

Participants in Group 1 (remainers) also identified that information being imparted from a peer when it was needed most was another source of education:

The experienced ones [nurses] were there to teach us. It was a great learning environment. I hadn't done much in high dependency, but as time went on, we did a wee bit more and I don't know if enjoy is really the word, is it? You sort of learn on the hoof sometimes and find yourself in some very scary surroundings, but it was good. You learn loads. (P3)

Several participants in Groups 1 (remainers), 2 (returners) and 4 (incomers) embraced technologies to network and collaborate with other health professionals and the increased opportunities through computer education were beneficial. Advances in technology lessened the feelings of isolation from other nurses and reduced or eliminated commuting time to urban centres. Advantages such as the convenience of undertaking online courses in the WI were highlighted:

So I continued in my job on the island and also on top of that was training for 2 years, distance learning, to get my specialist community public health nurse qualification. We are very lucky here because the hospital has a library that is fantastic to use for studying and my

colleagues and my manager were very supportive, and they gave me plenty time to go to the library. I then completed a child protection qualification, distance learning, through [NAME] University. It was 5 years since I qualified and oh it was tough when I got started. And I was lucky, very lucky to have that funded by the health board as well.
(P22)

Participants working in the more remote parts of the WI (P6 in Group 2 (returners) and P23 in Group 4 (incomers)) experienced poor internet connection issues which impacted negatively on their experience and led to feelings of isolation and frustration:

We have no library with medical books in [PLACE - WI]. And the University has online library that you need really good internet connection for, which we don't have in [PLACE - WI]. It's a real struggle.

I think that's what rural nursing and rural health board life is becoming. There's no money. They're asking you to VC to everyone, but they should try being in [PLACE - WI], where the connections are really poor. It's so frustrating. (P6)

We do a video link to make up for not attending lectures, but it's terrible, the connection down at the hospital. So, half the time the audio quality is really bad so you can see what's going on but you can't really hear what they are saying. When I moved up to [PLACE – WI], I didn't even know what video link was! (P23)

Rural and Remote Scope of Practice

Analysis of the interview data of all the participants in each group showed that the nature and scope of rural and remote nursing was clearly distinctive. Participants within all the groups defined rural and remote nursing as being a special variety of nursing in which the nurse must have a broad range of skills, assume multiple roles, have a wide knowledge of multiple specialities and an ability to practice proficiently in multiple clinical areas simultaneously along the career trajectory.

Even though most participants in Group 1 (remainers) had only worked in the WI they spoke of rural and remote nursing practice being unique from their urban counterparts:

I think because it's rural, specialities are so wide and varied which increases the challenges. It makes it so much harder to learn something that you are not doing every day, whereas, if you were on the mainland you would be working in orthopaedics, or general or gynae or whatever and just have the one speciality to learn. But here you have to learn a little bit of knowledge of all of it, which is challenging. (P3)

Much of rural and remote nursing research studies are replete with terms such as 'generalist' and 'expert generalist', but only one of the participants in this biographical study referred to the nature of rural and remote nursing as being generalist nursing:

When I was in [name of CITY] in theatre, it was more specific what my role was, very specific orthopaedics, but when you come to a smaller place, or a smaller unit or a ward, you could be looking after any type of patient or having to deal with any type of operations. So you have to become more of a generalist, which is good, but it doesn't make you become specifically good in any one area. (P13)

Comparing experiences gained in the city, the variety, scope, and unpredictability of nursing in the WI appealed to several participants who found it a facilitator to learning, and a potential useful adjunct to recruitment initiatives:

I felt that sometimes you could not be skilled in one particular area as maybe in other positions you could be because you had to have a knowledge of everything. I think that is an attractive point for working in theatres on the island. Whereas, where I was working before, it was all very specific. So having a broad range of skills and being able to carry out scrub or recovery for a mix of procedures, it's really great. (P9)

A commonality over the four groups was a sense of being overwhelmed and participants spoke about being out of their depth and frightened in some situations, especially when caring for a diverse group of patients with different needs:

Anything from gynae to orthopaedics to general surgery, and everything in between plus the 6 kids. When the need arose then you had to do what you had to do. It was terrifying, particularly when looking after sick children, absolutely terrifying. (P5)

It makes staff feel very nervous at times because there is always the fear of what if this happens, and what if that happens. However they have tremendous skills, they have tremendous generalist skills that they can, and I think it comes from having really good basics, that they can apply these basics to any given situation, which is assessment, learning to look after what you are seeing. Maybe you don't know what to do about it, but who are you escalating it to, and trying to get to a senior member of staff. (P13)

To cope with the unpredictability of the scope of remote and rural practice participants in all groups had to demonstrate resilience:

You've got no choice but to knuckle down and get on with it. We're on our own. (P1)

The participants in Group 4 (incomers) recognised the need for being resilient in the remote and rural setting and one nurse who had recently relocated to the WI iterated how she was in awe of how the local nurses had to make do with limited resources to aid their patients:

And it's a thin line really because I was like saying 'You can't use BiPAP on a cardiac patient, it doesn't work' and they just turned round to me and said 'Well, what are we meant to use, this is all we've got' and when I looked at it that way I said 'oh, yeah, put it on quick!'. So, it is better than not putting it on, it will help them, it just isn't the right way to help them. So, what I find interesting here is that

they don't have the resources that I am used to, and they almost make do. But in making do they are still fixing the patient.

So that took me down a peg or two, you know what I mean. So I thought, ok, fine! (P21)

The scope of rural and remote nursing involves intersections between nursing and medicine. Several participants in all the groups spoke of how the nursing role was evolving with the introduction of advanced practitioners and specialist nurses in the WI. They alluded to the need for effective continuous education to be able to assess, diagnose and begin to treat their patients until further help arrives:

This is the challenges of remote and rural. In a remote and rural environment, it is just so tough when you don't have the back up and you are so isolated, so that means that the person delivering the care whether it be the GP, the ANP, the district nurse. they need to know what they are doing. (P5)

I feel that training is the key isn't it. If you've got a little bit of knowledge then you are alright, it's when you don't know anything when you are presented with that patient, that's when it's scary. (P21)

To be able to practice autonomously, independently, and confidently one participant in Group 4 (incomers) who was undertaking the ANP training at the time of interview, felt that she would benefit from gaining more experience on the mainland before returning to the WI to better equip her to deal with the scope, variety, and unpredictability of rural and remote nursing:

I would love to become an advanced nurse practitioner at the end of it. But I think my plan is to move, in a few years, to [name of CITY], and to work as an ANP, because you'll see a lot more patients and feel a lot more confident. I think once I have got more experience, because I'm still relatively new to nursing, I'll move back to [PLACE – WI]. (P23)

Professional Isolation

Professional isolation may be geographic (a distance from), social (a lack of contact with) or ideological (outcasted from). Analysis of the interview data showed that participants in all groups recognised that professional isolation was one of the main stressors that impacts their ability to deliver care in the WI. Participants saw themselves as being vulnerable, cut off from the professional mainstream and being in emergency situations where there is no collegial support. Participants in Groups 1 (remainers) and 2 (returners) often spoke of being terrified, especially when being in the situation of waiting for a retrieval team to transfer a very sick patient to a mainland hospital:

Sometimes you would stabilise them just enough for them to be evacuated out. Utterly terrifying, and the amount of responsibility.
(P5)

Participants in all the groups emphasised the challenges of lone working in the rural and remote setting and interview accounts described how professional isolation was more apparent when it was compounded by geographical isolation. Several recounted the challenges of keeping their patients safe and ‘*firefighting*’ until help arrived and spoke of the added challenge of further delays due to difficulties connecting with peers due to poor signal:

It is likely that you may have to call the doctor to come in, and you don’t really know how long it will take him to get here. Or even if you can get hold of them because they might be down south and have no signal. So really we are like a safety harness to keep the patient safe until they arrive. (P21)

Participants in Group 2 (returners) and Group 4 (incomers) reflected on their previous experiences of working in an urban setting and feeling more at ease as they had numerous colleagues to ask for help and support. They compared how they felt more vulnerable and aware of having limited back-up and fewer resources in the WI. Although sensing professional and geographical isolation several participants in Group 3 (leavers) valued what they described as better teamwork and community cohesion in the WI. P17 expressed how she felt

professionally and personally isolated in the urban setting and largely unsupported and disconnected in her role:

I think that it makes such a difference when you work with a group of people that know you and can support you. Yeah, it's just very different working in a place that you don't have that same bond with people. (P17)

Similar feelings of being outcasted were apparent in several participants in Group 4 (incomers). P21, a nurse in a more remote part of the WI, stated that:

I think we are a 'poor relation' to Stornoway which is the basic premise here, so it's an uphill battle really. (P21)

Career Development

There was a consensus among all the groups of participants that there were frustrations and tensions around recruitment and retention in the WI. The early career pathways of participants in Group 1 (remainers) were clearly haphazard and several had difficulties in securing permanent employment after completing their training. Despite some engaging with unpredictable 'bank' nursing shifts (P2, P5) and two participants seeking employment out with the NHS for a short time (P4, P5) they all progressed to develop lucrative careers. The participants in Group 1 all had a rural upbringing, had strong blood ties to family, a sense of belonging and kinship to the WI. Some were educated locally to become ANP's and specialist nurses (P1, P4, P5). In essence, they were 'home grown' rural nurses:

I can't imagine working anywhere else. I do enjoy working here. When you are used to the ways of people. (P2)

Similarly, the participants in Group 2 (returners), although they either trained or worked on the mainland, returning to the WI to look after elderly parents, sick relatives or with a long-term plan to retire, they also had a rural upbringing and a strength of kinship and sense of belonging to the WI. Although several participants initially thought they were taking a

backward step by returning (P10, P11) they both developed professionally and benefitted from further local training which enhanced their careers.

Conversely, three participants in Group 3 (leavers) (P15, P17, P18) stated that there were no jobs available for them when they qualified and although they had a strong sense of belonging to the WI and despite being 'home grown' nurses they had to relocate to the urban setting. Their desire was to return to the WI, but they speculated that it would be difficult:

Jobs don't come up very easily. Often you see that people are retiring and then they are coming back on bank shifts. It's not fair, and it is having an effect on recruitment and retention. (P15)

P16, a participant in Group 3 (leavers), decided to leave as although she enjoyed nursing in the WI, she felt that there was no opportunity for career progression or promotion:

There was no scope for getting promotion. You had to wait for somebody to retire. Because once you got a job, you know, people who are living here, they stay, so there wasn't much scope for getting further up the career ladder. (P16)

Similarly, the lack of career progression or promotion influenced Group 4 (incomers) participants' decisions to stay or leave the WI. P21 felt that her employment opportunities were influenced by the fact that she was an outsider and had been unsuccessful in securing a permanent post:

I am on the bank now, so there's no real future progression, like they're not saying that there is any post coming out, so they're keeping a bit, cards close to their chest. So surprisingly, I thought that it was going to be relatively easy to get a job as a health care professional on the island, but it's not as easy as I thought. (P24)

Since coming to work in the WI P23 was given a good opportunity to undertake the ANP training but she felt that due to the scope, variety, and unpredictability of rural and remote nursing she planned to leave to gain more experience on the mainland, with a view to returning in the future:

My plan is to move, in a few years, and to work as an ANP, because you'll see a lot more patients and feel a lot more confident. I think once I have got more experience, because I'm still relatively new to nursing, I'll move back. (P23)

P21, a vastly experienced nurse, felt that to meet the needs of the employment opportunities in the rural and remote setting in the WI which required a broader skill set and knowledge base, and the ability to work autonomously and often isolated from colleagues, a higher banding for nurses would be appropriate:

I feel that if you are doing that kind of role and taking that kind of responsibility, you should be employed as a band 7. (P21)

Place related dimensions across four Groups

The realities of rural and remote living such as weather, distance and geographical isolation markedly affected the delivery of health care to rural populations and impacted upon participants' decisions to choose or remain in rural practice.

Weather/Terrain/Safety

Several participants in all the groups, and most especially public health and community nurses, were frequently lone workers who engaged in home visits, with some providing emergency first response. Safety issues were acknowledged as a common theme by all groups including driving for long distances, due to geographical isolation, in harsh conditions such as snow, ice and storms. This was often intensified by further challenges such as difficult terrain, sheep and cattle on single track roads and poor mobile phone signal:

I was scared on a number of occasions when the roads weren't gritted in the morning. That frightened me, and the strength of the wind. (P19)

Rural Culture

Rural culture was characterised by relatively close and long-term relationships with family and community. Several participants spoke of

having fewer resources and a limited staff pool and how health care professionals and rural residents pulled together to *make it work* in the WI.

Participants who were born and raised in the WI (remainers, returners and leavers) shared a common understanding that there was something unique about how geographical isolation and an appreciation of Gaelic heritage, language, and song with its depth of meaning shaped their perspective of rural culture. Feelings of ‘cianalas’ deepened when they re-located to the mainland:

There’s a real family bond up here! And I think I often look at the culture and I love some of the older songs, especially the Gaelic songs, and when you listen to the words of these songs, the depth of meaning. That was such an art. Beautiful.

And I think being away from home actually lets you see what you have, and I sometimes think you need to leave an area, leave somewhere, or leave home to actually appreciate what you had there. (P14)

Several local participants alluded to depending on their spiritual beliefs to help them become resilient. They reflected on the culturally strong and meaningful Christian belief system embracing kinship, a sense of identity, belonging and self-worth:

Just the culture, you know, and the family and my upbringing really. I was brought up here respecting people and the religious sort of aspect of it, and that has continued on with me. It’s where I’m from, and it’s home and you know most people and they are special to you or they’ve seen you grow up. It’s a totally different way of life. (P16)

Several participants who came to work in the WI (incomers) alluded to exercising an awareness, sensitivity, and respect of the religious aspect of rural culture and they felt cautious about causing offence:

Where I come from church wasn’t really a big, a massive part of the general population, to be honest, but moving up here, that is the predominant sort of aspect that is sometimes a bit of a challenge, but it becomes massive, really obvious. It’s just being very courteous of

people and making sure that you don't ever offend anyone, yeah, so it's just almost a bit like getting used to a different culture really.

(P24)

P24 experienced feelings of being an outsider especially regarding securing a permanent post in the WI which may indicate that although the cultural divide between rural and urban dwellers is narrowing due to migration patterns changing, there is still a keen perception and distrust of outsiders. To help embrace the rural culture of the WI and integrate into the community P19 undertook a Gaelic degree:

The Gaelic degree was a real doorway into meeting some wonderful, interesting people and it was fantastic as I was able to speak Gaelic to older people. (P19)

Tensions/paradoxes identified following data analysis

Overall, this chapter has looked across the four distinct groups of nurses and examined the commonalities, similarities, and differences of the groups by considering the afore-mentioned ten themes/subthemes which were shared by all the groups. Four tensions/paradoxes were identified from the second stage of data analysis:

- Anonymity/Visibility
- Longing/Belonging
- Ancestry/Acceptance
- Specialist/Generalist

These tensions will be further explored in the subsequent chapter.

Chapter Five: Discussion and Conclusion

Purpose of the chapter

The purpose of this concluding chapter is to discuss the key findings from this study that contribute to and advance the current knowledge on the person/al, profession/al and place related dimensions of rural and remote nursing and to consider how the interplay between these dimensions influence nurses' decision-making and experiences of working in the WI.

Chapter overview

A brief overview of previous chapters will be presented and there will be a demonstration of how the aims and objectives of this thesis have been addressed. The following four tensions/paradoxes will be discussed and presented with reference to current literature and against the backdrop of the rich heritage of the rural nursing theory base described by Long and Weinert, (1989):

- Anonymity/Visibility
- Longing/Belonging
- Ancestry/Acceptance
- Specialist/Generalist

After these discussions, emphasis will be placed on how this thesis has advanced the methodological understanding of biographical research. The evolving MacKay's 3P model will be presented as a useful adjunct to aid researchers and policy makers. Implications of this thesis for rural and remote nursing practice, policy, research, and education will subsequently be considered and recommendations will be drawn from the results.

Brief overview of previous chapters

In this thesis, by drawing on the results of the systematic literature review, it has been highlighted that rural and remote nursing is a complex issue with many facets and that due to global nursing shortages, recruitment and retention of nurses is a major international concern, exacerbated in rural and remote areas

(MacKay et al., 2021). At the outset of this thesis in Chapter One, by considering current literature, it was argued that existing evidence does not fully consider the multiple influences that may impact nurses' decisions to remain or leave rural and remote areas. Rather, much of both qualitative and quantitative research has focused on describing aspects of rural and remote nursing as individual entities, which does not provide insight into the complex dynamic of experiences that ultimately influences nurses' decisions to work in rural and remote healthcare settings. There is a paucity of rural and remote nursing qualitative research undertaken in the UK, no universal definition of the terms 'rural' or 'remote', and a lack of explicit definitions of remote and rural nursing in many studies. These conclusions, based largely on research that had been conducted outside of the Scottish context, which mainly include just a snapshot of nurses' experiences at a single moment in time, led to the proposal to examine and more fully understand the connections between the person/al, profession/al and place-related dimensions of rural nursing over the course of a career and fulfil the aims and objectives of the study. It was also proposed to explore the complexity of the decision-making process and implications of decisions made to work in the rural and remote locations of the WI by answering the following research questions:

1. What are the person/al, profession/al and place-related factors that influence choosing rural practice?
2. What is the interplay between people, profession, and place?
3. How does the interplay between people profession and place influence nurses' career destinations and transitions?

Chapter Two considered the methodology and methods of the research process and through undertaking biographical interviews with four groups of nurses (remainers, returners, leavers and incomers) the research questions have been addressed. Emphasis was placed on reflexive thematic analysis focusing on trustworthiness.

Chapter Three (Stage one of the analysis) depicted summaries of the chronological accounts of each participant (see Appendix 8) and presented an analysis of the key person/al, profession/al, and place related themes within the four different groups of participants. Chapter four (Stage two of the analysis)

focused on the commonalities, similarities, and differences of the four groups to better understand the complex interplay between the person/al, profession/al and place related dimensions that influence nurses' decision-making and experiences of working in the WI.

Ultimately, through comparing the results of the data analysis of the four groups of participants, the following four overarching tensions/paradoxes were evident:

- Anonymity/Visibility
- Longing/Belonging
- Ancestry/Acceptance
- Specialist/Generalist

What this chapter adds

By reflecting on existing literature and Rural Nursing Theory as a lens with which to view the four tensions/paradoxes in terms of the commonalities, similarities, and differences of the groups, this chapter will draw out and discuss the key findings to address the research questions. The implications that these findings have on future research, policy, and practice will be discussed and recommendations will be drawn from the results.

Figure 17 depicts the four tensions/paradoxes, and overlapping themes/sub themes, which influence nurses' person/al and profession/al decision making to work in rural and remote settings of the WI.

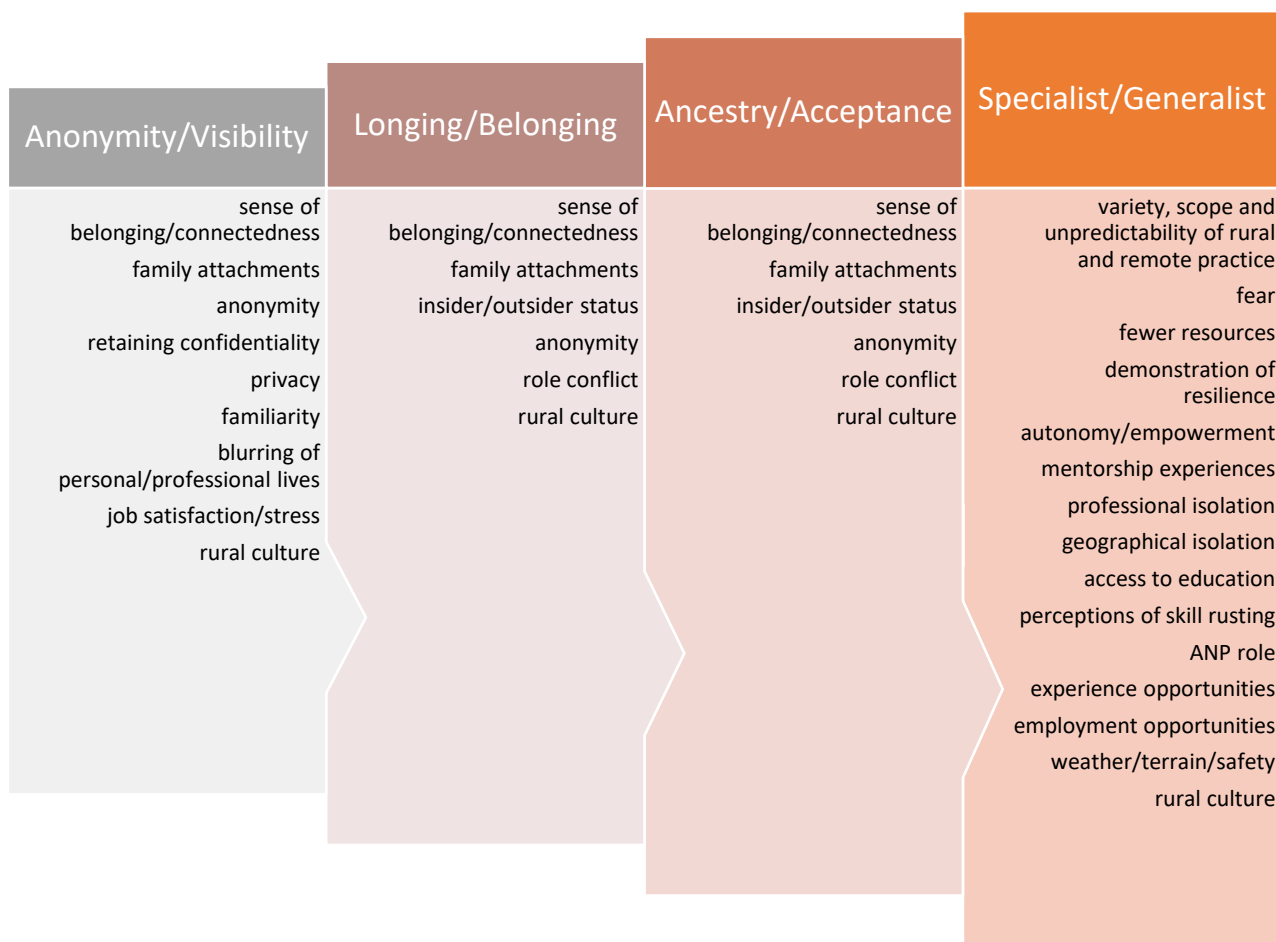


Figure 17: Four tensions/paradoxes and overlapping themes/sub themes

Four tensions/paradoxes

Daily work life is imbued with paradoxes, the contradictory yet interrelated elements that exist simultaneously and persist over time (Smith and Lewis, 2011). According to Putnam et al. (2016) paradoxes result in tensions. The following four paradoxical tensions identified from the data analysis will be unpacked and explored.

Anonymity/visibility

Nurses in all groups agreed that a lack of anonymity was inherent in a rural and remote environment and that there were links with the concepts of familiarity, privacy, and confidentiality. In their interview accounts the nurses who were born and brought up in the WI described the reality of being known by colleagues and patients and within the wider community and how this

challenged them in both their personal and professional lives. Being known, familiar and recognised in and out of work had more of a profound effect on local nurses to the extent that many of them no longer wished to socialise. They did not wish to be visible. The paradoxical nature of a lack of anonymity was viewed by some participants as, on one hand, it was often the intimate knowledge of the patient's health and social and psychological issues that can be a facilitator in delivering care, yet it was often the same attribute of rural practice that can lead to profound tensions and stress and concerns around retaining confidentiality.

Several nurses originating from the WI who returned home to work were equally challenged by the lack of anonymity. Being known both personally and professionally had a negative impact which influenced their career transitions to the extent that some felt that they could not take up employment in their chosen area as they would not be able to cope with the emotional aspect of providing emergency care to family, friends, or acquaintances especially in life threatening situations where they would often be the only healthcare professional available until help arrived.

Most nurses with their roots in the WI (remainers, returners and leavers) acknowledged that visibility was a consequence of being known and identifiable and that a lack of anonymity affected their relationships and individual behaviours. The more they were known the more they felt they were visible. From the data analysis local nurses described how visibility and lack of anonymity also affected patients in the rural and remote setting and that there was often some degree of awkwardness when caring for patients who were well known to the nurse.

Conversely, nurses from the mainland (incomers) appeared to embrace the concept of visibility and viewed it as a way of getting to know patients better and being accepted and integrated into rural and remote community life. Lack of anonymity promoted increased self-awareness, responsibilities for actions, accountability and established a reputation.

Chapter One indicated that the third statement of Rural Nursing Theory (RNT) focused on health care providers (HCPs) by suggesting that they experienced

lack of anonymity and much greater role diffusion than providers in urban or suburban settings. Referring to the seminal work of Long and Weinert (1989) a lack of anonymity also applied to the recipients of health care in rural areas as all persons in that environment had difficulty maintaining a private area in their lives. Being known and identified by name is the conceptual definition of anonymity (Lee, 1998). In a literature review, through the process of concept analysis, Swan and Hobbs (2017) expanded the meaning of a lack of anonymity and updated Lee's (1998) definition to include the attributes 'identifiable', 'establishing boundaries for public and private self', and 'interconnectedness'. The outcomes of a lack of anonymity were 'familiarity', 'visibility', 'awareness of privacy', and 'balance of lack of anonymity' (Swan and Hobbs, 2017). These outcomes were also apparent in this study. Depth of analysis revealed differences concerning a lack of anonymity between nurses who were born in the WI (remainers, returners and leavers) and nurses from the mainland (incomers) who came to work in the WI. There was a greater tension around a lack of anonymity with local nurses who generally did not want to socialise or be seen in the public arena. Synonymous with the findings of Swan and Hobbs (2017) in Chapter Four, many local nurses established boundaries for public and private self and isolated themselves from group activities, whereas the nurses in Group 4 (incomers) who re-located to the WI welcomed and embraced the opportunity to meet patients in places such as the grocery store as it seemed to enhance their feelings of acceptance and strengthen their connections to people and place.

By considering the research question 'How does the interplay between people, profession and place influence nurses' career destinations and decisions?' it was evident that a lack of anonymity had a negative impact on the decision making of several nurses in Group 2 (returners) who felt that on their return to the WI they would not be able to follow the career pathway of their choice as they felt too interconnected with patients. The interplay between the influences of rural culture and navigating personal and professional boundaries challenged many nurses in terms of how they strived to be effective clinicians while concurrently partaking in community life.

Internet and social media usage have also impacted on how a lack of anonymity is experienced (Swan and Hobbs, 2017). One nurse in Group 2 (returners) described how platforms such as Facebook may merge the personal and professional self together (Yonan et al. 2011) and spoke of tensions around crossing boundaries when patients requested to become friends using online communication. Szumer and Arnold (2023) promoted the development and maintenance of safe, ethical, and sustainable therapeutic relationships in rural and remote healthcare settings. Research on a lack of anonymity from a sociological perspective tends to focus on anonymity in online communities (Kim et al., 2019).

According to Swan et al. (2022) concepts such as anonymity and familiarity are core concepts in Rural Nurse Theory that have not been researched, well defined or understood in other disciplines. Many rural concept analyses in RNT are also dated. Most analyses regarding the third statement of rural RNT (lack of anonymity, familiarity) were undertaken by Swan and Hobbs (2017) and conducted using the Wilson method (Walker and Avant, 2011). However, some of the elements (definitions, antecedents, consequences and empirical referents) were not addressed. According to Winters (2022: 36) paramount is the need for validation of concepts with rural dwellers from multiple settings and varying races and ethnicities.

The findings from this research have added to RNT by suggesting that a lack of anonymity, lack of privacy and a familiarity creates tensions around personal and professional roles and adds to challenges with maintaining confidentiality for both health care professionals and patients. This study is novel as it has begun to understand how a lack of anonymity can affect nurses who were born in the WI in a different way from nurses from an urban background.

Longing/belonging

Although there is a growing body of research that has examined sense of belonging in the nursing setting, it tends to be focused on nursing students undertaking clinical placements (Sedgwick and Rougeau, 2010, Sedwick and Yonge, 2008). Ching et al. (2022) studied the experiences of newly qualified nurses and found that support and acceptance from clinical preceptors with

experience, patience, and empathy created a sense of belonging and encouraged retention of employees.

Local nurses (remainers, returners and leavers) experienced a stronger sense of belonging than those who came to the WI (incomers) from an urban background. Nurses originating in the WI felt that their sense of belonging was enhanced due to their familiarity and deep understanding of rural culture, community, and the work environment. Proximity to family members, especially elderly parents, or unwell relatives, also influenced their decisions to either remain in the WI or return after gaining work experience on the mainland. A sense of belonging was enriched as several participants recounted how they felt privileged and personally and professionally fulfilled as they cared for their own people.

The strength of feelings of belonging were exemplified when many of the nurses from the WI described their experiences of homesickness when on the mainland. The longing for home was so profound for some that they spoke of their desire to return to the WI as soon as they either gained further qualifications or experience in the urban setting.

Unique to the WI, the Gaelic word *Cianalas* means a deep-seated sense of belonging to the place where your roots lie. Feelings of *Cianalas* are often attributed to being parted from the Western Isles of Scotland and many of the nurses within this study reflected on and re-affirmed how the culture, heritage, language, religion, and music of the WI were realised as the most important things in life.

Belonging is a basic human need. Several nurses with an urban background (incomers) who relocated to the WI spoke of the challenges they faced as they endeavoured to develop a sense of belonging within their new environment. Results of one of the papers included in the systematic literature review concurred that rural nurses experienced a stronger sense of belonging than their urban counterparts (Sedwick and Rougeau, 2010). This paper suggested that preceptorship was beneficial to help newly qualified nurses to learn how to navigate through personal and professional relationships within a close-knit community to foster positive sense of belonging experiences.

It was an advantage if the nurses (incomers) had spouses with family links to the WI and a prior knowledge of differences in the social and cultural realities of remote and rural life. It made it easier for newcomers with links to the WI to foster a sense of community and belonging both professionally and socially. Socialisation is an integral part of nursing, a process of learning and incorporating norms, attitudes, behaviours, skills, roles and values of the profession which leads to the development of professional identity (Moon and Chang, 2023). Drawing from the work of sociologists and considering a recent review of rural education in America, Marietta and Marietta (2022) noted that community is of central importance in rural spaces and the idea of having a connection to community can be a source of strength which can absorb the pressures of life especially during challenging situations.

According to Levitt-Jones and Lathlean (2008) the concept of belongingness in nursing research and education literature is scarce and belongingness has been researched primarily using quantitative designs. Alienation (the antithesis of belonging) is said to result in anxiety, depression, lack of motivation and a lack of direction. There is a need for strategies that enhance nurses' sense of belonging and social wellbeing. Levitt-Jones and Lathlean (2008) concurred that in recognition of the significance that nursing students attributed to belongingness and the demonstrated influence it had on their learning, effective collaboration between education and health services was imperative. Environments that are welcoming, supportive, and receptive can foster a sense of belonging.

Several of the nurses in Group 4 (incomers) with young families who came to work in the WI and had challenges with childcare were largely dependent on their parents who also had to re-locate to the WI to help.

A few nurses in Group 4 (incomers) with no prior links to the WI, especially those with a young family, struggled to settle and felt largely unsupported and undervalued in their new role. One nurse was fearful that the result of not having a sense of belonging would influence her decision to leave and if she stayed her feelings of having to tolerate professional rejection would be

exemplified if, despite being asked to work 'bank' shifts in a team, she was unable to secure a permanent post.

Ancestry/acceptance

For many of the nurses who were from the WI originally (remainers, returners and leavers) their qualitative comments offered many perspectives related to how they perceived the concept of acceptability in their personal and professional capacity within the remote and rural setting. Much emphasis was placed on the strength of kinship and ancestry and how having a deep, intimate, and personal knowledge of their patients acted as a facilitator when delivering care. Local nurses described the attributes of being known and respected and having relationships within the community that stretched back to previous generations. Although this made anonymity non-existent, and personal and professional boundaries permeable, it also resulted in local nurses describing how enhanced familiarity had the potential to make patients more receptive and acceptant of receiving healthcare. There was only paper within the literature review (Caldwell, 2007), that clarified that the research participants were working in the same community that they were born in. This paper explored the life stories of nurse practitioners in rural Appalachia. Emphasis was placed on an invisible and spiritual kinship to land, blood ties to family and strong interrelationships with patients. Caldwell (2007) also clarified that this interconnection influenced nurses to stay and practice in the community of their birthplace.

Conversely, and paradoxically, several nurses, when they came to work in the WI (incomers) found some degree of scepticism amongst patients and colleagues and felt that it was much more difficult for them to feel accepted. One nurse, with no prior knowledge of the WI, felt particularly challenged and cited how she felt that the insider/outsider conundrum of remote and rural culture was a difficult barrier to overcome especially when endeavouring to feel trusted, valued and accepted. It was made considerably easier for nurses to feel accepted if they had some link to the WI such as their spouse having a family connection to the area, and they felt that their acceptability increased positively

through actively engaging with community events and groups which helped them develop new friendships and influenced their decision to remain in the WI.

One of the nurses who came to work in the WI spoke of how her experiences of being valued and accepted were enhanced. She equated her feelings of being accepted to how rural dwellers appreciated that she was engaging in the nursing profession. Therefore, she believed it was the ethos of the nursing profession that increased her credibility within the community. According to Lauder et al (2001) it is through being known and connected within a rural and remote community, that rural nurses gain social capital. Social capital is described as social connection within a community that bridges people and builds trust. Nurses practicing in rural settings tend to be more actively engaged professionally and personally in the rural communities in which they work (Bushy, 2000, Scharff, 2013) but more research is required to fully understand and appreciate the impact nurses have on rural health access and services.

Many applied and academic sociologists seek to better the lives of people and communities (Kersen, 2016). According to Michalski et al. (2020) forming and maintaining social relationships and the need for belonging has long been considered paramount to human motivation and well-being. With reference to one of the papers in the literature review, Heidelberg and Carson (2013) concluded that on a personal/social level non-resident workers in Australia's remote Northern Territory looked upon their place of work as being very much compartmentalised, lacking in social interactions which had a negative impact on their sense of belonging.

Chapter One indicated that the second statement pertaining to Rural Nursing Theory (RNT) is that "rural dwellers are self-reliant and resist accepting help or services from those seen as 'outsiders' or from agencies seen as national or regional 'welfare' programs" (Long and Weinert, 1989). RNT stated that rural persons preferred to seek health care from "insiders," persons with whom they were familiar. According to Knudtson (2000) the concept of familiarity led to significantly greater patient satisfaction with nurse practitioner services. Additional key concepts pertaining to the RNT statement are 'old-timer' and 'newcomer'. Winters (2022) purported that the second statement of RNT has

been both sustained and refuted by recent findings in current literature. The characteristic of self-reliance in rural dwellers continues to be an attribute influencing how they respond to illness and their care seeking behaviours, but Winters (2022) equated the availability of health information using the Internet to a possible removal of the cultural barrier of approaching 'outsiders' for health and medical care.

There is a paucity of research pertaining to the 'insider' or 'outsider' status of rural and remote nursing practice. This study adds to RNT and validates the suggestion by Leipert and Anderson (2012) that a nurse's status as an 'insider' or an 'outsider' in the community can affect interactions, acceptance, and effectiveness. The close-knit culture found within rural and remote communities can often make it difficult for newcomers to be accepted as they may be viewed as 'outsiders' or strangers. Winters (2022) considers the defining attributes of an insider to include being a member of a group, having access to privileged information, having an awareness of implicit assumptions and social context, and being a long-time occupant.

Specialist/generalist

Some of the nurses in this study had only worked in the WI but most nurses had experience of working in both the rural and remote as well as in the urban setting. Irrespective of where they gained their experience all the nurses in this study contended that there was a distinctive nature and scope of rural and remote nursing practice in the WI which was different to nursing practice in the urban setting.

The nurses all shared their various perspectives of the skills required to practice in the WI where they alluded to needing a vast knowledge base to enable them to deliver care safely across various specialist areas, often with limited resources and variable staffing patterns whilst feeling both geographically and professionally isolated. The need to work independently and often take on multiple roles with little back up often led nurses to feel out of their depth, afraid, and cognisant of the necessity to engage in continuous professional development to meet the needs of the role and allay feelings of fear. Working across different specialities and in a variety of areas often led nurses to feel

stressed and uncomfortable as they regularly had to practice skills that they did not utilise daily.

Although existing literature is replete with terms such as ‘generalist’ and expert generalist’ to describe the characteristics of rural and remote nursing, only one nurse in this study (returner) referred to the need to be a ‘generalist’ to work in this area. Rather, within the interview data, there was more emphasis on rural nursing being a specialised discipline with unique challenges and rewards.

Descriptions of this special type of nursing included the need to assume multiple roles often in isolation, the requirement to have a broad range of knowledge of different specialities and a strong demonstration of resilience to be able to cope with the scope, variety, and unpredictability of the role. Many nurses felt out of their depth at times and some nurses from the WI alluded to feelings of fear and isolation. One nurse from the mainland (incomer) felt ill equipped to cope with the unique challenges of nursing in the WI and this influenced her decision to return to an urban setting to gain more experience which she felt would better prepare her to come back to re-engage with rural and remote nursing in the future.

Current definitions and descriptions of rural and remote nursing are problematic. The term ‘expert generalist’ has provided a foundational theory of rural nursing (Bushy 2002, Long and Weinert 1989) and the ‘generalist’ work role conceptualised in RNT and early nursing studies (Bigbee, 1993), continues to feature and be described in the more contemporary rural and remote nursing literature (Montour et al, 2009, Keane et al, 2011, Barrett et al, 2016). Recent frameworks such as The National Rural and Remote Nursing Generalist Framework 2023-2027 (Australian Government, 2023) assume the ‘generalist’ stance and describe rural nurses as ‘generalists’ who deliver care across the lifespan and health continuum. Knight et al. (2016) refuted the term ‘expert generalist’ taken from RNT and have stated that choosing an alternative way to articulate the distinctive nature of rural nursing practice has eluded authors in Australia and internationally. A model developed by Knight et al. (2016: 1764) offered a new perspective on what makes the practice of rural nurses distinctive. Viewing the rural nurse role as *ambiguity master*, rather than *expert generalist*, represented a shift in thinking. The components of the model to

master ambiguity were *Knowing the rural community* reflected in the rural nurses' deep sense of being and purpose, *Mindful negotiation of multiple perspectives, factors & possibilities*, *Aesthetic judgment to make intelligent decisions*, and *Creativity to find a best outcome*.

There was only one participant (returner) in this study who mentioned the term 'generalist' when describing rural and remote nursing practice but there was consensus amongst all the participants that the scope, variety, and unpredictability of the practice of rural and remote nurses was unique.

Drawing on the novel biographical research methods utilised in this study it can be argued that preconceived mindsets do not fit the complexities of rural and remote nursing practice and in accordance with MacLeod et al. (2004) traditional definitions and descriptions provide limited understanding of nursing practice in this setting. The results of this study suggested that there is a complex interplay between the person/al, profession/al and place-related dimensions and domains affecting nurses' experience and decision-making to work in rural and remote areas and highlighted tensions around the broad knowledge and skill base required within the scope of practice. Participants recognised that in the WI they were engaged in a special variety of nursing, unique from their urban counterparts, and in the face of workforce shortages, geographical and professional isolation and fewer resources, tensions and paradoxes were apparent regarding the provision and delivery of safe, effective, and quality care to rural and remote populations. Many local nurses equated the experience they gained in the WI of the variety, scope, and unpredictability of nursing practice to having a broad knowledge and skill base and although they often felt overwhelmed, due to the need to be able to work across many specialities, they developed a strong demonstration of resilience. Some local nurses described how experience gained in the WI facilitated their transition to urban nursing and fostered a sense of empowerment. Paradoxically, results from this study depicted several nurses (incomers), who upon coming from the city to work in the WI, felt the need for continuous education to better equip them to cope with the scope, variety, and unpredictability of the role. Although working as an ANP in the WI, one nurse intended to return to the mainland to work across specialities and gain more experience to then be able to practice

more effectively, confidently, and autonomously in the rural and remote setting in the future. In this study, nurses in the WI described their work as different from other nursing roles. This supports the classification of remote and rural nursing as a specialty practice area (McCullough et al, 2022).

Many frustrations and tensions were apparent around recruitment and retention in the WI. The early career pathways of participants were clearly haphazard and several had difficulties in securing permanent employment after completing their training. Despite some engaging with unpredictable 'bank' nursing shifts and having to seek employment out with the NHS for a short time, many participants in Group 1 (remainers) progressed to develop lucrative careers. Several participants in Group 4 (incomers) were influenced to contemplate leaving the WI as they saw little opportunity for career progression or promotion.

This thesis clearly highlighted that all the groups of participants highly commended the training, education and the support from tutors in the Western Isles. Much of the teaching that was received by the local nurses was undertaken solely real time face-to-face in the classroom. More recently, especially in light of the COVID-19 pandemic, education was delivered using a variety of methods. The rural issues of distance lend themselves to online and hybrid models for teaching. All the nurses spoke about how good collaborative relationships were fostered based on effective communication, flexibility, empathy and engagement between students and faculty staff. Many interview accounts described how the nurses felt well supported in a smaller class with approachable tutors and how if undertaking placements they felt that their nursing skills were far superior to their counterparts on the mainland. Several nurses who were 'incomers', when they considered their training on the mainland, concluded that the local training in the WI was better. Local nurses found it was a benefit to stay at home in their own communities whilst working towards their degree. Exposing students to cardiac, neurological, paediatric and obstetric are just a few subpopulations curriculum requires to produce well-educated, prepared nurses. Local nurses spoke of gaining vast knowledge in the WI as they experienced working in multiple specialities and were introduced to and prepared for the scope, variety and unpredictability of rural and remote practice. To meet the needs of the community, nurses from all the groups

described how they required additional skills to function in what MacLeod et al. (2004) referred to as a multi-specialist role.

Findings from the systematic literature review formed the backdrop for this thesis and suggested three key implications for further research, policy, and practice. First, to support further research in this area consensus should be reached around the terms 'rural' and 'remote'. There is a need for more clarity whereby authors should explicitly report the definition of a rural or remote area used in their research. It is methodologically important (Wakerman, 2004). To more accurately assess the rurality of a community it may be more appropriate to include both quantitative (ie distance and population size) and qualitative criteria (ie community relationships, individual attitudes). Often 'remote' and 'rural' are used together without a clear understanding about the distinction between the two. The concept of rural or remote is complex, variable and evolving (Wakerman, 2004). The small but growing literature around remote health recognises that recruitment and retention issues arise as remote populations are smaller, more isolated, and more highly dispersed – often relying on visiting services (fly-in fly-out) (Heilderbeer and Carson, 2013). Due to the multidisciplinary and generalist nature of practice in remote settings, policymakers and planners are mandated to direct resources and programs such as the preparation of specially credentialed remote area nurses to address the health needs of populations in these areas (Wakerman et al., 2017). Second, policymakers involved in developing recruitment and retention strategies should consider how the key factors that influence nurses' decision-making to work in rural and remote areas, identified here, can be incorporated into campaigns to attract and retain nurses in these areas. The review highlighted some of the many advantages for nurses working in rural and remote settings that could be emphasised in recruitment approaches or marketing materials. Some described the opportunities available for them to step up in challenging situations, make leadership decisions and have more than one role. Evidently nurses who choose to work in rural and remote settings do so because of a combination of factors, and an understanding of their experiences and decision-making can help devise effective recruitment and retention strategies for this workforce at a time of global nursing shortages.

Finally, the literature has only begun to explore the connections between the person/al, profession/al and place-related dimensions of rural nursing and, although the systematic review highlighted and described the complex interconnections, further work is needed to fully understand the complexity of nurses' experiences of working in rural and remote settings and examine the interplay between the factors in MacKay's 3P model. Specifically, as most articles included a snapshot of nurses' experiences at a single moment in time, this thesis has addressed a particular need to understand nurses' experiences over time. In this way the complexity of the decision-making process and implications of decisions made to work in rural and remote settings has been better understood within the four groups of nurses over the course of their careers.

Implications for practice, policy and research

Theoretical implications

This thesis was guided by the theoretical underpinnings of Rural Nurse Theory. Viewing existing knowledge through the lens of RNT connected the researcher to develop the research questions and inform the rest of the design. The study findings have contributed to RNT by suggesting that there was a difference concerning a lack of anonymity between nurses who were born in the WI and nurses from the mainland and adding to and verifying RNT to include the concepts of '*visibility*', '*familiarity*', '*awareness of privacy*', and '*balance of lack of anonymity*'. RNT was also added to by suggesting and concurring with Liepert and Anderson (2012) that a nurses' status as an 'insider' or 'outsider' in the community can affect interactions, acceptance and effectiveness. Findings within this thesis have also refuted the term '*expert generalist*' and proposed that the distinctive nature of rural and remote nursing practice needs to be redefined to support classification of rural and remote nursing as a speciality practice area.

Implications for practice

Central to this thesis is the distinctive nature and scope of rural and remote nursing practice and the complex interplay between the person/al, profession/al and place related dimensions and factors. Findings from the study have

highlighted that each of the four individual groups of nurses (remainers, returners, leavers and incomers) have unique experiences. Some tensions/paradoxes (anonymity/visibility; longing/belonging; ancestry/acceptance; specialist/generalist) were identified which have practical implications to further understanding what influences nurses to choose rural and remote practice.

Positive aspects of a lack of anonymity, recounted by several participants in Group 2 (returners) on their return to nursing in the WI, such as developing a trusting and meaningful relationship and a fulfilment through looking after patients that are well known to them, need to be better understood. This could be done by examining how a lack of anonymity affects the nurse-patient relationship. Elucidating and encompassing patient experiences and perceptions of nursing care provided by a nurse well-known to them versus an unknown nurse has the potential to advance knowledge from both the nurses' and the patients' perspective regarding a lack of anonymity in the rural and remote setting. The negative aspect of a lack of anonymity such as challenges around maintaining confidentiality also requires further research.

Several nurses who were born in the WI felt that a lack of anonymity affected their practice in terms of accountability, responsibility and establishing a reputation. Some recounted how being known and visible and readily observed made them guard against anything in their personal or professional lives that could possibly mar the essential traits of a good character. Further examination of the practice of nurses in the rural and remote setting who experience a lack of anonymity may help to comprehend how these desirable qualities may be fostered. Further guidance in navigating the paradoxical nature of a lack of anonymity in rural and remote nursing practice could potentially come from employers or universities during student placements.

Nurses born in the WI had a deep-rooted sense of belonging, but this study emphasised that 'incomers' with no ancestral links or cultural connection to the WI found it more difficult to foster a sense of belonging. This has practical implications in terms of retention of staff and highlights the need to offer support to 'incomers' to facilitate meaningful connection to community. Within their Plan,

Recruit, and Retain framework Abelsen et al. (2020) considered that social, recreational, and other activities were key in ensuring a positive start and long stay in rural and remote communities. These strategies included involving local partners in meeting with new recruits and their families, giving guided tours of the place and engaging with schools to promote recreational and other programmes.

This support could be extended by adopting the initiative of the Scottish Rural Medicine Collaboration (SRMC) who along with The Remote and Rural Healthcare Education Alliance (RRHEAL), which is part of NHS Education for Scotland (NES), developed the Buddy Framework within the international project 'Making it Work' (2019). Being a buddy in the WI would involve supporting new nurses into the team. This initiative also encourages the self-selected supportive relationship to take place out with normal working hours and has the potential for buddies to help new nurses to navigate the nuances and complexities of the rural and remote context.

Rural nursing is unique and requires innovative nursing education methods that promote recruitment and retention of nurses from rural areas. Caldwell (2007) recommends that education is built into programmes that highlight the unique aspects of rural and remote practice, including nursing research, leadership, and rural culture.

Educational scholarships/fellowships for rural residents through 'grow your own' approaches, involving training local health workers to the scope of skills needed in the community and fostering their connection to the community through support, mentoring and good working conditions, is a recommendation of the World Health Organisation, (WHO, 2020). This initiative targets undergraduate nursing or midwifery students and links these students to a rural health care facility near the students' local preference, thereby addressing the shortage of healthcare workers in rural and remote areas and strengthening ancestral links and connections.

There is a paucity of research describing the practice of rural and remote area nurses despite the specialised context of practice (McCullough, 2022). This study has demonstrated that the variety, scope, and unpredictability of practice

in the WI was different from the role nurses undertake in the urban setting. To meet the needs of the community, nurses from all the groups described how they required additional skills to function in what MacLeod et al. (2004) referred to as a multi-specialist role. Through gaining a rich and deep understanding of the capabilities and characteristics required of both local nurses and nurses who came to work in the WI this thesis proposes that the practice of remote and rural nurses needs to be redefined. The term 'expert generalist' which has historically provided a foundation theory for rural and remote nurses (Knight et al., 2016) does not adequately address the deeper, intangible complexities and interplay of practice required in the rural and remote setting, where nurse's practice is intertwined with and shaped by the community and culture. Nurses often feel overwhelmed and see themselves as being isolated from the professional mainstream with no collegial support as they realise the need to have a wide range of advanced knowledge and ability to practice proficiently in multiple clinical areas simultaneously along the career trajectory. In no other setting is a nurses' practice so thoroughly and integrally a constant factor in a nurses' life (Scharff, 2022) as they are stripped of their own anonymity while simultaneously charged with protecting their patients' privacy. This thesis suggests that the practice of rural and remote nurses should be redefined and considered as a specialty area in its own entity.

By considering the practice of remote and rural nursing as a specialism there are new options for rural and remote nurse policy and education development that extends beyond strategies involving the clinical scope of practice of the nurse. Rural and remote nursing recruitment is concerned with attracting the right person who holds a specific skill set, followed by retention strategies encapsulating the need to focus on autonomous practice to allow the person to flourish within the realities of a rural environment. In Australia, considering rural and remote nursing as a specialty area in its own right, led to the development of a specialist category of nursing – Rural Area Nurses (CRANApplus, 2016). This professional body ensures the delivery of safe, high-quality healthcare to remote and isolated areas of Australia by representing, supporting, and educating health professionals. There is potential for this initiative to be developed more widely. Giving rural and remote nurses career advancement

opportunities in rural areas through specialist training which results in the recognition of expertise, and a pathway of rural career progression, may attract nurses to plan a rural career.

There are opportunities to think differently about the curriculum development in rural nurse preparation and continued professional development. Due to the variety, scope, and unpredictability of rural and remote practice there is a need for ongoing education opportunities to keep nurses updated and confident to work with a higher degree of independence with limited or delayed access to resources. Continuous professional development (CPD) initiatives tend to be delivered in larger centres (Jones et al, 2019) which is a disadvantage for rural and remote nurses in terms of incurring additional travel and accommodation costs and time spent away from family. This has a negative effect on the individual and the organisation. The emergence of the COVID-19 pandemic resulted in a sudden transition to remote learning (Wallace et al., 2021) and progress has clearly been made in harnessing the power of technology to enhance CPD. The RCN (2023), in response to the Scottish government's (2022) inquiry on healthcare in remote and rural areas, stated that there needs to be an understanding that nursing staff may feel professionally isolated and there should be more focus on their continuous learning and development. Policy makers and educators need to ensure that nurses and other professionals are confident users of technology, and that time is allowed to them for training and support. Several nurses in this study felt at a disadvantage in the WI due to poor signal when engaging with technology to further their studies. Better broadband infrastructure is also needed to connect with patients and support the workforce.

Further implementation of the ANP role whereby nurses are highly qualified to manage complex cases and engage in multiple nursing roles would benefit the safe delivery of care in the rural and remote setting where the nearest doctor may be many miles and hours away. Strachan et al. (2022) suggested that ANP roles can be implemented with greater success when advanced nursing knowledge is valued, when there is leadership at all levels, and where appropriate education programmes are delivered.

There are several innovative strategies for policy makers to consider which have the potential to address recruitment challenges in the rural and remote setting including engaging with educational scholarships or fellowships for rural residents or 'grow your own' programmes. Following an evaluation of a pre-nursing scholarship programme in rural Scotland, Smith et al. (2015) highlighted that evidence suggested that pre-nursing experience that alerts aspirant nurses to the availability of training closer to home may increase recruitment and retention of health care workers in rural and remote areas. The association between rural living and the increased likelihood of remaining/returning to the rural workforce is long established (Dunbabin and Levitt, 2003). This has been recognised by rural medical workforce initiatives such as the 'rural pipeline' which works by nurturing candidates from a rural background into training programmes, with the assumption that when these candidates qualify, they will be ever more likely to engage in rural or remote practice. It may be beneficial to learn from a recent Scottish initiative, Scotland's first graduate entry, undergraduate medical programme (ScotGEM), which focuses on rural medicine. As a monetary incentive, graduates are offered a 'return of service' bursary in exchange for a commitment to work in NHS Scotland for four years (NHS, 2023).

As a useful adjunct to the nursing student's education, clinical practice in rural and remote settings have been demonstrated to be vital (Conger and Plager 2008). Students need to be introduced to concepts such as the lack of anonymity, insider/outsider status, professional and geographical isolation, scope, variety, and unpredictability of the role. This can be done through an exchange programme. According to Neill and Taylor (2002) placing students in rural clinical practicums increased graduates choosing rural or remote employment. Kenny and Duckett (2003, p. 619) advocated for such practice and asserted that "if they (nursing students) understand what rural practice is like and get a taste of it when they are studying, they come here with their eyes wide open."

Several participants in this study (leavers) who hoped to come back to work in the WI after gaining experience in the urban setting were very concerned that they would have difficulty securing a permanent position on their return and

reference was made to how they felt it was unfair that older nurses were retiring and then coming back to work on an ad hoc basis. According to MacLeod et al (2021) following a study to better understand what it means for retired nurses to work after retirement, it was found that transitioning to retirement in rural and remote practice can be re-imagined in ways to involve both the community and the workplace. The older nurse has a wealth of knowledge and skills to navigate the scope, variety, and unpredictability of rural and remote nursing practice along with a nuanced knowledge of community, geography, people, networks of relationships, culture, and resources. This complex knowledge will be lost when nurses fully retire. Policy makers have the potential to draw on this wealth of knowledge by creating new opportunities for retired nurses to engage in mentoring, teaching, and supporting a multigenerational workforce, hence, giving back to their colleagues and community.

Implications for policy

According to Palmer and Rolewicz (2020) it is nothing new that rural and remote providers experience problems that differentiate them from their urban counterparts. However, the Covid-19 pandemic has both exposed these further and compounded challenges such as exacerbating workforce recruitment and retention issues. Despite this, many of the national standards and policies were not appropriately adapted to meet the needs of rural areas even before the pandemic struck. Offerings of policies are scant (Palmer and Rolewicz, 2022). However, recent drivers by the Scottish Government (2022) show commitment to developing a remote and rural workforce recruitment strategy by the end of 2024, which will provide a framework which will support employers to ensure that Health and Social Care needs of people who live in remote and rural communities are met. To achieve these ambitious aims it is vital that the Scottish Government (2022) engages with the evidence about the complexity of rural and remote health care delivery while embracing the potential to develop innovative and sustainable solutions that also capitalise on living and working in these unique settings. This strategy will aim to transform ways in which the workforce is recruited, trained, equipped, and organised. Findings from this study provide new insights into factors that influence nurses' decisions to work in the WI.

Implications for research

This thesis has important implications for research in two differing domains. First, by indicating further empirical research necessary to enhance our understandings of nurses' decision-making to work in rural and remote settings and second, by its contribution to biographical research methods.

Biographical research methods

As suggested in Chapter Two using biographical methods has much to offer in terms of building information to provide an overview of the events that have shaped a person's life (Denzin, 1989). The epistemological and ontological underpinnings of this research complimented the biographical approach as it treats humans as agents who actively give meaning to their lives and learning (Stroobants, 2005). The aim of this research study was to explore nurses' experiences over the course of a career to generate insights into the complex interplay between the person/al, profession/al and place related dimensions of rural and remote nursing and understand the complexity of the decision-making process and the implications of decisions to work in rural and remote settings. Through biographical semi structured interviews, the participants were empowered to share a lifetime of occupational experiences, and an understanding of how personal, social, economic, historical, and geographical influences shaped these experiences.

The evolving MacKay's 3P model

This thesis has introduced the MacKay's 3P model (Figure 3). As a result of conducting the systematic review and meta-synthesis of qualitative research (MacKay et al., 2021) MacKay's 3P model was developed. The model depicts three dimensions: person/al, profession/al and place and eighteen interrelated domains which highlight the multiple and complex factors at play that guide nurses' decisions to remain or leave rural and remote settings. The model has been utilised throughout the research process in this PhD study. It has provided a theoretical framework, driven the research questions and informed thematic analysis of data. MacKay's 3P model has evolved and complexity has been added to the model. Thematic analysis has revealed a further ten domains. The person/al, profession/al and place related themes and subthemes can be

visualised in Table 6, hence clarifying that through undertaking this research the empirical knowledge in this field has been added to and Rural Nursing Theory has been advanced.

Research Dissemination

Research findings from this PhD study will be submitted for publication in a peer reviewed journal.

Recommendations

Further qualitative biographical research is merited. While this thesis makes a substantial contribution to qualitative understandings of the person/al, profession/al and place related dimensions of rural and remote nursing and implications of decisions to work in a rural and remote setting the study has potential limitations. The findings relate to NHS Western Isles of Scotland and therefore might not necessarily be transferable to different socio-cultural contexts. Hence, this research should be replicated in different rural and remote settings.

The variation in definitions of 'rural' has important methodological implications. As well as defining 'rural' in terms of population and population density, and proximity to urban areas, including more subjective definitions such as culture and social perceptions in research studies is important.

Findings from this research have added to the body of evidence in Rural Nurse Theory by indicating that a lack of anonymity affected nurses who were born in the WI in a different way from nurses from an urban background and local nurses experienced a stronger sense of belonging than 'incomers' who had difficulties being accepted. There is a need to support nurses transitioning to rural practice by strengthening their connections to people and place and adopting initiatives such as mentoring, preceptorship, socialisation through community partners meeting with new recruits and their families, giving guided tours of the place, and engaging with schools to promote recreational and other programmes (Plan, Recruit and Retain Framework, Abelson, 2020), and the Buddy Framework (Making it Work, 2019) to facilitate retention.

It is apparent that there is a need for a review of workforce structures in rural and remote areas to facilitate recruitment and retention. Areas of consideration for educators and policy makers include access to structured training programmes enabling the development of recognised 'specialised' career paths and educational scholarships/fellowships for rural residents through 'grow your own' approaches.

Strengths and weaknesses of the study

The novelty of this research study is characterised as one of the strengths. It is novel because rather than describing aspects of rural and remote nursing as individual entities, it has provided insight into the complex dynamic of experiences that ultimately influences nurses' decisions to work in the rural and remote setting of the Western Isles of Scotland. The strengths of the study are exemplified in its worth and relevance; its depth and detail; its contribution to advancing rural nursing theory; its unique application of MacKay's 3P model to guide all aspects of the research process. Capturing the depth, detail and richness of the data is attributed to the qualitative, semi structured biographical interviews which provided an effective way to understand the nurses' experiences over the course of a career. Reflexive thematic analysis for the four different groups of nurses (remainers, returners, leavers and incomers) revealed new understandings such as the differences between the consequences of a lack of anonymity between nurses who were born in the WI and nurses who came to work in the WI.

Sampling in this research was conducted mainly by purposive sampling. Another strength of this study is shown in Table 5 which highlighted the participants' role at the time of interview and demonstrated that there was a good variation of roles including hospital and community nurses, midwives, health visitors and specialist nurses. Out of the twenty-five participants three were male and thirteen participants were unknown to the researcher.

The concept of validity was strengthened by critically appraising the qualitative articles retained for synthesis in the literature review paper by MacKay et al. (2021), by applying the Critical Appraisal Skills Programme (CASP) tool (2018) for qualitative research. This PhD study has also been assessed using the

Consolidated criteria for reporting qualitative research (COREQ) (Tong et al., 2007). This 32-item checklist evaluated researcher bias, validity, reliability, importance of the research project, clarity and coherence of research reports, ethics, and the use of appropriate and rigorous methods. Notwithstanding the use of qualitative appraisal tools there still remains a degree of subjectivity, and although all articles in the literature review were critically appraised and scored by the researcher and then independently scored by the PhD supervisors, it is possible that other researchers may have appraised the quality of the studies in a different way.

Whilst this study has provided important insights into the experiences of rural and remote nurses in the WI, it could be contested that it was restrictive, limiting its applicability to other settings. This work provides further avenues for research that was not possible within the confines of this study.

Conclusion to thesis

This research study is novel. The use of biographical research methods has underpinned the study and captured deep and rich data which provided unique insights and enhanced understanding of the complex interplay between the person/al, profession/al and place related factors that influence nurses' decisions to work in the rural and remote setting of the Western Isles of Scotland. Reflecting on existing literature, guided by MacKay's 3P model (MacKay et al., 2021) and the rich heritage of Rural Nurse Theory thematic analysis of the interview accounts of four groups of nurses (remainers, returners, leavers and incomers) identified four tensions: anonymity/visibility; longing/belonging; ancestry/acceptance; specialist/generalist.

This study has added to RNT by highlighting that a lack of anonymity affected nurses who were born in the WI (remainers, returners, leavers) in a different way from nurses from an urban background (incomers). Local nurses felt a greater tension due to a lack of anonymity which negatively affected their relationships and behaviours, whereas 'incomers' welcomed a lack of anonymity which enhanced their feelings of acceptance and strengthened their connections to people and place.

The strength of kinship, proximity to family members and understanding of rural culture, heritage, language, religion and music fostered a profound sense of belonging in local nurses influencing them to remain in the WI or return to the WI. Findings suggested that the transition from the mainland was made easier for those who had spouses with family origins in the WI, but 'incomers' with no ties to the WI found it difficult to become accepted, and some felt personally and professionally unsupported.

Nurses from all the groups acknowledged the need for a broad range of knowledge of different specialities and a strong demonstration of resilience to be able to cope with the scope, variety and unpredictability of rural and remote nursing. Frustrations and tensions were apparent around recruitment and retention in the WI. Early career pathways of nurses were clearly haphazard due to some having difficulties securing permanent employment after completing their training. Despite engaging with unpredictable 'bank' nursing shifts and having to seek employment out with the NHS for a short time, many 'remainers' progressed to develop lucrative careers. 'Incomers' were influenced to contemplate leaving the WI as they saw little opportunity for career progression or promotion. By considering the practice of rural and remote nursing as a 'specialism' there are new options for rural and remote nurse policy and education development.

It is evident that the practice of rural nursing is dimensionally distinctive. Giving rural and remote nurses career advancement opportunities through specialist training will result in the recognition of expertise, and a pathway of rural career progression, which may attract nurses to plan a rural career. A whole of community approach to workforce will facilitate opportunities for both family members, and the health professional to be part of the rural and remote community.

Appendix 1

Country	Government definitions/classifications of 'rural' using specific indicators																														
Australia	The 3 main geographical classifications to guide rural health policy in Australia are – 1. the Rural, Remote and Metropolitan Areas Classification (RMMA), 2. the Accessibility/Remoteness Index of Australia Classification (ARIA) and 3. the Australian Standard Geographical Classification – Remoteness Area Classification (ASGC-RA) RMMA classification – consists of 3 zones (metropolitan, rural and remote) and 7 classes. Used for research purposes and in some cases to allocate funding to areas. <table><tr><th>ZONE</th><th>CLASS</th><th>ABBREVIATION</th></tr><tr><td>Metropolitan Zone</td><td>Capital cities Other metropolitan centres (urban centre population greater than 100,000)</td><td>M1</td></tr><tr><td>Rural Zone</td><td>Large rural centres (urban centre population 25,000 – 99,999) Small rural centres (urban centre population 10,000 – 24,999) Other rural areas (urban centre population less than 10,000)</td><td>R1 R2 R3</td></tr><tr><td>Remote Zone</td><td>Remote centres (urban centre population greater than 5,000) Other remote centres (urban centre population less than 5,000)</td><td>Rem 1 Rem 2</td></tr></table> ARIA classification – relies on road distance as a surrogate for remoteness and on the population size of a service centre as a surrogate for the availability of services. The ARIA methodology produces index values between 0 and 12 for 11,340 populated localities. Areas with an ARIA index value of 0 have the highest levels of access to goods and services, and areas with an ARIA index value of 12 have the highest levels of remoteness. Method 1. Service centres in Australia were allocated to 4 categories based on population size in 1996 Census. A - equal to or more than 250,000 persons B - 48,000 to 249,999 persons C - 18,000 to 47,999 persons D - 5,000 to 19,999 persons 2. For each of the 11,340 populated localities the road distance to closest locality A B C and D service centres were calculated. 3. Average distance was also calculated from all 11,340 populated localities to the nearest categories A B C and D 4. Distance calculated in step 2 divided by average distance in step 3 to give ratio 5. Ratio capped at a value of 3.0 6. For each populated locality the ratios relating to each of the 4 categories of service centres were summed to give an index value out of 12 STRUCTURE OF ARIA CLASSIFICATION <table><tr><th>CLASS</th><th>ABBREVIATION</th><th>INDEX VALUE RANGE</th></tr><tr><td>Highly accessible</td><td>HA</td><td>0 – 1.84</td></tr><tr><td>Accessible</td><td>A</td><td>Greater than 1.84 – 3.51</td></tr><tr><td>Moderately accessible</td><td>MA</td><td>Greater than 3.51 – 5.80</td></tr><tr><td>Remote</td><td>R</td><td>Greater than 5.80 – 9.08</td></tr><tr><td>Very remote</td><td>VR</td><td>Greater than 9.08 - 12</td></tr></table> Classes characterised broadly as follows: HA – relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction A – some restrictions to accessibility of some goods and services and opportunities for social interaction MA – significantly restricted accessibility of goods and services and opportunity for social interaction R – very restricted access of goods, services and opportunity for social interaction VR – very little access of goods, services and opportunity for social interaction ASGC-RA classification is based on ARIA + methodology but uses a different island weighting factor for Tasmania and has an index value which is based on 5 categories of service centres, A B C D and E (populations of 1,000 – 4,999 persons)	ZONE	CLASS	ABBREVIATION	Metropolitan Zone	Capital cities Other metropolitan centres (urban centre population greater than 100,000)	M1	Rural Zone	Large rural centres (urban centre population 25,000 – 99,999) Small rural centres (urban centre population 10,000 – 24,999) Other rural areas (urban centre population less than 10,000)	R1 R2 R3	Remote Zone	Remote centres (urban centre population greater than 5,000) Other remote centres (urban centre population less than 5,000)	Rem 1 Rem 2	CLASS	ABBREVIATION	INDEX VALUE RANGE	Highly accessible	HA	0 – 1.84	Accessible	A	Greater than 1.84 – 3.51	Moderately accessible	MA	Greater than 3.51 – 5.80	Remote	R	Greater than 5.80 – 9.08	Very remote	VR	Greater than 9.08 - 12
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Remote Australia	R	Greater than 5.92 – 10.53																	
Very Remote Australia	VR	Greater than 10.53 - 15																	
Canada	6 ways of defining 'rural' for national level analysis in Canada <table><tr><th>AREA</th><th>DESCRIPTION</th></tr><tr><td>Census rural</td><td>Individuals living in the countryside outside centres of 1,000 or more population. Population living outside places with densities of 400 or more people per square kilometre</td></tr><tr><td>Rural and Small Town (RST)</td><td>Individuals in towns or municipalities outside the community zone of larger urban centres (with 10,000 or more population). These individuals may be disaggregated into zones according to the degree of influence of a larger urban centre (called census metropolitan and census agglomeration influenced zones (MIZ)). MIZ disaggregates the RST population into 4 sub-groups based on the size of commuting flows to any larger urban centre (of 10,000 or more)</td></tr><tr><td>OECD (Organisation of Economic Co-operation and Development) rural communities</td><td>Individuals in communities with less than 150 persons per square kilometre. This includes the individuals living in the countryside, towns and small cities (inside and outside the commuting zone of larger urban centres)</td></tr><tr><td>OECD (Organisation of Economic Co-operation and Development) predominantly rural regions</td><td>Individuals living in census divisions with more than 50 percent of the population living in OECD rural communities. This includes all census divisions without a major city</td></tr><tr><td>Beale non-metropolitan region</td><td>Individuals living outside metropolitan regions with urban centres of 50,000 or more population. Non-metropolitan areas are sub divided into 3 groups based on settlement type and a 4th group based on location in the North. The groups are further divided into metropolitan 'adjacent' and 'non-adjacent' categories. Non-metropolitan regions include urban settlements with populations of less than 50,000 people and areas with no urban settlements (where 'urban settlements' are defined as places with a population of 2,500 or more)</td></tr><tr><td>Rural Postal Codes</td><td>Individuals with a '0' as the second character in their postal code. These individuals live in areas where there are no letter carriers (i.e. residents go to a post office or corner postal box to pick up their mail)</td></tr></table> STATISTICS CANADA., 2006. <i>Rural and Small Town Canada Analysis Bulletin</i>. Available: http://www.communityaccounts.ca Accessed on [31/05 :2014]}.	AREA	DESCRIPTION	Census rural	Individuals living in the countryside outside centres of 1,000 or more population. Population living outside places with densities of 400 or more people per square kilometre	Rural and Small Town (RST)	Individuals in towns or municipalities outside the community zone of larger urban centres (with 10,000 or more population). These individuals may be disaggregated into zones according to the degree of influence of a larger urban centre (called census metropolitan and census agglomeration influenced zones (MIZ)). MIZ disaggregates the RST population into 4 sub-groups based on the size of commuting flows to any larger urban centre (of 10,000 or more)	OECD (Organisation of Economic Co-operation and Development) rural communities	Individuals in communities with less than 150 persons per square kilometre. This includes the individuals living in the countryside, towns and small cities (inside and outside the commuting zone of larger urban centres)	OECD (Organisation of Economic Co-operation and Development) predominantly rural regions	Individuals living in census divisions with more than 50 percent of the population living in OECD rural communities. This includes all census divisions without a major city	Beale non-metropolitan region	Individuals living outside metropolitan regions with urban centres of 50,000 or more population. Non-metropolitan areas are sub divided into 3 groups based on settlement type and a 4 th group based on location in the North. The groups are further divided into metropolitan 'adjacent' and 'non-adjacent' categories. Non-metropolitan regions include urban settlements with populations of less than 50,000 people and areas with no urban settlements (where 'urban settlements' are defined as places with a population of 2,500 or more)	Rural Postal Codes	Individuals with a '0' as the second character in their postal code. These individuals live in areas where there are no letter carriers (i.e. residents go to a post office or corner postal box to pick up their mail)				
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Rural Postal Codes	Individuals with a '0' as the second character in their postal code. These individuals live in areas where there are no letter carriers (i.e. residents go to a post office or corner postal box to pick up their mail)																		
England & Wales	Rural and Urban Area Classification 2004 (Office for the Deputy Prime Minister- ODPM) <table><tr><th>Band</th><th>Settlement Definition (2004)</th></tr><tr><td>Urban Areas</td><td>Settlements with a population of 10,000 or more people</td></tr><tr><td>Rural Areas A Small Town B Village C Hamlets and Dispersed</td><td>Identified using population density of 1 hectare grid – squares of settlements with a population less than 1,000 people and open countryside</td></tr></table> Rural/Urban Local Authority Classification using Output Area Level Classes based on 2001 Census <table><tr><td>Major Urban</td><td>100,000 people or 50% in urban areas with a population of more than 750,000</td></tr><tr><td>Large Urban</td><td>50,000 people or 50% urban areas with a population between 250,000 and 750,000</td></tr><tr><td>Other Urban</td><td>Less than 26% living in rural settlements and larger market towns</td></tr></table>	Band	Settlement Definition (2004)	Urban Areas	Settlements with a population of 10,000 or more people	Rural Areas A Small Town B Village C Hamlets and Dispersed	Identified using population density of 1 hectare grid – squares of settlements with a population less than 1,000 people and open countryside	Major Urban	100,000 people or 50% in urban areas with a population of more than 750,000	Large Urban	50,000 people or 50% urban areas with a population between 250,000 and 750,000	Other Urban	Less than 26% living in rural settlements and larger market towns						
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Large Urban	50,000 people or 50% urban areas with a population between 250,000 and 750,000																		
Other Urban	Less than 26% living in rural settlements and larger market towns																		

	Significant Rural	Between 26 and 50% living in rural settlements and larger market towns
	Rural-50	At least 50% but less than 80% living in rural settlements and larger market towns
	Rural-80	At least 80% living in rural settlements and larger market towns
	OFFICE FOR NATIONAL STATISTICS., 2004. <i>Rural and Urban Area Classification 2004 – An Introductory Guide</i> . Available: www.ons.gov.uk/ons/guide-method/census2001/ Accessed on [31/05:2014].	
Ireland	Northern Ireland Statistics and Research Agency Classification and Delineation of Settlements. Band A-E = URBAN. Band F-H = RURAL.	
	LABEL	NAME
	Band A	Belfast Metropolitan Urban Area (BMUA)
	Band B	Derry Urban Area (DUA)
	Band C	Large Town
	Band D	Medium Town
	Band E	Small Town
	Band F	Intermediate Settlement
	Band G	Village
	Band H	Small Village, Hamlet and Open Countryside
	SETTLEMENT POPULATION SIZE (2001 CENSUS)	
Scotland	C 580,000	
	C 90,000	
	18,000 or more and under 75,000 (outside BMUA and DUA)	
	10,000 or more and under 18,000 (outside BMUA and DUA)	
	4,500 or more and under 10,000 (outside BMUA and DUA)	
	2,250 or more and under 4,500 (outside BMUA and DUA)	
	1000 or more and under 2,250 (outside BMUA and DUA)	
	Settlements of less than 1000 people and open countryside (outside BMUA and DUA)	
	NORTHERN IRELAND STATISTICS & RESEARCH AGENCY., 2005. <i>Report of the Inter-Departmental Urban-Rural Definition Group</i> . Available: nisra.gov.uk . Accessed on [26/04:2014].	
	Scottish Government Urban/Rural Classification- combining both population (National Records of Scotland –population density postcodes) and accessibility (drive time analysis) measures.	
	6-fold classification to distinguish between urban, rural and remote areas	
	CLASS	CLASS NAME
	1	Large Urban Areas
	2	Other Urban Areas
	3	Accessible Small Towns
	4	Remote Small Towns
	5	Accessible Rural Areas
	6	Remote Rural Areas
	DESCRIPTION	
	Settlements of over 125,000 people	
	Settlements of 10,000 to 125,000 people	
	Settlements of between 3,000 and 10,000 people, and within a 30 minute drive time of a Settlement of 10,000 or more	
	Settlements of between 3,000 and 10,000 people, and with a drive time of over 30 minutes to a Settlement of 10,000 or more	
	Areas with a population of less than 3,000 people, and within a 30 minute drive time of a Settlement of 10,000 or more	
	Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes to a Settlement of 10,000 or more	
	8-fold classification to distinguish between urban, rural, remote and very remote areas	
	CLASS	CLASS NAME
	1	Large Urban Areas
	2	Other Urban Areas
	3	Accessible Small Towns
	4	Remote Small Towns
	5	Very Remote Small Towns
	6	Accessible Rural Areas
	7	Remote Rural Areas
	DESCRIPTION	
	Settlements of over 125,000 people	
	Settlements of 10,000 to 125,000 people	
	Settlements of between 3,000 and 10,000 people, and within a 30-minute drive time of a Settlement of 10,000 or more	
	Settlements of between 3,000 and 10,000 people, and with a drive time between 30 and 60 minutes to a Settlement of 10,000 or more	
	Settlements of between 3,000 and 10,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more	
	Areas with a population of less than 3,000 people, and within a drive time of 30 minutes to a Settlement of 10,000 or more	
	Areas with a population of less than 3,000 people, and with a drive time of between 30 and 60 minutes to a Settlement of 10,000 or more	

	8	Very Remote Rural Areas	Areas with a population of less than 3,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more
	THE SCOTTISH GOVERNMENT., 2012. <i>Scottish Government Urban/Rural Classification 2011-2012</i> . Edinburgh. The Scottish Government.		
United States of America	The United States government has at least 15 different official definitions of 'rural'- the 3 most common federal definitions are as follows:		
	The US Census Bureau – identifies 2 types of urban areas. ('Rural' encompasses all population, housing and territory not included within an 'urban area')		
	AREA	DESCRIPTION	
	Urbanized Areas (UA's)	Areas with a population of 50,000 or more people.	
	Urban Clusters (UC's)	Areas with a population of at least 2,500 and less than 50,000 people	
	Office of Management and Budget (OMB) – designates areas based on the standards for Delineating Metropolitan and Micropolitan Statistical Areas		
	AREA	DESCRIPTION	
	Metropolitan Statistical Area	Areas with at least one urbanised area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties	
	Micropolitan Statistical Area	Areas with at least one urban cluster of at least 10,000 but less than 50,000 population plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties	
	US Department of Agriculture Economic Research Services (ERS) researchers analyse conditions in 'Rural' America and study conditions in non-metropolitan areas, defined on the basis of counties.		
	AREA	DESCRIPTION	
	Non-metropolitan county	Includes a combination of open countryside, rural towns (places with fewer than 2,500 people) and urban areas with a population ranging from 2,500 to 49,000, that are not part of larger labour market areas (metropolitan areas)	
	UNITED STATES DEPARTMENT OF AGRICULTURE., 2007. <i>National Agricultural Library – Rural Information Centre</i> . Available: http://ric.nas.usda.gov/what-is-rural Accessed on [31/05 2014]		
	Further selected classifications of 'rural'		
	US Department of Veteran Affairs, Office of Rural Health		
AREA	DESCRIPTION		
Urban Area (Census Bureau defined urbanized area)	Areas with a population density of at least 1000 people per square mile.		
Rural Area	Any non-urban or non-highly rural area		
Highly rural area	An area having less than 7 civilians per square mile		
UNITED STATES DEPARTMENT OF VETERAN AFFAIRS., 2007. <i>Office of Rural Health</i> . Available: http://www.ruralhealth.va.gov/about/rural-veterans.asp . Accessed: 31/05:2014			
Rural-Urban Continuum Codes (RUCC). Urban (Metro) Codes 1-3 and Rural (Non-Metro) Codes 4-9.			
AREA	DESCRIPTION OF CODES		
Urban: Metro Codes 1-3	Code 1 – Counties in metro areas of 1 million or more people. Code 2 – Counties in metro area with 250,000 to 1 million people. Code 3 – Counties in metro areas with less than 250,000 people		
Urban Influence Codes (UIC)			
AREA	DESCRIPTION OF CODES		
Urban – Counties identified as metropolitan based on the OMB classification	Code 1 – large metro area Code 2 – small metro area		
Rural – non-metropolitan counties are divided into 10 groups, first by micro and	Non-metropolitan Micropolitan Codes (3,5,8)		

	non-core status, then subdivided into groups based on adjacency to metropolitan areas	Code 3 – Micropolitan adjacent to large metro Code 5 – Micropolitan adjacent to small metro Code 8 – Micro not adjacent to a metro area Non-core codes (4,6,7,9,10-12) Code 4 – Non-core adjacent to large metro. Code 6 – Non-core adjacent to small metro with own town Code 7 – Non-core adjacent to small metro with no own town Code 9 – Non-core adjacent to micro with own town Code 10 – Non-core adjacent to micro with no own town Code 11 – Non-core adjacent to metro or micro with own town Code 12 – Non-core not adjacent to metro or micro with no own town
Rural – Urban Commuting Area (RUCA) – based on OMB metropolitan and micropolitan core and used to identify small geographical areas (census tracts. 10 primary codes are subdivided into 30 secondary codes used to identify secondary and overlapping commuting flows)		
AREA		DESCRIPTION
Urban		Codes 1-9 indicate metro and micro cores and high and low commuting flows Code 1 – Urban core census tract (CT) Code 2 – CT strongly tied to urban core Code 3 – CT weakly tied to urban core Code 4 – Large town CT Code 5 – CT strongly tied to large town Code 6 – CT weakly tied to large town Code 7 – Small town CT Code 8 – CT strongly tied to small town Code 9 – CT weakly tied to small town
Rural		Areas outside the metropolitan and micropolitan areas Code 10 – identifies rural commuting flow and is considered an isolated small rural CT
PROUTY VANDERBOOM, C. and MADIGAN, E.A., 2007. Federal Definitions of Rurality and the Impact on Nursing Research, <i>Research in Nursing & Health</i> , 30, pp. 175-184.		
American Hospital Association Statistics The American Hospital Association ‘s (AHA) section for small and rural hospitals has over 1600 small or rural hospital members. To become a section member the hospital must meet at least one of the following criteria:		
AHA MEMBER		CRITERIA
Small and Rural Hospital		1. To have 100 or fewer beds 2. To have 4000 or fewer admissions 3. To be located outside a Metropolitan Statistical Area
American Hospital Association Statistics., 2007. <i>Section for Small or Rural Hospitals</i> . Available: www.aha.org/about/membership/smallrural/ Accessed on 31/05:2014		
California Office of Statewide Planning and Development (OSHPD) definition of Rural Medical Service Study Areas (MSSA). MSSA's are sub-city and sub-county geographical units used to organise and display population, demographic and physician data by incorporating the US Census total population, socioeconomic and demographic data.		
RURAL MEDICAL SERVICE STUDY AREA (MSSA)		DESCRIPTION
Urban MSSA		Population range of 75,000 to 125,000. Reflect recognised community and neighbourhood boundaries.
Rural MSSA		Population density of less than 250 persons per square mile. No population centre exceeds 50,000
Frontier MSSA		Population density of less than 11 persons per square mile

	California Office of Statewide Planning and Development (OSHPD)., 2007. Available: www.oshpd.ca.gov Accessed on 31/05:2014
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Appendix 2



26 September 2017

Ms S Mackay
22 Coll
Back
Isle of Lewis HS2 OJR

Dear Seonaid

**Rural Nursing
NICR 16/17 – Paper No.76**

Thank you for your email of 15 September 2017 including the following attachments:

- Covering letter;
- Rural Nursing Protocol (V2)
- Consent Form (V2)
- Participant Information Sheet (V2)
- IRAS (V2)
- NHS Western Isles – approval of project

I am pleased to advise that your study has been granted approval, and wish you and your team all the best.

May I remind you of the need to inform NICR (nicr@stir.ac.uk) prior to making any amendments to this protocol, or any changes to the duration of the project and provide notification of study completion. A site file of all documents related to the research should be maintained throughout the life of the project, and kept up to date at all times. The site file template can be found on the NICR webpage at:

<http://www.stir.ac.uk/research/integritygovernanceethics/researchethics/formsandguidance/>

Please bear in mind that your study could be audited for adherence to research governance and research ethics protocols.

NICR 16/17 – Paper No.76

Yours sincerely

A handwritten signature in blue ink, appearing to read "Josie Evans".

Dr Josie Evans
(Depute Chair)

□

Appendix 3

Bòrd SSN nan Eilean Siar Western Isles NHS Board	37 South Beach Stornoway Western Isles HS1 2BB Telephone 01851 702997 Fax 01851 704405 http://www.wihb.scot.nhs.uk	NHS Eileanan Siar Western Isles
Public Health Department		
Seonaid C Mackay 22 Coll Back Isle of Lewis HS2 0JR	Date: 05.09.2017 Your Ref: Our Ref: MM/LM/130 Enquiries to: Martin Malcolm Extension: 3055 Direct Line: 01851 708055 E-mail: martin.malcolm@nhs.net	
Dear Ms Mackay		
Re. Management Approval for Non-Commercial Research		
MREC Ref: Not Applicable NRS Ref: Not Applicable Project title: Rural Nursing.		
I am pleased to tell you that on behalf of Western Isles NHS you now have Management Approval for the research project named above. This is based on the documents received from yourself and the relevant Approvals being in place. In particular I acknowledge that:		
• The project is sponsored by University of Stirling. • The project does not require external funding. • The project is Site-Specific Assessment exempt. • NHS Ethics approval not required.		
The following conditions apply:		
• The responsibility for monitoring and auditing this project lies with University of Stirling. • This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the Research Governance Framework for Health and Community Care in Scotland (2006, 2nd Edition), however prior written notice of audit will be given. • Any researchers coming into NHS Western Isles for the purposes of carrying out research with patients will require the submission of a Research Passport, Occupational Health approval and Letter of Access before starting the study at this site. Please contact Martin Malcolm (martin.malcolm@nhs.net) for further assistance, if this is required. • All amendments (minor or substantial) to the protocol or to the REC application should be copied to the R&D Lead Western Isles with a copy of the corresponding approval letter.		
Oifisean Bòrd na Slàinte 37 Mol a Deas, Steòrnabhagh, Eileanan Siar, HS1 2BB	Headquarters 37 South Beach Street, Stornoway, Western Isles, HS1 2BB	
Cathraiche: Ceannard an Gniomh:	N. Mac a'Bhreatannaich G. MacSheumais	Chair: Chief Executive: Neil Galbraith Gordon Jamieson
		<i>Western Isles NHS Board is the common name of Western Isles Health Board</i>

Appendix 3 (cont)



- The paperwork concerning all incidents, adverse events and serious adverse events, thought to be attributable to participant's involvement in this project should be copied to the R&D Lead, Western Isles NHS Board.

It is particularly important that you inform by email the R&D Lead in NHS Western Isles both when the study commences and terminates in the Western Isles together with details of monthly recruitment rates including dates of recruitment and participant trial ID numbers.

Please report the information detailed above, or any other changes in resources used, or staff involved in the project, to the Western Isles NHS, R&D Lead, Head of Public Health Intelligence & information Service, Martin Malcolm, (01851 708055), martin.malcolm@nhs.net and Frances Hines, NHS Highland R&D Manager, (01463 255822, frances.hines@nhs.net).

I wish you well with your study and look forward to seeing the findings once complete.

Yours sincerely,

A handwritten signature in black ink, appearing to be 'M. Malcolm'.

Martin Malcolm
(R&D Lead), Head of Public Health Intelligence & Information Services, NHS Western Isles

cc Frances Hines, NHS Highland Research Office, Room S101, The Centre for Health Science, Old Perth Road, Inverness, IV2 3JH
Pamela Shand, Senior Administrator, NHS Research Scotland CC, Research and Development Office, Foresterhill House Annexe, Foresterhill, Aberdeen, AB25 2ZB

Appendix 4

PARTICIPANTS NEEDED FOR A RURAL AND REMOTE NURSING RESEARCH STUDY



- Did you train in the Western Isles and continue to work here?
- Did you train in the Western Isles and leave to work somewhere else and then return?
- Did you train/work somewhere else then come to work in the Western Isles?

If you have answered YES to any of the above would you be willing to take part in a research study to explore your experiences regarding your career destinations/transitions?

As a participant in this study you would be invited to meet for an individual interview lasting approximately 1 hour which can be undertaken in a location that suits you.



This research is being undertaken as part of a PhD study through the University of Stirling

For more information, or to volunteer to participate in this study, please contact:



Seonaid C MacKay

Email s.c.mackay@stir.ac.uk

seonaid.mackay@nhs.scot

Appendix 5

PARTICIPANT INFORMATION SHEET

Title: Understanding how the interplay between the ‘personal’, ‘professional’ and ‘place-related’ dimensions of rural nursing influences nurses’ career destinations and transitions.

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear, or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this

Background and aims of this study

Rural nursing practice is very specific and challenging and failure to recruit and retain talented nurses in rural settings is an international major concern. There is a huge diversity in terms of ‘What is rural?’ and ‘Who is a rural nurse?’ Most current research has been undertaken in Australia, Canada and USA.

The aim of this study is to explore the experiences of rural nurses in the Western Isles of Scotland to better understand what personal, professional or place-related factors have influenced nurses’ career trajectories.

Why have I been chosen?

We aim to recruit 20-24 nurses and would like to include:

- nurses who trained/worked in the Western Isles and continued working there
- nurses who trained in the Western Isles and left to work elsewhere and either remained there or returned, and
- nurses who trained and/or worked somewhere else and then came/returned to work in the Western Isles

Do I have to take part?

Taking part in this study is entirely voluntary. You do not have to take part. If you do decide to take part, you will be asked to sign a consent form. You are free to withdraw at any time and for any reason, and you do not have to tell us why you changed your mind.

What will I have to do?

You may be asked to take part in a life history interview with the researcher. The biographical interview will last about 1 hour, depending on what you have to say. The researcher will listen to your story about your personal and professional experiences of working in the Western Isles or elsewhere, how your career developed, and how your experiences are shaped by particular places. The researcher will allow you to relate your story without interrupting.

The interview will be recorded and typed up afterwards. The interview will be arranged at a place and time that suits you. If it is more convenient for you the interview can be conducted via Skype.

Will my taking part in this study remain confidential?

Only the research team will have access to information collected for this study. Your name and contact details will be kept completely separate from the interview material that you share with us, so that you cannot be identified from interview recordings. Interview quotes used in written reports and publications will not include names or identifying details.

What will happen to the results of this study?

The information from the interviews will be used to learn more about experiences of rural nursing. A report will be written for the University of Stirling and shorter articles will be written for publication in academic journals. Sharing our findings will help inform other research in this area.

Who is organising this research?

The University of Stirling is leading the research, which will be undertaken as a PhD in the Faculty of Health Sciences and Sport. *A research ethics committee at the University of Stirling and locally at the Western Isles Health Board has approved the research.*

If you would like more information about the study –

You can contact the researcher:

Seonaid C MacKay

Western Isles Campus

University of Stirling

s.c.mackay@stir.ac.uk

07376251199

You can contact the academic supervisor:

Dr Annetta Smith

Head of Nursing

School of Nursing

University of the Highlands and Islands

Centre for Health Studies

Old Perth Road

Inverness

IV2 3JH

Annetta.smith@uhi.ac.uk

01463 255618

Should you have any concerns or wish to speak to someone independent of the study, please contact:

Professor Jayne Donaldson

Dean of Faculty

Faculty of Health Sciences and Sports

University of Stirling

FK9 4LA

Jayne.donaldson@stir.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix 6

CONSENT FORM

Title: Understanding how the interplay between the ‘personal’, ‘professional’ and ‘place-related’ dimensions of rural nursing influences nurses’ career destinations and transitions: a qualitative exploratory study using a biographical approach.

Researcher: Seonaid C MacKay

Academic Supervisor: Dr Annetta Smith

Please INITIAL Box

1. I confirm that I have read and understand the information sheet dated August 2017 (version 2) for the above study. I have had the opportunity to consider the information, ask questions, and I have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time during the study period, without giving any reason. ☐
3. I understand that my participation in this study will be anonymous and data will be stored on password protected university computers. ☐
4. I understand that if some of my data or views are quoted in a report or published papers, this will be done in a way that ensures that I cannot be identified. ☐
5. I understand that my views will be audio recorded for the purpose of the study and that any recordings will be destroyed at the end of the study. ☐
Anonymised transcripts of the recordings will be kept for a period of 10 years to ensure accurate reporting, in any future publications.
6. I agree to take part in the study. ☐
7. I would like to receive summary results of the above study. ☐

_____	_____	_____
Name	Date	Signature
_____	_____	_____
Name of Researcher taking consent	Date	Signature

Appendix 7

DEMOGRAPHIC DATA

Study Title: Understanding how the interplay between the ‘personal’, ‘professional’ and ‘place-related’ dimensions of rural nursing influences nurses’ career destinations and transitions: a qualitative exploratory study protocol using a biographical approach

Researcher: Seonaid C MacKay

Academic Supervisor: Dr Annetta Smith

PERSONAL DETAILS						
NAME						
ADDRESS						
PHONE NUMBER						
E-MAIL						
AGE GROUP	18-24	25-34	35-44	45-54	55-64	65-74
PLACE OF BIRTH						
MARITAL STATUS	Single		Married/domestic partnership			
DEPENDENT CHILDREN/RELATIVES						

TRAINING AND QUALIFICATIONS	
LOCATION OF NURSE TRAINING AND YEAR	QUALIFICATIONS ACHIEVED

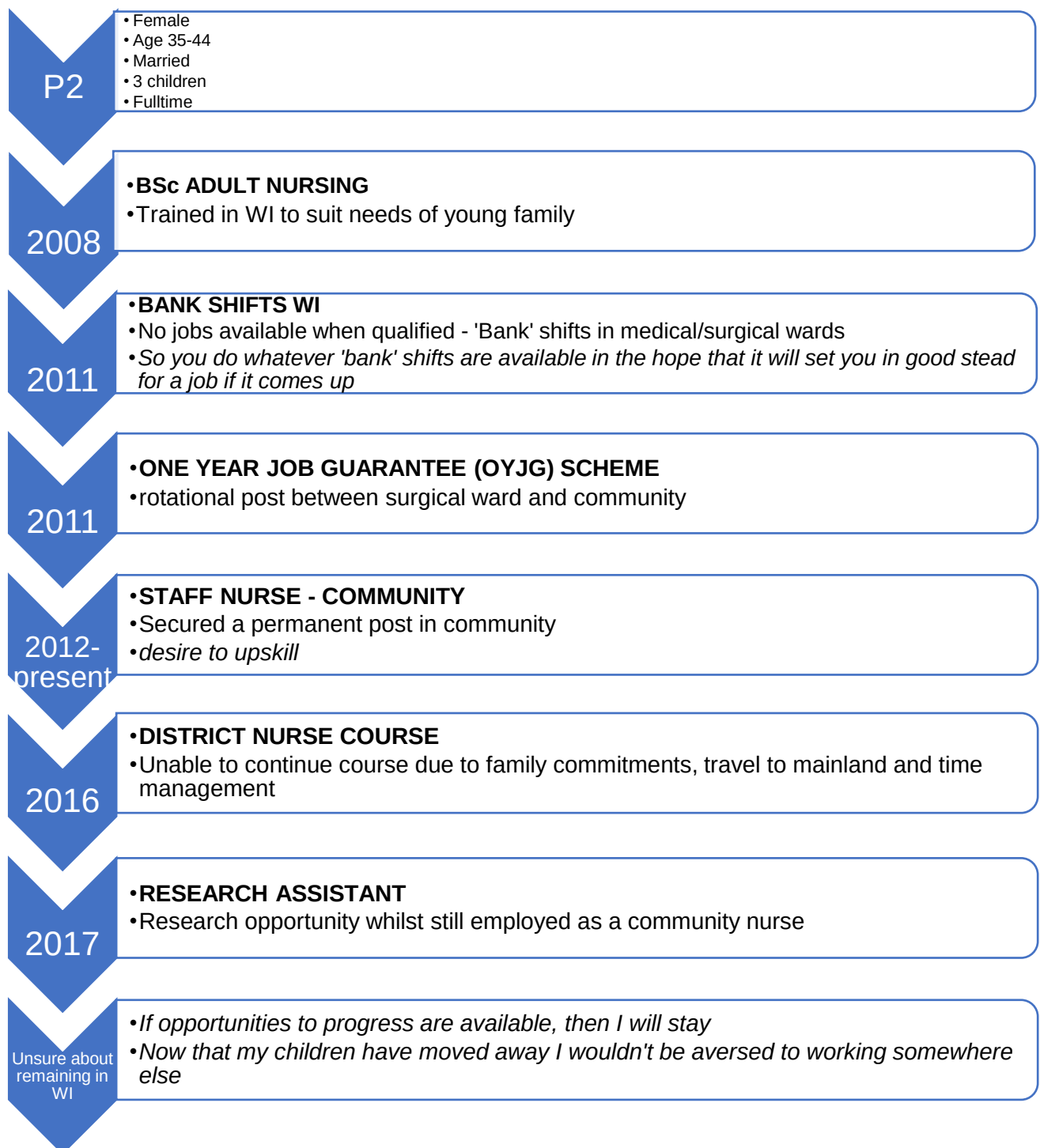
PRESENT POST	
JOB TITLE	
LOCATION	
FULL/PART TIME	

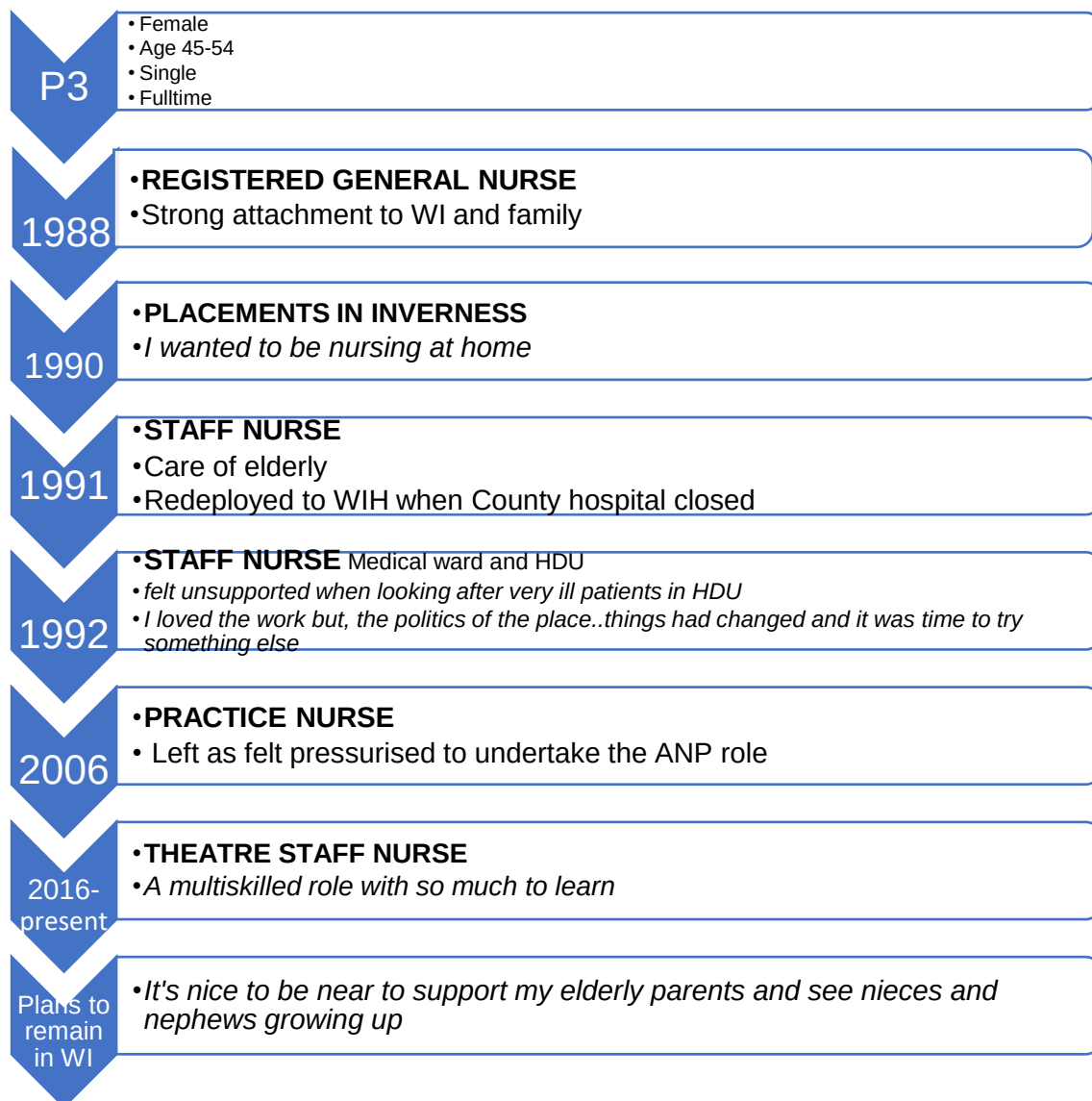
Appendix 8

ILLUSTRATED TIMELINES

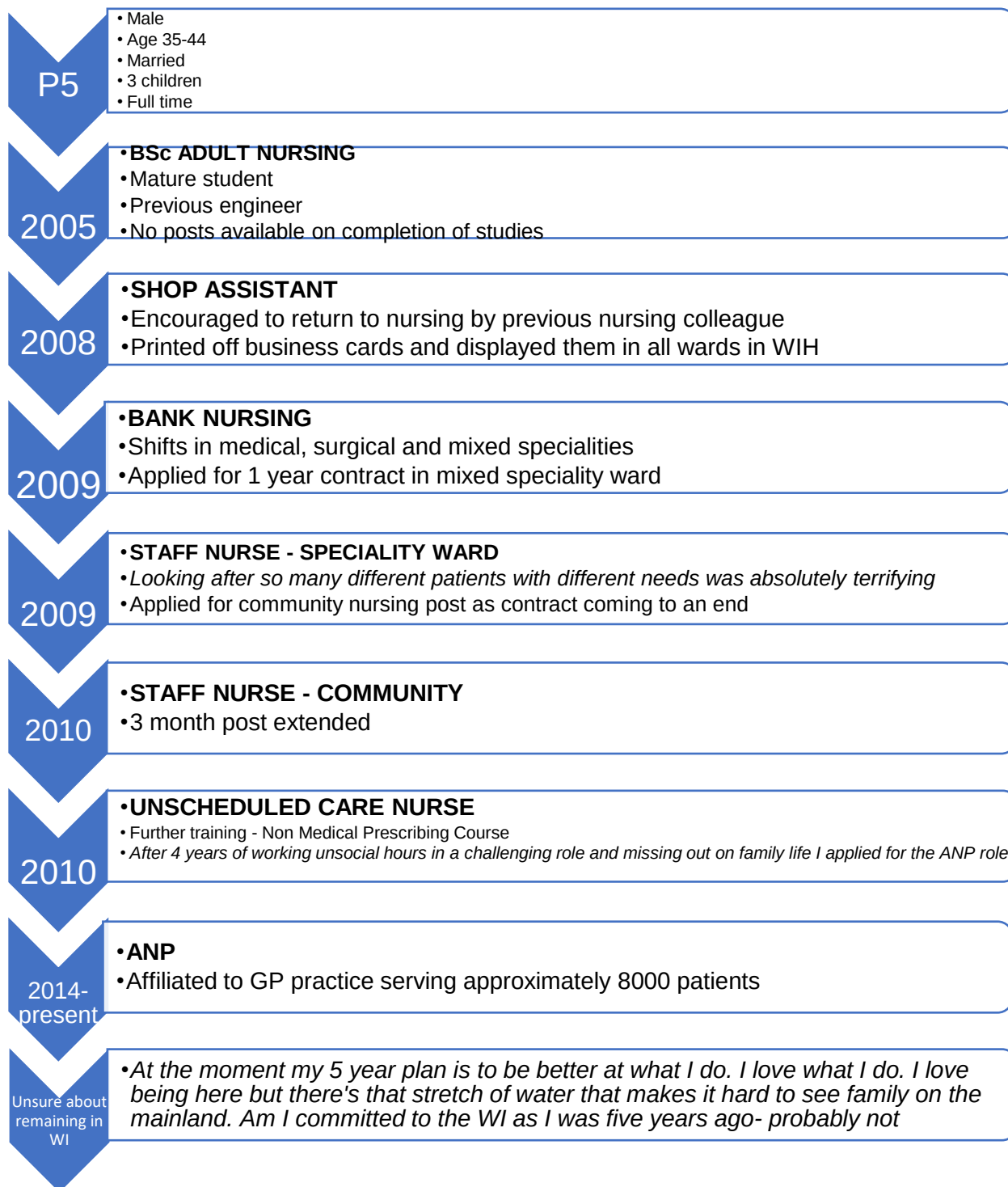
GROUP 1: 'REMAINERS'
NURSES BORN IN THE WESTERN ISLES (WI) – TRAINED IN WI – REMAINED IN WI (n=5)





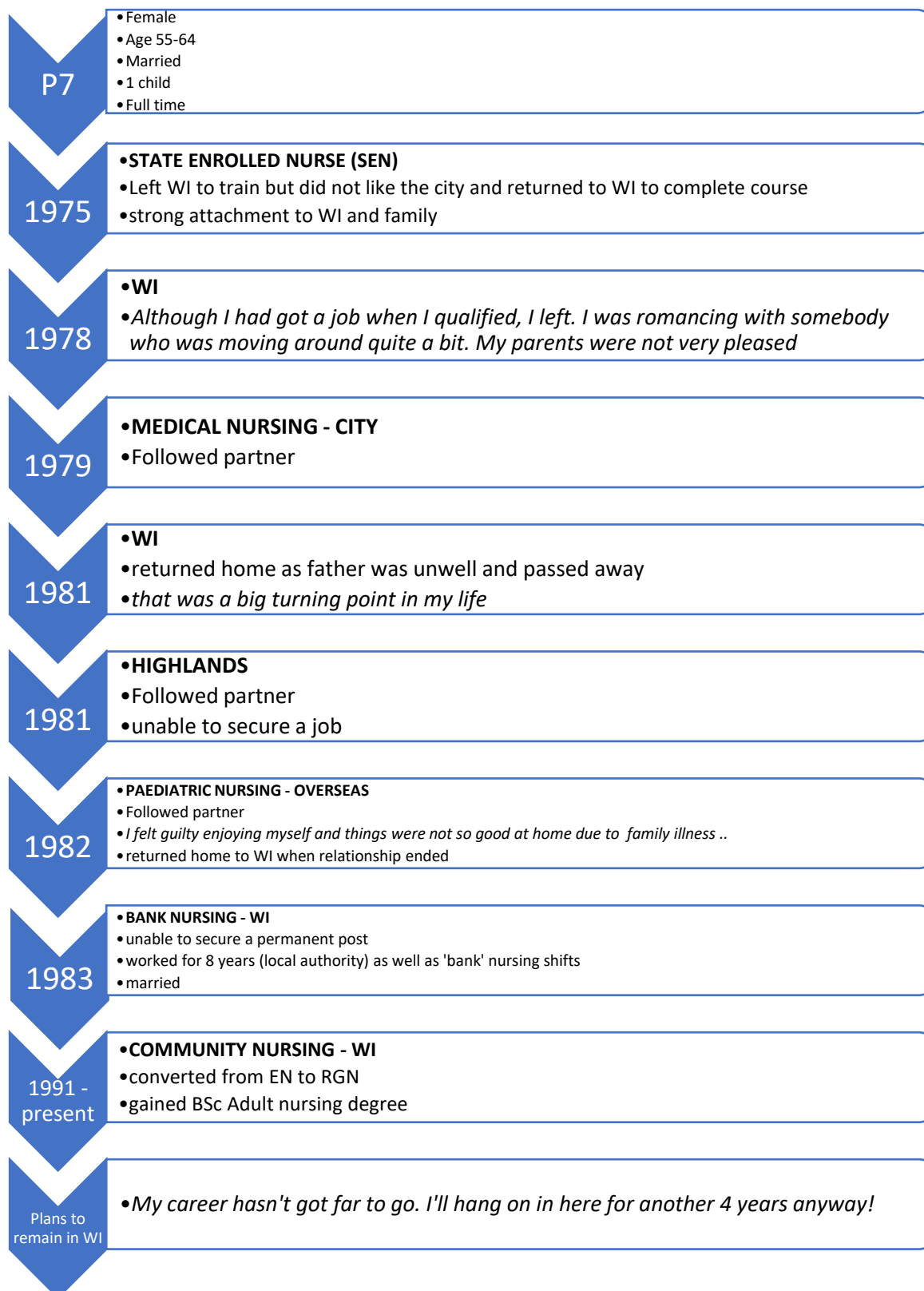


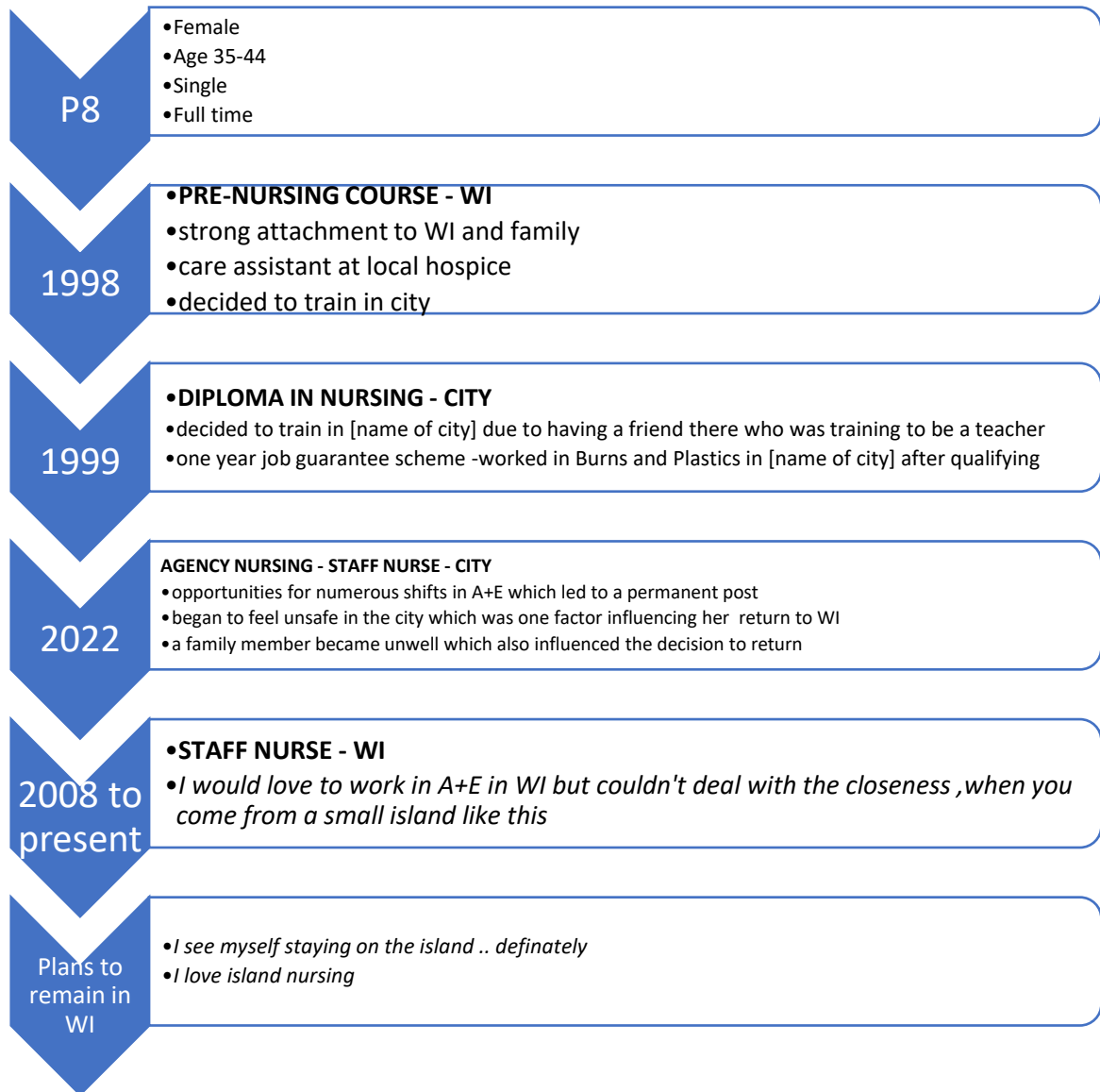


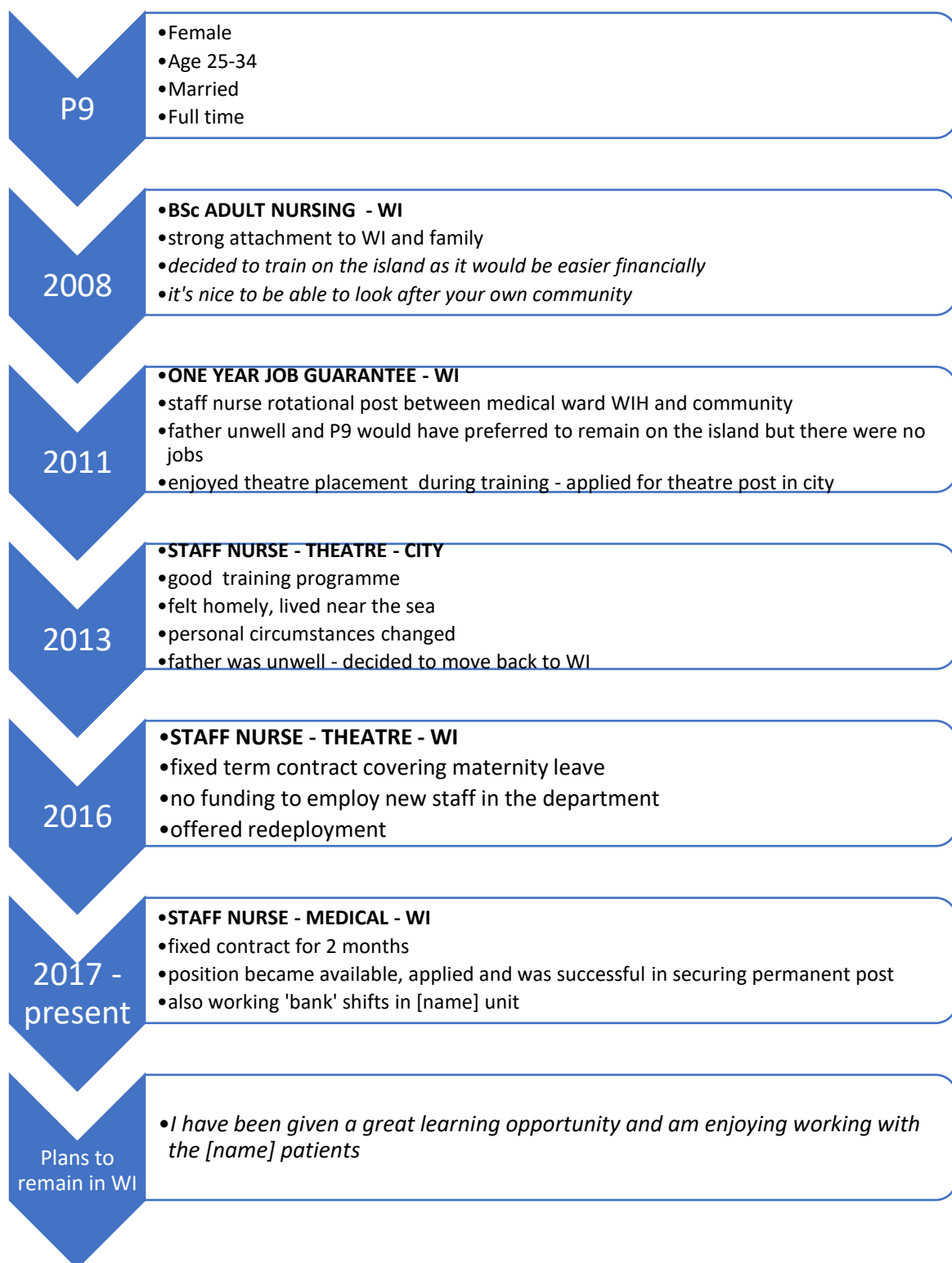


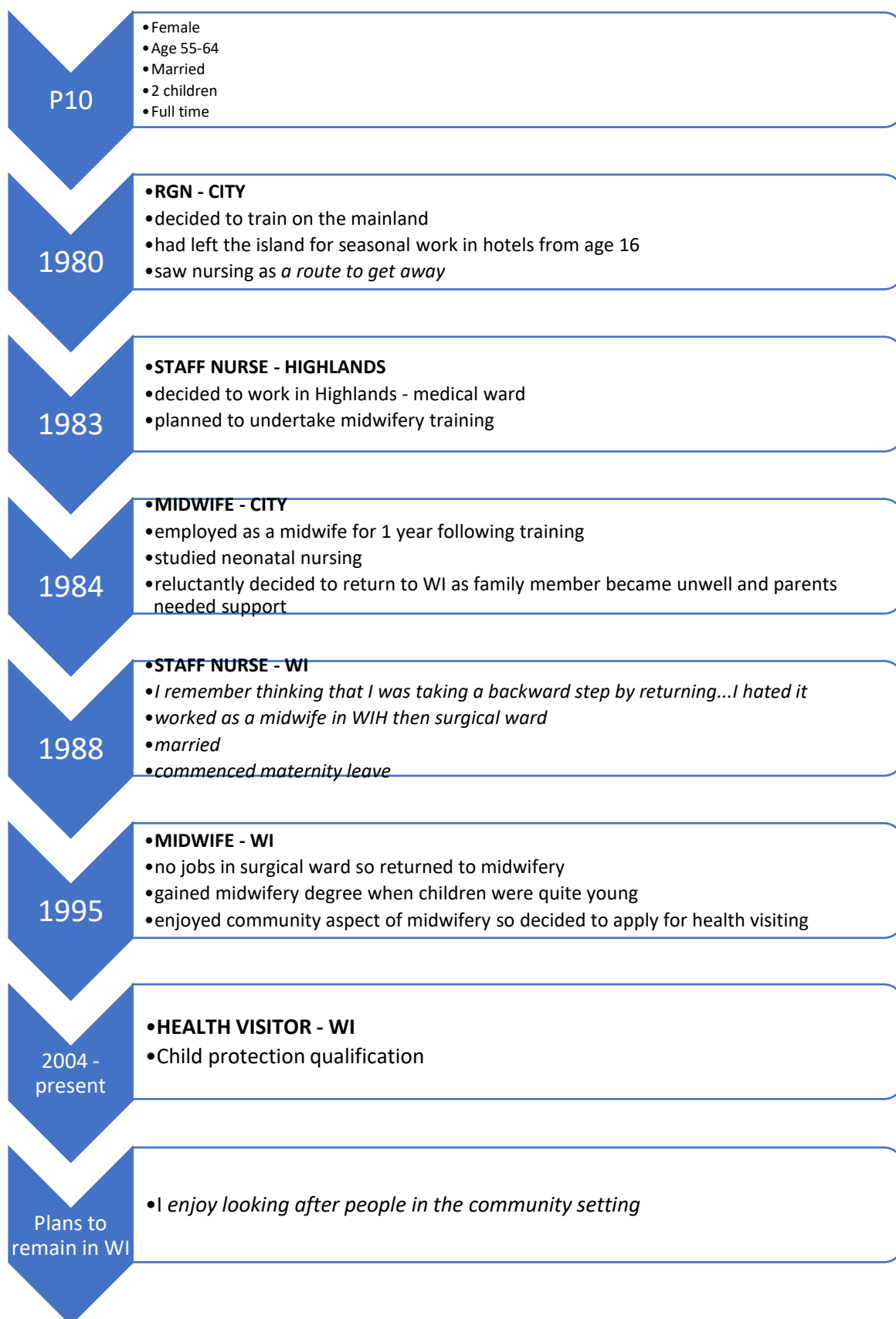
GROUP 2: 'RETURNERS'
NURSES BORN IN THE WESTERN ISLES (WI) – TRAINED IN WI or MAINLAND – WORKED
MAINLAND - RETURNED TO WI (n=9)



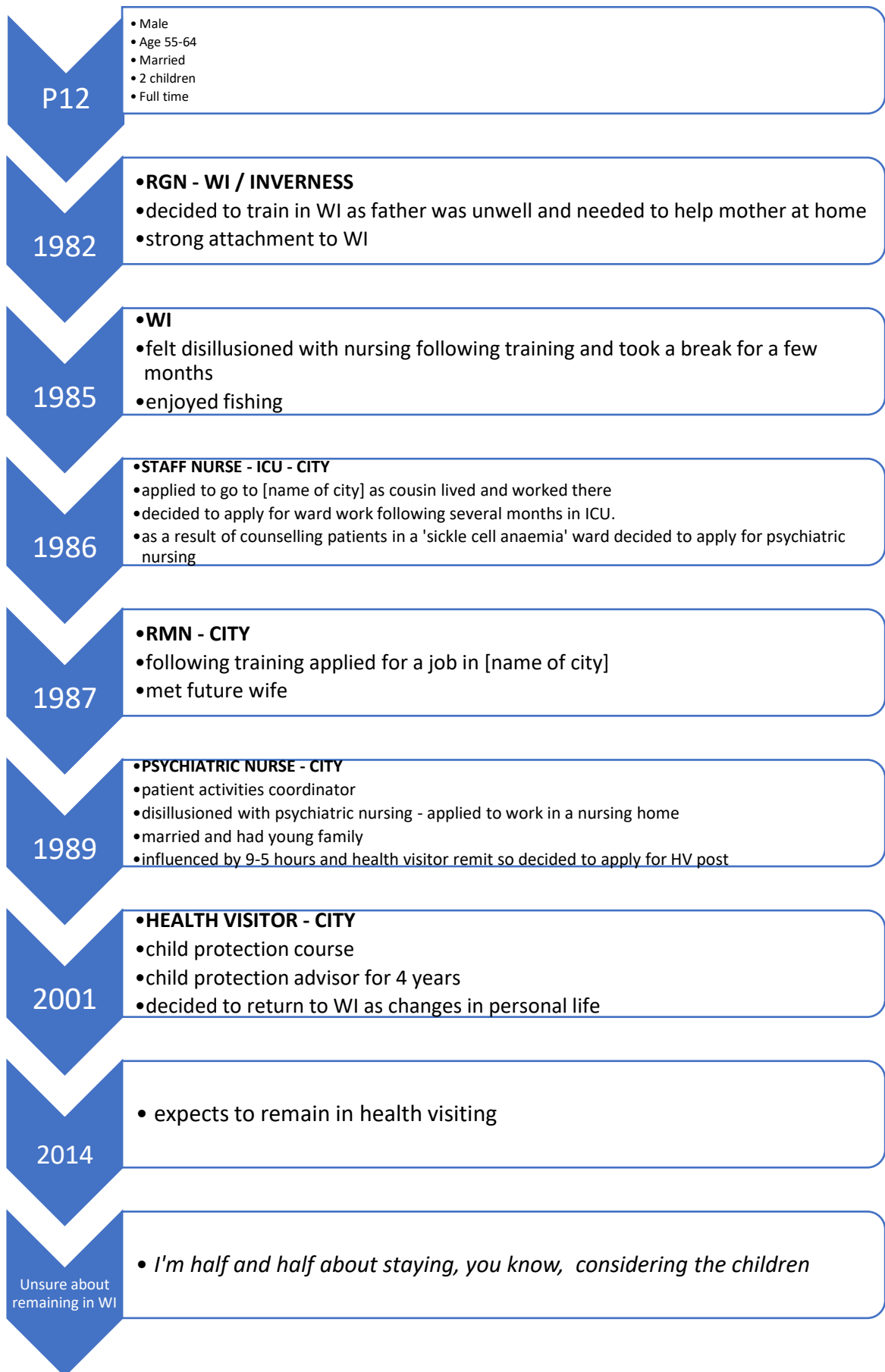


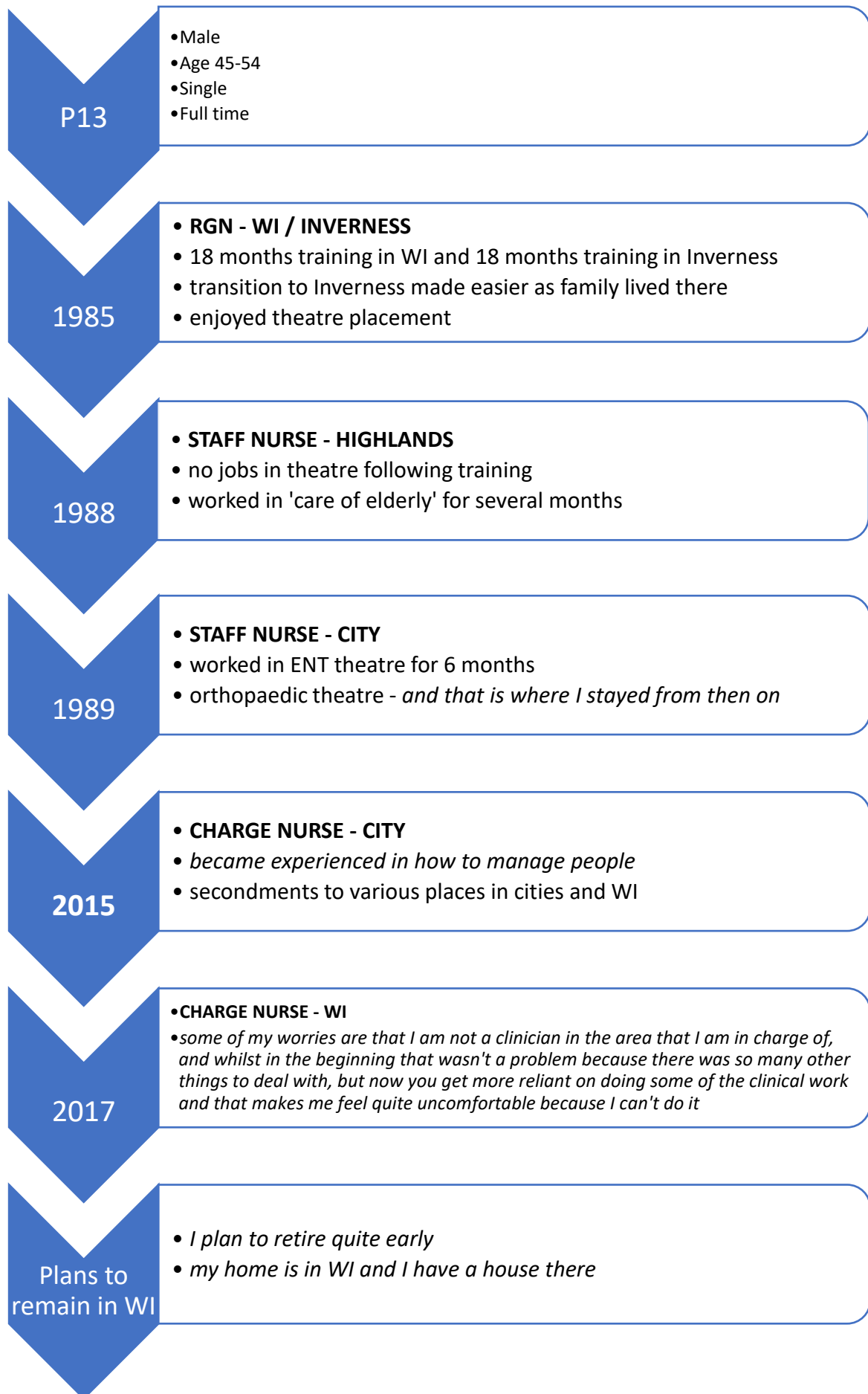


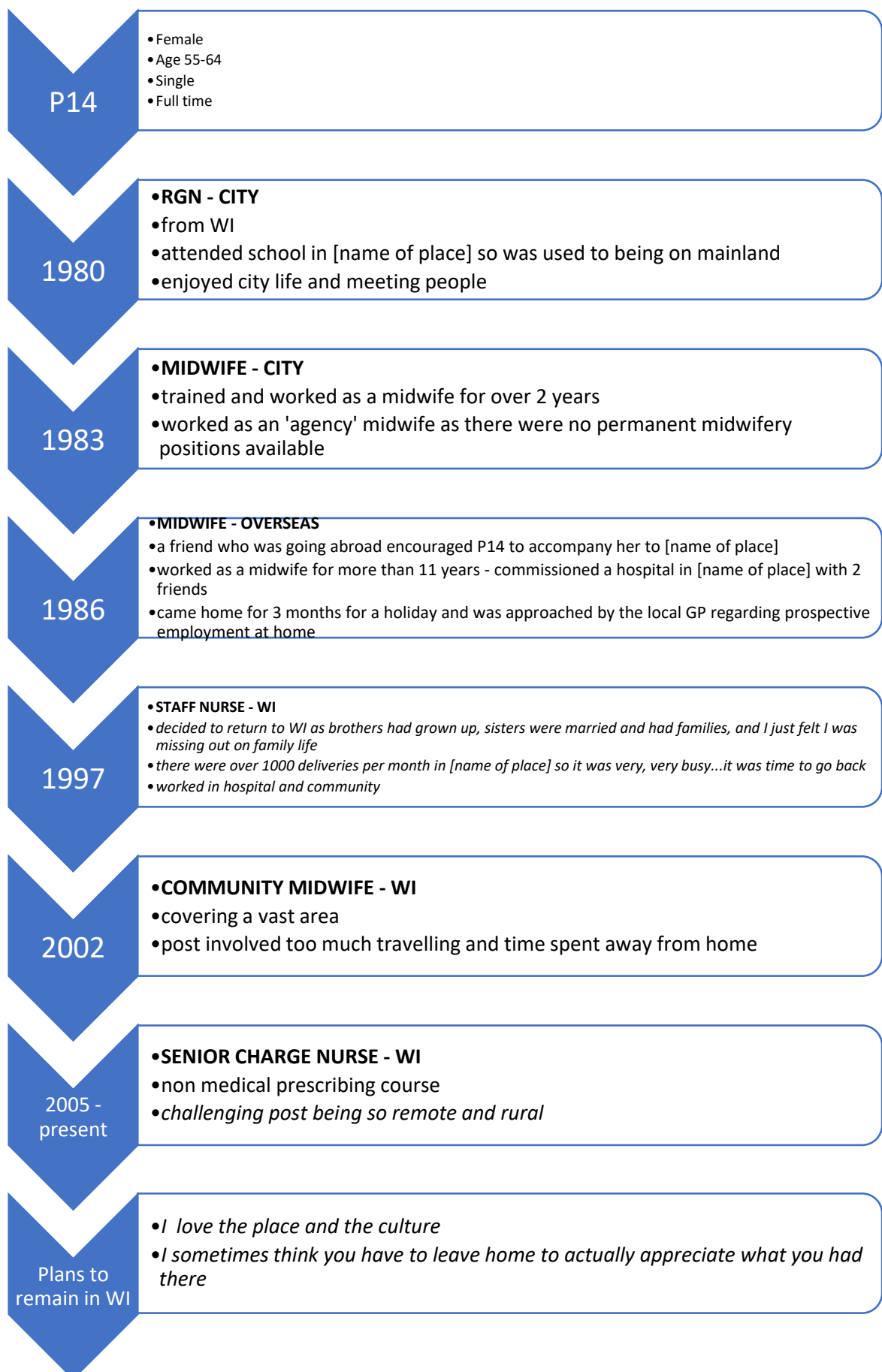






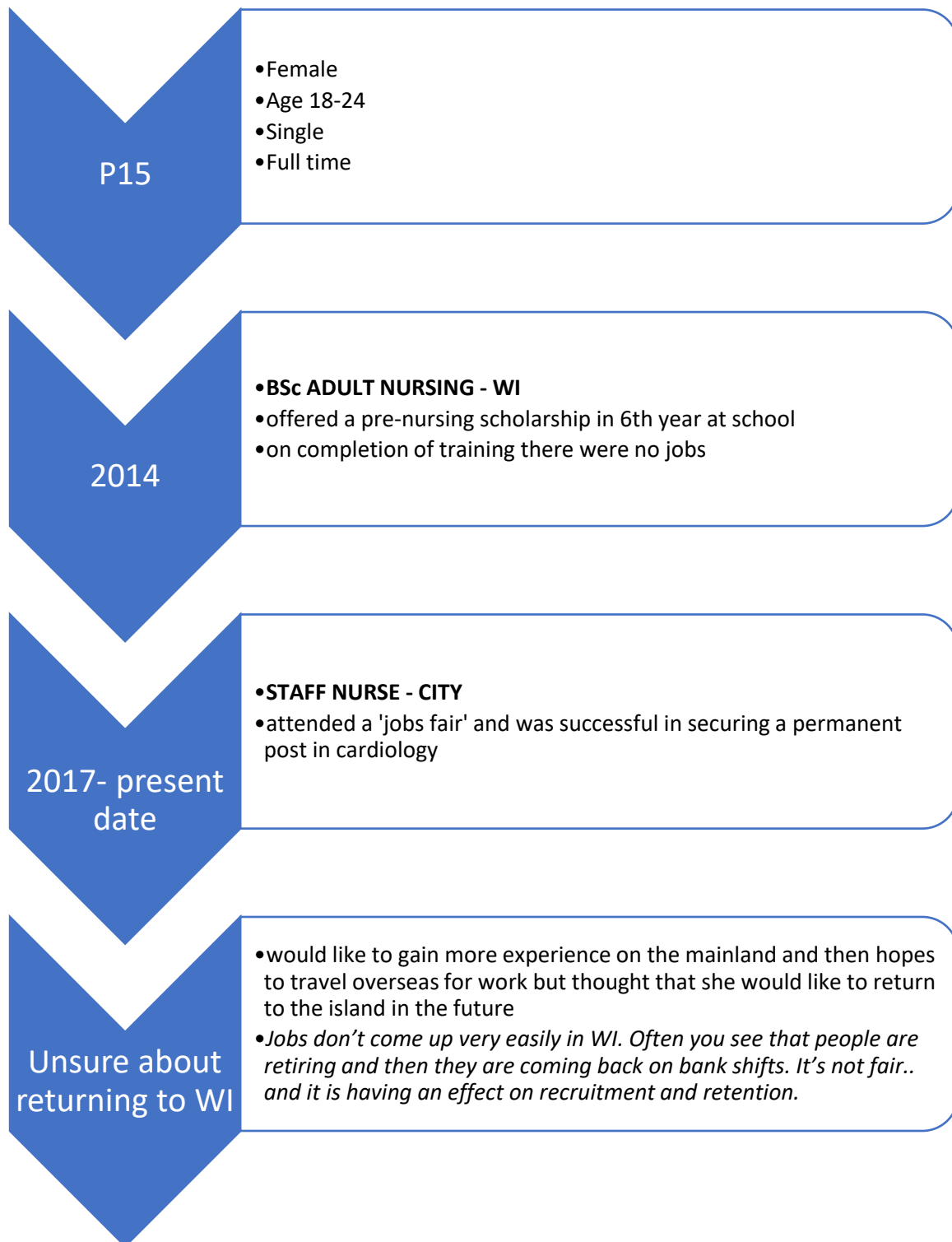


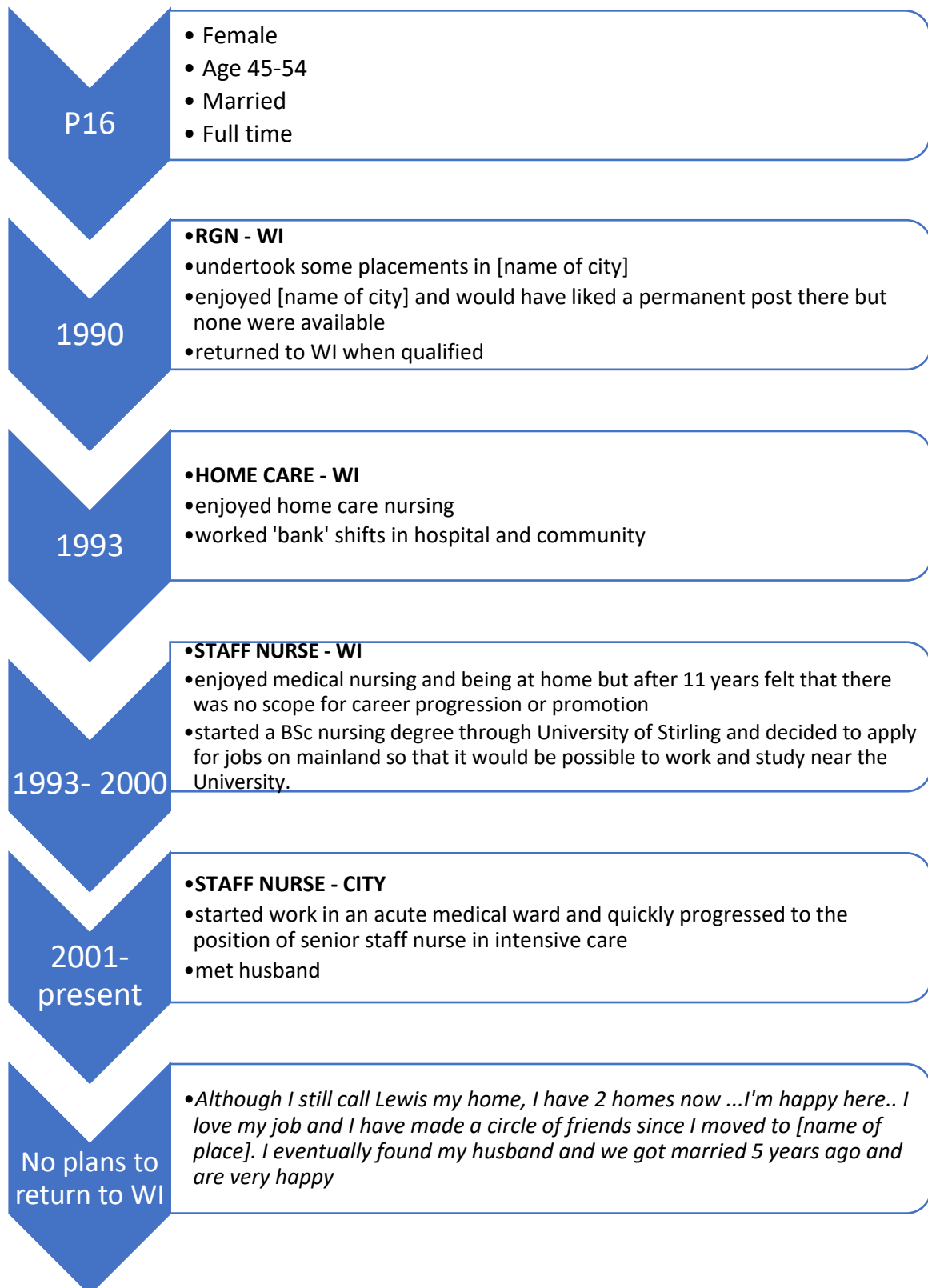




GROUP 3: 'LEAVERS'

NURSES BORN IN THE WESTERN ISLES (WI) OR MAINLAND – TRAINED/WORKED IN WI – LEFT TO WORK ON MAINLAND – REMAINED ON MAINLAND (n=5)





P17

- Female
- Age 18-24
- Single
- Fulltime

2014

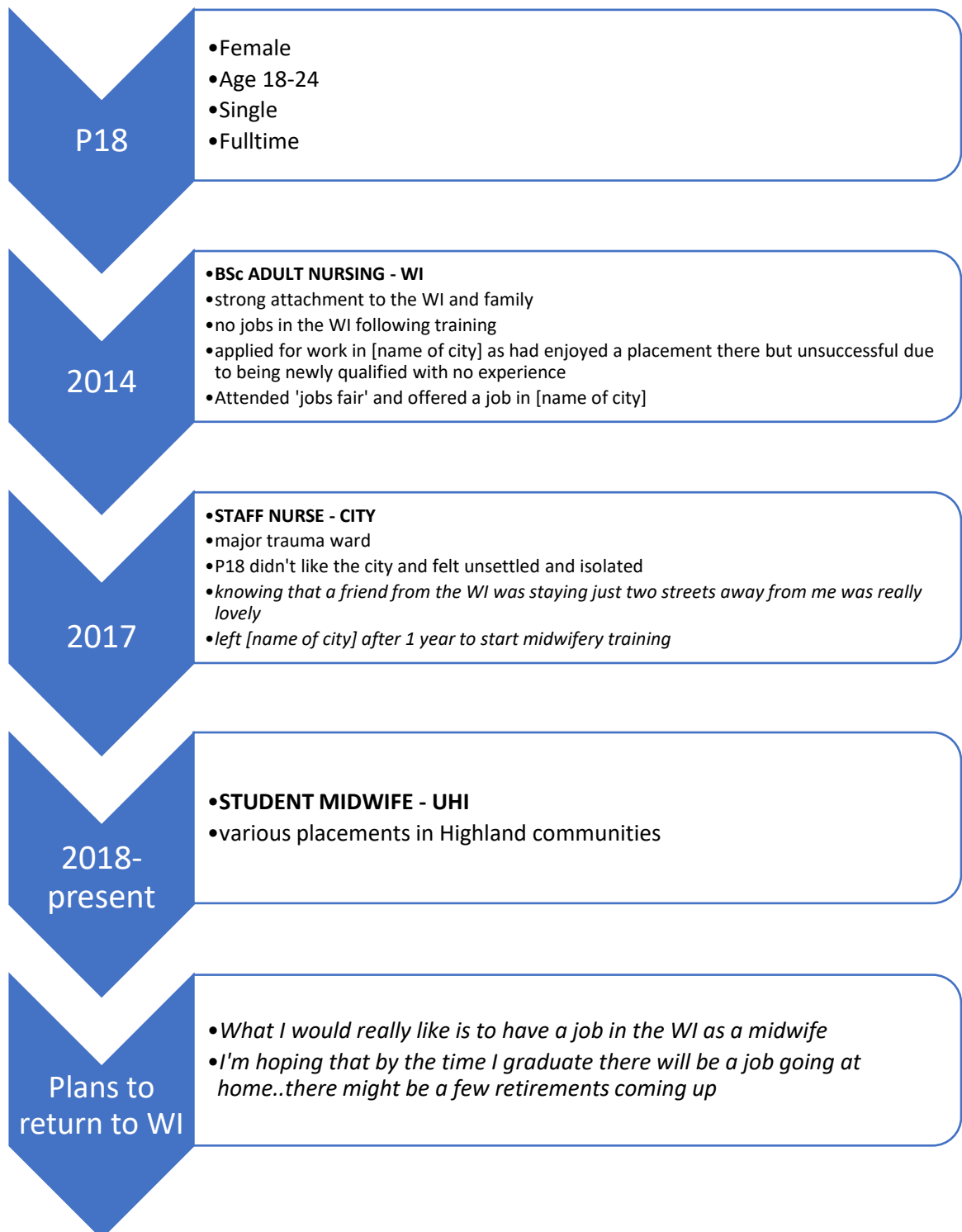
- BSc ADULT NURSING - WI**
- mother who is also a nurse tried to dissuade P17 from a nursing career but undertaking youth work in a local care home inspired her to apply
- father influenced P17 to train in WI
- following training decided to apply for a rotation programme in city

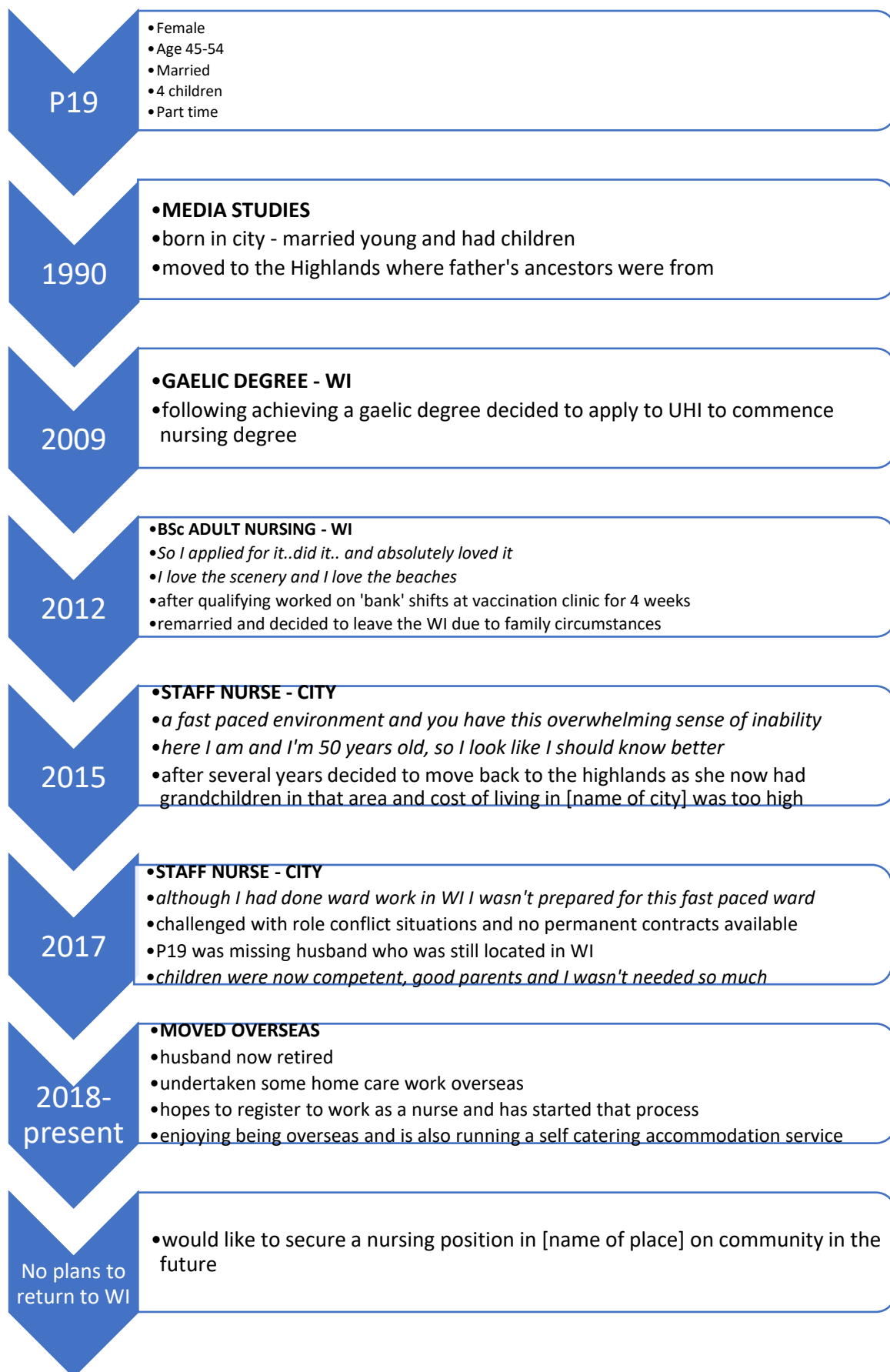
2017- present

- STAFF NURSE - CITY**
- influenced to go to the city as a friend had engaged on the same rotational programme and was enjoying it
- wished to take advantage of experience opportunities when just newly qualified as *I knew I wouldn't do it further down the line*
- I don't think this teaching opportunity is offered at home, or in Scotland*

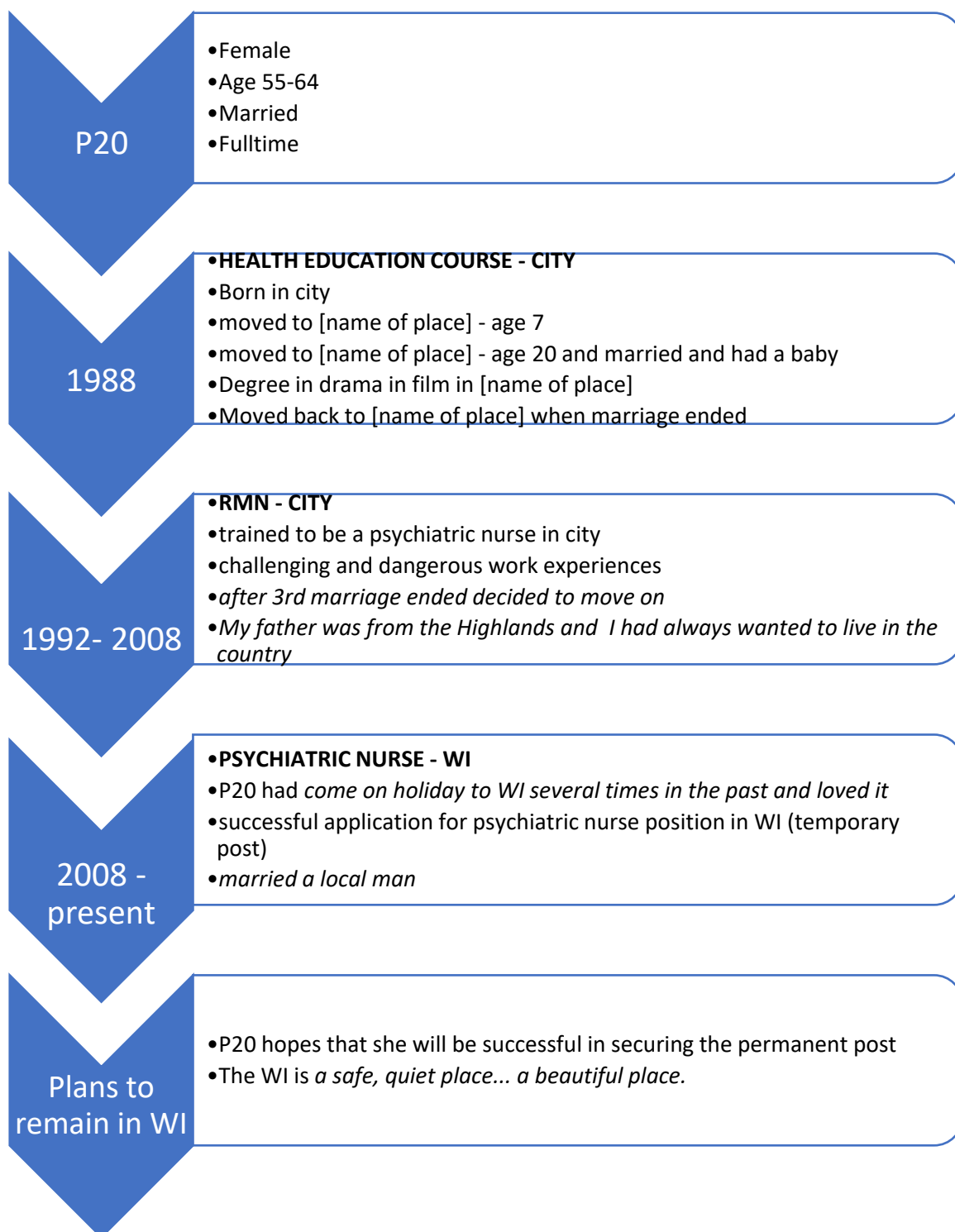
Plans to
return to WI

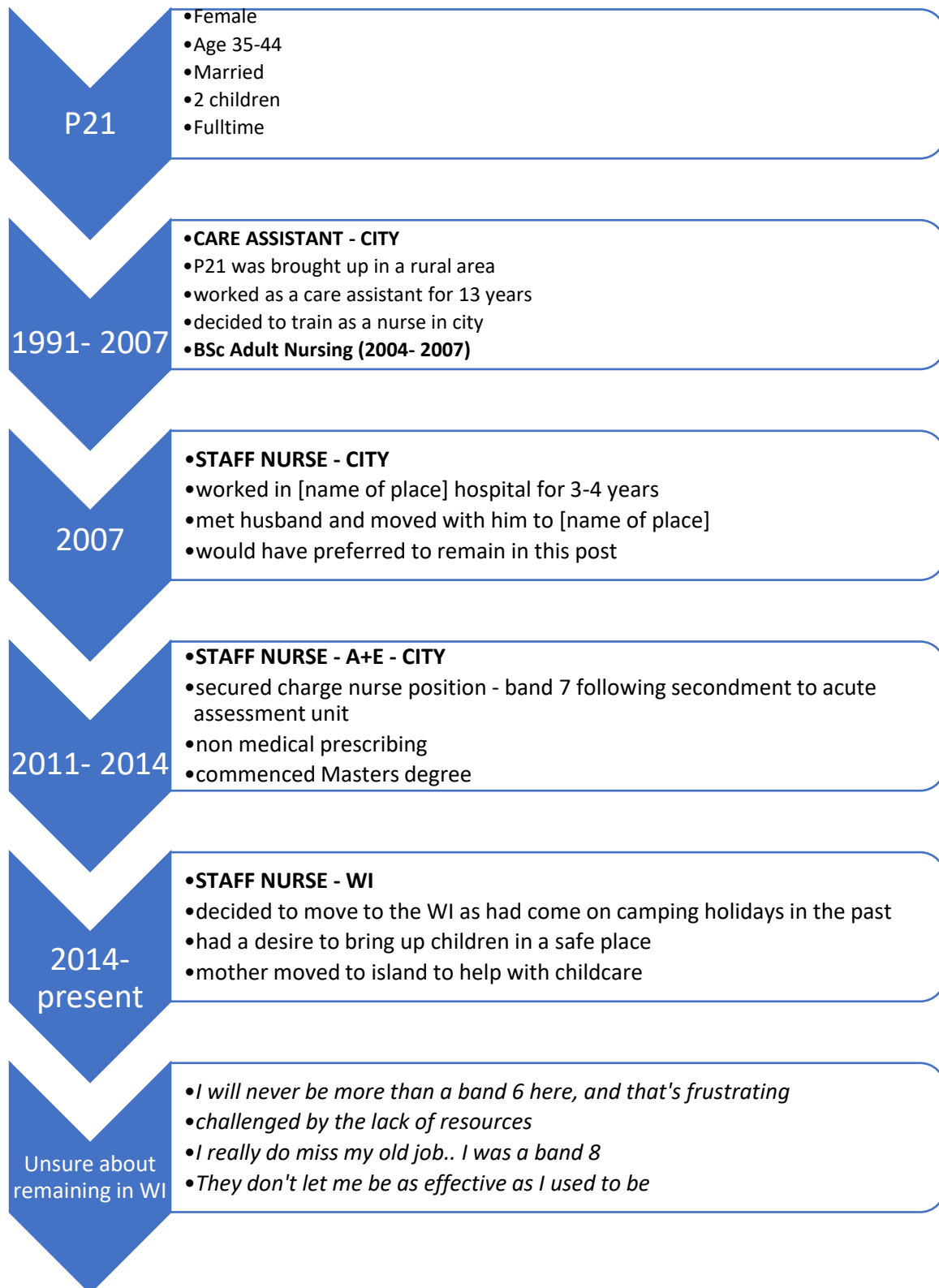
- strong attachment to WI and family*
- I just wanted to move away for a different type of experience..and I feel that I've done what I wanted to do and I'm proud to want to go back to the WI because that's where I'm from*
- I have my mind set on doing the rural midwifery course*
- I would like to be dual trained and and I think that working and studying at home again will work well...in a small, close-knit community*

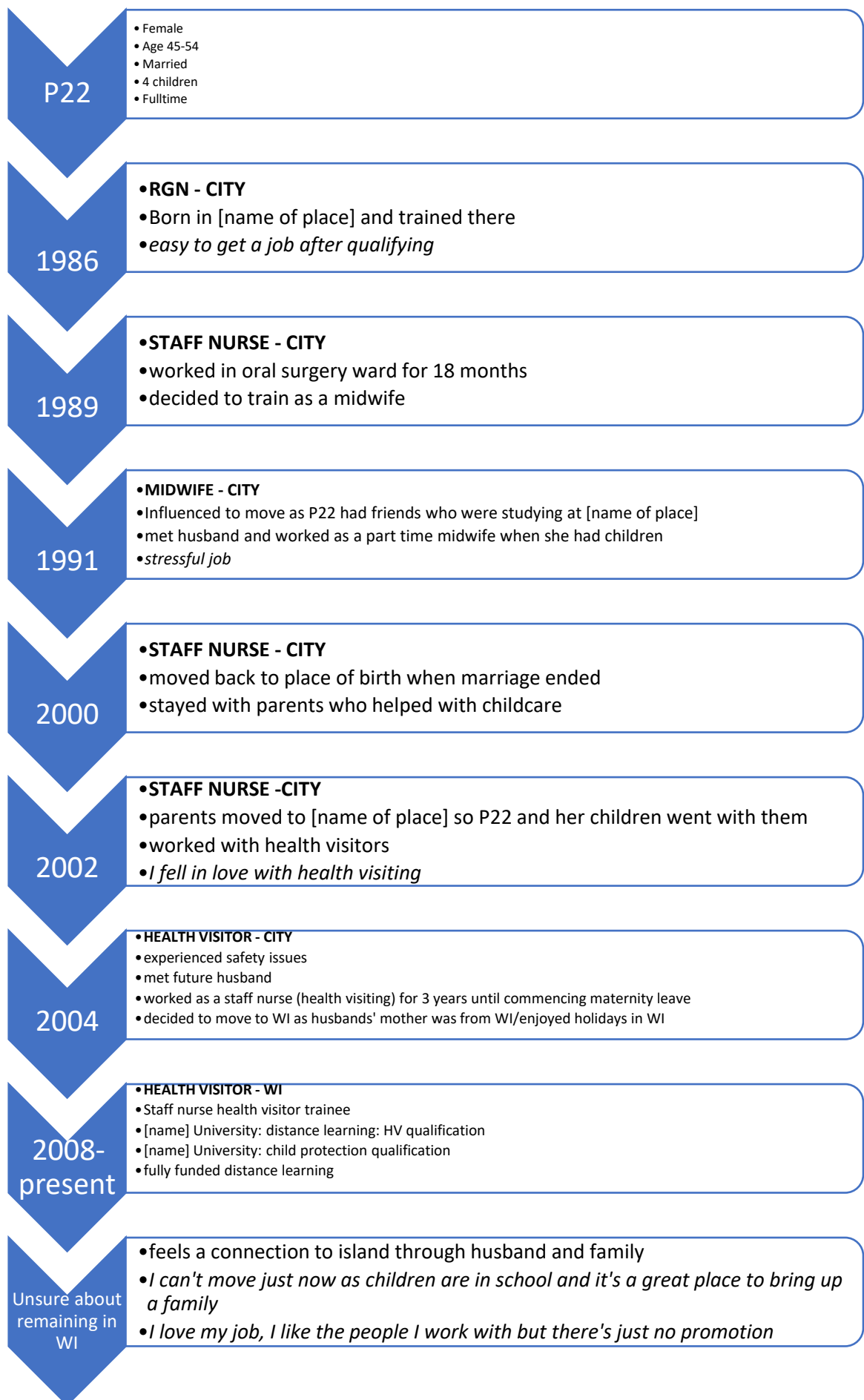


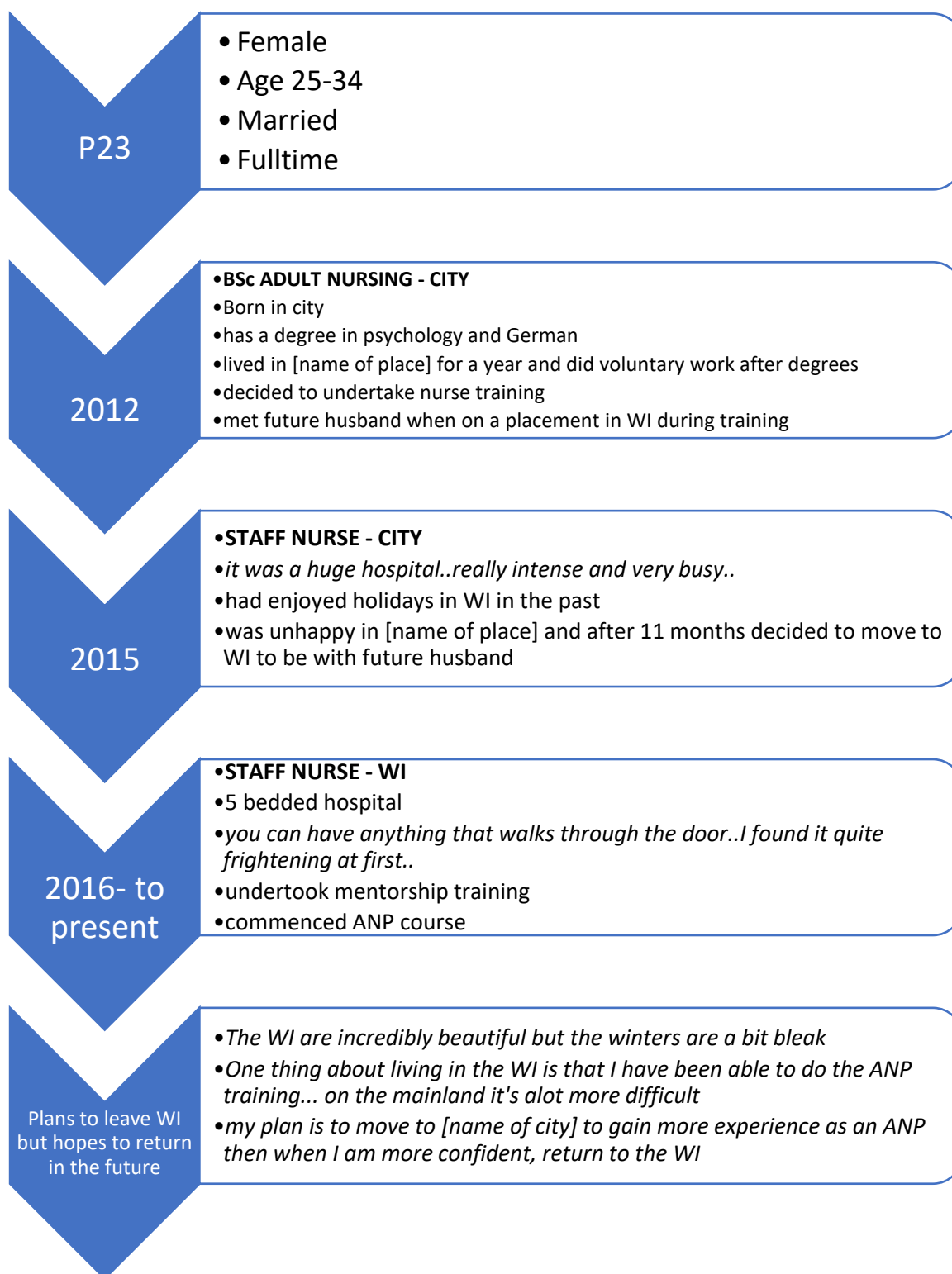


GROUP 4: 'INCOMERS'
**NURSES BORN ON MAINLAND – TRAINED/WORKED ON MAINLAND – CAME TO
 WORK/TRAIN IN THE WI (n=6)**

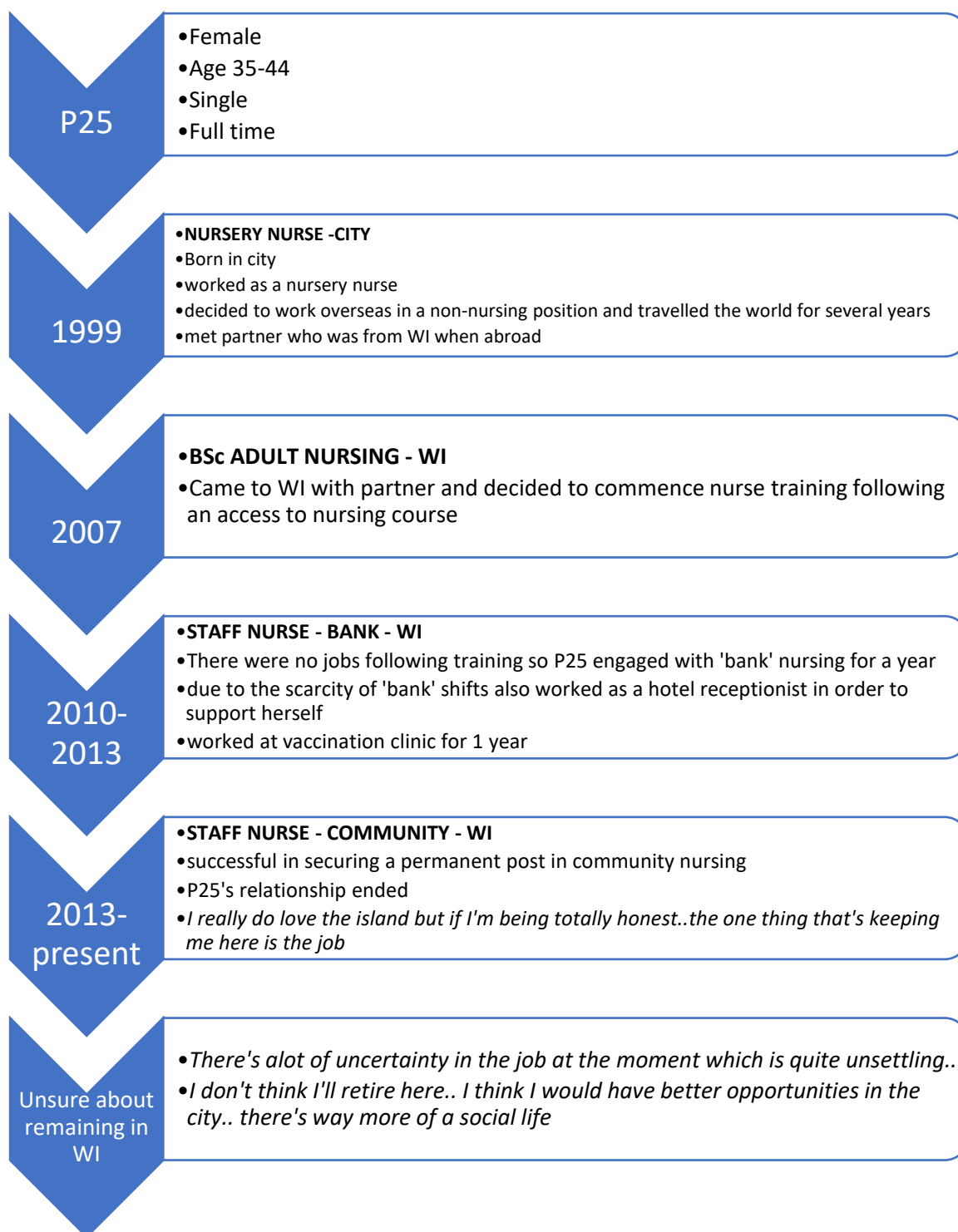












Appendix 9

COREQ (COnsolidated criteria for Reporting Qualitative research) Checklist.

A checklist of items that should be included in reports of qualitative research. You must report the page number in your manuscript where you consider each of the items listed in this checklist.

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research Team and reflexivity			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	SCM: PhD student
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	BSc (Hons) MRes
Occupation	3	What was their occupation at the time of the study?	Ophthalmic Nurse Practitioner
Gender	4	Was the researcher male or female?	Female
Experience and training	5	What experience or training did the researcher have?	PhD Student
Relationship established	6	Was a relationship established prior to study commencement?	74-77
Participant knowledge of interviewer	7	What did the participants know about the researcher? E.g. personal goals, reasons for doing the research	Appendix 5
Interviewer characteristics	8	What characteristics were reported about the interviewer/facilitator? E.g. Bias, assumptions, reasons and interests in the research topic	75
Domain 2: Study design			
Methodological orientation and Theory	9	What methodological orientation was stated to underpin the study? E.g. grounded theory, discourse analysis, phenomenology, content analysis	62-66
Sampling	10	How were participants selected? E.g. purposive, convenience, consecutive, snowball	73
Method of approach	11	How were participants approached? E.g. face-to-face, telephone, mail, email	74-77
Sample size	12	How many participants were in the study?	77
Non-participation	13	How many people refused to participate or dropped out? Reasons?	0
Setting of data collection	14	Where was the data collected? E.g. home, clinic, workplace	78-81

Presence of non-participants	15	Was anyone else present besides the participants and researchers?	No
Description of sample	16	What are the important characteristics of the sample? E.g. demographic data, date	Appendix 8
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	82-83
Repeat interviews	18	Were repeat interviews carried out? If yes, how many?	No
Audio/visual recording	19	Did the interviewer use audio or visual recording to collect the data?	81
Field notes	20	Were field notes made during or after the interview or focus group?	Yes
Duration	21	What was the duration of the interviews or focus groups?	Approx 1 hour
Data saturation	22	Was data saturation discussed?	78
Transcripts returned	23	Were transcripts returned to the participants for comment and/or correction?	Yes
Domain 3: analysis and findings			
Number of data coders	24	How many data coders coded the data?	SCM, AS, RGK, MB
Description of the coding tree	25	Did authors provide a description of the coding tree?	89-90
Derivation of themes	26	Were themes identified in advance or derived from the data?	From data
Software	27	What software, if applicable, was used to manage the data?	NVivo
Participant checking	28	Did participants provide feedback on the findings?	Yes
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings?	Yes
Data and findings consistent	30	Was there consistency between the data presented and the findings?	Yes
Clarity of major themes	31	Were major themes clearly presented in the findings?	Yes
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Yes

Developed from: Tong, A., Sainsbury, P. and Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, 19 (6), pp. 349-357.

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